





ILLINOIS DEPARTMENT OF Healthcare and Family Services

EXTERNAL QUALITY REVIEW ANNUAL REPORT

State Fiscal Years 2017-2018
(July 1, 2017-June 30, 2018)

Illinois Department of Healthcare and Family Services
Division of Medical Programs

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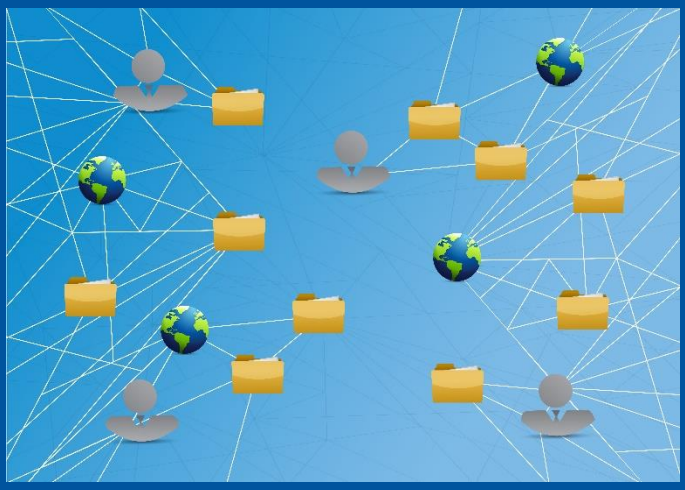
1. Executive Summary

Overview

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). As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364, HFS contracted with HSAG to prepare an annual, independent technical report that provides a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the Medicaid managed care health plans (health plans). The CFR requires that states contract with an EQRO to conduct an annual evaluation of health plans that serve Medicaid beneficiaries to determine each health plan's compliance with federal quality assessment and performance improvement (QAPI) standards.



Purpose of This Report

The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO. This state fiscal year (SFY) 2018 External Quality Review (EQR) Technical Report focuses on federally mandated EQR activities that HSAG performed from July 1, 2017, to June 30, 2018. See the federal requirements for this report in Appendix A2.

Scope of Report

Mandatory activities included:

- Validation of performance measures in accordance with §438.358(b)(2).
- Compliance monitoring as set forth in 42 CFR §438.358.
- Validation of performance improvement projects (PIPs) for compliance with requirements set forth in 42 CFR §438.330(b)(1).
- Validation of network adequacy as described in §438.358(b)(1)(iv).
- Development of a Medicaid managed care quality rating system, as set forth in §438.334.
- Evaluation of the Managed Care State Quality Strategy, as described in §438.340(c)(2)(i).

Administration of quality of care consumer surveys (or CAHPS®)[1-1] is one of the optional EQR activities described at 42 CFR §438.358(c)(2). Additional optional EQR activities are described in Appendix A2.

Illinois Medicaid Overview

Illinois Medicaid Expansion

Effective managed care expansion was central to HFS' planning as it 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). Care coordination was the centerpiece of Illinois' Medicaid reform. Initial expansion began with a focus on the most complex, expensive beneficiaries and was expanded with the development and implementation of additional managed care programs that offered the benefits of care coordination, as shown in

Figure 1-1 below.

In SFY 2017, HFS released a Request for Proposals (RFP) seeking services from qualified, experienced, and financially sound managed care organizations (MCOs) to enter into risk-based contracts to deliver healthcare to Medicaid enrollees. Awards were announced in SFY 2018 and enrollment began in January 2018.

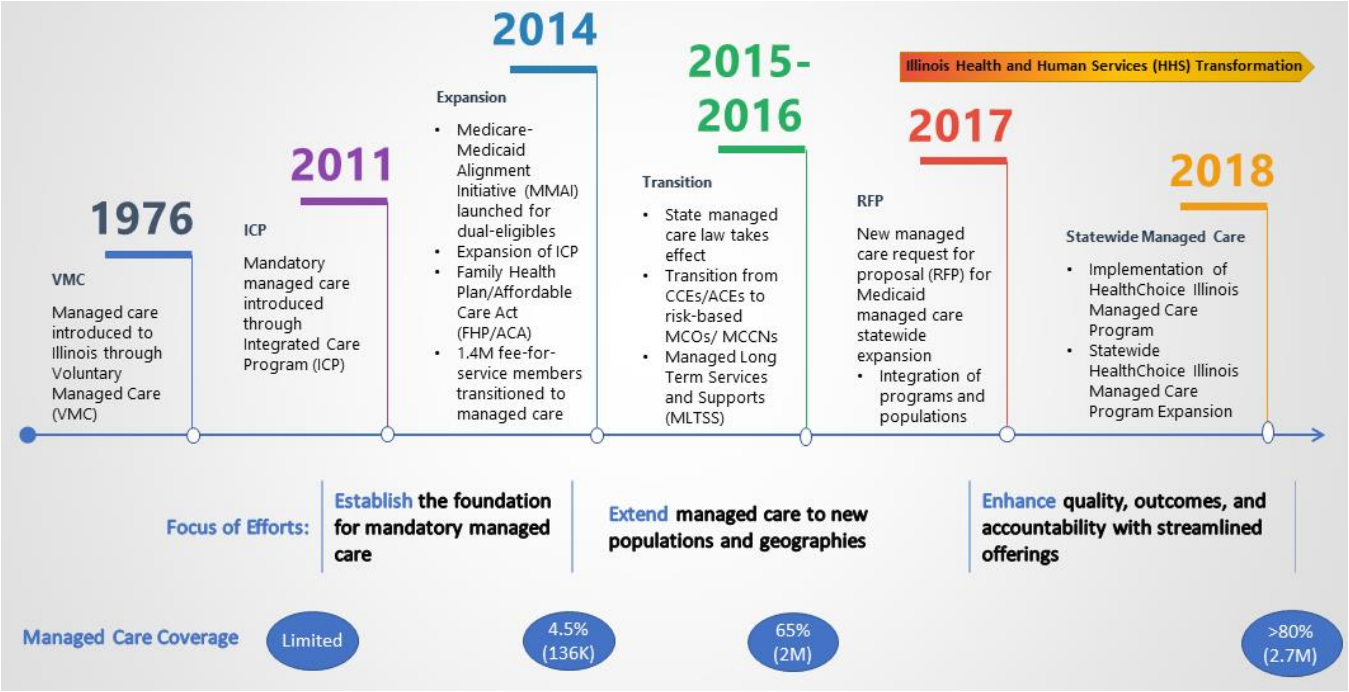
On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, launching HealthChoice Illinois to serve approximately 2.7 million residents. Seven health plans were contracted by HFS to provide care for 80 percent of all Medicaid enrollees statewide. The key objectives of the reboot were to reduce Medicaid program costs, more efficiently manage utilization of healthcare services, and improve healthcare quality and outcomes. The managed care program prior to January 1, 2018, was designed to operate in 30 counties; as of April 1, 2018, expansion included all 102 counties statewide. Although expansion plans include coverage for children in the care of the

[1-1] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Department of Children and Family Services (DCFS Youth) and Managed Long-Term Services and Supports (MLTSS) program, implementation for those programs is delayed until 2019.

The Primary Care Case Management (PCCM) program, Illinois Health Connect, provided care coordination statewide for individuals in counties where there was no mandatory participation in MCOs. The program terminated on December 31, 2017, with the implementation of HealthChoice Illinois, which expanded managed care into all counties statewide. Individuals enrolled in the PCCM program were transitioned to a HealthChoice Illinois MCO.

Figure 1-1—Illinois Medicaid Expansion



Medicaid Managed Care Health Plans (Health Plans)

HFS' overall goal in utilizing managed care 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 contracted with the health plans shown in Table 1-1 to provide healthcare services to HealthChoice Illinois beneficiaries. Five of the seven HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. Further details about the health plans and the program populations are included in Appendix A2.

Table 1-1—HealthChoice Illinois Health Plans for SFY 2018

Health Plan Name	Abbreviation
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (Serves Cook County only)	CountyCare
Harmony Health Plan of Illinois, Inc.	Harmony
IlliniCare Health Plan, Inc.	IlliniCare
Meridian Health, Inc.	Meridian
Molina Healthcare of Illinois, Inc.	Molina
NextLevel Health Partners, LLC (Serves Cook County only)	NextLevel

Quality Strategy

HFS developed and maintains a Department of Healthcare and Family Services Comprehensive Medical Programs Quality Strategy (Quality Strategy) in accordance with 42 CFR §438.200 et seq. More details about the Quality Strategy are located in Appendix A2. This report provides a review of health plan performance in comparison to the Quality Strategy goals.

Performance Domains

Healthcare Effectiveness Data and Information Set (HEDIS®)[1-2] results are presented to demonstrate the overall strengths and weaknesses regarding the quality, timeliness, and access of the care provided by the health plans serving Illinois' Medicaid beneficiaries. Descriptions of the three performance domains can be found in Appendix A2.

[1-2] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Snapshot

Table 1-2 below provides a high-level snapshot of statewide performance for HEDIS measures, compliance monitoring, PIPS, and CAHPS results for SFY 2018. The HEDIS results represent the HFS priority measures (listed in Appendix A2), and percentiles refer to national Medicaid percentiles. Additional details about these results can be found in Appendix A2 and in subsequent sections of this report.

Table 1-2—Performance Snapshot SFY 2018

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	24 Quality Measure Rates[i]	2 Timeliness Measure Rates[ii]	3 Access Measure Rates[iii]
Notable 	HEDIS	≥75th Percentile • 1 of 24 measure rates (4.2%) *Statin Therapy for Patients with Diabetes* ≥50th Percentile • 10 of 24 measure rates (41.6%)	≥50th Percentile • 1 of 2 measure rates (50.0%) *Prenatal and Postpartum Care*	≥50th Percentile • 1 of 3 measure rates (33.3%) *Prenatal and Postpartum Care*
	Compliance	Of the 9 standards reviewed during the administrative review process, most health plans demonstrated overall compliance with the Standard X—Enrollment and Disenrollment; Standard IX—Confidentiality; Standard XI—Grievance and Appeal System; Standard XIII—Fraud, Waste and Abuse; and Standard XVIII—Quality Assessment and Performance Improvement Program.		
	PIPs	For the Care Coordination PIP, all but one FHP/ACA health plan and one ICP health plan performed at rates above 85 percent for Study Indicator 1 (the percentage of high-to-moderate-risk members who have not had a readmission within 30 days of initial discharge).		
	CAHPS	≥ 90th Percentile Adult Aggregate Results: • *How Well Doctors Communicate* FHP/ACA Child Aggregate Results: • *Rating of All Health Care* • *Rating of Personal Doctor* • *Rating of Specialist Seen Most Often*	Between the 75th and 89th Percentiles FHP/ACA Child Aggregate Results: • *Rating of Health Plan (statistically significantly higher than the score for 2017)*	Between the 50th and 75th Percentiles Adult Aggregate Results: • *Rating of Personal Doctor* • *Rating of Specialist Seen Most Often* Child Aggregate Results: • *How Well Doctors Communicate*

i. HEDIS results are based on the statewide weighted average (inclusive of all health plans) with FHP/ACA and ICP results combined. The 24 Quality Measures reported for this table are those that could be compared to NCQA's Quality Compass national Medicaid percentiles for HEDIS 2017. Many HEDIS measures specify more than one rate or indicator. For example, the *Follow-Up After Hospitalization for Mental Illness* measure includes two rates: *7-Day Follow-Up* and *30-Day Follow-Up*. Refer to Appendix A2 for a list of the measures and rates that are included in the quality, timeliness, and access domains. Please note that three measures (with a total of six measure rates) are included all three domains.
ii. Only two timeliness measures were compared to national Medicaid percentiles for HEDIS 2017 due to changes in the technical specifications for the other timeliness measures; NCQA does not recommend trending between 2018 and prior years nor does it recommend performing comparisons to benchmarks.
iii. Only three access measures were compared to national Medicaid percentiles for HEDIS 2017 due to changes in the technical specifications for the other access measures.

Table 1-3—Performance Snapshot SFY 2018

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	24 Quality Measures	2 Timeliness Measures	3 Access Measures
Needs Work 	HEDIS	**Between the 25th and 50th Percentile** • 9 of 24 measure rates (37.5%) **≤ 25th Percentile** • 4 of 24 measure rates (16.7%) ○ *Adult BMI Assessment* ○ *Childhood Immunization Status—Combinations 2* and *3* ○ *Controlling High Blood Pressure* • *Follow-Up After Hospitalization (FUH) for Mental Illness—7-Day and 30-Day Follow-Up*[1-3]	**Between the 25th and 50th Percentile** • 1 of 2 measure rates (50.0%) ○ *Timeliness of Prenatal Care*	**≤ 25th Percentile** • 1 of 3 measure rates (33.3%) ○ *Adults' Access to Preventive/ Ambulatory Health Services—Total*
	Compliance	The area with the greatest opportunity for improvement identified in the **administrative review** was Standard IV—Children's Mental Health System. The results for this standard across all health plans identified a lack of compliance with inclusion of all program requirements in policies and procedures and oversight of the contracted vendor Chrysalis. The areas with the greatest opportunities for improvement identified in the **readiness reviews** included: Assurances of Adequate Capacity and Services, Coordination and Continuity of Care (Including Transition of Care), Children's Behavioral Health Services, Subcontractual Relationships and Delegation, and Provider Compliant Resolution System.		
	PIPS	The *FUH for Mental Illness* HEDIS measure rates *(7-Day and 30-Day)* were the study indicators for the Behavioral Health PIP. All health plans performed ***below*** the minimum goal for both study indicators.		

[1-3] While this measure could not be compared to NCQA benchmarks or trended due to changes in the specifications, performance on the measure had declined.

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	24 Quality Measures	2 Timeliness Measures	3 Access Measures
Needs Work 	CAHPS	**≤ 50th Percentile** Adult Aggregate Results: • *Rating of All Health Care* • *Rating of Health Plan (ratings for both measures declined from 2017–2018)* Adult and Child Results: • *Customer Service (Adult star ratings declined for the Adult measure from 2017–2018)*	**≤ 25th Percentile** Adult and Child Aggregate Results: • *Getting Needed Care* • *Getting Care Quickly*	**≤ 25th Percentile** Adult and Child Aggregate Results: • *Getting Needed Care* • *Getting Care Quickly*

Performance Measures Summary

Please see Appendix A1 for a snapshot of health plan performance on HFS priority performance measures.

Recommendations for Improvement

Table 1-4 identifies recommendations for improvement based on performance measures, CAHPS, compliance monitoring, provider network validation, and PIP results. Additional compliance monitoring and PIP recommendations are presented in Table 1-5 and (Table 1-6), respectively. See Appendix A2 for the rationale for inclusion, performance on key indicators, current interventions, barriers, recommendations, and alignment with HFS' Quality Strategy. Sources for information referenced are also located in Appendix A2.

Table 1-4—Recommendations for Improvement (Based on Performance Measures, CAHPS, Compliance Monitoring, Provider Network Validation and PIP results)

	Focused Populations and Processes Targeted for Improvement			
	Behavioral Health (BH)	**Health Plan Customer Service**[i]	**Appropriate Care—Chronic Conditions**	**Preventive Ambulatory Health Services**
Domain(s)	**Quality, Access, and Timeliness**	**Quality**	**Quality**	**Access**
Cost Justification	• BH beneficiaries make up 25% of the Medicaid population but account for 56% of Medicaid spending. • Costliest 10% of Medicaid BH beneficiaries account for more than 70% of all Medicaid BH spending.	• Low customer service ratings.[ii] • Better service equals higher customer satisfaction which may decrease costs since satisfied beneficiaries may be more likely to follow clinical advice and increase revenue by reducing negative referrals.	• **Controlling High Blood Pressure**: Known as the "silent killer," high blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States.[1-4.] • **Pre-Natal Care and Postpartum Care:** Although many women experience uncomplicated pregnancies, timely and adequate prenatal care can prevent poor birth outcomes.[1-5]	• People with a usual source of care experience have (a provider or facility where one regularly receives care) improved health outcomes and reduced disparities. • Two of the main causes of poor immunization rates in a medical practice are missed opportunities by clinicians for immunizations and patients not coming in for appointments.

[1-4] Centers for Disease Control and Prevention (CDC). 2012. About high blood pressure. Available at: http://www.cdc.gov/bloodpressure/about.htm. Accessed on: Apr 25, 2019.

[1-5] National Institutes of Health (NIH). Eunice Kennedy Shriver National Institute of Child Health and Human Development. 2017. What is prenatal care & why is it important? Available at: https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx. Accessed on: Apr 25, 2019.

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	Focused Populations and Processes Targeted for Improvement			
	Behavioral Health (BH)	**Health Plan Customer Service[i]**	**Appropriate Care—Chronic Conditions**	**Preventive Ambulatory Health Services**
Domain(s)	**Quality, Access, and Timeliness**	**Quality**	**Quality**	**Access**
Plan Performance	**≤ 25th Percentile[iii]** *Follow-Up After Hospitalization for Mental Illness* • *7-Day Follow-Up* • *30-Day Follow-Up*	**≤ 50th Percentile** Adult Aggregate Results: • *Rating of All Health Care* • *Rating of Health Plan* Adult and Child Results: • *Customer Service*	**≤ 25th Percentile** • *Controlling High Blood Pressure* **≤ 50th Percentile** • *Timeliness of Prenatal Care*	**≤ 25th Percentile** • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Childhood Immunization Status—Combinations 2 and 3* • Adult and Child: *Getting Needed Care and Getting Care Quickly (CAHPS)*
Recommendations for Health Plans	• Evaluate effectiveness of transitions of care from inpatient settings to home and community-based services (HCBS) settings. • Evaluate effectiveness of care coordination/care management (CC/CM) for beneficiaries with complex healthcare needs. • Evaluate effectiveness of CC/CM for children with BH conditions. • Continue to participate in the quarterly monitoring and reporting of the BH Transitions of Care Quality Improvement Plan implemented in 2018. • Continue collaboration with community BH organizations. • Provide easy access to prior-authorization, pharmacy, and claims data for CC/CM staff.	• Evaluate the need for a service recovery program, complaints and grievances (C/G) tracking system, and standards and service level reporting for customer service. • Evaluate C/G data to identify failure points/root causes. • Track trends and use data to improve service processes. • Train and empower front line employees to resolve C/G quickly and effectively.	• Consider a focused project to analyze commonalities and barriers to achieving hypertension control. • Use consumer advisory committees to identify barriers to care and factors that motivate beneficiaries to seek care. • Examine barriers for women to access pre-natal care, including appointment availability and wait times for (obstetrics and gynecology) OB/GYN providers. • Examine methods used for finding pregnant women. • Evaluate outreach and engagement programs to find pregnant members. • Evaluate the effectiveness of established pre-natal/pregnancy programs.	• Conduct a root cause analysis to identify barriers to obtaining appointments. • Consider targeted outreach campaigns. • Identify frequent/high ED users and connect them with CC/CM programs. • Evaluate provider compliance with appointment availability and after-hours access. • Gain access to real-time ED visit and discharge data from hospitals for timely follow-up. • Evaluate "gaps in care" and "unable to reach" programs. ***See additional recommendations for health plans below.**

	Focused Populations and Processes Targeted for Improvement			
	Behavioral Health (BH)	**Health Plan Customer Service**[i]	**Appropriate Care—Chronic Conditions**	**Preventive Ambulatory Health Services**
Domain(s)	**Quality, Access, and Timeliness**	**Quality**	**Quality**	**Access**
Recommendations for HFS	• Continue implementation and training for health plan participation in the rapid-cycle approach for the BH PIP.[iv] • Continue collaboration between state agencies and health plans. • Continued review of adequacy of the BH network and explore options for telemedicine. • Consider integrated care measures to support HFS goals for physical and mental health integration.	• Encourage health plans to utilize consumer advisory committees to determine opportunities to improve member satisfaction, including benefits or incentives. • Consider including program-specific analysis of Statewide Child CAHPS to compare member satisfaction between the fee-for-service (FFS) and managed care programs.	• Encourage health plans to use consumer advisory committees to determine opportunities to improve barriers to accessing pre-natal care.	• Implement the secret shopper appointment availability survey to evaluate member access to appointments. • Verify health plan access to the (Illinois Comprehensive Automated Immunization Registry Exchange) I-CARE immunization registry. • Align managed care improvement efforts to improve immunization rates with the Illinois Department of Public Health (IDPH).
Alignment With State Quality Strategy	• 1115 Demonstration Waiver (physical and mental health integration). • Healthy People/Healthy Communities—promote integration of behavioral and physical healthcare.	• Healthy People/Healthy Communities—Create consumer-centric healthcare delivery system. • Quality rating system supports informed decisions about healthcare for beneficiaries.	• Better Care—improve population health.	• Healthy People/Healthy Communities—improve participation in preventive care and screenings.

*Preventive Ambulatory Health Services—Additional Recommendations for Health Plans
Access
• Utilize the I-CARE immunization registry to obtain access to immunization records in an effort to supplement immunization data. • Follow up with parents of children who have missed appointments and assist with rescheduling. • Identify providers who have evening/weekend clinics to accommodate working parents. • Develop incentive programs to entice parents to get their children immunized. • Increase awareness about the importance of immunizations through culturally appropriate education campaigns. • Use health fairs and mobile vans to enhance immunization education.

i. Consumer Satisfaction with Customer Service, Health Plan, and Overall Health Care.

ii. In 2017, 18 percent of adult Medicaid members reported "never" or "sometimes" when asked if the health plan's customer service gave them the information or help they needed.

iii. Percentiles refer to national Medicaid percentiles.

iv. The rapid-cycle PIP methodology is intended to improve processes and outcomes of healthcare through continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.

Table 1-5—Additional Recommendations for Improvement (Based on Compliance Monitoring Results)

	Quality, Timeliness, Access
Compliance Monitoring Standards	Standard I—Availability of Services Standard II—Assurance of Adequate Capacity and Services Standard III—Coordination and Continuity of Care Standard VI—Children's Behavioral Health Services Standard XI—Grievance and Appeal Systems Standard XII—Organization and Governance Standard XV—Subcontractual Relationships and Delegation
Overall Improvement Opportunities for Compliance Monitoring	• **Improve health plan monitoring and oversight of access and availability by:** o Monitoring providers' open and closed panels, compliance with Americans with Disabilities Act, and network adequacy—remains an area for continued improvement by the health plans. o Utilizing results of provider access and availability survey results to improve monitoring of PCP appointment availability. o Improving the accuracy of the provider directory through regular audits and timely updates when changes are identified—remains an area of continued improvement for the health plans. o Improving the accuracy of provider network reporting for pediatric specialty and long-term services and supports (LTSS) providers. o Developing time and distance standards for LTSS providers where the enrollee is required to travel to the provider to receive services. o Developing a list of Medicaid approved HCBS providers to enhance the EQRO validation of the health plan-contracted HCBS providers. o Conducting root cause analysis of beneficiary access-related grievances to identify barriers in accessing care and services. • **Improve compliance with CC/CM requirements by:** o Evaluating effectiveness of the CC/CM program and enhancing training and oversight of CC/CM activities. o Evaluating and strengthening transition of care programs and improving communication with hospitals to improve transitions of care. o Evaluating effectiveness of care management/care coordination for children with behavioral health conditions. o Improving CC/CM documentation systems, unable-to-reach programs, and compliance with HCBS training requirements. • **Improve compliance with subcontracts and delegation contract requirements by:** o Improving oversight of delegated vendors through monthly operations meetings and quarterly review of delegate performance. o Improving performance feedback to delegated vendors and monitoring remediation actions. o Complete delegation agreements and implement oversight of the behavioral health crisis line. • **Improving compliance with critical incidents requirements by:** o Improving systems used for the intake, processing, tracking, and reporting of critical incidents. • **Improve network provider satisfaction through:** o Implementing systems and processes for timely resolution of provider complaints. o Using the results of provider satisfaction surveys to identify root causes of provider dissatisfaction. o Streamline and standardize the prior-authorization process across managed care plans.

Table 1-6—Additional Recommendations for Improvement (Based on PIP results)

	Quality, Timeliness, Access
Community Based Care Coordination PIP	Due to a lack of progress/value added and a lack of causality between PIP study indicators, HSAG recommends that the Care Coordination PIP be retired, and efforts be focused on transitions of care.
Follow-up After Hospitalization for Mental Illness Behavioral Health Collaborative PIP	Due to the lack of improved performance on the indicators for the BH PIP, HFS implemented the Institute for Healthcare Improvement's (IHI's) rapid-cycle performance improvement approach for the PIP, which places a greater emphasis on improving outcomes using quality improvement science.[i]

i. Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Mar 19, 2018.

2. Performance Measures

Overview

The Illinois Department of Healthcare and Family Services (HFS) assesses strengths, needs, and challenges to identify target populations and prioritize improvement efforts.

In alignment with HFS' Quality Strategy, results from selected Healthcare Effectiveness Data and Information Set (HEDIS) measures are presented in this section to provide a snapshot of performance of Illinois' Medicaid health plans in these areas:

- Access/Utilization of Care
- Preventive Care
- Child & Adolescent Care
- Women's Health
- Appropriate Care
- Behavioral Health

HFS also contracts with Health Services Advisory Group, Inc. (HSAG), to conduct an annual validation of performance measures for the Primary Care Case Management (PCCM) Program and the Children's Health Insurance Program Reauthorization Act (CHIPRA). These results, along with additional measures and performance results, are presented in the appendices of this report.

HSAG is also contracted to validate quality withhold performance measures for the health plans participating in Managed Long-Term Services and Supports (MLTSS). Results for the state fiscal year (SFY) 2018 MLTSS Quality Withhold Performance Measure Validation (PMV) validation are presented in this section.

Understanding Results

HEDIS is a nationally recognized set of performance measures used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.[2-1] To evaluate performance levels and to provide an objective, comparative review of Illinois health plans' quality-of-care outcomes and performance measures, HFS required its health plans to report results following the National Committee for Quality Assurance's (NCQA's) HEDIS protocols.

A key element of improving healthcare services is easily understood, comparable information on the performance of health plans. 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 health plans to make informed judgments about the effectiveness of existing processes, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives. HFS requires health plans to monitor and evaluate the quality of care using HEDIS and HFS-defined performance measures.

This section of the report displays results for measures selected by HFS that demonstrate health plan performance in domains of care that HFS prioritizes for improvement. Table 2-2 identifies the measures in each of the domains of care. Descriptions are provided for each domain of care and each performance measure to indicate what is measured and why it is important.

With statewide Medicaid expansion (HealthChoice Illinois), only seven health plans continued to serve Illinois Medicaid beneficiaries in 2018. To allow HFS optimum use of the results for future quality improvement considerations, HSAG has included results only for those seven plans in this section. However, results for all health plans are presented in Appendix C.

In this report, Illinois health plans' performance for required HEDIS 2018 measures is compared to NCQA's Quality Compass®[2-2] national Medicaid health maintenance organization (HMO) percentiles (national Medicaid percentiles) for HEDIS 2017, when available, which is an indicator of health plan performance on a national level. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2017 since this indicator is not published in Quality Compass.

For purposes of reporting and comparing the results, the data have been combined for the Family Health Plan/Affordable Care Act (FHP/ACA) and Integrated Care Program (ICP) health plans, where appropriate. To combine the FHP/ACA and ICP rates for a health plan, a combined mean is calculated, weighted by the size of the eligible population within each population. This formula is used to compute the combined mean (X_c) for each applicable measure:

$$X_c = \frac{n_1 \overline{X}_1 + n_2 \overline{X}_2}{n_1 + n_2}$$

Where:

n_1 = number of ICP members in the eligible population

n_2 = number of FHP/ACA members in the eligible population

$\overline{X}_1$ = ICP population rate

$\overline{X}_2$ = FHP/ACA population rate

[2-1] National Committee for Quality Assurance. HEDIS & Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Dec 12, 2018.

[2-2] Quality Compass® is a registered trademark of the National Committee for Quality Assurance.

See Appendix C for performance measure results for the health plans broken out by population (i.e., FHP/ACA and ICP). For most of the required measures, two years of data (HEDIS 2017 and HEDIS 2018) have been collected and are trended in this section. Due to changes in the technical specifications for some measures in HEDIS 2018 (e.g., *Follow-Up After Hospitalization for Mental Illness*), NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed.

Of note, NextLevel Health Partners, LLC (NextLevel), reported rates calculated using only administrative data. Therefore, caution should be exercised when comparing NextLevel's measure results with a hybrid option to national benchmarks and to other health plans, which were established using administrative and/or medical record review data.

Benchmarking data (e.g., Quality Compass) are the proprietary intellectual property of NCQA; therefore, this report does not display actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays. Since the HEDIS process is retrospective, HEDIS 2017 results are calculated using calendar year (CY) 2016 data and HEDIS 2018 results are calculated using CY 2017 data.

Table 2-1 displays the health plans for SFY 2017 and 2018. "N/A" represents health plans that do not serve that population. Of note, NextLevel began serving the FHP/ACA population in CY 2016 (HEDIS 2017 results) and SFY 2017 is considered the health plan's baseline reporting year.

Table 2-1—Health Plans for SFYs 2017 and 2018

Health Plan	FHP/ACA		ICP	
	SFY 2017	SFY 2018	SFY 2017	SFY 2018
Meridian Health Plan, Inc. (Meridian) ◆	✓	✓	✓	✓
Blue Cross Blue Shield of Illinois (BCBSIL) ◆	✓	✓	✓	✓
Aetna Better Health (Aetna)	✓	✓	✓	✓
IlliniCare Health Plan, Inc. (IlliniCare) ◆	✓	✓	✓	✓
Family Health Network (FHN)	✓	✓	N/A	N/A
Molina Healthcare of Illinois, Inc. (Molina) ◆	✓	✓	✓	✓
Harmony Health Plan of Illinois, Inc. (Harmony) ◆	✓	✓	N/A	N/A
CountyCare Health Plan (CountyCare) ◆	✓	✓	✓	✓
NextLevel Health Partners, LLC (NextLevel) ◆	Baseline	✓	1st Year	✓
Humana Health Plan, Inc. (Humana)	N/A	N/A	✓	✓
Community Care Alliance of Illinois (CCAI)	N/A	N/A	✓	✓
Cigna-HealthSpring of Illinois (Cigna)	N/A	N/A	✓	✓

◆ Due to the statewide expansion RFP process, only seven health plans will continue to serve Illinois Medicaid beneficiaries in 2018. To allow HFS optimum use of the information presented in this section for future quality improvement considerations, HSAG has only presented results for those seven plans indicated with a green diamond in this section and in Appendix A1 of this report. However, results for all health plans are presented in other sections.

Table 2-2—HFS Required Measures by Domain of Care for HEDIS 2018

Measures
Access/Utilization of Care
Adults' Access to Preventive/Ambulatory Health Services
Total
Ambulatory Care (per 1,000 Member Months)
Emergency Department (ED) Visits—Total
Outpatient Visits—Total
Preventive Care
Adult BMI Assessment
Adult BMI Assessment
Child & Adolescent Care
Childhood Immunization Status
Combination 2
Combination 3
Immunizations for Adolescents
Combination 1 (Meningococcal, Tdap)
Combination 2 (Meningococcal, Tdap, HPV)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Well-Child Visits in the First 15 Months of Life
Six or More Well-Child Visits
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Women's Health
Breast Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Total
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care

Measures
Appropriate Care
Annual Monitoring for Patients on Persistent Medications
Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)
Diuretics
Total
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Testing
Eye Exam (Retinal) Performed
Medical Attention for Nephropathy
Controlling High Blood Pressure
Controlling High Blood Pressure
Medication Management for People With Asthma
Medication Compliance 50%—Total
Medication Compliance 75%—Total
Statin Therapy for People With Diabetes
Received Statin Therapy
Statin Adherence 80%
Behavioral Health
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up
30-Day Follow-Up
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
Initiation of AOD Treatment—Total—Total
Engagement of AOD Treatment—Total—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Total

Summary of Performance

Access/Utilization of Care

The access and utilization of primary care is essential for Illinois Medicaid beneficiaries to achieve the best health outcomes. Obtaining good access to care often requires Medicaid beneficiaries to find a trusted primary care provider to meet their needs. Medicaid beneficiaries should utilize their primary care provider to help them prevent illnesses and encourage healthy behaviors through needed services.[2-3]

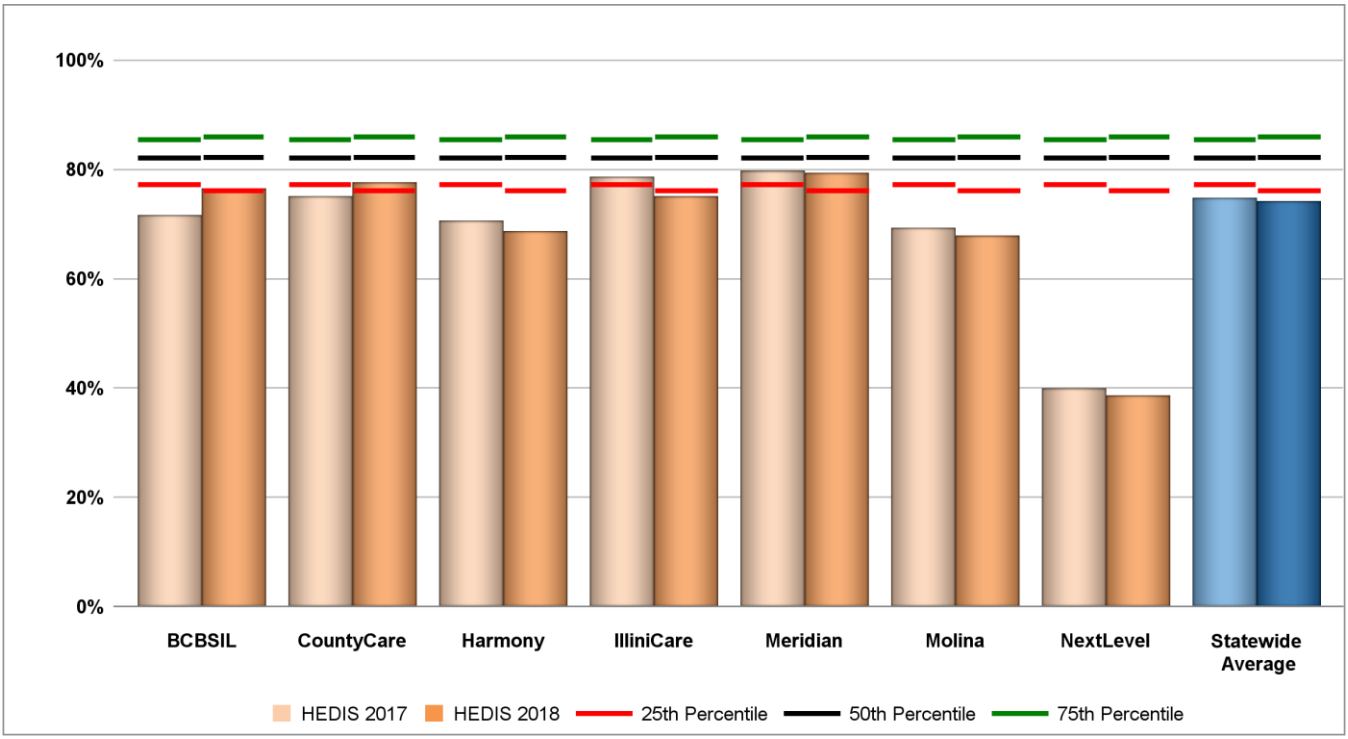
This section presents the three-required access/utilization of care measure rates reported by the health plans. Additional access/utilization of care measure results can be found in Appendix C.

[2-3] Agency for Healthcare Research and Quality. National Healthcare Disparities Report, 2011. Available at: https://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap9.html#. Accessed on: Dec 12, 2018.

Adults' Access to Preventive/Ambulatory Health Services—Total

Monitoring this measure is an important step in identifying if adult beneficiaries have access to ambulatory or preventive care by determining if beneficiaries ages 20 years and older had an ambulatory or preventive care visit during the measurement year. If they have not, interventions can be developed to identify, understand, and ultimately eliminate barriers to services. Figure 2-1 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.

Figure 2-1—*Adults' Access to Preventive/Ambulatory Health Services—Total*—HEDIS 2017 and 2018



Notable

- None.

Needs Work

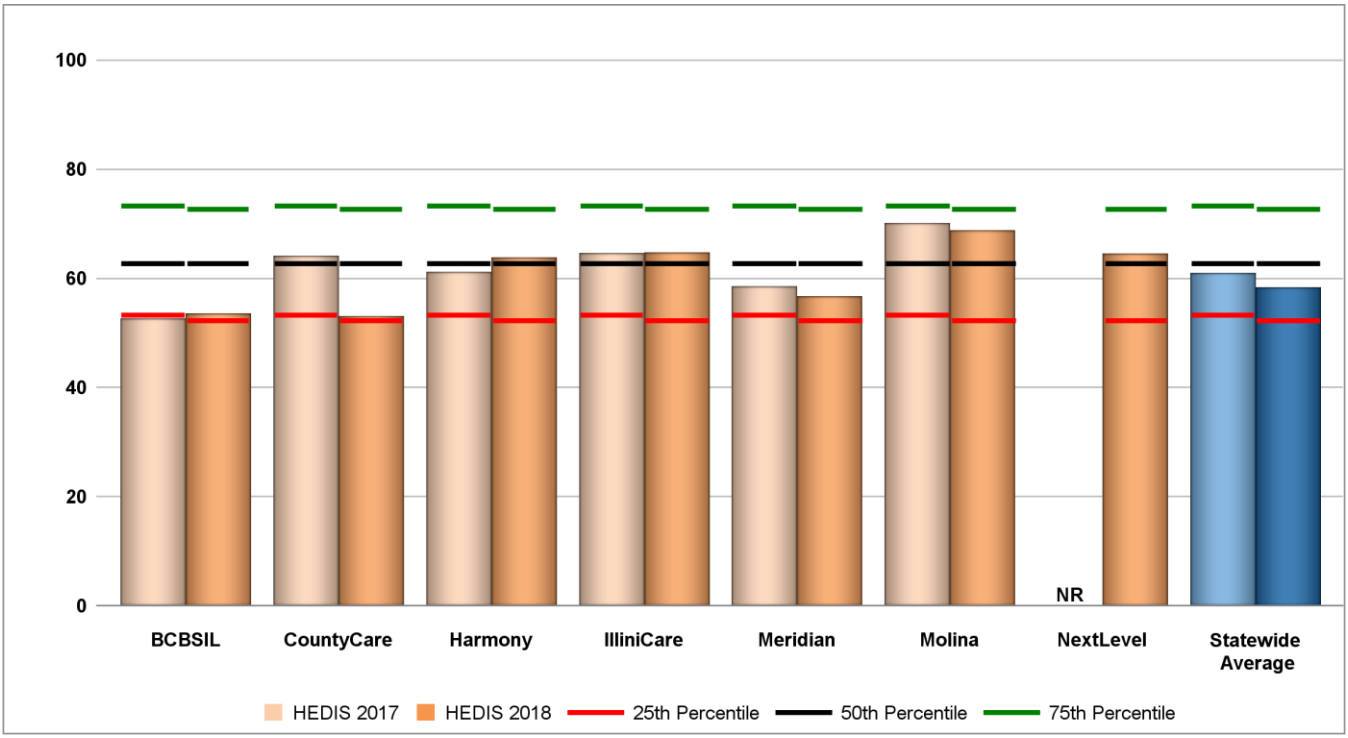
- The statewide average for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator fell below the national Medicaid 25th percentile for HEDIS 2018. Additionally, no health plan ranked at or above the national Medicaid 50th percentile.
- Performance declined for the statewide average and five of the seven (71.4 percent) health plans.

Ambulatory Care (per 1,000 Member Months)

ED Visits—Total

This measure indicator tracks ambulatory care utilization in an ED setting that did not result in an inpatient stay. Figure 2-2 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure indicator.

Figure 2-2—*Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*—HEDIS 2017 and 2018



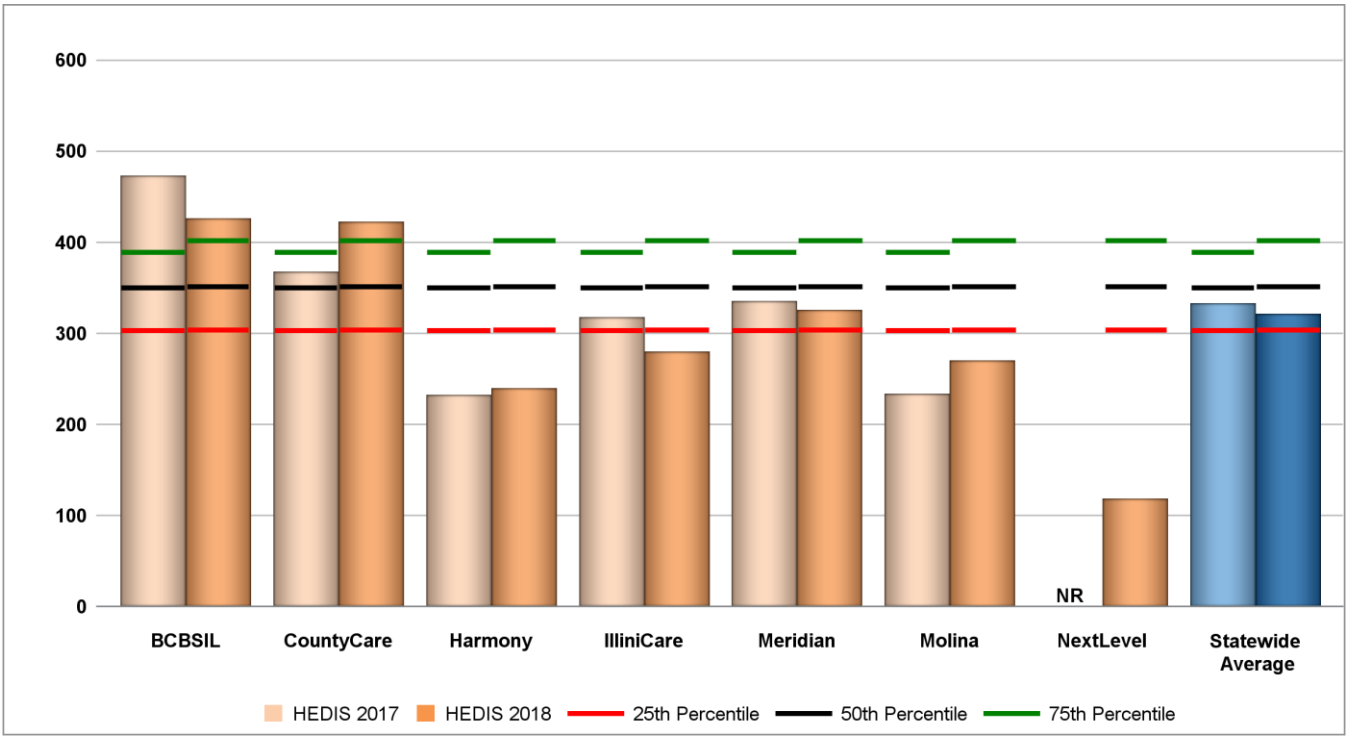
NR indicates the rate was not reported.

Since the rates reported for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure indicator do not take into consideration the demographic and clinical characteristics of each health plan's members, these utilization rates in isolation do not necessarily correlate with the quality of services provided. Therefore, these rates are provided strictly for information only. Caution should be exercised when comparing measure rates between health plans.

Outpatient Visits—Total

This measure indicator tracks utilization of ambulatory care in the outpatient setting. Figure 2-3 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total* measure indicator.

Figure 2-3—*Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total*—HEDIS 2017 and 2018



NR indicates the rate was not reported.

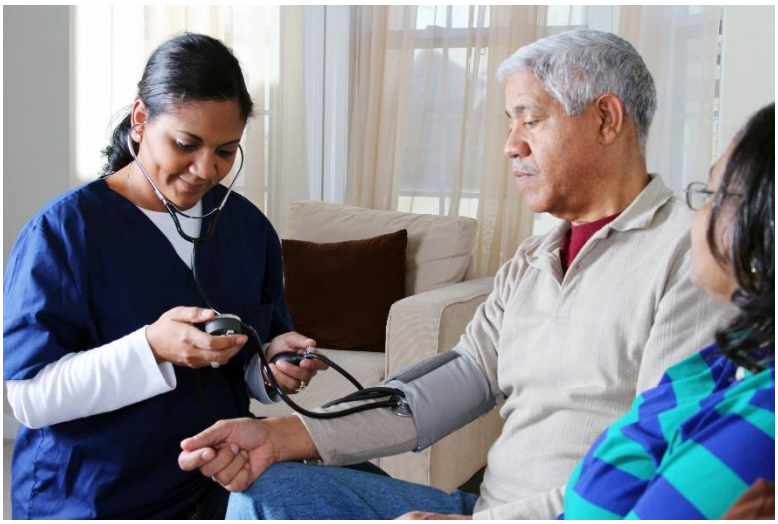
Since the rates reported for the *Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total* measure indicator do not take into consideration the demographic and clinical characteristics of each health plan's members, these utilization rates in isolation do not necessarily correlate with the quality of services provided. Therefore, these rates are provided strictly for information only. Caution should be exercised when comparing measure rates between health plans.

Access/Utilization of Care Conclusions

In the Access/Utilization of Care domain, the HEDIS 2018 statewide average for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure rate fell below the national Medicaid 25th percentile, indicating an area for improvement.

Of note, the measure rates for *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* and *Outpatient Visits—Total* should be used strictly for information only.

Preventive Care



Preventive care is provided by healthcare providers to prevent illnesses or diseases, through tests and treatments such as screenings, counseling, and health checks.[2-4]

Health plans reported the *Adult BMI Assessment* measure because obesity is associated with an increased risk of death and is prevalent in more than 30 percent of adults in the United States. Monitoring of BMI helps healthcare providers identify adults who are at risk for certain diseases, such as heart disease, high blood pressure, and diabetes. Healthcare providers can recommend behavioral interventions, such as setting weight-loss goals and improving physical activity, that can lead to weight loss.[2-5] Results for this measure are presented in this section.

In addition, several preventive care measure rates that correlate to child and adolescent care and women's health are presented in subsequent sections. Additional preventive care measure results can be found in Appendix C of this report.

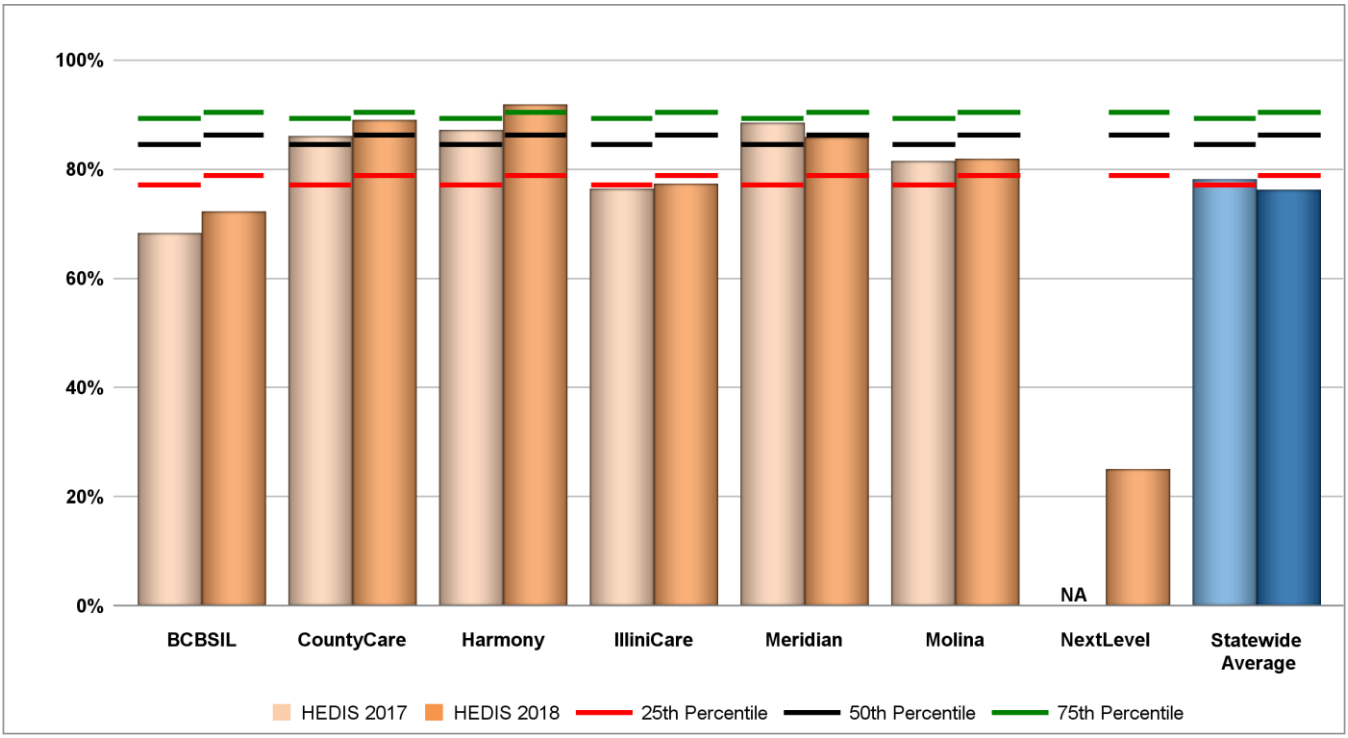
Adult BMI Assessment

This measure assesses the percentage of beneficiaries 18 to 74 years of age who had an outpatient visit in the past two years and had their body mass index (BMI) documented. Figure 2-4 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Adult BMI Assessment* measure.

[2-4] U.S. Preventive Services Task Force. Information for Consumers: Browse Information for Consumers. Available at: https://www.uspreventiveservicestaskforce.org/Tools/ConsumerInfo/Index/information-for-consumers. Accessed on: Dec 12, 2018.

[2-5] U.S. Preventive Services Task Force. Screening for and Management of Obesity in Adults: Consumer Guide. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management. Accessed on: Dec 12, 2018.

Figure 2-4—*Adult BMI Assessment*—HEDIS 2017 and 2018



NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- Performance across the health plans varied for the *Adult BMI Assessment* measure for HEDIS 2018, with one of the seven (14.3 percent) health plans, Harmony, exceeding the national Medicaid 75th percentile.
- Measure rates for five of the six (83.3 percent) health plans that reported rates in both years showed improvement.

Needs Work

- The statewide average fell below the national Medicaid 25th percentile for HEDIS 2018. Additionally, measure rates for three of the seven (42.9 percent) health plans—BCBSIL, IlliniCare, and NextLevel—fell below the national Medicaid 25th percentile.

Preventive Care Conclusions

In the Preventive Care domain, the statewide average for HEDIS 2018 declined slightly in performance with the addition of NextLevel, reporting a rate to now fall below the national Medicaid 25th percentile for the *Adult BMI Assessment* measure rate, indicating an area for improvement.

Child & Adolescent Care

Illinois Medicaid provides healthcare to over 1.5 million children, nearly half of the population HFS serves.[2-6] Appropriate standardized measures of health are needed to improve the overall quality of child healthcare, as the health status of children and adolescents is important for society, helping to determine the health of the next generation.[2-7]

The results of nine child and adolescent care measure rates for the FHP/ACA health plans are presented in this section, as the ICP health plans do not serve child beneficiaries. Additional child and adolescent care measure results can be found in Appendix C of this report.

Childhood Immunization Status

Childhood vaccines protect children from over a dozen diseases by helping them become immune to serious diseases without getting sick first.[2-8] Vaccines are one of the most cost-effective clinical preventive services and provide a high return on investment when a routine immunization schedule is followed.[2-9]

Combination 2

This measure indicator assesses the percentage of children who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); and one chicken pox (VZV) vaccines by their second birthday. Figure 2-5 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Childhood Immunization Status—Combination 2* measure indicator.

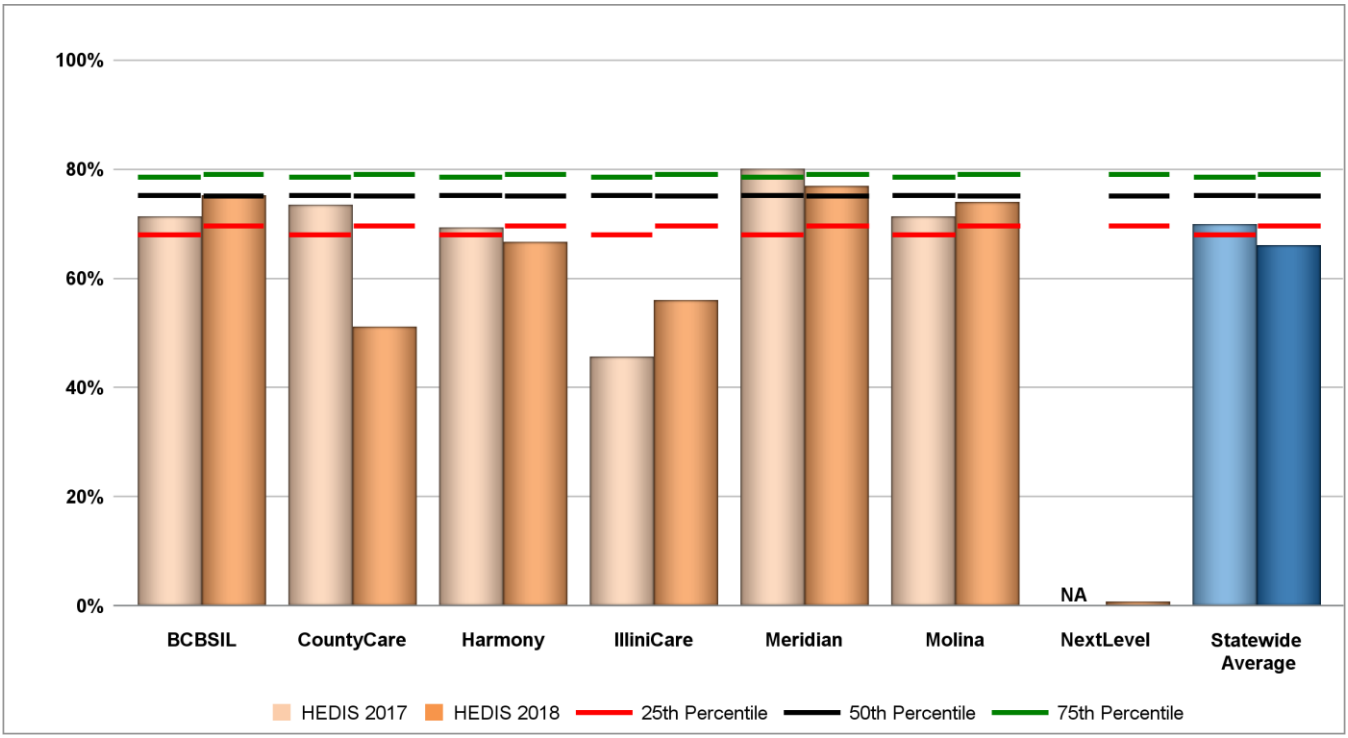
2-6 Illinois Department of Healthcare and Family Services. Annual Report, April 1, 2016. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/FY2015_Annual_Report_3-31-16_final.pdf. Accessed on: Dec 12, 2018.

2-7 National Quality Forum. Pediatric measures: Final Report, June 15, 2016. Available at: https://www.qualityforum.org/Publications/2016/06/Pediatric_Measures_Final_Report.aspx. Accessed on: Dec 12, 2018.

2-8 U.S. Department of Health and Human Services. Childhood Immunizations. Available at: https://medlineplus.gov/childhoodimmunization.html. Accessed on: Dec 12, 2018.

2-9 U.S. Department of Health and Human Services. 2020 Topics & Objectives: Immunizations and Infectious Diseases. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases. Accessed on: Dec 12, 2018.

Figure 2-5—*Childhood Immunization Status—Combination 2*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- Performance across health plans varied for the *Childhood Immunization Status—Combination 2* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, BCBSIL and Meridian, ranking above the national Medicaid 50th percentile.

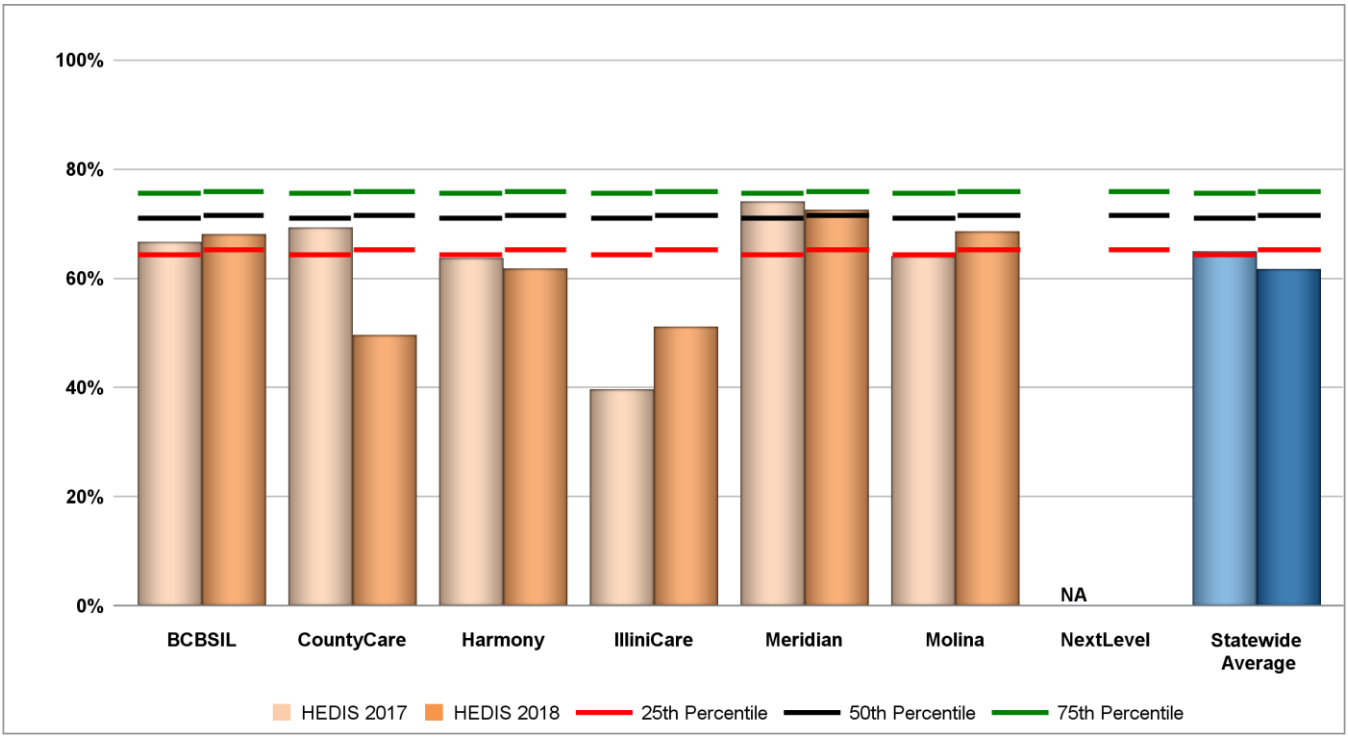
Needs Work

- The statewide average and measure rates for four of the seven (57.1 percent) health plans—CountyCare, Harmony, IlliniCare, and NextLevel—fell below the national Medicaid 25th percentile for HEDIS 2018.
- Decline in performance was demonstrated as the measure rate decreased for the statewide average and for three of the six (50.0 percent) health plans that reported rates in both years.

Combination 3

This measure indicator assesses the percentage of children who had the immunizations listed in *Combination 2* plus four pneumococcal conjugate (PCV) vaccines by their second birthday. Figure 2-6 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Childhood Immunization Status—Combination 3* measure indicator.

Figure 2-6—*Childhood Immunization Status—Combination 3*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- Performance across health plans varied for the *Childhood Immunization Status—Combination 3* measure indicator for HEDIS 2018, with only one of the seven (14.3 percent) health plans, Meridian, ranking above the national Medicaid 50th percentile.

Needs Work

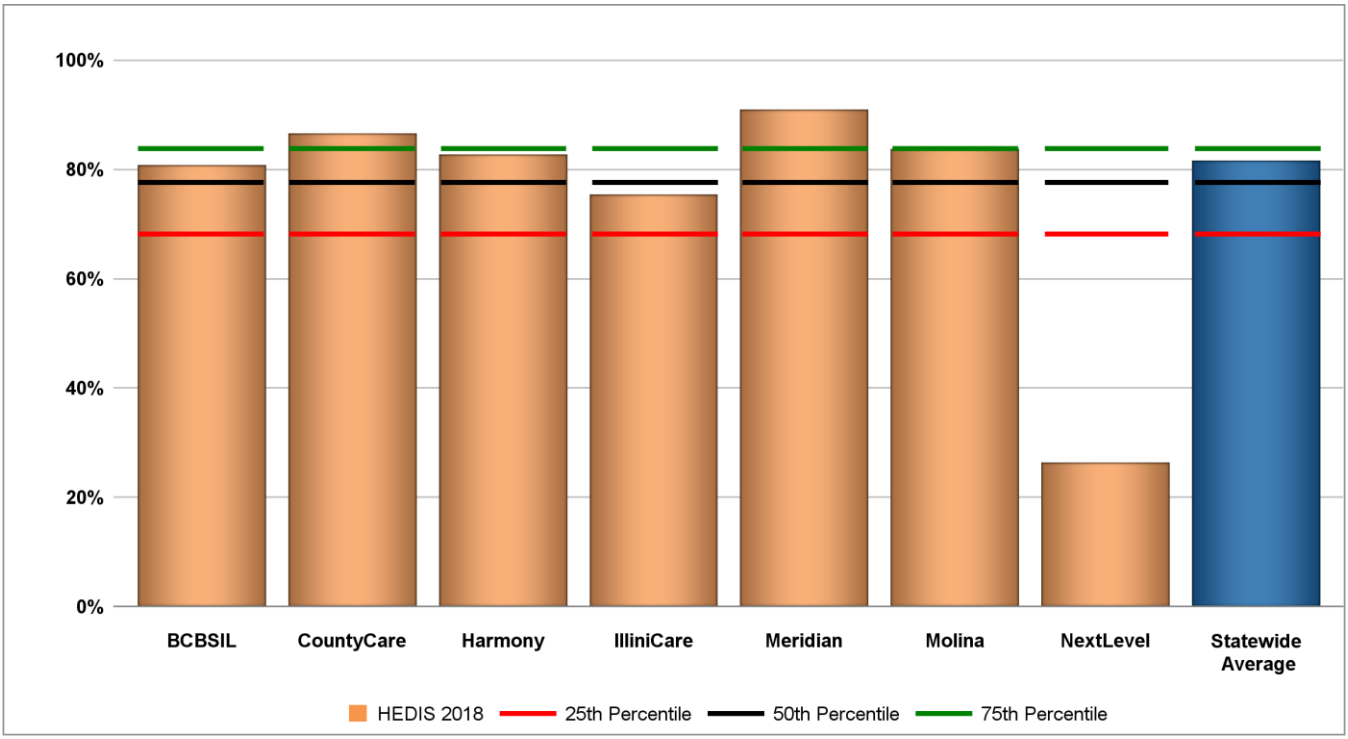
- The statewide average and measure rates for four of the seven (57.1 percent) health plans—CountyCare, Harmony, IlliniCare, and NextLevel—fell below the national Medicaid 25th percentile for HEDIS 2018.
- Decline in performance was demonstrated as the measure rate decreased for the statewide average and for three of the six (50.0 percent) health plans that reported rates in both years.

Immunizations for Adolescents

Combination 1 (Meningococcal, Tdap)

This measure indicator assesses the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. The health plans were not required to report a rate for this measure for HEDIS 2017; therefore, historical rates are not displayed. Figure 2-7 presents the HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator.

Figure 2-7—*Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*—HEDIS 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.
NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- The statewide average for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator ranked between the national Medicaid 50th and 75th percentiles for HEDIS 2018.
- Performance across the health plans varied, with two of the seven (28.6 percent) health plans, CountyCare and Meridian, exceeding the national Medicaid 75th percentile.

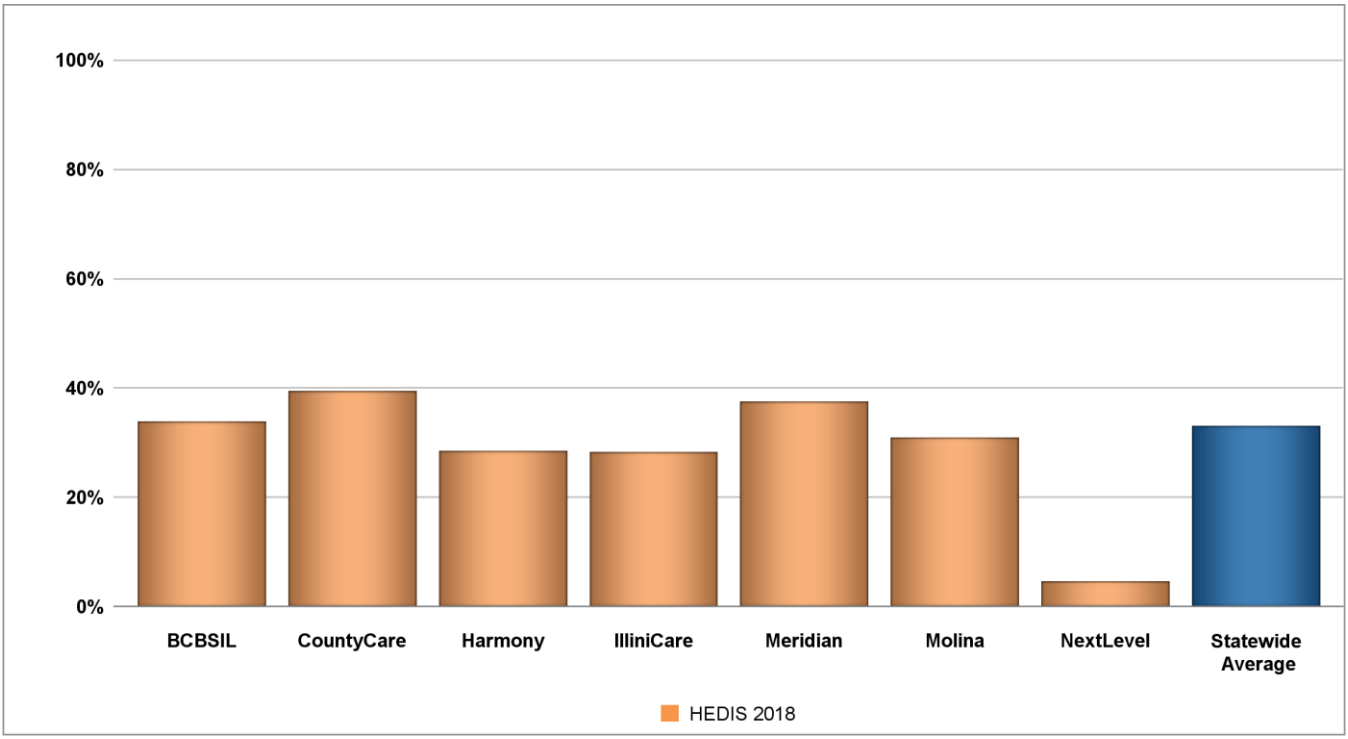
Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Combination 2 (Meningococcal, Tdap, HPV)

This measure indicator assesses the percentage of adolescents who had the immunizations listed in *Combination 1 (Meningococcal, Tdap)* plus completion of the human papillomavirus (HPV) vaccine by their 13th birthday. The health plans were not required to report a rate for this measure for HEDIS 2017; therefore, historical rates are not displayed. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, comparisons to national benchmarks are not performed for this measure. Figure 2-8 presents the HEDIS 2018 rates for the FHP/ACA health plans and the statewide average for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicator.

Figure 2-8—*Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*—HEDIS 2018



Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to national benchmarks are not performed.

The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by nearly 35 percentage points.

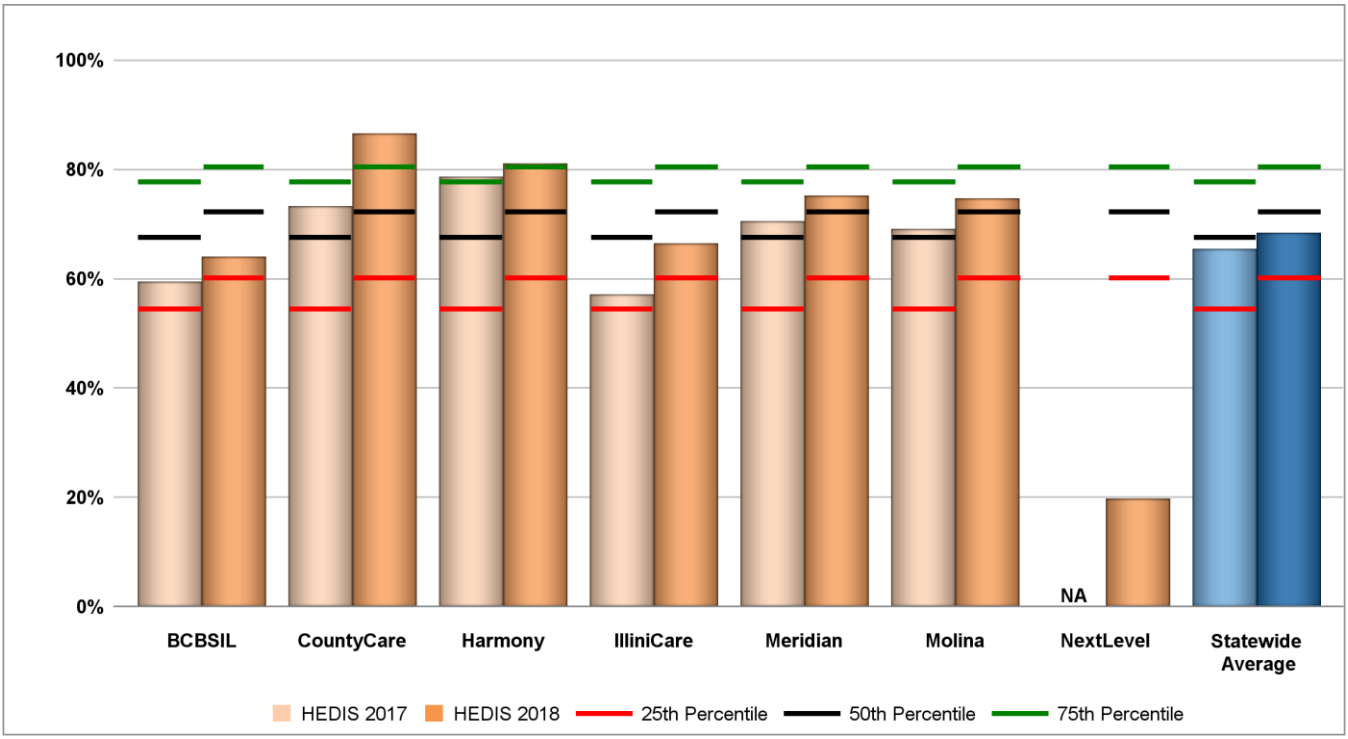
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Research shows that childhood obesity has more than tripled since the 1970s, making it a primary health concern since obesity has both immediate and long-term effects on health and well-being. Promoting regular physical activity and healthy eating is essential to addressing the problem, and documenting BMI is a useful screening tool for assessing and tracking the degree of obesity among adolescents.[2-10]

BMI Percentile Documentation—Total

This measure indicator evaluates whether members 3 to 17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) had evidence of BMI percentile documentation during the measurement year. Figure 2-9 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator.

Figure 2-9—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.
NA indicates the rate was withheld because the denominator was less than 30.
NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

[2-10] Centers for Disease Control and Prevention. Childhood Obesity Facts. Available at: https://www.cdc.gov/obesity/data/childhood.html. Accessed on: Feb 12, 2018.

Notable

- Performance across the health plans varied for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, CountyCare and Harmony, exceeding the national Medicaid 75th percentile.
- All six health plans that reported rates for both years showed improvement in performance.

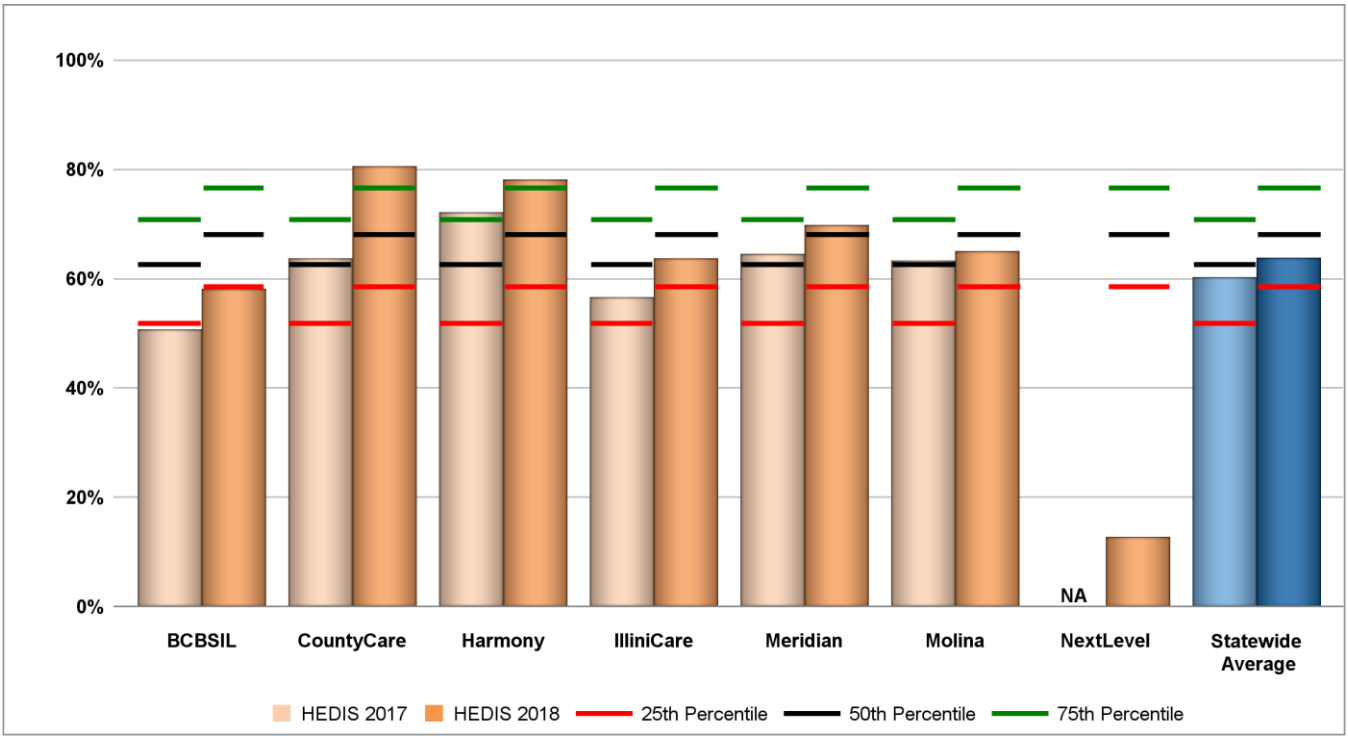
Needs Work

- Despite demonstrating an increase in performance for HEDIS 2018, the statewide average fell below the national Medicaid 50th percentile. Additionally, the measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Counseling for Nutrition—Total

This measure indicator is used to assess whether beneficiaries 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN had evidence of counseling for nutrition during the measurement year. Figure 2-10 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator.

Figure 2-10—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- Two of the seven (28.6 percent) health plans, CountyCare and Harmony, exceeded the national Medicaid 75th percentile for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator for HEDIS 2018.
- All six health plans that had reportable rates in both years demonstrated an increase in performance for HEDIS 2018.

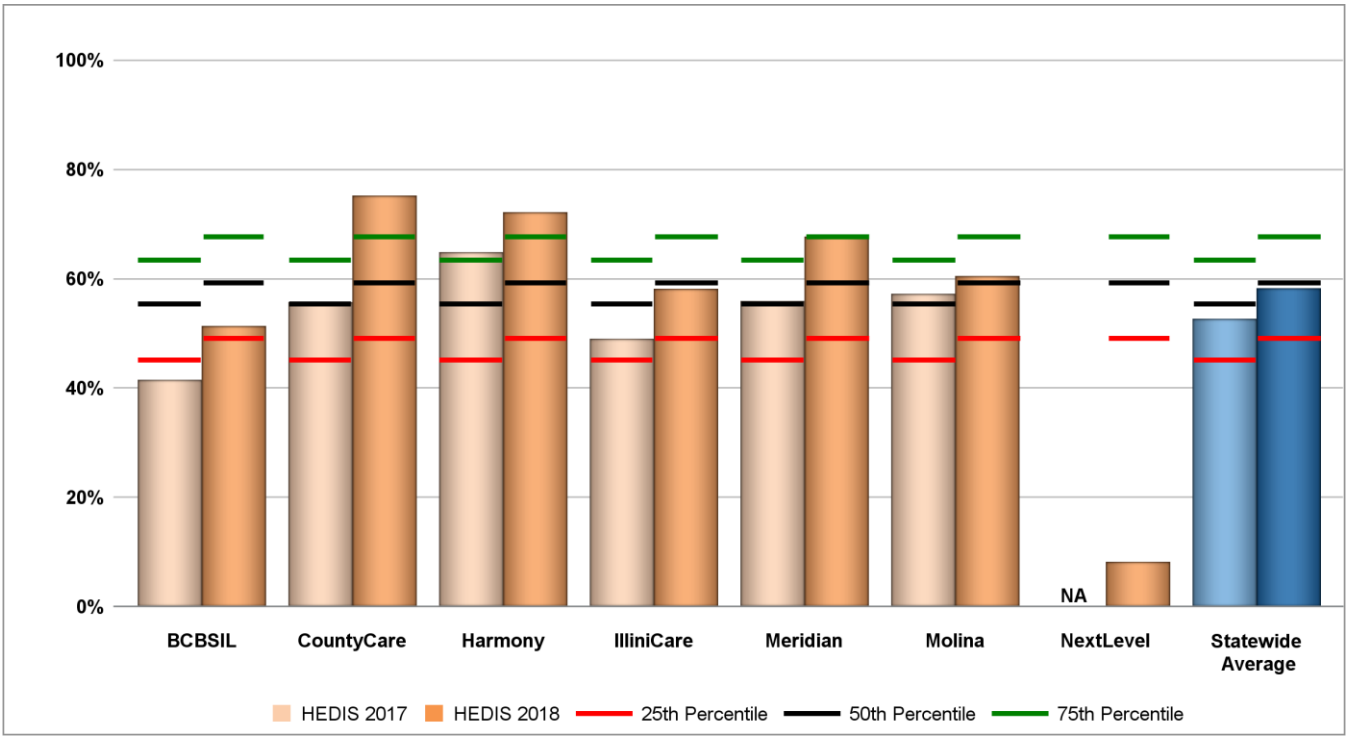
Needs Work

- Despite demonstrating an increase in performance for HEDIS 2018, the statewide average fell below the national Medicaid 50th percentile. Additionally, measure rates for two of the seven (28.6 percent) health plans, BCBSIL and NextLevel, fell below the national Medicaid 25th percentile for HEDIS 2018.

Counseling for Physical Activity—Total

This measure indicator is used to assess whether beneficiaries 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN had evidence of counseling for physical activity during the measurement year. Figure 2-11 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator.

Figure 2-11—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- Performance across the health plans varied for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator for HEDIS 2018, with three of the seven (42.9 percent) health plans—CountyCare, Harmony, and Meridian—meeting or exceeding the national Medicaid 75th percentile.
- All six health plans that reported rates for both years showed an improvement in performance.

Needs Work

- Despite demonstrating an increase in performance for HEDIS 2018, the statewide average fell below the national Medicaid 50th percentile. Additionally, the measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

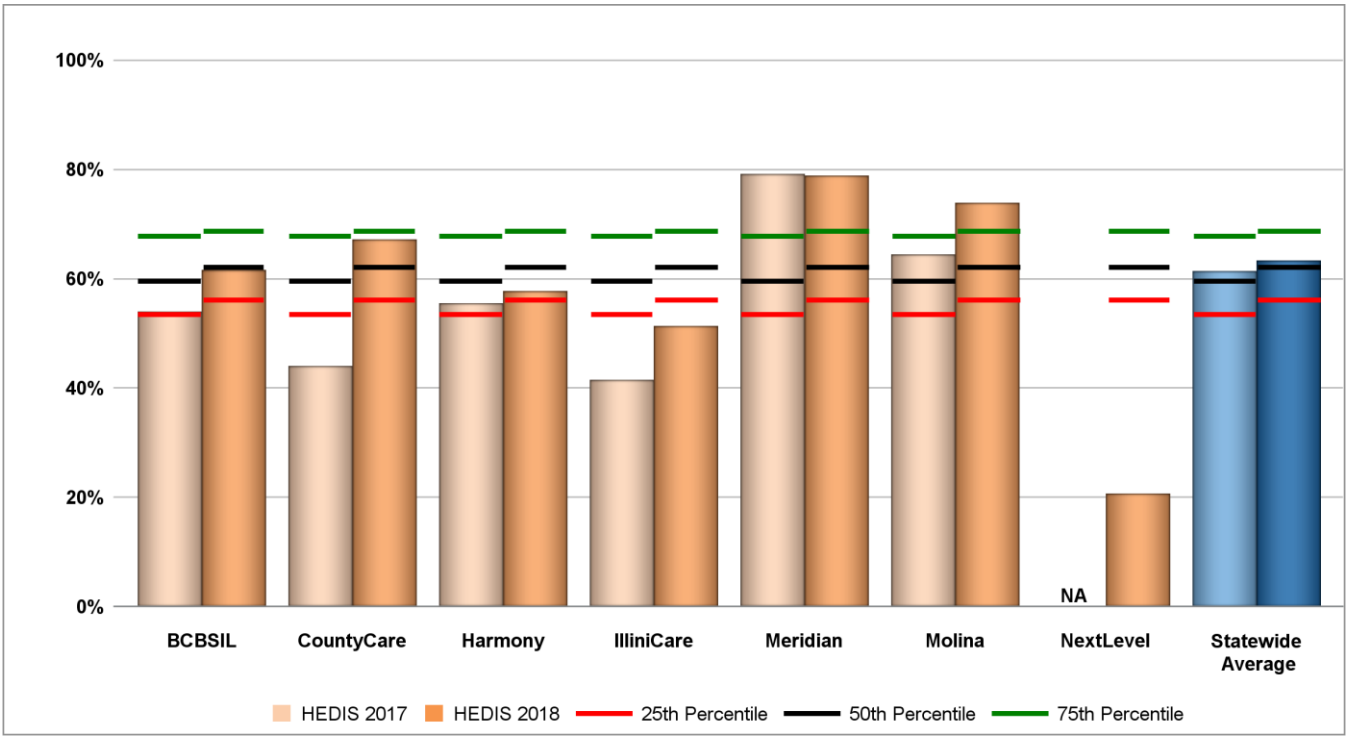
Well-Child Visits

Regular well-child visits represent a critical opportunity for screening and monitoring the health and well-being of children and adolescents as they grow and mature. Assessing physical, emotional, and social development provides an opportunity for providers to impact health and development.[2-11]

Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits

Well-child visits during the early months of a child's life provide physicians with the opportunity to assess growth patterns; provide immunizations; and answer questions about nutrition, behavioral, and physical development, and other childhood milestones.[2-12] This measure assesses the percentage of beneficiaries who had the recommended number of well-child visits with a PCP during their first 15 months of life. Figure 2-12 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure indicator.

Figure 2-12—*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

[2-11] Child Trends. Well-Child Visits: Indicators of Child and Youth Well-Being. Available at: https://www.childtrends.org/wp-content/uploads/2014/10/93_Well_Child_Visits.pdf. Accessed on: Dec 12, 2018.

[2-12] Ibid.

Notable

- Performance across the health plans varied for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, Meridian and Molina, exceeding the national Medicaid 75th percentile.
- The statewide average measure rate demonstrated in increase in performance from HEDIS 2017 to HEDIS 2018 and ranked between the national Medicaid 50th and 75th percentiles. Additionally, measure rates increased for five of the six (83.3 percent) health plans that reported rates in both years.

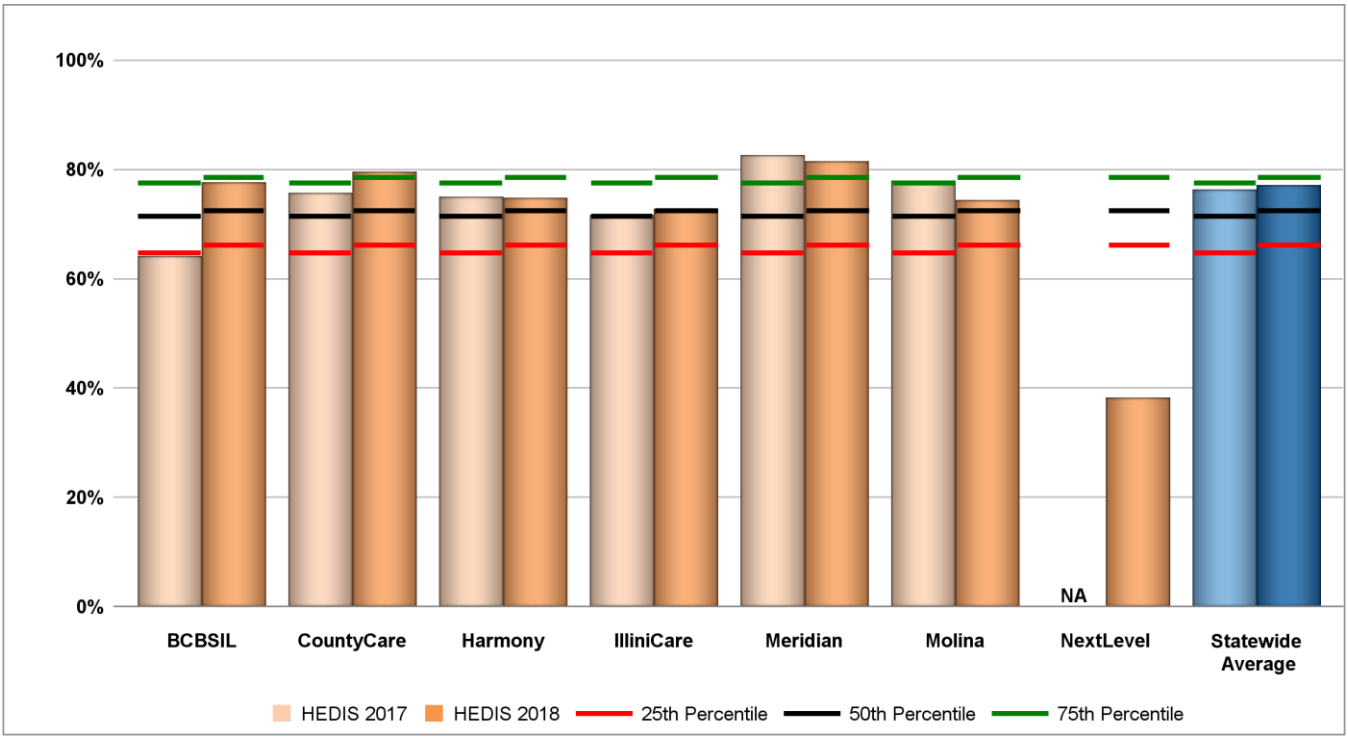
Needs Work

- Measure rates for IlliniCare and NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

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

Regular well-child visits are important to monitor the health and well-being of children as they grow and mature. A physician/patient relationship is important in fostering overall good health during these important developmental years as parents turn to pediatricians as their guide.[2-13] This measure assesses the percentage of children 3 to 6 years of age who received one or more well-child visits with a PCP during the measurement year. Figure 2-13 presents the HEDIS 2017 and HEDIS 2018 rates for the FHP/ACA health plans and the statewide average compared to national Medicaid percentiles for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.

Figure 2-13—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*—HEDIS 2017 and 2018



The rates only contain data for the FHP/ACA population, as the ICP population was not required to report this measure.

NA indicates the rate was withheld because the denominator was less than 30.

NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

[2-13] Ibid.

Notable

- Performance across the health plans varied for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for HEDIS 2018, with just two of the seven (28.6 percent) health plans, CountyCare and Meridian, exceeding the national Medicaid 75th percentile.
- The statewide average demonstrated an increase in performance and ranked between the national Medicaid 50th and 75th percentiles.

Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Child & Adolescent Care Conclusions

In the Child & Adolescent Care domain, the HEDIS 2018 statewide average ranked above the national Medicaid 50th percentile for only three of eight (37.5 percent) measure rates that could be compared to benchmarks. Additionally, the statewide average for the *Childhood Immunization Status* measure rates demonstrated a decline in performance and fell below the national Medicaid 25th percentile, indicating opportunities to increase immunizations for children.

Women's Health

Quality in women's healthcare is assessed with preventive measures such as *Breast Cancer Screening* and obstetrical measures such as *Prenatal and Postpartum Care*.

Five women's health measure rates are presented below, with additional results found in Appendix C of this report.

Breast Cancer Screening

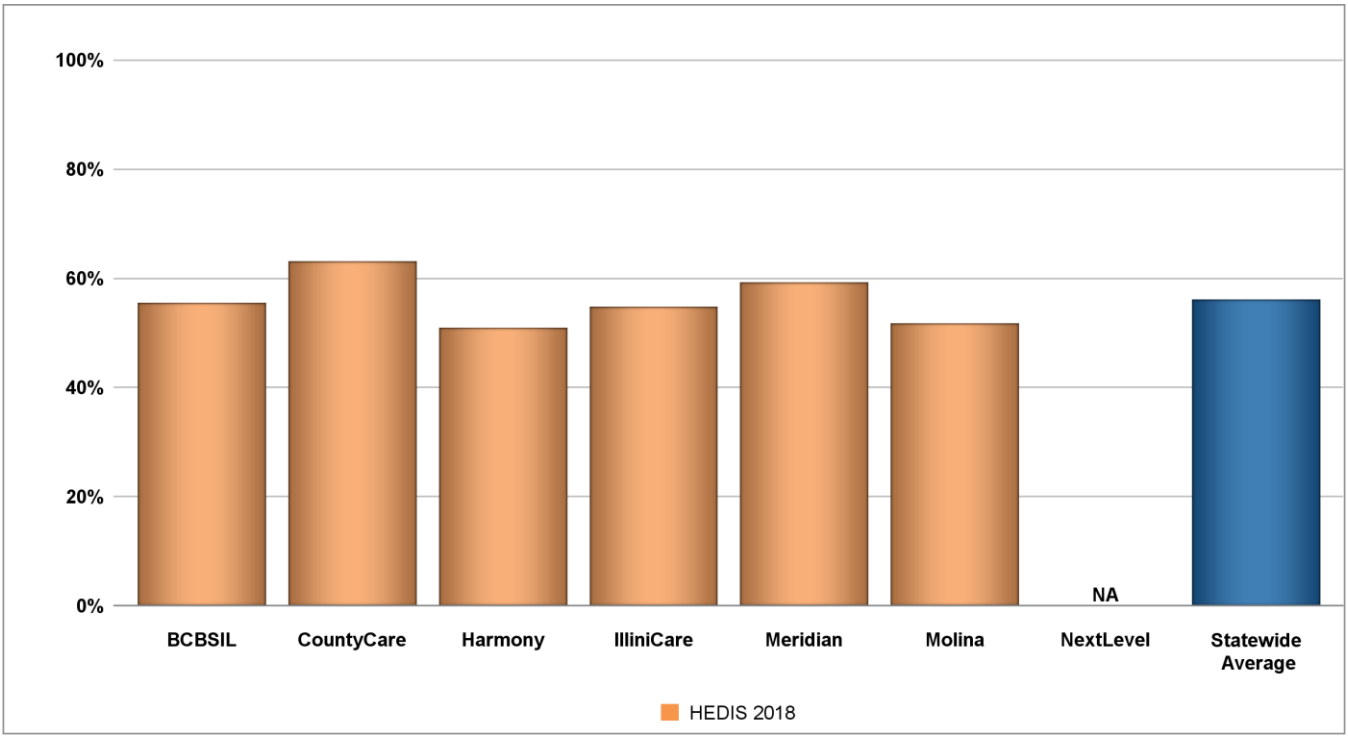
Breast cancer is the most common cancer for females and the second leading cause of cancer deaths among women in the United States.[2-14] Regular mammography screenings can help identify breast cancer in the early stage and reduce the risk of death by up to 35 percent for women ages 50 to 69 from breast cancer.[2-15]

This measure assesses women 50 to 74 years of age who had at least one mammogram to screen for breast cancer in the past 27 months. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to national benchmarks are not performed for this measure. Figure 2-14 presents the HEDIS 2018 rates for the health plans and the statewide average for the *Breast Cancer Screening* measure.

[2-14] U.S. Department of Health and Human Services, Health Resources and Services Administration. Breast Cancer Screening. Available at: http://www.hrsa.gov/quality/toolbox/508pdfs/breastcancerscreening.pdf. Accessed on: Dec 13, 2018.

[2-15] Ibid.

Figure 2-14—*Breast Cancer Screening*—HEDIS 2018



Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to national benchmarks are not performed.

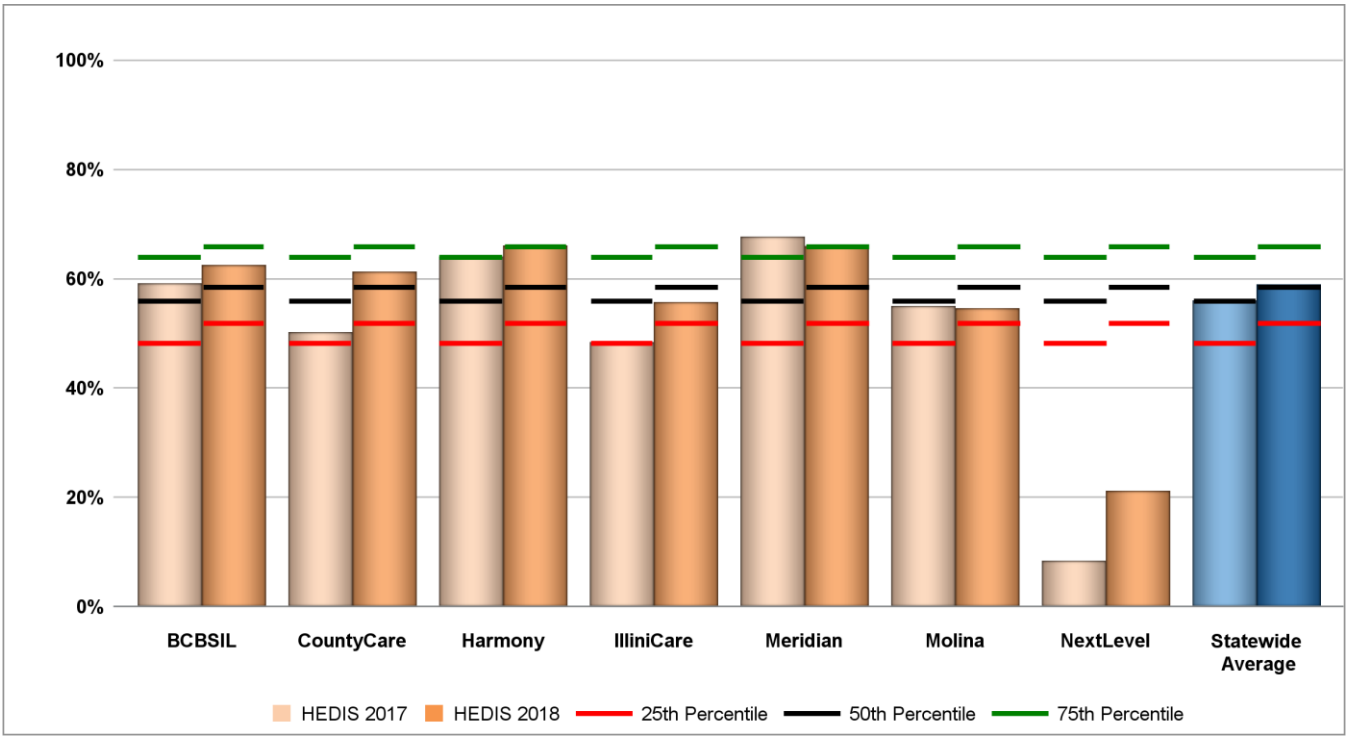
NA indicates the rate was withheld because the denominator was less than 30.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by more than 10 percentage points.

Cervical Cancer Screening

Cervical cancer is one of the most commonly diagnosed cancers for women; however, effective screening has reduced the mortality rate by more than 50 percent over the last 30 years.[2-16] Cervical cancer is often preventable because of effective screening tests and if detected early, treatment options are less extensive and more successful.[2-17] This measure assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer. Figure 2-15 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Cervical Cancer Screening* measure.

Figure 2-15—*Cervical Cancer Screening*—HEDIS 2017 and 2018



NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

[2-16] American Cancer Society. Cancer Facts & Figures 2016. Atlanta, Ga: American Cancer Society; 2016. Available at: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/cancer-facts-and-figures-2016.pdf. Accessed on: Dec 13, 2018.

[2-17] Ibid.

Notable

- Performance across the health plans varied for the *Cervical Cancer Screening* measure for HEDIS 2018, with just two of the seven (28.6 percent) health plans, Harmony and Meridian, exceeding the national Medicaid 75th percentile.
- Five of seven (71.4 percent) health plans and the statewide average demonstrated an increase in performance from HEDIS 2017 to HEDIS 2018. The HEDIS 2018 statewide average ranked between the national Medicaid 50th and 75th percentiles.

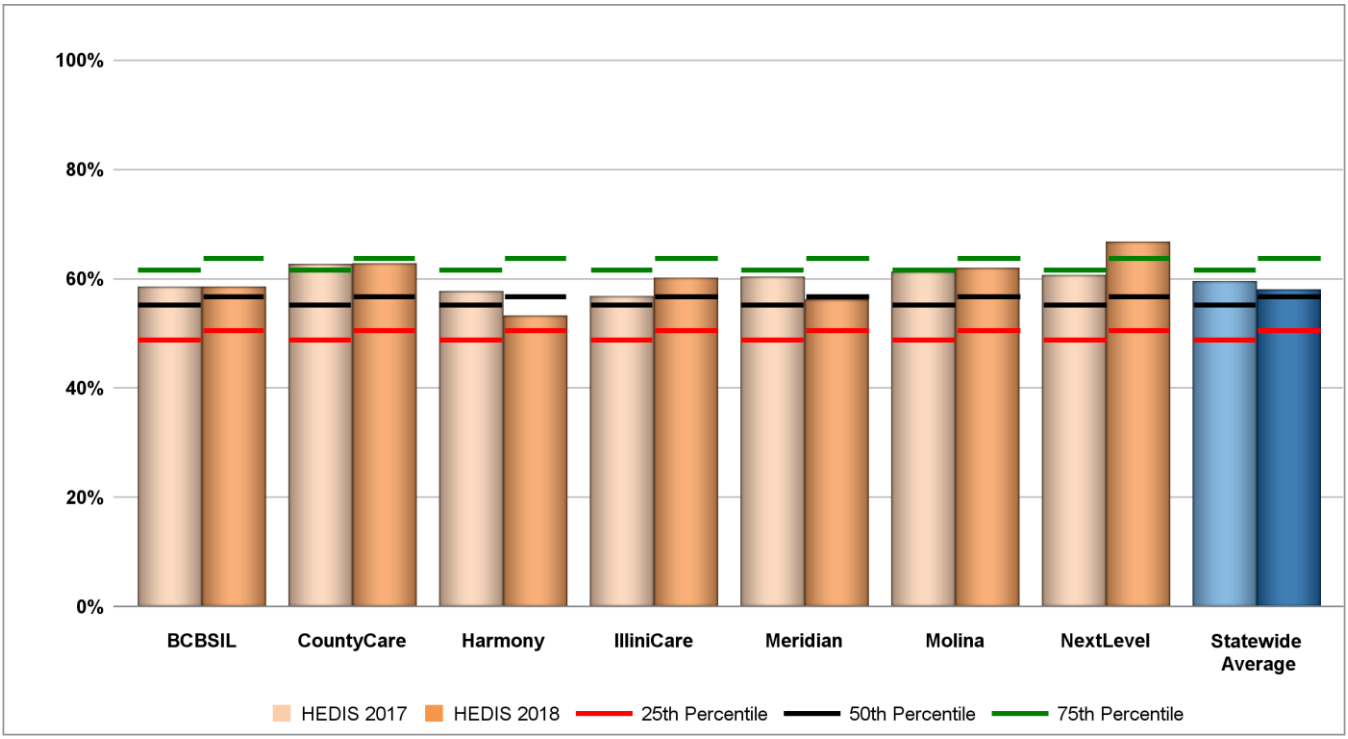
Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Chlamydia Screening in Women—Total

In the United States, chlamydial infections are highly prevalent among young women and if left untreated can lead to health complications such as infertility, ectopic pregnancy, and chronic pelvic pain. Therefore, screening is essential since most women who have the condition do not experience symptoms.[2-18] This measure assesses whether women 16 to 24 years of age who were identified as sexually active had at least one test for chlamydia during the measurement year. Figure 2-16 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Chlamydia Screening in Women—Total* measure indicator.

Figure 2-16—*Chlamydia Screening in Women—Total*—HEDIS 2017 and 2018



Notable

- For the *Chlamydia Screening in Women—Total* measure indicator, only one of the seven (14.3 percent) health plans, NextLevel, exceeded the national Medicaid 75th percentile for HEDIS 2018.

Needs Work

- Measure rates for two of the seven (28.6 percent) health plans, Harmony and Meridian, declined from HEDIS 2017 to HEDIS 2018 and fell below the national Medicaid 50th percentile for HEDIS 2018.

[2-18] Centers for Disease Control and Prevention. Chlamydia. Available at: https://www.cdc.gov/std/stats16/chlamydia.htm. Accessed on: Dec 13, 2018.

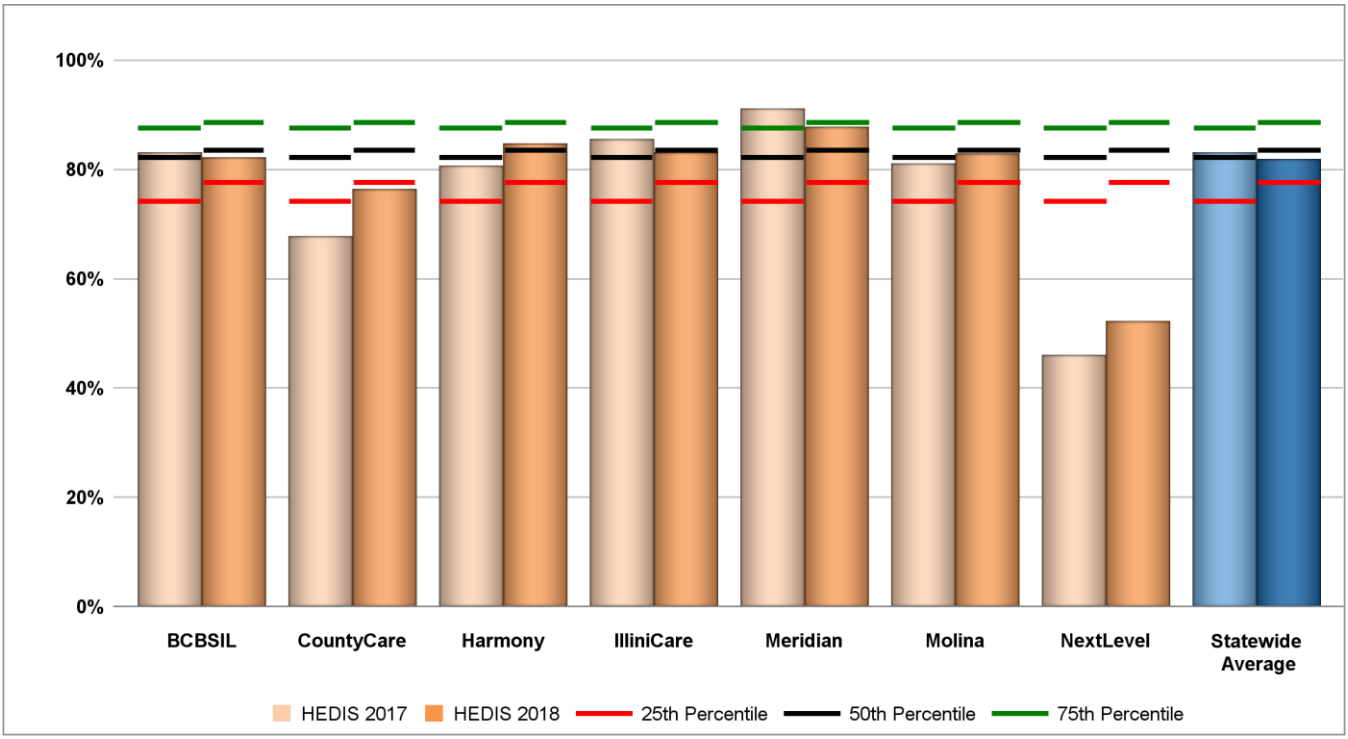
Prenatal and Postpartum Care

Prenatal care is important for women to keep themselves and their baby healthy.[2-19] After a child's birth, effective postpartum care includes managing the mother's physical and mental well-being.[2-20]

Timeliness of Prenatal Care

This measure indicator assesses the percentage of deliveries resulting in live births that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in the health plan. Figure 2-17 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator.

Figure 2-17—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*—HEDIS 2017 and 2018



NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

[2-19] U.S. Department of Health and Human Services. Prenatal Care. Available at: https://medlineplus.gov/prenatalcare.html. Accessed on: Dec 13, 2018.

[2-20] Mayo Clinic. Postpartum Care. Available at: https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/basics/postpartum-care/hlv-20049465. Accessed on: Dec 13, 2018.

Notable

- Performance across the health plans varied for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, Harmony and Meridian, ranking above the national Medicaid 50th percentile.

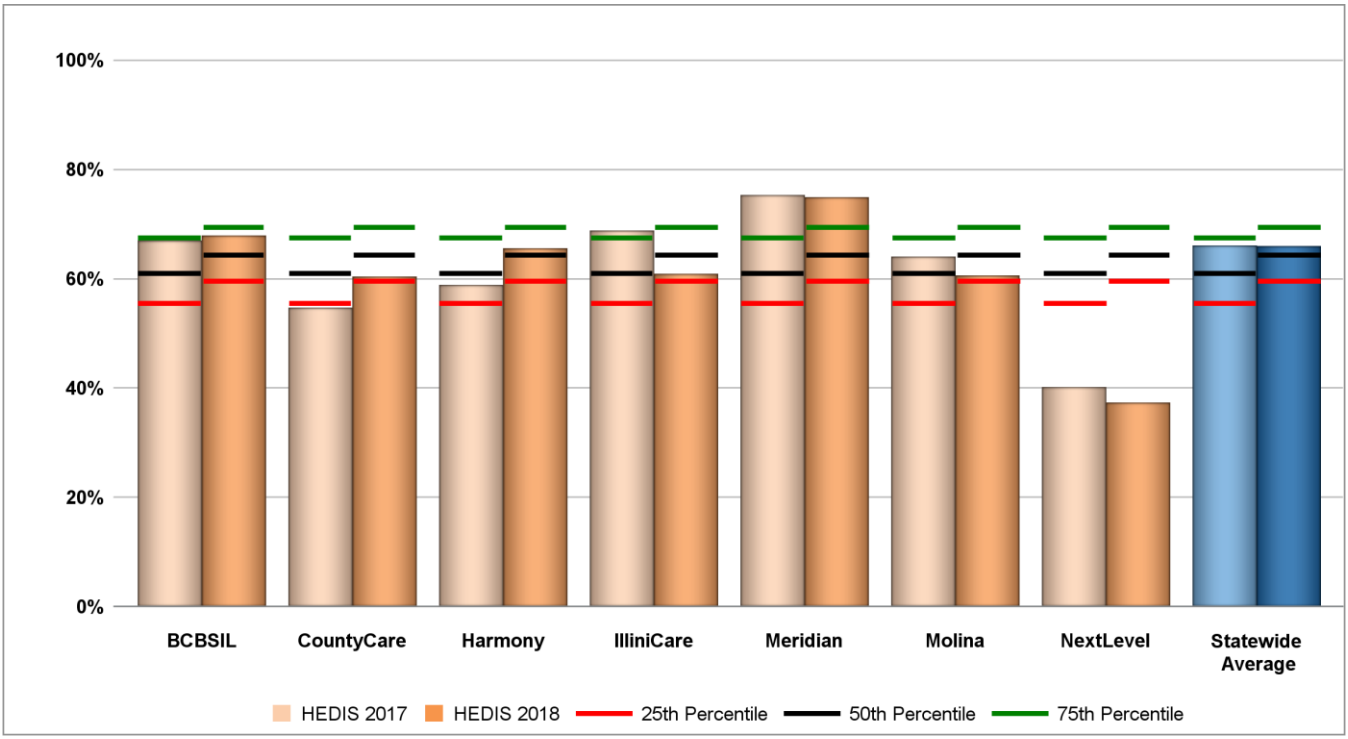
Needs Work

- The statewide average declined in performance and fell below the national Medicaid 50th percentile.
- Measure rates for two of the seven (28.6 percent) health plans, CountyCare and NextLevel, fell below the national Medicaid 25th percentile for HEDIS 2018.

Postpartum Care

This measure indicator assesses the percentage of deliveries resulting in live births that had a postpartum visit on or between 21 and 56 days after delivery. Figure 2-18 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator.

Figure 2-18—*Prenatal and Postpartum Care—Postpartum Care*—HEDIS 2017 and 2018



NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- The statewide average for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator ranked between the national Medicaid 50th and 75th percentiles for HEDIS 2018.
- Performance across the health plans varied, with only one of the seven (14.3 percent) health plans, Meridian, exceeding the national Medicaid 75th percentile.

Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Women's Health Conclusions

In the Women's Health domain, the HEDIS 2018 statewide average ranked above the national Medicaid 50th percentile for three of the four (75.0 percent) measure rates that were comparable to benchmarks. Conversely, the statewide average for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate demonstrated a decline in performance and fell below the national Medicaid 50th percentile, indicating an opportunity to ensure women are receiving timely prenatal care.

Appropriate Care

Appropriate healthcare is when the potential health benefits outweigh the potential negative effects. Appropriate care requires effective treatment options, quality clinical skills, up-front communication, and a justification for the type and extent of care.[2-21]

The results of 11 appropriate care measure rates for the health plans are presented in this section. The results for additional appropriate care measure results can be found in Appendix C of this report.

Annual Monitoring for Patients on Persistent Medications

Patients with long-term medication use and who take multiple medications are at increased risk of preventable adverse drug events, which contribute to health complications and high costs but can be reduced through appropriate monitoring.[2-22] This measure assesses the percentage of adults 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and received at least one therapeutic monitoring event in the measurement year. Results for this measure are reported as two rates separately and as a total rate.

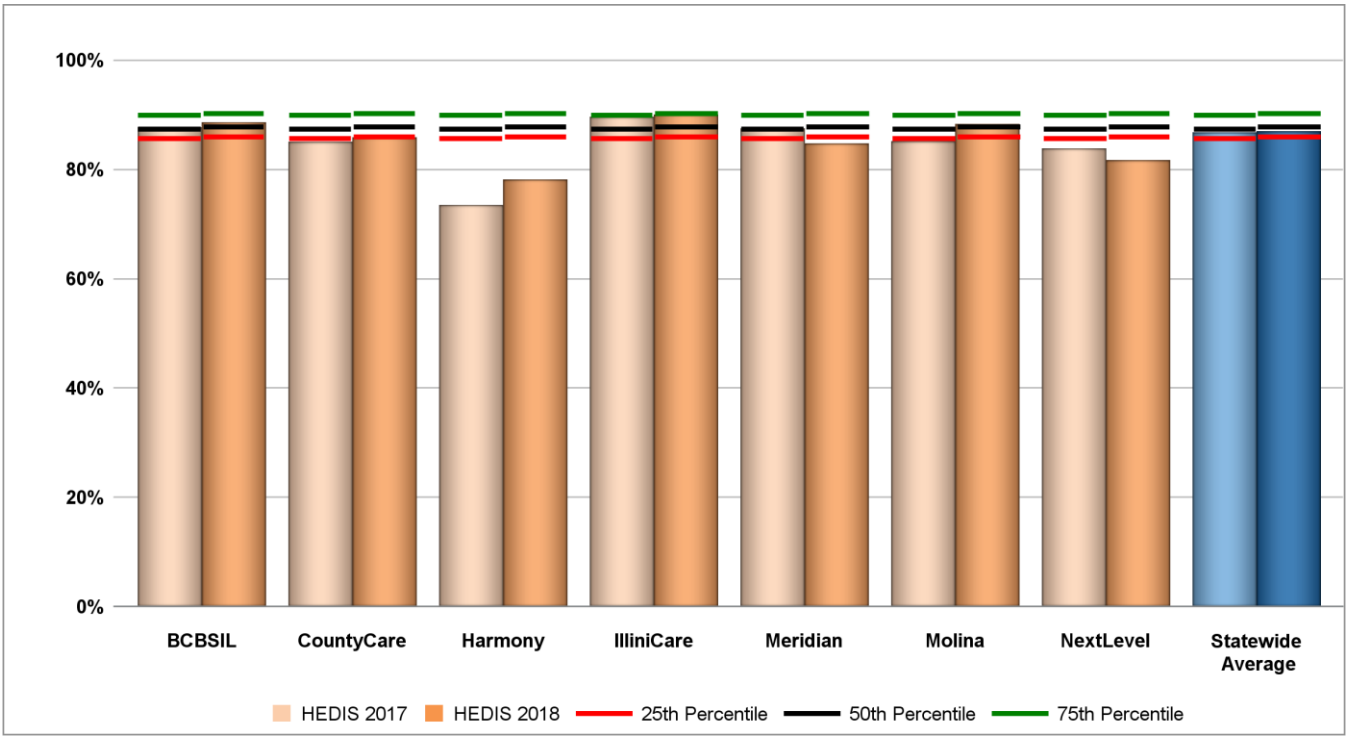
[2-21] What do we mean by appropriate healthcare? Report of a working group prepared for the Director of Research and Development of the NHS Management Executive. *Quality in Health Care*. 1993; 2(2):117–123. Available at: http://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC1055096&blobtype=pdf. Accessed on: Dec 13, 2018.

[2-22] National Committee for Quality Assurance. Annual Monitoring for Patients on Persistent Medications. Available at: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2017-table-of-contents/persistent-medications. Accessed on: Dec 13, 2018.

ACE Inhibitors or ARBs

Figure 2-19 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure indicator.

Figure 2-19—*Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*—HEDIS 2017 and 2018



Notable

- Performance across the health plans varied for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure indicator for HEDIS 2018, with just three of the seven (42.9 percent) health plans—BCBSIL, IlliniCare, and Molina—exceeding the national Medicaid 50th percentile.

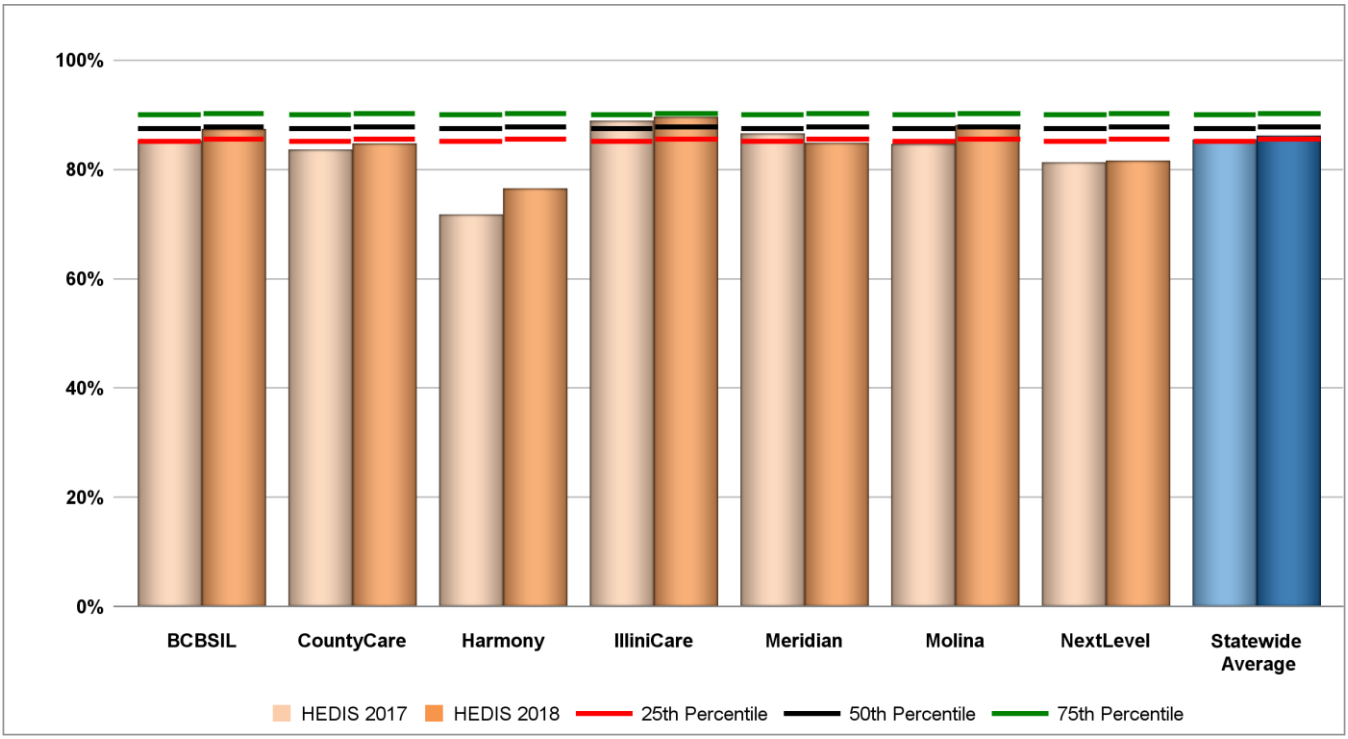
Needs Work

- Despite demonstrating a slight increase in performance, the statewide average fell below the national Medicaid 50th percentile for HEDIS 2018.
- Measure rates for four of the seven (57.1 percent) health plans—CountyCare, Harmony, Meridian, and NextLevel—fell below the national Medicaid 25th percentile.

Diuretics

Figure 2-20 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure indicator.

Figure 2-20—*Annual Monitoring for Patients on Persistent Medications—Diuretics*—HEDIS 2017 and 2018



Notable

- Performance across the health plans varied for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, IlliniCare and Molina, ranking above the national Medicaid 50th percentile.

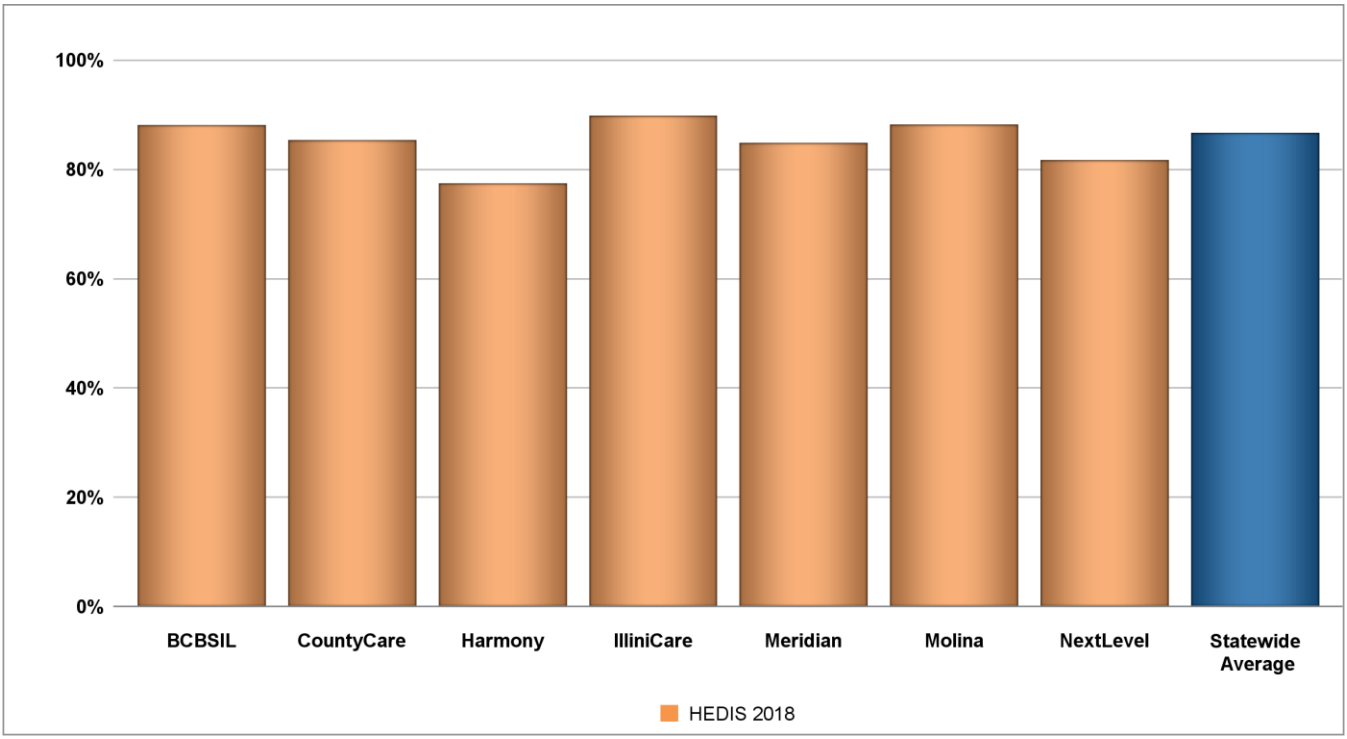
Needs Work

- Despite demonstrating a slight increase in performance, the statewide average fell below the national Medicaid 50th percentile for HEDIS 2018.
- Measure rates for four of the seven (57.1 percent) health plans—CountyCare, Harmony, Meridian, and NextLevel—fell below the national Medicaid 25th percentile.

Total

The *Total* rate equals the sum of the two numerators for the other indicators (*ACE Inhibitors or ARBs* and *Diuretics)* divided by the sum of the two denominators. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to national benchmarks are not performed for this measure. Figure 2-21 presents the HEDIS 2018 rates for the health plans and the statewide average for the *Annual Monitoring for Patients on Persistent Medications—Total* measure indicator.

Figure 2-21—*Annual Monitoring for Patients on Persistent Medications*—Total—HEDIS 2018



Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to national benchmarks are not performed.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by more than 10 percentage points.

Comprehensive Diabetes Care

Diabetes is a highly prevalent chronic disease in the United States and the country's seventh leading cause of death.[2-23] The *Comprehensive Diabetes Care* measure includes rates for several distinct components of care that are critical to maintaining a healthy lifestyle.

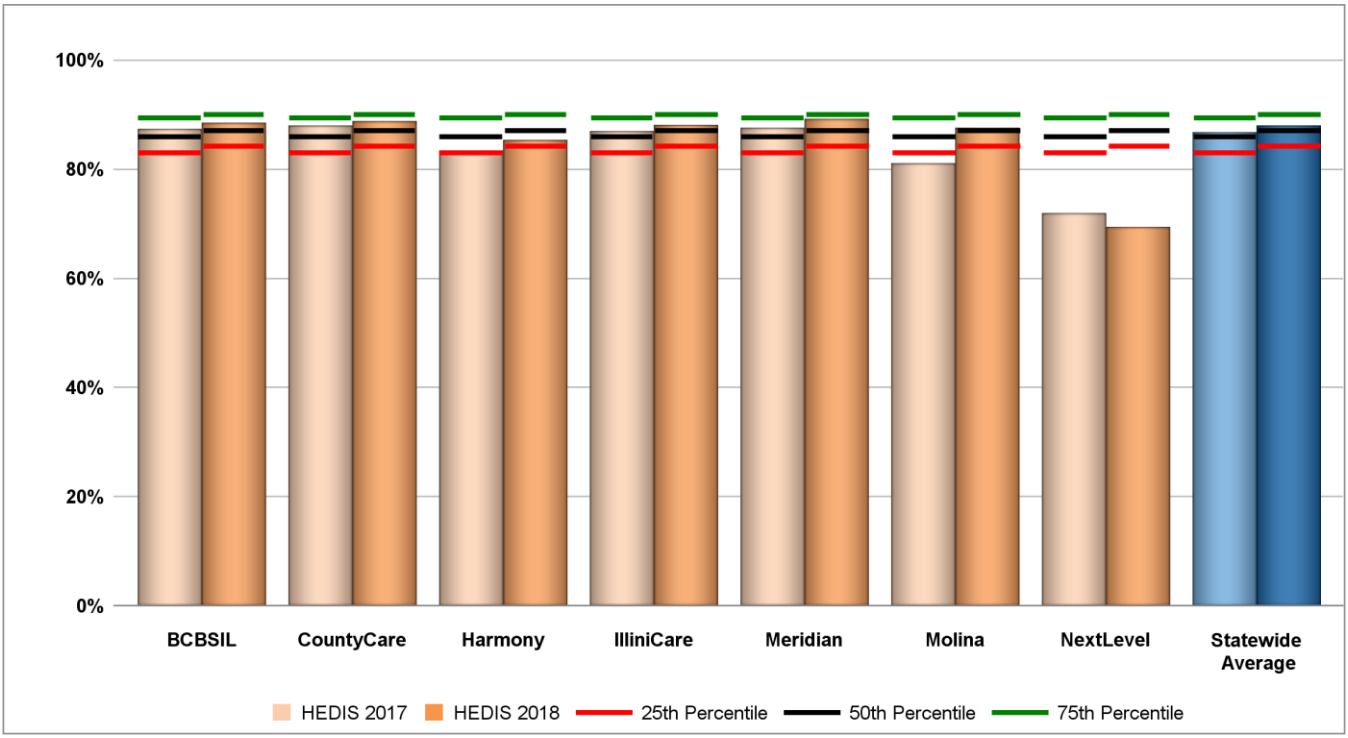
HbA1c Testing

The HbA1c test presents information about a person's levels of blood glucose from the previous three months. The test can be performed at any time of the day and does not require fasting, making it more convenient for people to manage their diabetes.[2-24] This measure indicator assesses the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test performed during the measurement year. Figure 2-22 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator.

[2-23] U.S. Department of Health and Human Services. 2020 Topics & Objectives: Diabetes. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes. Accessed on: Dec 13, 2018.

[2-24] National Institute of Diabetes and Digestive and Kidney Diseases. The A1C Test & Diabetes. Available at: https://www.niddk.nih.gov/health-information/diabetes/overview/tests-diagnosis/a1c-test. Accessed on: Dec 13, 2018.

Figure 2-22—*Comprehensive Diabetes Care—HbA1c Testing*—HEDIS 2017 and 2018



NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- Six of the seven (85.7 percent) health plans and the statewide average for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator demonstrated an increase in performance for HEDIS 2018.
- Measure rates for the statewide average and five of the seven (71.4 percent) health plans—BCBSIL, CountyCare, IlliniCare, Meridian, and Molina—ranked above the national Medicaid 50th percentile.

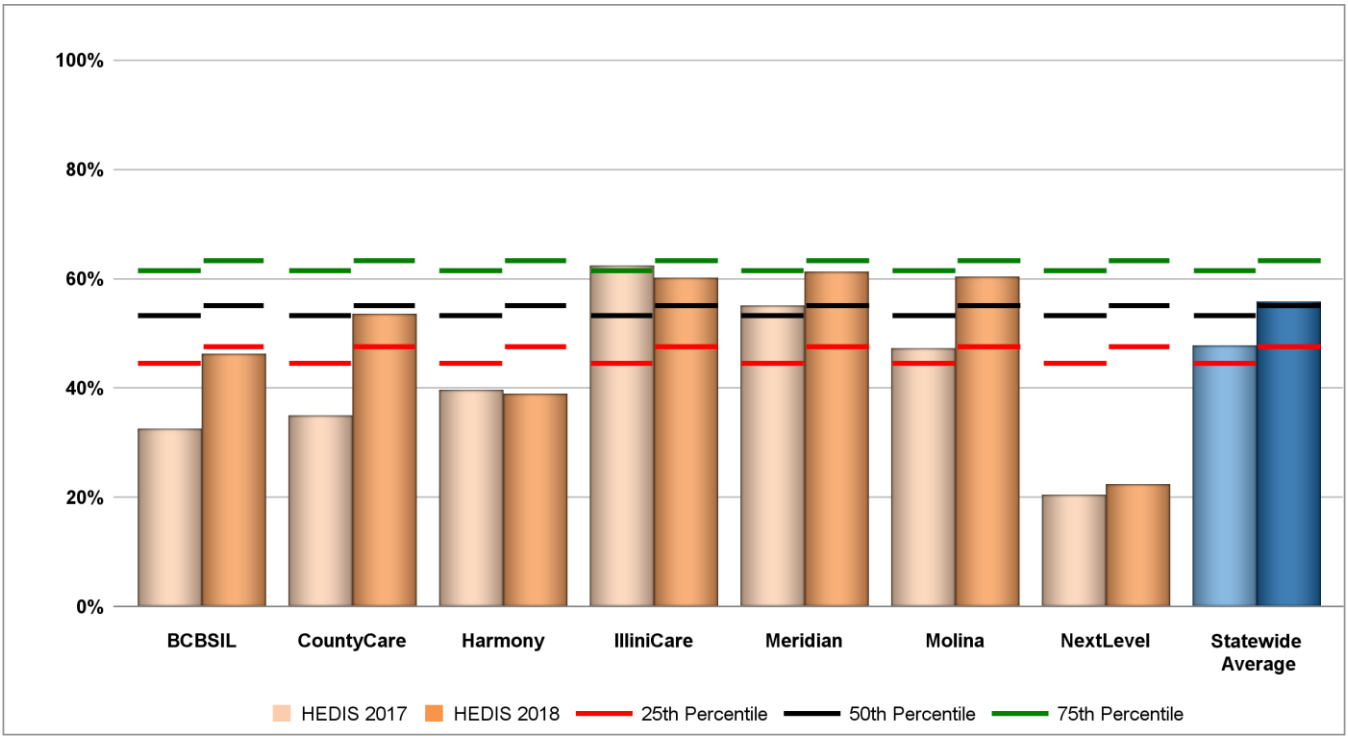
Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Eye Exam (Retinal) Performed

Diabetic retinopathy affects patients with both type 1 and type 2 diabetes posing a serious threat to vision. Patients with a longer duration of diabetes have a higher risk of retinopathy.[2-25] This measure assesses the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had an eye screening for diabetic retinal disease. Figure 2-23 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator.

Figure 2-23—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*—HEDIS 2017 and 2018



NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- The statewide average and measure rates for five of the seven (71.4 percent) health plans for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator demonstrated improvement in performance for HEDIS 2018.
- Measure rates for the statewide average and three of the seven (42.9 percent) health plans—IlliniCare, Meridian, and Molina—ranked above the national Medicaid 50th percentile.

Needs Work

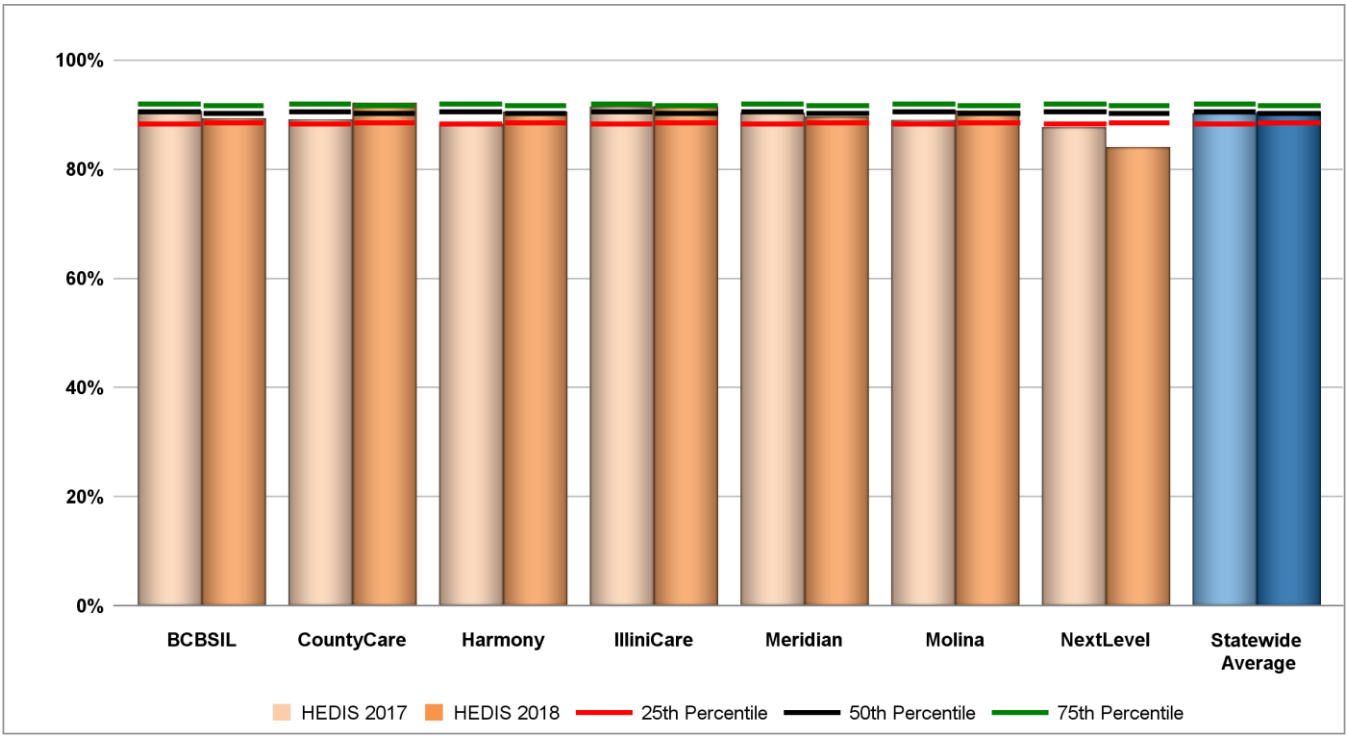
- Measure rates for BCBSIL, Harmony, and NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

[2-25] American Diabetes Association. Diabetic Retinopathy. *Diabetic Care* 2002; 25(suppl 1):S90. Available at: http://care.diabetesjournals.org/content/diacare/25/suppl_1/s90.full.pdf. Accessed on: Dec 13, 2018.

Medical Attention for Nephropathy

This measure indicator assesses the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had a nephropathy screening or monitoring test or evidence of nephropathy. Figure 2-24 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator.

Figure 2-24—*Comprehensive Diabetes Care—Medical Attention for Nephropathy*—HEDIS 2017 and 2018



NextLevel reported this measure using the administrative methodology. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Notable

- The statewide average for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator ranked between the national Medicaid 50th and 75th percentiles for HEDIS 2018. Additionally, four of the seven (57.1 percent) health plans exceeded the national Medicaid 50th percentile.

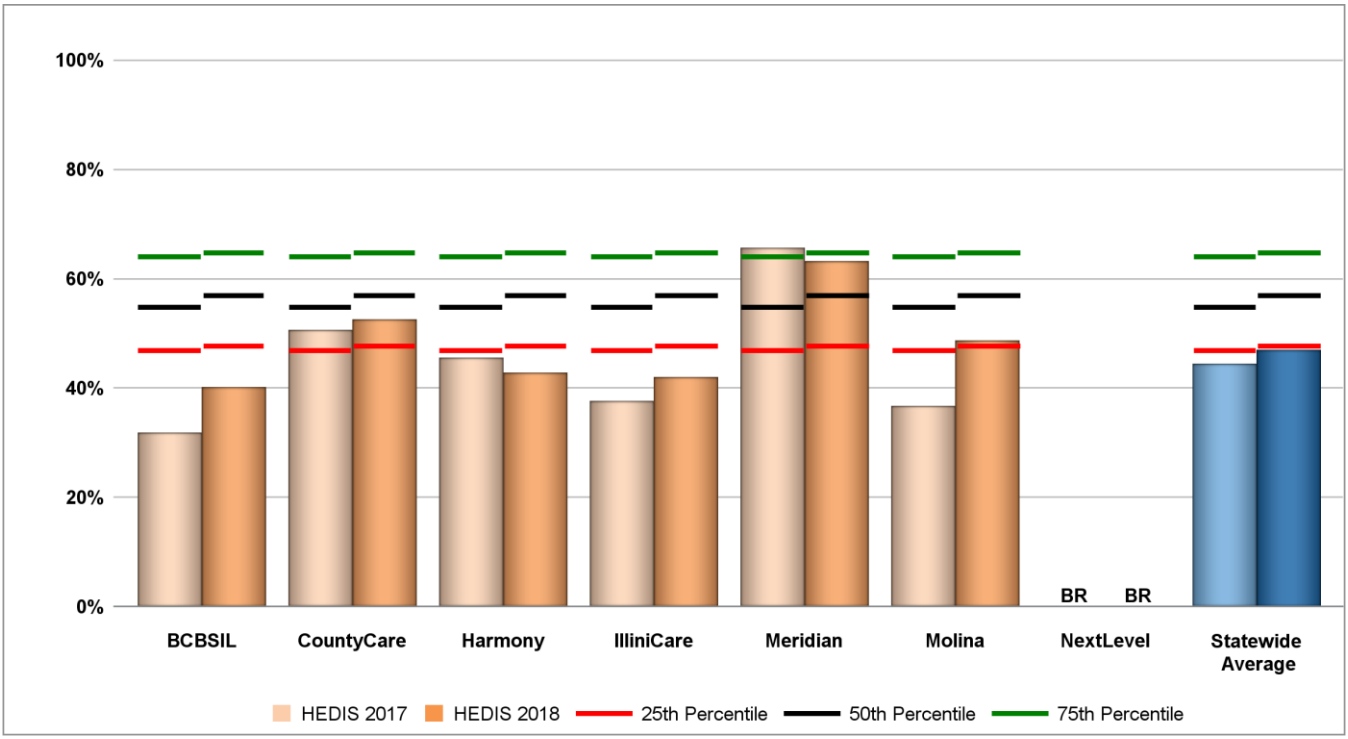
Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Controlling High Blood Pressure

This measure assesses the percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria: members 18 to 59 years of age whose BP was <140/90 mm Hg; members 60 to 85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg; or members 60 to 85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. Figure 2-25 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Controlling High Blood Pressure* measure.

Figure 2-25—*Controlling High Blood Pressure*—HEDIS 2017 and 2018



BR indicates that the rate was materially biased.

Notable

- Performance across the health plans varied for the *Controlling High Blood Pressure* measure for HEDIS 2018, with only one of the six (16.7 percent) health plans with a reportable rate, Meridian, ranking above the national Medicaid 50th percentile.

Needs Work

- The statewide average and measure rates for three of the six (50.0 percent) health plans with a reportable rate—BCBSIL, Harmony, and IlliniCare—fell below the national Medicaid 25th percentile.
- NextLevel was not able to report an accurate rate for this measure for the second consecutive year.

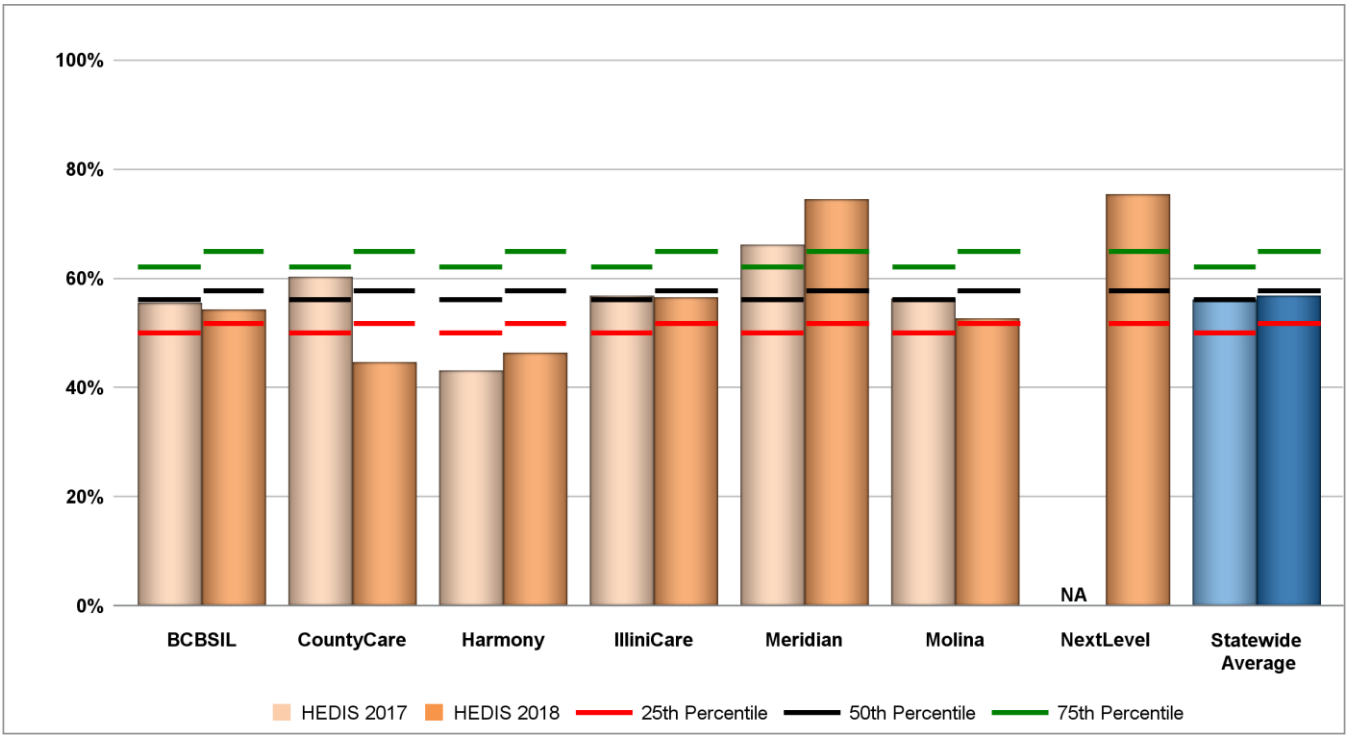
Medication Management for People With Asthma

Asthma is a treatable condition that affects more than 25 million people in the United States. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and education regarding the correct usage of medications.[2-26]

Medication Compliance 50%—Total

This measure indicator assesses the percentage of beneficiaries 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed an asthma controller medication that they remained on for at least 50 percent of their treatment period. Figure 2-26 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure indicator.

Figure 2-26—*Medication Management for People With Asthma—Medication Compliance 50%—Total*—HEDIS 2017 and 2018



Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.
NA indicates the rate was withheld because the denominator was less than 30.

[2-26] Centers for Disease Control and Prevention (CDC). CDC Vital Signs: Asthma in the US. Available at: http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf. Accessed on: Dec 13, 2018.

Notable

- Performance across the health plans varied for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, Meridian and NextLevel, exceeding the national Medicaid 75th percentile.

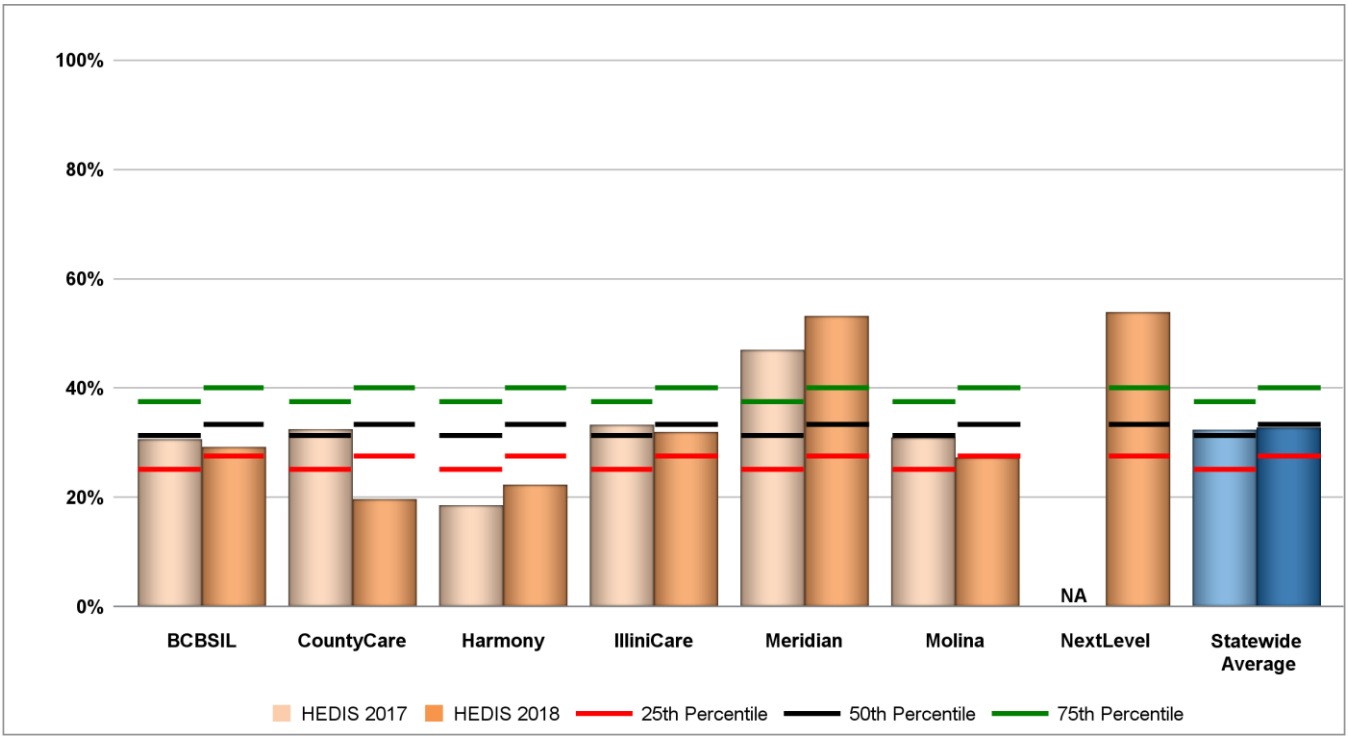
Needs Work

- Despite demonstrating a slight increase in performance, the statewide average fell below the national Medicaid 50th percentile for HEDIS 2018.
- Measure rates for two of the seven (28.6 percent) health plans, CountyCare and Harmony, fell below the national Medicaid 25th percentile.

Medication Compliance 75%—Total

This measure assesses the percentage of beneficiaries 5 to 64 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period. Figure 2-27 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure indicator.

Figure 2-27—*Medication Management for People With Asthma—Medication Compliance 75%—Total*—HEDIS 2017 and 2018



NA indicates the rate was withheld because the denominator was less than 30.

Notable

- Performance across the health plans varied for the *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, Meridian and NextLevel, exceeding the national Medicaid 75th percentile.

Needs Work

- Despite demonstrating a slight increase in performance, the statewide average fell below the national Medicaid 50th percentile for HEDIS 2018.
- Measure rates for three of the seven (42.9 percent) health plans—CountyCare, Harmony, and Molina—fell below the national Medicaid 25th percentile.

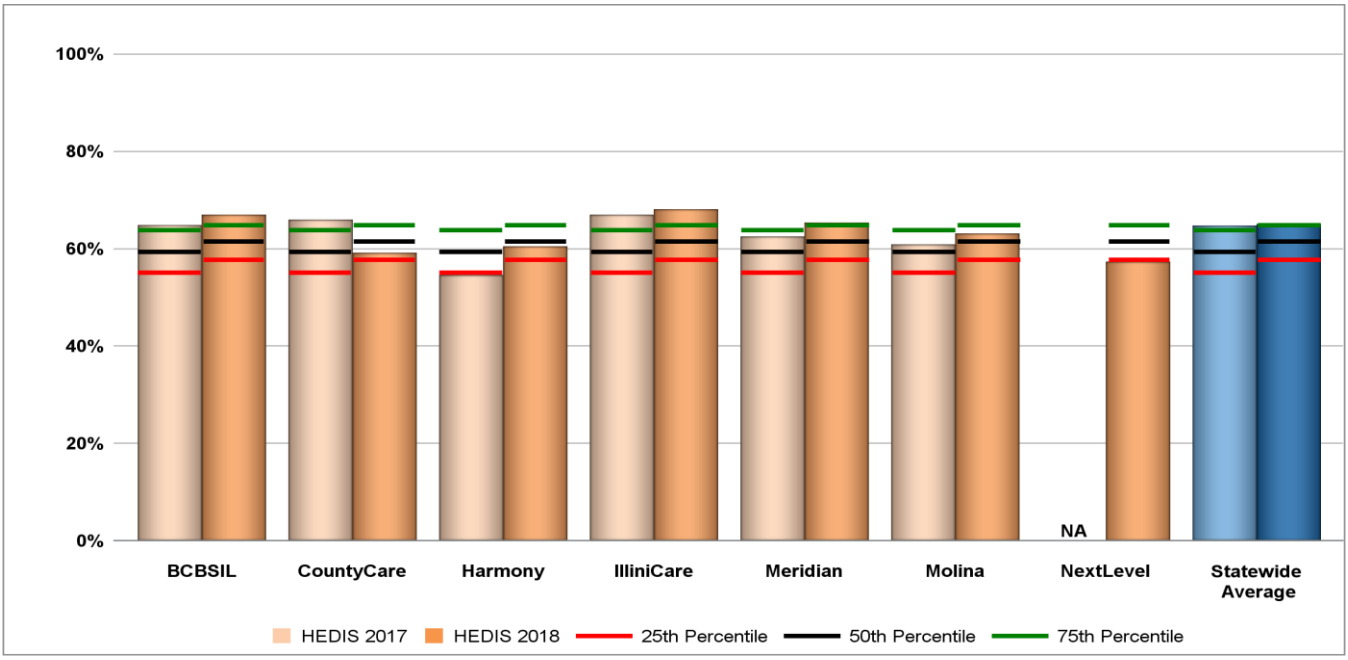
Statin Therapy for People With Diabetes

This measure assesses whether members 40 to 75 years of age during the measurement year with diabetes who did not have clinical atherosclerotic cardiovascular disease (ASCVD) were administered statin medications. Two rates are reported—*Received Statin Therapy* and *Statin Adherence 80%*.

Received Statin Therapy

This measure indicator assesses the percentage of members who were dispensed at least one statin medication of any intensity during the measurement year. Figure 2-28 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator.

Figure 2-28—*Statin Therapy for People With Diabetes—Received Statin Therapy*—HEDIS 2017 and 2018



Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.

NA indicates the rate was withheld because the denominator was less than 30.

Notable

- The statewide average for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator exceeded the national Medicaid 75th percentile for HEDIS 2018. Additionally, measure rates for three of the seven (42.9 percent) health plans—BCBSIL, IlliniCare, and Meridian—exceeded the national Medicaid 75th percentile.
- Five of the six (83.3 percent) health plans that reported rates for both years showed improvement.

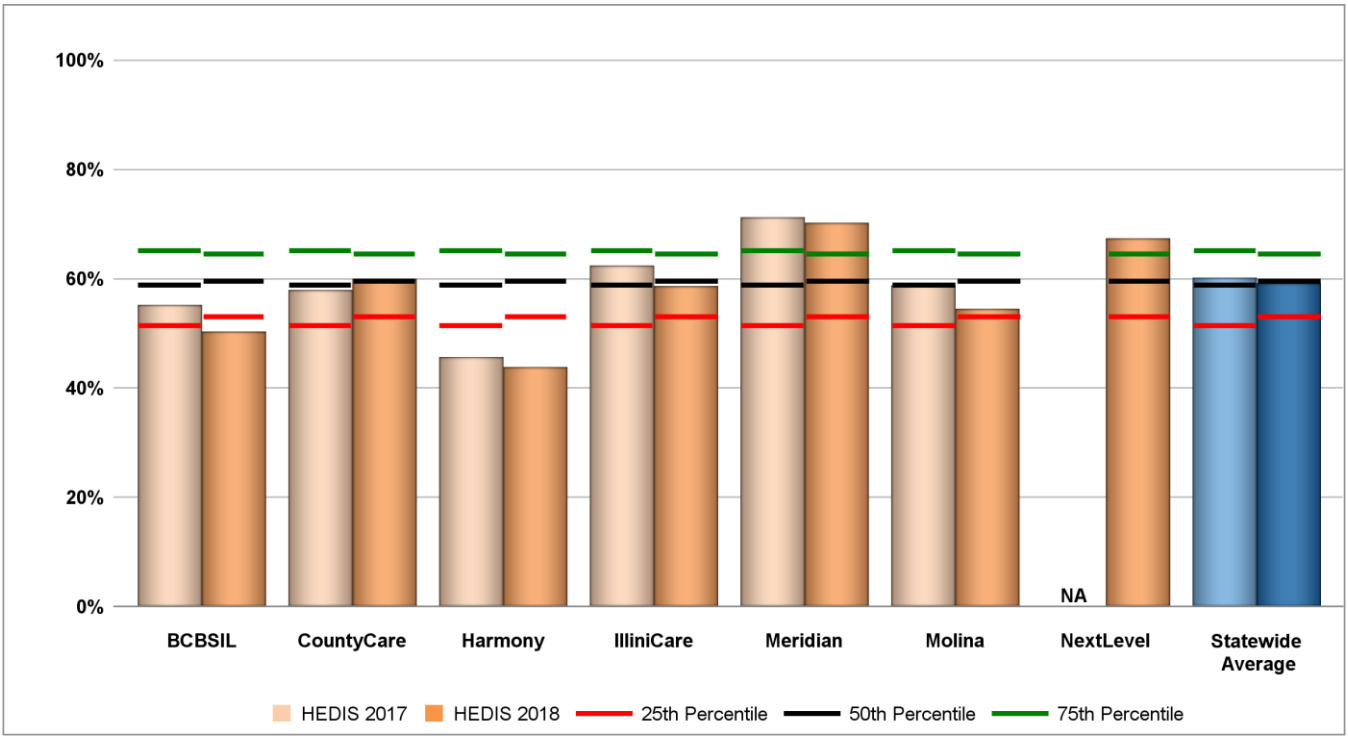
Needs Work

- The measure rate for NextLevel fell below the national Medicaid 25th percentile for HEDIS 2018.

Statin Adherence 80%

This measure indicator assesses the percentage of members who remained on a statin medication of any intensity for at least 80 percent of their treatment period. Figure 2-29 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Stain Therapy for People With Diabetes—Statin Adherence 80%* measure indicator.

Figure 2-29—*Statin Therapy for People With Diabetes—Statin Adherence 80%*—HEDIS 2017 and 2018



Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.

NA indicates the rate was withheld because the denominator was less than 30.

Notable

- Performance across the health plans varied for the *Stain Therapy for People With Diabetes—Statin Adherence 80%* measure indicator for HEDIS 2018, with just two of the seven (28.6 percent) health plans, Meridian and NextLevel, exceeding the national Medicaid 75th percentile.

Needs Work

- The statewide average fell below the national Medicaid 50th percentile for HEDIS 2018. Additionally, measure rates for two of the seven (28.6 percent) health plans, BCBSIL and Harmony, fell below the national Medicaid 25th percentile.
- Five of the six (83.3 percent) health plans that reported rates for both years showed a decline in performance.

Appropriate Care Conclusions

In the Appropriate Care domain, the HEDIS 2018 statewide average exceeded the national Medicaid 75th percentile for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator, indicating strength. Conversely, the statewide average fell below the national Medicaid 50th percentile for six of the 10 (60.0 percent) measure rates, with the statewide average for *Controlling High Blood Pressure* falling below the 25th percentile. Therefore, opportunities exist for the health plans to increase services and improve performance for members with diabetes, high blood pressure, and those with persistent medication use.

Behavioral Health

Good mental health is important for productivity, building relationships, and personal well-being. Mental illnesses, such as anxiety and depression, affect physical health by hindering health-promoting behaviors.[2-27]

The results of five behavioral health measure rates for the health plans are presented in this section. Additional measure results can be found in Appendix C of this report.

Follow-Up After Hospitalization for Mental Illness

Approximately one in five adults in the United States experience a mental health issue in a given year.[2-28] Timely follow-up after hospitalization for a mental illness is an important step toward recovery and may reduce rehospitalization and promote better health outcomes.[2-29]

2-27 U.S. Department of Health and Human Services. 2020 Topics & Objectives: Mental Health and Mental Disorders. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: Dec 13, 2018.

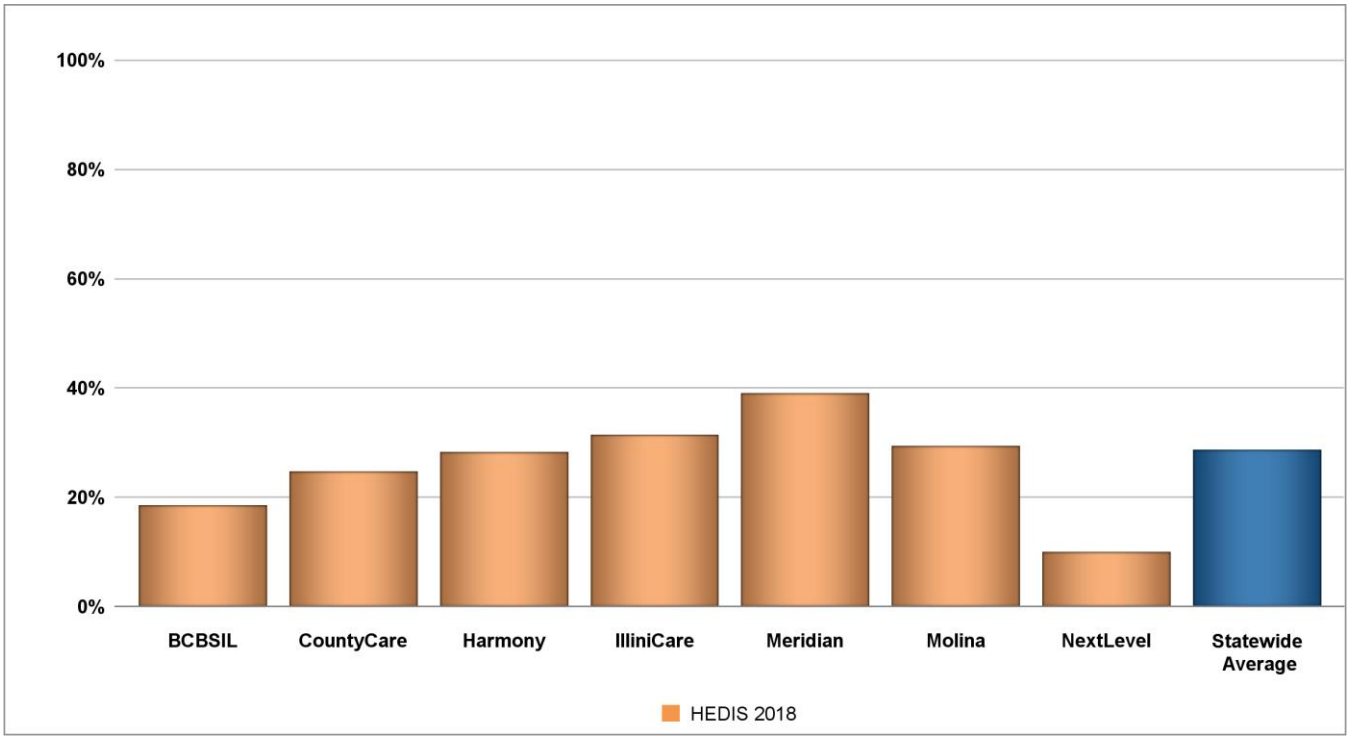
2-28 Substance Abuse and Mental Health Services Administration. Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm#fn4. Accessed on: Dec 13, 2018.

2-29 Carson NJ, Vesper A, Chen C-N, et al. Quality of Follow-Up After Hospitalization for Mental Illness Among Patients From Racial-Ethnic Minority Groups. *Psychiatric Services*. 2014; 65(7):888–896.

7-Day Follow-Up

This measure assesses the percentage of beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and had a follow-up visit with a mental health practitioner within 7 days of hospital discharge. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to national benchmarks are not performed for this measure. Figure 2-30 presents the HEDIS 2018 rates for the health plans and the statewide average for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator.

Figure 2-30—*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*—HEDIS 2018



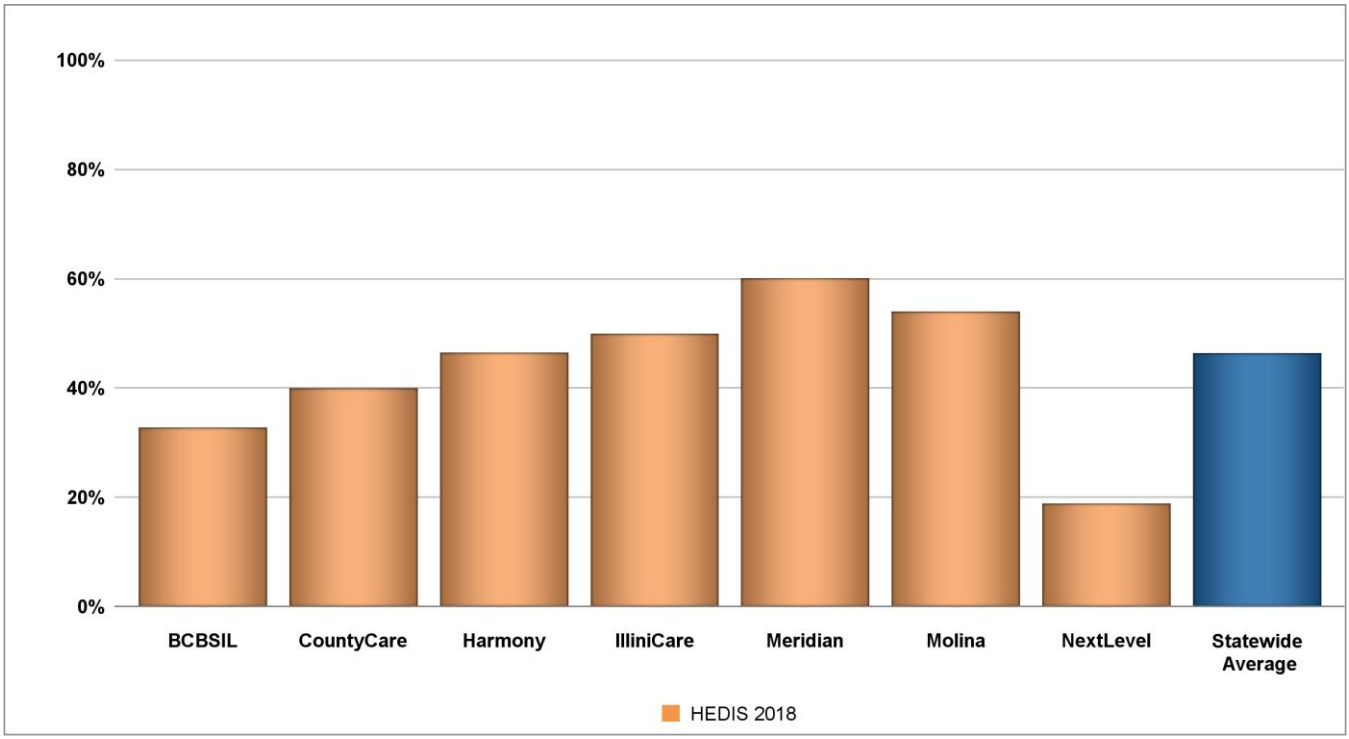
Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to national benchmarks are not performed.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by nearly 30 percentage points.

30-Day Follow-Up

This measure assesses the percentage of beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and had a follow-up visit with a mental health practitioner within 30 days of hospital discharge. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to national benchmarks are not performed for this measure. Figure 2-31 presents the HEDIS 2018 rates for the health plans and the statewide average for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator.

Figure 2-31—*Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*—HEDIS 2018



Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to national benchmarks are not performed.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by more than 40 percentage points.

Initiation and Engagement of AOD Abuse or Dependence Treatment

AOD dependence is an illness that can affect anyone. There are several types of treatment options available such as inpatient, outpatient, intensive outpatient, and partial hospitalization. The length of treatment varies, but the longer a person stays in treatment the more likely that person will have a successful recovery.[2-30] The growing misuse of drugs and related health consequences caused by substance abuse place a huge burden on the healthcare system.[2-31]

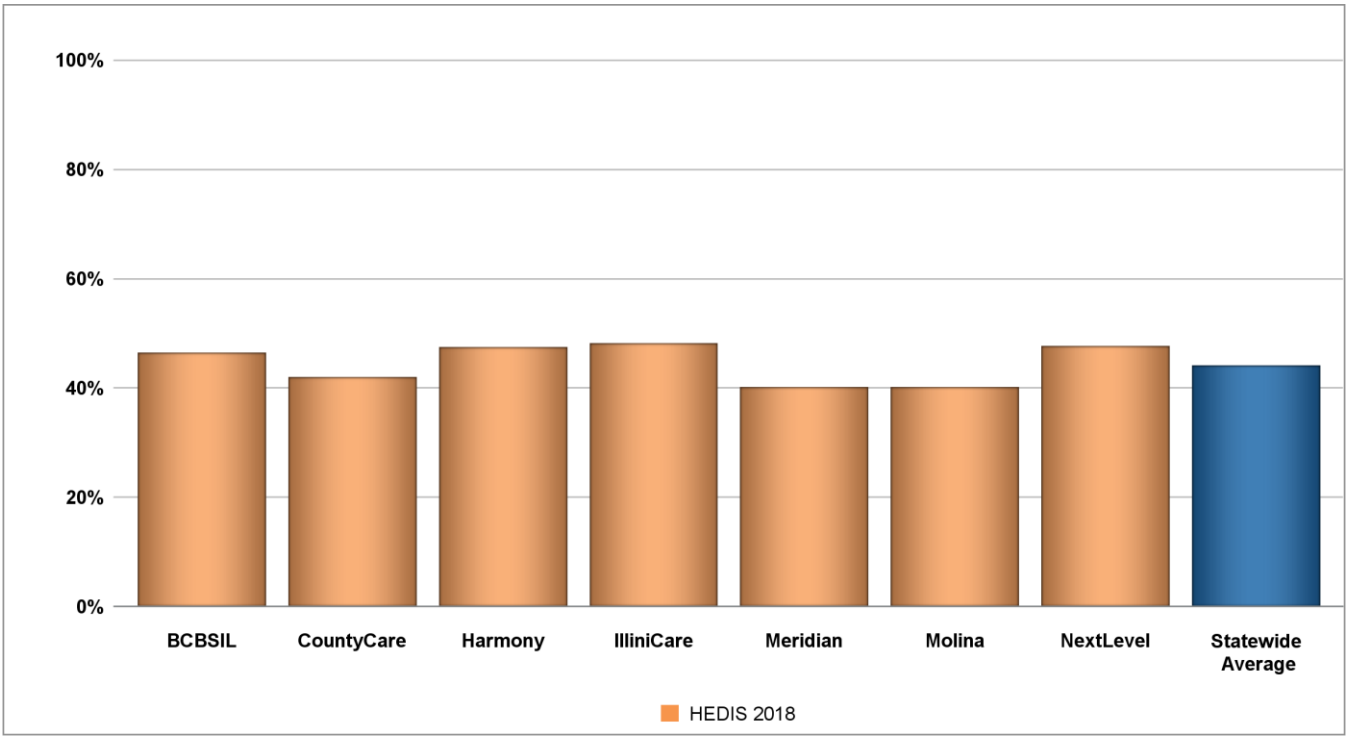
Initiation of AOD Treatment—Total—Total

This measure indicator assesses the percentage of adolescent and adult beneficiaries with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to national benchmarks are not performed for this measure. Figure 2-32 presents the HEDIS 2018 rates for the health plans and the statewide average for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* measure indicator.

[2-30] Substance Abuse and Mental Health Services Administration. What is Substance Abuse? (Publication No. (SMA) 08-4126). Available at: https://store.samhsa.gov/system/files/sma14-4126.pdf. Accessed on: Feb 13, 2018.

[2-31] National Institute on Drug Abuse. Trends & Statistics. Available at: https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs. Accessed on: Dec 12, 2018.

Figure 2-32—*Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total*—HEDIS 2018



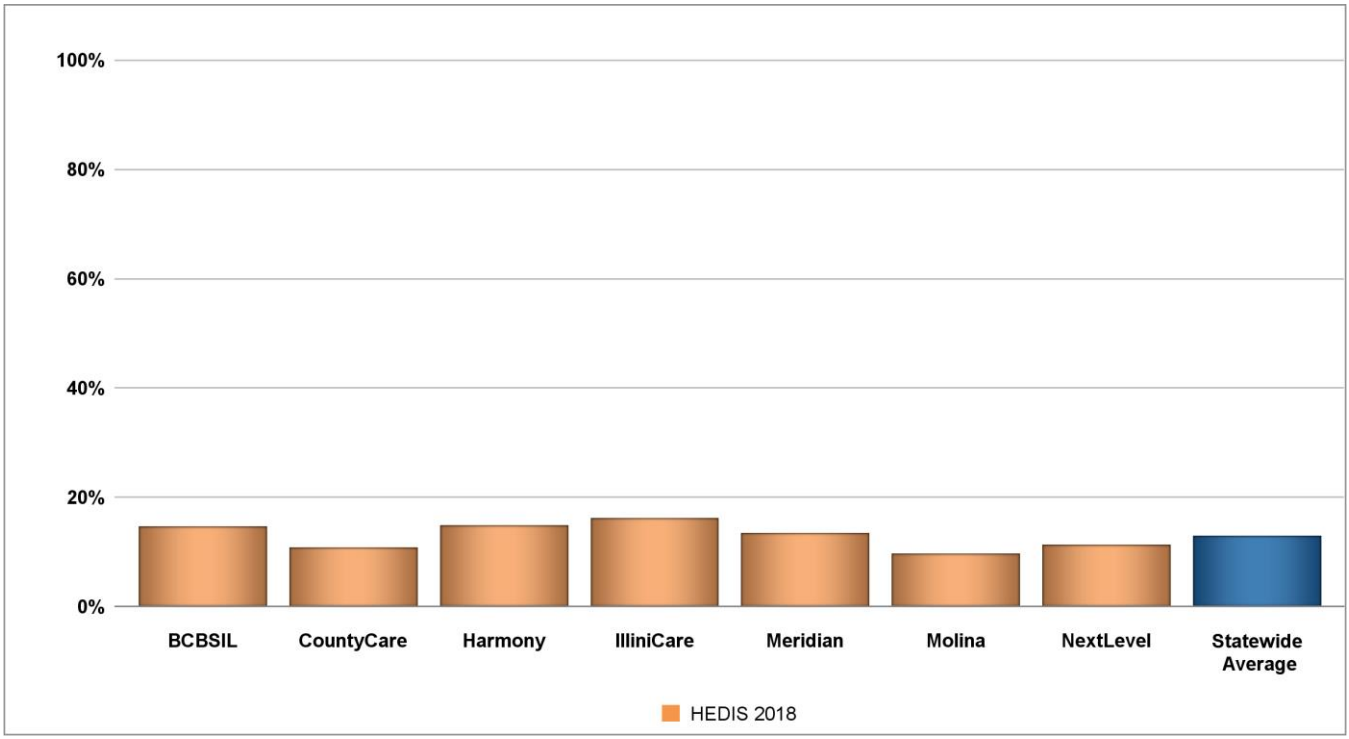
Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to benchmarks are not performed.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by less than 10 percentage points.

Engagement of AOD Treatment—Total—Total

This measure indicator assesses the percentage of adolescent and adult beneficiaries with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit. Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to national benchmarks are not performed for this measure. Figure 2-33 presents the HEDIS 2018 rates for the health plans and the statewide average for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total* measure indicator.

Figure 2-33—*Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total*—HEDIS 2018



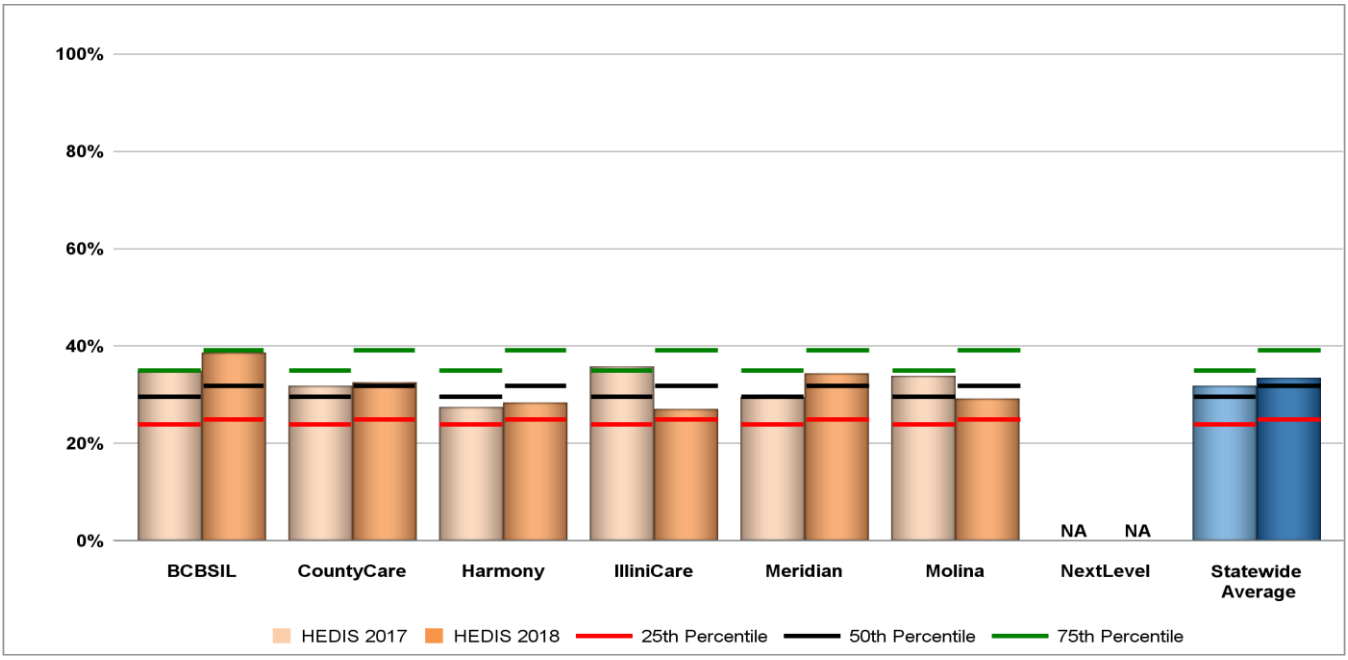
Due to changes in NCQA's technical specifications for this measure, only HEDIS 2018 rates are displayed and comparisons to benchmarks are not performed.

Due to changes in the technical specifications in HEDIS 2018 for this measure indicator, a comparison to prior year's rates and to national benchmarks is not appropriate. Therefore, the rates in the figure above are presented for information only. Health plan performance varied by more than 5 percentage points.

Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total

This measure is important because the frequency of prescribing antipsychotics in children and adolescents has increased rapidly. Additionally, children and adolescents prescribed antipsychotics are more at risk for health concerns, including weight gain, metabolic effects, hyperprolactinemia, and extrapyramidal side effects (e.g., anxiety, distress, paranoia, etc.).[2-32] This measure assesses the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Figure 2-34 presents the HEDIS 2017 and HEDIS 2018 rates for the health plans and the statewide average compared to national Medicaid percentiles for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total* measure indicator.

Figure 2-34—*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*—HEDIS 2017 and 2018



NA indicates the rate was withheld because the denominator was less than 30.

Notable

- The statewide average for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total* measure indicator ranked between the national Medicaid 50th and 75th percentiles for HEDIS 2018. Additionally, measure rates for four of the six (66.7 percent) health plans with a reportable rate showed an increase in performance.

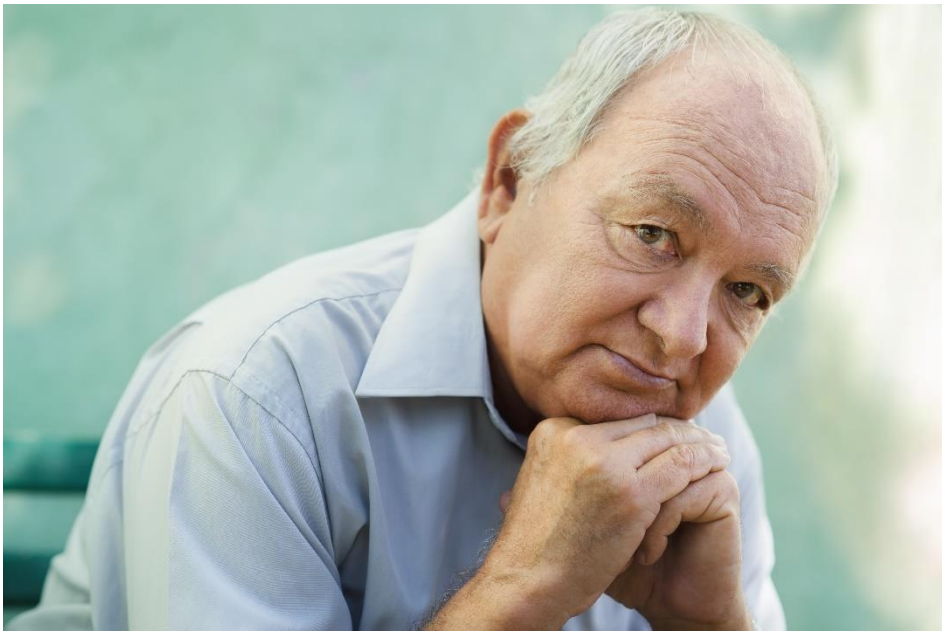
Needs Work

- Measure rates for Harmony, IlliniCare, and Molina fell below the national Medicaid 50th percentile for HEDIS 2018.

[2-32] National Committee for Quality Assurance. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC). Available at: https://www.ncqa.org/hedis/measures/use-of-multiple-concurrent-antipsychotics-in-children-and-adolescents/. Accessed on: Dec 10, 2018.

Behavioral Health Conclusions

Within the Behavioral Health domain, only one measure for HEDIS 2018 could be compared to national benchmarks. The statewide rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total* ranked above the national Medicaid 50th percentile. Health plans should monitor the rates within this domain.



Improvement Initiatives and Follow-Up on Prior Recommendations

As this is the first year of reporting measure rates for the health plans as combined FHP/ACA and ICP populations, no previous recommendations were provided for the domains of care presented in this section. In subsequent reports, improvement initiatives and prior recommendations will be evaluated.

Recommendations for Improving Performance Measure Rates

HSAG recommends that HFS work with the health plans to analyze and identify components for the measure rates noted in this section that would lead to improved care for beneficiaries and improved measure rates. Health plans should conduct a root cause analysis of measure indicators that have been identified as areas of low performance to determine the nature and scope of problems, identify causes and their interrelationships, identify specific populations for targeted interventions, and establish potential performance improvement strategies and solutions.

Further, health plans are encouraged to use the Plan-Do-Study-Act (PDSA) worksheet for any interventions.[2-33] HSAG recommends that the health plan frequently measure and monitor targeted interventions to provide timely, ongoing feedback regarding the effectiveness of interventions in achieving desired results.

[2-33] Institute for Healthcare Improvement. *Plan-Do-Study-Act (PDSA) Worksheet*. Available at: http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed on: Mar 6, 2018.

Managed Long Term Services and Supports (MLTSS) Performance Measure Validation (PMV) Results

Introduction

The Centers for Medicare & Medicaid Services (CMS) allows HFS to validate quality withhold performance measures for the health plans participating in the MLTSS program. Under the MLTSS capitated model, CMS and the State withhold a percentage of their respective portion of the capitation rate paid to each health plan to ensure that its members receive high-quality care and to encourage quality improvement. The withheld amounts are repaid based on the health plan's performance on specific core and state-specific quality withhold measures, which are a subset of the entire set of measures that health plans are required to report.

HFS contracted with HSAG, the external quality review organization (EQRO) for Illinois, to conduct validation of selected measures for data collected by the health plans during CY 2017. HFS selected two measures for validation:

- MLTSS Measure 2.2: Moderate- and high-risk members with a comprehensive assessment completed within required timeframes.
- MLTSS Measure 3.2: Enrollees with documented discussions of person-centered care goals.

To ensure full submission of data and complete all validation activities, HFS scheduled the MLTSS Quality Withhold Performance Measure Validation (PMV) for completion during SFY 2019.

Methodology

HSAG will validate the data collection and reporting processes used by the health plans to report the quality withhold performance measure data for CY 2017 in accordance with the CMS publication *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[2-34] Details regarding the methodology are provided in Appendix E of this report.

[2-34] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 4, 2019.

Centers for Medicare & Medicaid Services (CMS) Home- and Community-Based Services (HCBS) Waiver Performance Measures Record Reviews

Overview

HFS works in partnership with its operating agencies, contractors, and CMS to oversee the design and implementation of each waiver's quality improvement system. To monitor the quality of services and supports provided to the HCBS waiver program enrollees, HSAG began on-site record reviews for ICP health plans in SFY 2014 to monitor performance on the HCBS Waiver performance measures. In SFY 2015, MMAI health plans were included in on-site reviews. In SFY 2016, HSAG continued ICP and MMAI quarterly record reviews and began conducting reviews for FHP/ACA enrollees who were eligible for HCBS waiver programs. Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois Managed Care Program (HealthChoice), on January 1, 2018, which combined the FHP/ACA and ICP populations into one managed care program. HCBS data continued to be collected from and reported for the separate FHP/ACA and ICP populations through the end of SFY 2018 to maintain consistency.

HSAG also worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the measures. Ongoing performance was monitored through quarterly record reviews, plan-specific feedback, and remediation of record review findings. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, resulting in better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

ICP Record Reviews

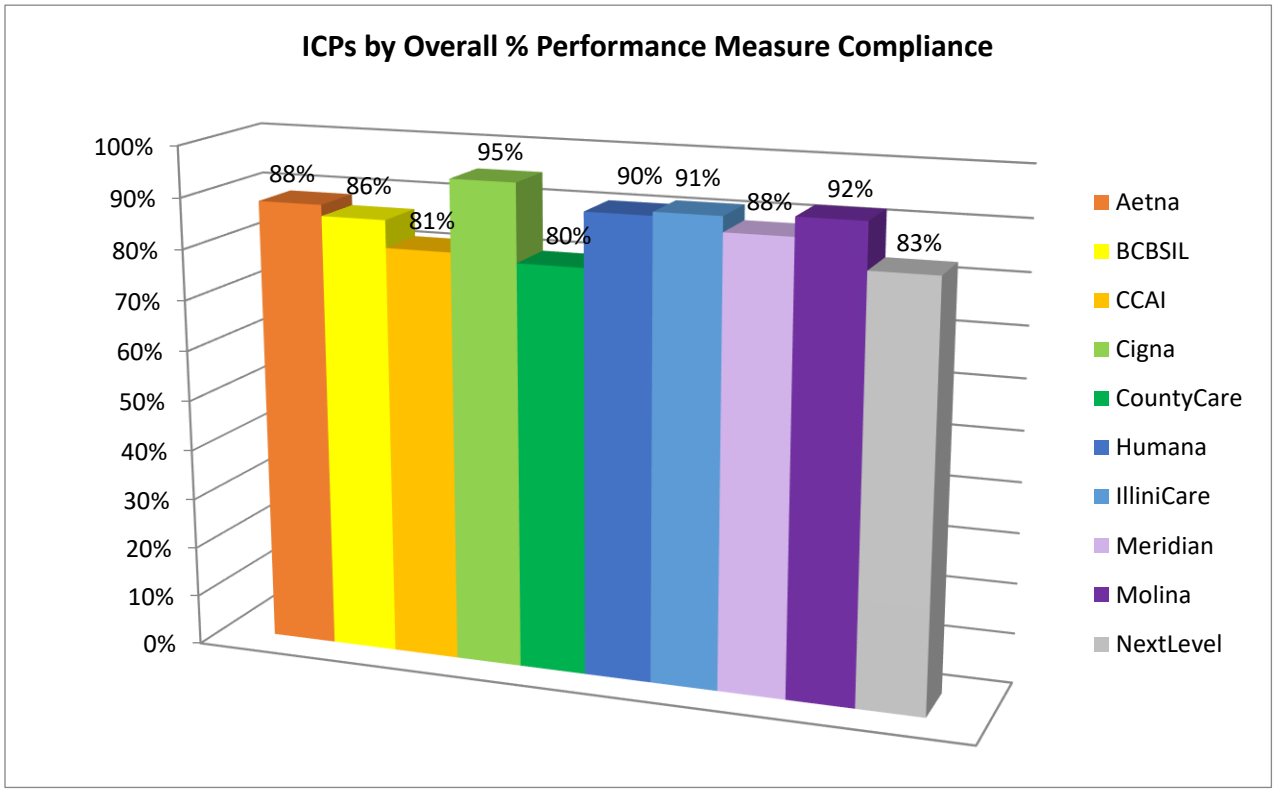
Table 2-3 displays the ICP health plans reviewed by quarter for SFY 2018. A total of 10 ICP health plans were reviewed during SFY 2018. After the transition to HealthChoice, several health plans exited the Medicaid managed care market and were no longer reviewed, effective Quarter (Q) 3 SFY 2018: Aetna Better Health, Community Care Alliance of Illinois, and Humana Health Plan, Inc. Unrelated to the transition to HealthChoice, Cigna-HealthSpring of Illinois exited the ICP market and was no longer reviewed effective Q3 SFY 2018.

Table 2-3—ICP Health Plans Reviewed by Quarter SFY 2018

ICP Health Plan	Q1	Q2	Q3	Q4
Aetna Better Health (Aetna)	X	X	—	—
Blue Cross Blue Shield of Illinois (BCBSIL)	X	X	X	X
Cigna-HealthSpring of Illinois (Cigna)	X	X	—	—
Community Care Alliance of Illinois (CCAI)	X	X	—	—
CountyCare Health Plan (CountyCare)	X	X	X	X
Humana Health Plan, Inc. (Humana)	X	X	—	—
IlliniCare Health Plan, Inc. (IlliniCare)	X	X	X	X
Meridian Health Plan, Inc. (Meridian)	X	X	X	X
Molina Healthcare of Illinois, Inc. (Molina)	X	X	X	X
NextLevel Health Partners, LLC (NextLevel)	X	X	—	X

Figure 2-35 displays a computed average of the total performance achieved by each ICP health plan on all 15 CMS waiver performance measures reviewed by HSAG for SFY 2018. This display is used as a comparison of overall compliance for each ICP health plan and as a compliance comparison across health plans.

Figure 2-35—Overall ICP Compliance—SFY 2018



Four of the 10 health plans averaged 90 percent or greater compliance in SFY 2018. There was a 15-percentage- point difference (80 percent to 95 percent) among health plans. CountyCare's performance (80 percent) represented the greatest opportunity for improvement.

Analysis of the individual performance measures demonstrated that 11 of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018. The following measures had the greatest opportunity for improvement:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 37 percent compliance in SFY 2018.
- Measure 37D, *timely completion of service plan*, demonstrated a statistically significant decrease in performance in SFY 2018 when compared to SFY 2017 (-15 percentage points, p=<0.0001). Six of the 10 health plans demonstrated statistically significant decreases in performance from SFY 2017 to SFY 2018. Performance on 37D correlates directly with performance on 4A (records found to be non-compliant for 37D constitute the denominator for 4A).
- Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 51 percent and 44 percent compliance for the BI and HIV waivers, respectively, in SFY 2018.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, averaged 51 percent compliance in SFY 2018. Seven of the 10 health plans performed at a rate of less than 50 percent in SFY 2018.

FHP/ACA Record Reviews

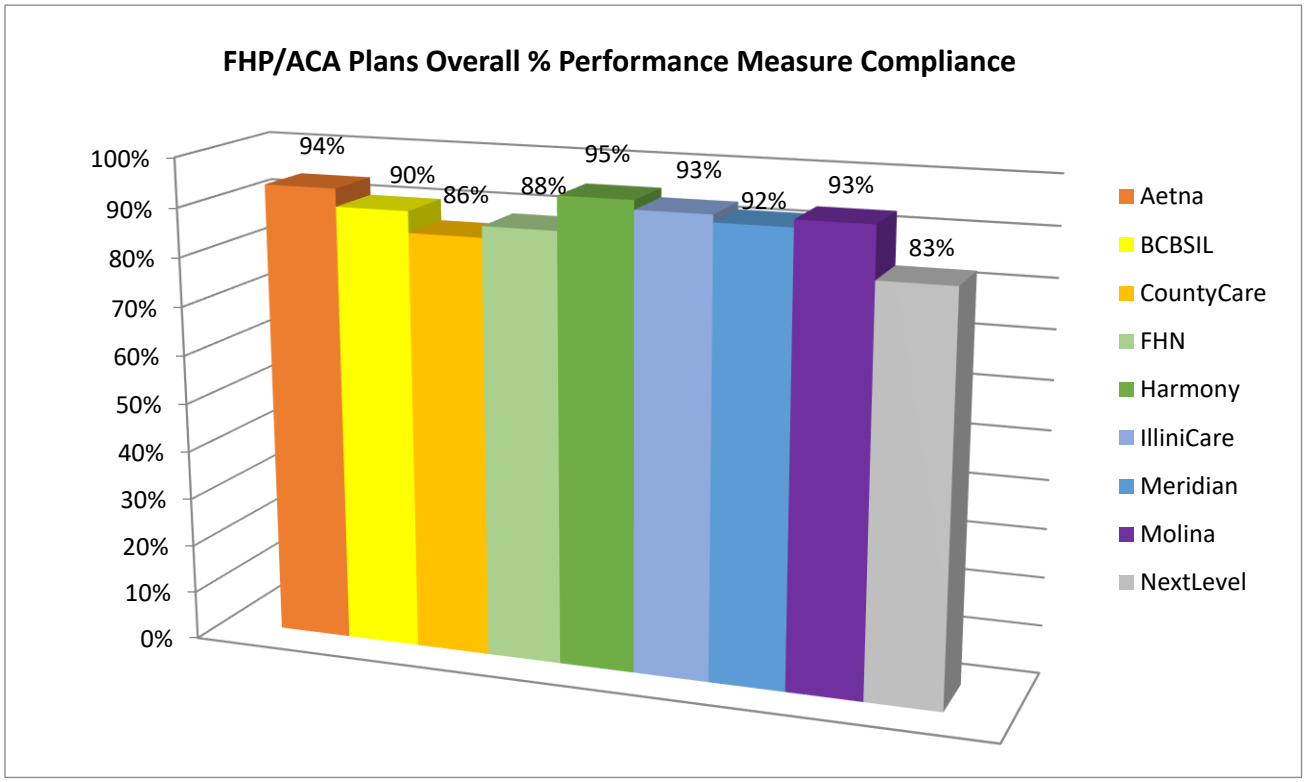
Table 2-4 displays the FHP/ACA health plans reviewed by quarter for SFY 2018. A total of nine FHP/ACA health plans were reviewed during SFY 2018. After the transition to HealthChoice, several health plans exited the Medicaid managed care market and were no longer reviewed effective Q3 SFY 2018: Aetna and Family Health Network (FHN).

Table 2-4—FHP/ACA Health Plans Reviewed by Quarter—SFY 2018

FHP/ACA Health Plan	Q1	Q2	Q3	Q4
Aetna	X	X	—	—
BCBSIL	X	X	X	X
CountyCare	X	X	X	X
FHN	X	—	—	—
Harmony	X	X	—	X
IlliniCare	X	X	X	X
Meridian	X	X	X	X
Molina	X	X	X	X
NextLevel	X	X	—	X

Figure 2-36 displays a computed average of the total performance achieved by each FHP/ACA health plan on all 15 CMS waiver performance measures reviewed by HSAG in SFY 2018. This graph compares overall compliance for each FHP/ACA health plan as well as compliance across health plans.

Figure 2-36—Overall FHP/ACA Compliance—SFY 2018



Six of the nine health plans averaged 90 percent or greater overall compliance in SFY 2018. There was a 12 percentage point difference (83 percent to 95 percent) among health plans. NextLevel's performance (83 percent) represented the greatest opportunity for improvement.

Analysis of the individual performance measures demonstrated that 12 of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018. The following measures had the greatest opportunity for improvement:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 38 percent compliance in SFY 2018.
- Measure 37D, *timely completion of service plan*, demonstrated a statistically significant decrease in performance in SFY 2018 when compared to SFY 2017 (-7 percentage points, p=<0.0001). Performance on 37D correlates directly with performance on 4A (records found to be non-compliant for 37D constitute the denominator for 4A).
- Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 56 percent and 40 percent compliance for the BI and HIV waivers, respectively, in SFY 2018.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, averaged 43 percent compliance in SFY 2018. Seven of the nine health plans performed at a rate of less than 50 percent in SFY 2018.

MMAI Record Reviews

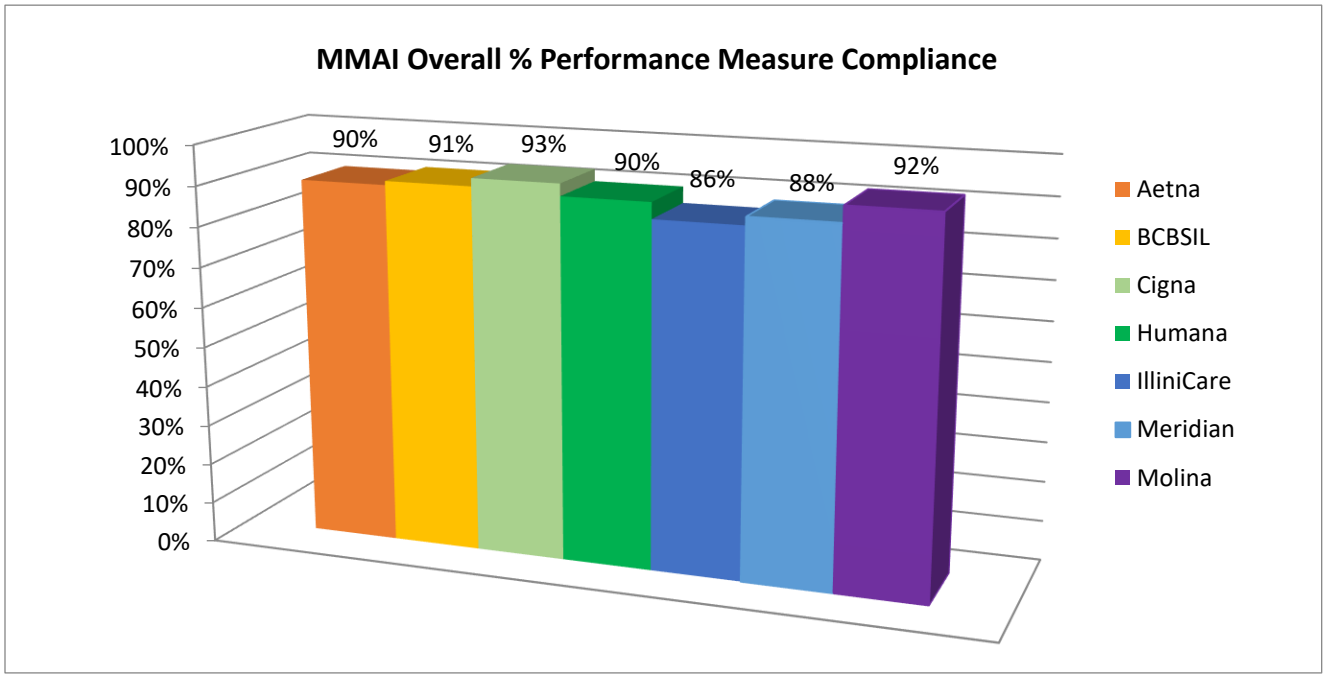
Table 2-5 displays the MMAI health plans reviewed by quarter. A total of seven MMAI health plans were reviewed during SFY 2018.

Table 2-5—MMAI Health Plans Reviewed by Quarter SFY 2018

MMAI Health Plan	Q1	Q2	Q3	Q4
Aetna	X	X	X	X
BCBSIL	X	X	X	X
Cigna	X	X	—	—
Humana	X	X	X	X
IlliniCare	X	X	X	X
Meridian	X	X	X	X
Molina	X	X	X	X

Figure 2-37 displays a computed average of the total performance achieved by each MMAI health plan on all 15 CMS waiver performance measures reviewed by HSAG for SFY 2018. This graph compares overall compliance for each MMAI health plan as well as compliance across health plans.

Figure 2-37—Overall MMAI Compliance—SFY 2018



Five of the seven health plans averaged 90 percent or greater overall compliance in SFY 2018. There was a 7 percentage point difference (86 percent to 93 percent) among health plans. IlliniCare's performance (86 percent) represented the greatest opportunity for improvement.

Analysis of the individual performance measures demonstrated that 10 of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018. The following measures had the greatest opportunity for improvement:

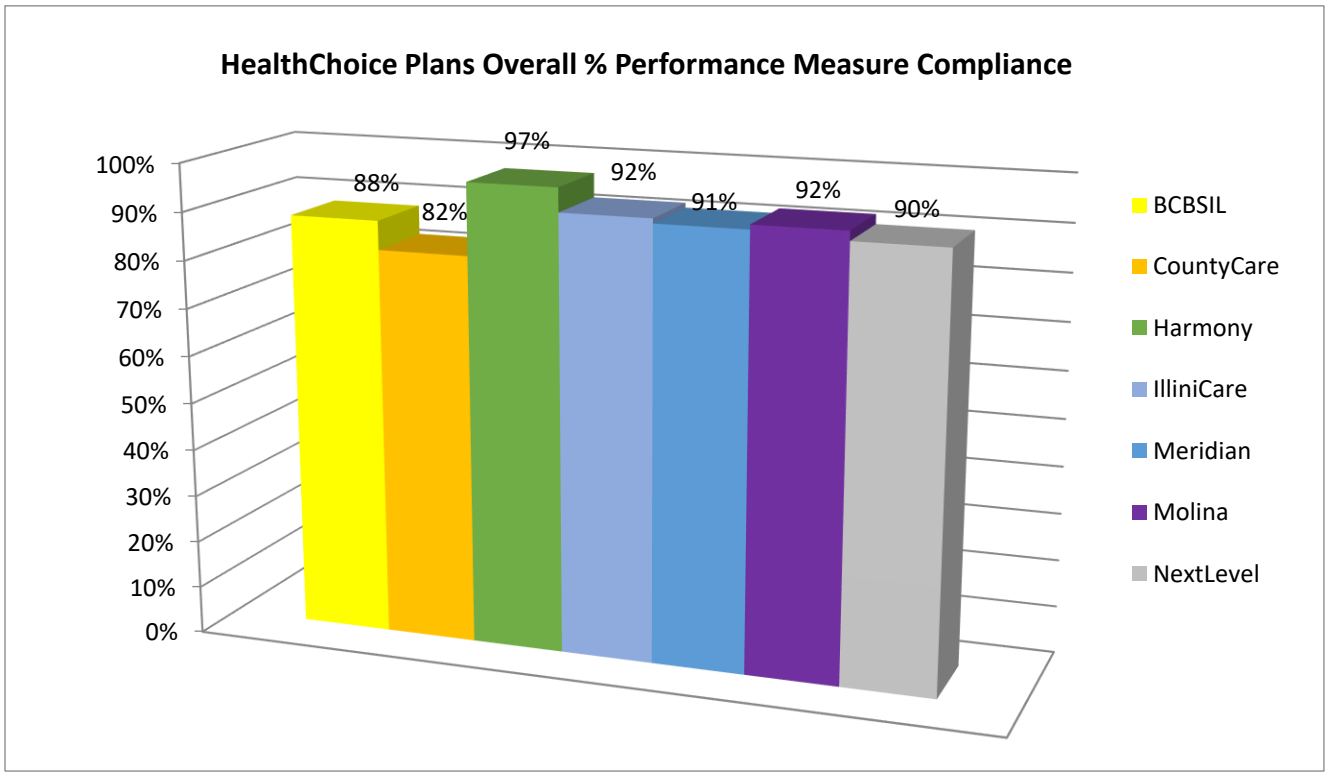
- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 36 percent compliance in SFY 2018. All seven health plans performed at a rate of 50 percent or less in SFY 2018.
- Measure 37D, *timely completion of service plan*, demonstrated a statistically significant decrease in performance in SFY 2018 when compared to SFY 2017 (-14 percentage points, p=<0.0001). Performance on 37D correlates directly with performance on 4A (records found to be non-compliant for 37D constitute the denominator for 4A).
- Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 58 percent and 45 percent compliance for the BI and HIV waivers, respectively, in SFY 2018.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, averaged 55 percent compliance in SFY 2018. All seven health plans performed at a rate of 60 percent or less in SFY 2018.

HealthChoice Illinois Record Reviews

On January 1, 2018, Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois, which combined the FHP/ACA and ICP populations into one managed care program. As a result, data from the individual populations were able to be combined to provide overall HealthChoice results for Q3 and Q4 SFY 2018.

Figure 2-38 displays a computed average of the total performance achieved by each health plan on all 15 CMS waiver performance measures reviewed by HSAG in Q3 and Q4 of SFY 2018. This graph compares overall compliance for each health plan, as well as compliance across health plans.

Figure 2-38—Overall HealthChoice Illinois Compliance—SFY 2018



Five of the seven health plans averaged 90 percent or greater overall compliance in Q3 and Q4 SFY 2018. There was a 15 percentage point difference (82 percent to 97 percent) among health plans.

Remediation, Health Plan Interventions, and Process Improvements

Remediation

In SFY 2018, the health plans were required to document all actions taken to address each of the noncompliant findings from the record reviews in the remediation tracking database. The health plans received training on how to use database and were required to remediate individual record review findings within the required time frames. HFS and the health plans received a report of findings subsequent to each on-site record review. The health plans were required to remediate the noncompliant findings and implement performance improvement strategies to improve the quality of care management/care coordination activities for HCBS waiver enrollees; documentation of such was considered remediation. Compliance with remediation of these findings was monitored by the EQRO within 30, 60, and 90 days as required by CMS and HFS.

In SFY 2018, for performance measures requiring remediation within 30 days, all FHP/ACA, ICP, and MMAI health plans demonstrated full compliance. For performance measures requiring remediation within 60 days, all FHP/ACA, ICP and MMAI health plans demonstrated full compliance.

Health Plan Interventions and Process Improvements

The SFY 2018 comparative analysis revealed many improvements in performance scores. These improvements resulted from the health plans' efforts to address HSAG's recommendations following the conclusion of SFY 2018 reviews, to incorporate technical assistance received during on-site reviews, and to integrate HFS guidance into internal processes. Although it is not possible to definitively determine causal relationships, some of the health plans' improvement efforts are listed below.

- Retraining of case management/care coordination staff.
- Most health plans indicated that noncompliant findings were addressed either individually with the case manager/care coordinator involved with the finding, or training was provided to all staff; however, the health plans did not indicate that root cause analysis was completed on noncompliant findings.
- Health plans provided information to support remediation actions during their remediation validation reviews.

HCBS Provider Network Monitoring

As described in Section 5, HSAG validates and monitors the network of HCBS providers for each health plan serving HCBS waiver enrollees.

3. Beneficiary Satisfaction With Care

Overview

A key Illinois Department of Healthcare and Family Services (HFS) strategy for the oversight of health plans is to conduct an annual satisfaction survey of Medicaid beneficiaries. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are designed to capture beneficiary perspectives on healthcare quality. HFS uses CAHPS results to monitor health plan and provider performance, measure beneficiary satisfaction with services and access to care, and evaluate program characteristics.

Each year, managed care beneficiaries rate their overall satisfaction with their health plans, health care services, personal doctor, and specialists. They also answer questions related to different aspects of care, such as getting the care they need, timeliness of care, and how well their doctors communicate. Beneficiary satisfaction is assessed through the evaluation of nine performance measures.

Health plans are required to independently administer satisfaction surveys which provide HFS with important feedback on performance and are used to initiate changes to improve beneficiary satisfaction with the managed care programs. Additional details about CAHPS results are presented in Appendix G of this report.

CAHPS Measures

The CAHPS surveys were administered to the adult and child Medicaid populations. The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite measures. The global ratings reflected beneficiaries' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care.

For All Kids and Illinois Medicaid, in addition to the four global ratings and five composite measures, the CAHPS survey also included the children with chronic conditions (CCC) measurement set of survey questions, which are categorized into five measures of satisfaction. These measures include three CCC composite measures and two CCC individual item measures. The CCC composites and items depict different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

With statewide Medicaid expansion (HealthChoice Illinois) beginning in January 2018, only seven health plans continued to serve Illinois Medicaid beneficiaries. To allow HFS optimum use of the results for future quality improvement considerations, HSAG has included results only for those seven plans. The table below displays the Family Health Plan/Affordable Care Act (FHP/ACA) adult and child Medicaid populations and the Integrated Care Program (ICP) adult populations that are included in the 2018 CAHPS results. For the adult Medicaid population, HSAG has combined the CAHPS results for the FHP/ACA and ICP health plans.[3-1]

Table 3-1—2018 FHP/ACA and ICP Population

Plan Name	FHP/ACA	ICP
Blue Cross Blue Shield of Illinois (BCBSIL)	✓	✓
CountyCare Health Plan (CountyCare)	✓	✓
Harmony Health Plan of Illinois, Inc. (Harmony)	✓	N/A
IlliniCare Health Plan, Inc. (IlliniCare)	✓	✓
Meridian Health Plan, Inc. (Meridian)	✓	✓
Molina Healthcare of Illinois, Inc. (Molina)	✓	✓
NextLevel Health Partners, LLC (NextLevel)	✓	✓

[3-1] Due to combining the FHP/ACA and ICP health plans, HSAG calculated a weighted aggregate for the 2017 and 2018 results for the adult population.

HSAG performed three separate analyses on the survey results: top-box percentage calculations, national comparisons of the three-point means, and a trend analysis on the top-box percentages. The top-box scoring of the global ratings, composite measures, and CCC composites and items involved assigning top-level responses a score of 1 with all other responses receiving a score of 0. After applying this scoring methodology, the percentage of top-level responses (i.e., top-box percentages) was calculated to determine the rates for the global ratings, composite measures, and CCC composites and items.

To evaluate trends in member satisfaction, HSAG performed a trend analysis that compared the 2018 top-box percentage to the corresponding 2017 top-box percentage. Top-box percentage results that were statistically significantly higher in 2018 than in 2017 are noted with upward (▲) triangles. Top-box percentages in 2018 that were not statistically significantly higher or lower than scores in 2017 are not noted with triangles.

In addition to the top-box percentage calculations and trend analysis, a three-point mean was calculated for each of the global ratings and four of the composite measures, and star ratings were derived. Star ratings are derived from a comparison of the resulting three-point means to national Medicaid percentiles. Member satisfaction is depicted using ratings of one (★) to five (★★★★★) stars, with one star being the lowest possible rating and five stars being the highest possible rating, using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

Summary of Performance

Adult CAHPS Medicaid Surveys

To assess satisfaction of Medicaid services for the adult population, FHP/ACA and ICP health plans utilize the National Committee for Quality Assurance (NCQA)-certified CAHPS survey vendors to survey a sample of adult beneficiaries.

The aggregate results for all FHP/ACA and ICP health plans combined are displayed in the table below.

Table 3-2—Adult Aggregate Results

	2017	2018	Trending Results (2017–2018)
Composite Measures			
Getting Needed Care	77.2% ★★	75.8% ★	—
Getting Care Quickly	78.7% ★★	77.5% ★	—
How Well Doctors Communicate	90.7% ★★★★★	91.8% ★★★★★	—
Customer Service	86.7% ★★★	87.0% ★★	—
Shared Decision Making	77.5% NB	76.7% NB	—
Global Ratings			
Rating of All Health Care	51.3% ★★	51.9% ★★	—
Rating of Personal Doctor	62.8% ★★★	64.1% ★★★	—
Rating of Specialist Seen Most Often	64.9% ★★★	65.1% ★★★	—
Rating of Health Plan	53.6% ★★	56.9% ★★	▲

NB indicates that NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.
▲ indicates the 2018 score is statistically significantly higher than the 2017 score
— indicates the 2018 score is not statistically significantly higher or lower than the 2017 score

Satisfaction With Care

Adult CAHPS

Notable

- Compared to national Medicaid percentiles, 2018 satisfaction survey results indicated that adult beneficiaries were generally satisfied with how well their doctors communicate.
- The 2018 score was statistically significantly higher than the 2017 score for *Rating of Health Plan*.

Needs Work

- Compared to national Medicaid percentiles, 2018 satisfaction survey results indicated that adult beneficiaries were generally dissatisfied with their ability to get needed care, their ability to get care quickly, the customer service provided by their health plan, their overall health care, and their overall health plan.
- Star ratings declined from 2017 to 2018 for *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Child CAHPS Medicaid Results

To assess satisfaction of Medicaid services for the child population, FHP/ACA health plans utilize NCQA-certified CAHPS survey vendors to survey a sample of child beneficiaries.

FHP/ACA Health Plan Results

The aggregate results for all FHP/ACA health plans combined are displayed in the table below.

Table 3-3—FHP/ACA Child Aggregate Results (Without CCC Survey)

	2017	2018	Trending Results (2017–2018)
Composite Measures			
Getting Needed Care	80.7% ★	77.7% ★	—
Getting Care Quickly	84.5% ★	83.9% ★	—
How Well Doctors Communicate	93.3% ★★★	93.2% ★★★	—
Customer Service	86.0% ★★	86.4% ★★	—
Shared Decision Making	78.4% NB	78.6% NB	—
Global Ratings			
Rating of All Health Care	66.9% ★★★★	69.9% ★★★★★	—
Rating of Personal Doctor	76.2% ★★★★★	78.2% ★★★★★	—
Rating of Specialist Seen Most Often	78.9% ★★★★★	75.3% ★★★★★	—
Rating of Health Plan	68.4% ★★	71.0% ★★★★	▲

NB indicates that NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.
▲ indicates the 2018 score is statistically significantly higher than the 2017 score
— indicates the 2018 score is not statistically significantly higher or lower than the 2017 score

Satisfaction With Care

Child CAHPS

Notable

- Compared to national Medicaid percentiles, 2018 satisfaction survey results indicated that FHP/ACA parents/caretakers were generally satisfied with their child's overall health care, their child's personal doctor, their child's specialist, and their child's overall health plan.
- Star ratings improved from 2017 to 2018 for *Rating of All Health Care* and *Rating of Health Plan*.
- The 2018 score was statistically significantly higher than the 2017 score for *Rating of Health Plan*.

Needs Work

- Similar to the adult population, 2018 satisfaction survey results indicated that compared to national Medicaid percentiles, FHP/ACA parents/caretakers were generally dissatisfied with the ability to get needed care for their child, their ability to get care quickly for their child, and the customer service provided by their child's health plan.

Statewide Survey Results

HSAG administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. These child CAHPS surveys include questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines, access to specialized services). Results are calculated for the population of children identified as having a chronic condition and for the general child population. HFS does not require the health plans to administer the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS) supplemental item set and the CCC measurement set; however, HSAG uses this survey for Illinois Medicaid and All Kids.

General Population

The CAHPS results for the general child population for the Illinois statewide program aggregate (i.e., Illinois Medicaid and All Kids combined) are displayed in the table below.[3-2]

Table 3-4—Statewide Survey General Child Population Aggregate Results

	2017	2018	Trending Results (2017–2018)
Composite Measures			
Getting Needed Care	87.0% ★★	82.7% ★★	—
Getting Care Quickly	90.0% ★★	85.9% ★	—
How Well Doctors Communicate	92.7% ★★★	92.1% ★★★	—
Customer Service	85.5% ★	85.1% ★	—
Shared Decision Making	80.9% NB	78.2% NB	—
Global Ratings			
Rating of All Health Care	67.4% ★★★★★	63.2% ★★★★★	—
Rating of Personal Doctor	74.6% ★★★★	74.6% ★★★★★	—

[3-2] NCQA does not publish separate benchmarks and thresholds for the Children's Health Insurance Program (CHIP) population; therefore, caution should be exercised when interpreting the results of the national comparisons analysis (i.e., star ratings).

Satisfaction With Care

Statewide Survey

	2017	2018	Trending Results (2017–2018)
Rating of Specialist Seen Most Often	68.5% ★★★★★	76.6% ★★★★★	—
Rating of Health Plan	62.9% ★	61.3% ★	—

NB indicates that NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.
— indicates the 2018 score is not statistically significantly higher or lower than the 2017 score

Notable

- Compared to national Medicaid percentiles, 2018 satisfaction survey results indicated that the parents/caretakers of the general child population for the Illinois statewide program aggregate were generally satisfied with their child's overall health care, their child's personal doctor, and their child's specialist.
- Star ratings improved from 2017 to 2018 for *Rating of Personal Doctor*.

Needs Work

- Compared to national Medicaid percentiles, 2018 satisfaction survey results indicated that the parents/caretakers of the general child population for the Illinois statewide program aggregate were generally dissatisfied with the ability to get needed care for their child and to get it quickly, the customer service provided by their child's health plan, and their child's overall health plan.
- Star ratings declined from 2017 to 2018 for *Getting Care Quickly*.

CCC Population

The CAHPS results for the CCC population for the Illinois statewide program aggregate (i.e., Illinois Medicaid and All Kids combined) are displayed in the table below.[3-3]

Table 3-5—Statewide Survey CCC Population Aggregate Results

	2017	2018	Trending Results (2017–2018)
Composite Measures			
Getting Needed Care	86.4%	84.8%	—
Getting Care Quickly	90.4%	88.8%	—
How Well Doctors Communicate	94.6%	94.3%	—
Customer Service	84.9%	81.7%	—
Shared Decision Making	84.7%	83.2%	—
Global Ratings			
Rating of All Health Care	60.9%	61.7%	—
Rating of Personal Doctor	71.2%	71.4%	—
Rating of Specialist Seen Most Often	72.3%	72.8%	—
Rating of Health Plan	55.4%	53.4%	—
CCC Composites and Items			
Access to Specialized Services	69.7%	72.8%	—
Family-Centered Care: Personal Doctor Who Knows Child	90.0%	90.1%	—
Coordination of Care for Children with Chronic Conditions	80.7%	79.4%	—

[3-3] NCQA does not publish benchmarks and thresholds for the CCC population; therefore, star ratings could not be calculated for the CCC population.

	2017	2018	Trending Results (2017–2018)
Access to Prescription Medicines	89.0%	87.8%	—
Family-Centered Care: Getting Needed Information	91.2%	90.5%	—

Notable

- Top-box rates increased slightly from 2017 to 2018 for the Illinois statewide program aggregate for five measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Access to Specialized Services*, and *Family-Centered Care: Personal Doctor Who Knows Child*.

Needs Work

- None of the top-box rates decreased substantially from 2017 to 2018 (i.e., decreased by 5 percentage points or more from the previous year) for the Illinois statewide program aggregate for any of the measures; therefore, there are no specific areas that need work for the CCC population.

Overall Findings and Conclusions

For the adult aggregate results of all FHP/ACA and ICP health plans combined, the 2018 score for one global rating (*Rating of Health Plan*) was statistically significantly higher than the 2017 score, indicating that adult members' satisfaction with their overall health plan is improving. However, the 2018 score for this measure fell below the 50th percentile compared to national Medicaid benchmarks along with four other measures (*Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*). Adult members showed greatest satisfaction with the *How Well Doctors Communicate* composite measure, as this measure scored at or above the 90th percentile compared to national Medicaid benchmarks.

Similar to the adult aggregate results, the child aggregate results of all FHP/ACA health plans combined showed that the 2018 score for the *Rating of Health Plan* global rating was statistically significantly higher than the 2017 score. Furthermore, three of the same composite measures (*Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*) scored below the 50th percentile compared to national Medicaid benchmarks, indicating that adult members and parents/caretakers of child members were less satisfied with these measures. However, parents/caretakers of child members showed greater satisfaction with all of the global ratings (i.e., *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*), as these measures scored at or above the 75th percentile compared to national Medicaid benchmarks.

When the 2018 scores for the general child population for the Illinois Statewide Program Aggregate were compared to national benchmarks, three measures (*Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) scored at or above the 90th percentiles; however, four measures (*Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Health Plan*) performed poorly, falling below the 50th percentiles compared to national Medicaid benchmarks. When comparing the 2018 top-box rates to 2017 for the CCC population for the Illinois Statewide Program Aggregate, none of the measures increased or decreased substantially.

Based on these results for both the adult and child populations, FHP/ACA and ICP health plans and the Illinois Statewide Program Aggregate have opportunities for improvement regarding members' access to and timeliness of care and customer service skills. Improvements in these areas may increase members' overall rating of their health plan.

4. Performance Improvement Projects

Overview

As part of its quality assessment and performance improvement program, the Illinois Department of Healthcare and Family Services (HFS) requires each health plan to conduct performance improvement projects (PIPs) in accordance with the Code of Federal Regulations (CFR) at 42 §438.330.

The purpose of a PIP is to achieve, through ongoing measurement and intervention, significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving health plan processes can have a favorable effect on health outcomes and member satisfaction. Federal requirements for PIPs include:

- 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.

Additional details about PIPs results are presented in Appendix H of this report.

Summary of Performance

Statewide Mandatory PIPs

Conducting statewide PIPs allows HFS to focus health plans' improvement efforts toward areas of concern with the goal of statewide improvement. In addition to improving the quality, access, or timeliness of service delivery, the process of completing a PIP functions as a learning opportunity for the health plans. The processes required in PIPs, such as indicator development, root cause analysis, and intervention development are transferable and can lead to improvement in other health areas. HFS required participation from all health plans in two mandatory statewide PIPs: the *Community Based Care Coordination* PIP and *Follow-up After Hospitalization for Mental Illness Behavioral Health Collaborative* PIP.

Community Based Care Coordination PIP (Care Coordination PIP)

The Care Coordination PIP focused on the relationship between care coordination, timely ambulatory care services, reducing readmission rates within 30 days of discharge, improving care coordination during hospitalization and post-acute care discharge, and improving access to community care resources. The study population included members stratified as high and moderate risk with a recent hospital discharge.

Evidence suggests an increased risk for relapse and readmission within a one-year period of time under traditional discharge arrangements and instructions, which fail to provide connection to and collaboration with community resources. Evidence has also identified a direct correlation between early outpatient follow-up and decreased hospital readmission rates.[4-1] Three study indicators were established to examine readmission rates, care coordination interactions, and access to community resources post-discharge.

For this collaborative PIP, the health plans met and identified the importance of community alliances and provider collaborations to meet the goals. The health plans continued to identify enhancements to care coordination efforts to effect readmission rates.

Follow-up After Hospitalization for Mental Illness Behavioral Health Collaborative PIP (Behavioral Health PIP)

The Behavioral Health PIP is a collaborative PIP. The clinical significance of the PIP, according to national statistics, is that approximately one in five adults in the United States experience a mental illness. Those who experience a mental illness are often less likely to use medical care and follow treatment plans. and nearly 60 percent of adults with a mental illness do not receive the mental health services they need.[4-2] Without the proper care, those with mental illness can expect to see a decline in

[4-1] Viggiano T, et al. Care transition interventions in mental health. *Current Opinion in Psychiatry* 25. 2012; 551–558.

[4-2] National Alliance on Mental Illness (NAMI). Mental Health Facts in America. Available at: https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf. Accessed on: Mar 12, 2017.

their overall health and well-being. With proper follow-up care, health outcomes are more likely to improve.

Evidence suggests that the rate of avoidable behavioral health-related rehospitalization can be reduced with various interventions. The Healthcare Effectiveness Data and Information Set (HEDIS) measure *Follow-up After Hospitalization Measure for Mental Illness (FUH)* was chosen as the study indicator for this PIP. This is an industry standard for measurement of transitions in care between inpatient and behavioral health outpatient levels of care. The goals of this PIP were to improve the rate of beneficiaries receiving follow-up appointments within seven days and 30 days of discharge from an inpatient stay for mental health treatment.

Evaluation of PIPs

Validation

As one of the mandatory external quality review (EQR) activities under the Balanced Budget Act of 1997 (BBA), the State is required to validate the PIPs conducted by its health plans. HFS contracts with Health Services Advisory Group, Inc. (HSAG), to meet this validation requirement. The primary objective of PIP validation is to determine each health plan's compliance with federal requirements.

- HSAG validates PIPs according to the Centers for Medicare & Medicaid Services (CMS) PIP Protocol, which includes 10 required activities such as selecting a study topic, use of sound sampling techniques, assessing for real improvement, etc. Each required activity was evaluated on one or more elements that form a valid PIP, for a total of 37 evaluation elements. HSAG designated 10 of the evaluation elements pivotal to the PIP process as critical elements.
- Using the methodology described in Appendix H of this report, HSAG calculated a validation status of *Met*, *Partially Met*, or *Not Met* and an overall percentage score for all evaluation elements (including critical elements) for each PIP. The goal of HSAG's PIP validation is to ensure that the State and key stakeholders can have confidence that any reported improvement can be directly linked to the quality improvement strategies and interventions conducted by the health plan for the duration of the PIP.
  - *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
  - *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
  - *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

Outcomes

PIPs include measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement. To determine study indicator outcomes, HSAG evaluates for real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over the baseline and sustain this improvement with a subsequent measurement period.

Barriers/Interventions

The identification of barriers through a causal/barrier analysis, and the selection of corresponding interventions to address these barriers, is necessary to improve outcomes. The health plan's choice of interventions, combination of intervention types, timing and sequence of implementation, and the evaluation of effectiveness of each intervention are essential to the health plan's overall success in achieving the desired outcomes.

Care Coordination PIP Results

Validation

SFY 2018

Table 4-1 displays the overall state fiscal year (SFY) 2018 validation results for each health plan for the Care Coordination PIP.

Table 4-1—SFY 2018 Validation Results Across All Health Plans for Care Coordination PIP

Health Plan	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Validation Status
Blue Cross Blue Shield of Illinois (BCBSIL)	89%	100%	*Met*
CountyCare Health Plan (CountyCare)	86%	100%	*Met*
Harmony Health Plan of Illinois, Inc. (Harmony)	86%	100%	*Met*
IlliniCare Health Plan, Inc. (IlliniCare)	89%	100%	*Met*
Meridian Health Plan, Inc. (Meridian)	86%	100%	*Met*
Molina Healthcare of Illinois, Inc. (Molina)	89%	100%	*Met*
NextLevel Health Partners, LLC (NextLevel)	83%	100%	*Met*

For the SFY 2018 validation, all health plans received an overall *Met* validation status and a 100 percent *Met* score for all applicable critical evaluation elements for the Care Coordination PIP. Health plans were generally able to meet the documentation requirements of the PIP; however, lack of improvement in the study indicator outcomes contributed to a lower percentage score of evaluation elements *Met*.

Outcomes

Three study indicators assessed the percentage of high-to-moderate risk members who did not have a readmission within 30 days of an initial discharge (Indicator 1), who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge (Indicator 2), and who accessed community resources within 14 days of discharge (Indicator 3). Results for the Family Health Plan/Affordable Care Act (FHP/ACA) and Integrated Care Program (ICP) populations are presented separately.

FHP/ACA Outcomes

SFY 2018 was the third year of participation in the Care Coordination PIP for the FHP/ACA health plans, so second remeasurement rates were reported. Trended results are presented in Appendix H of this report. Figure 4-1, Figure 4-2, and Figure 4-3 display the results for each study indicator for the Care Coordination PIP for each FHP/ACA health plan.

Figure 4-1—SFY 2018 Study Indicator 1 Results for FHP/ACA Health Plans for Care Coordination PIP

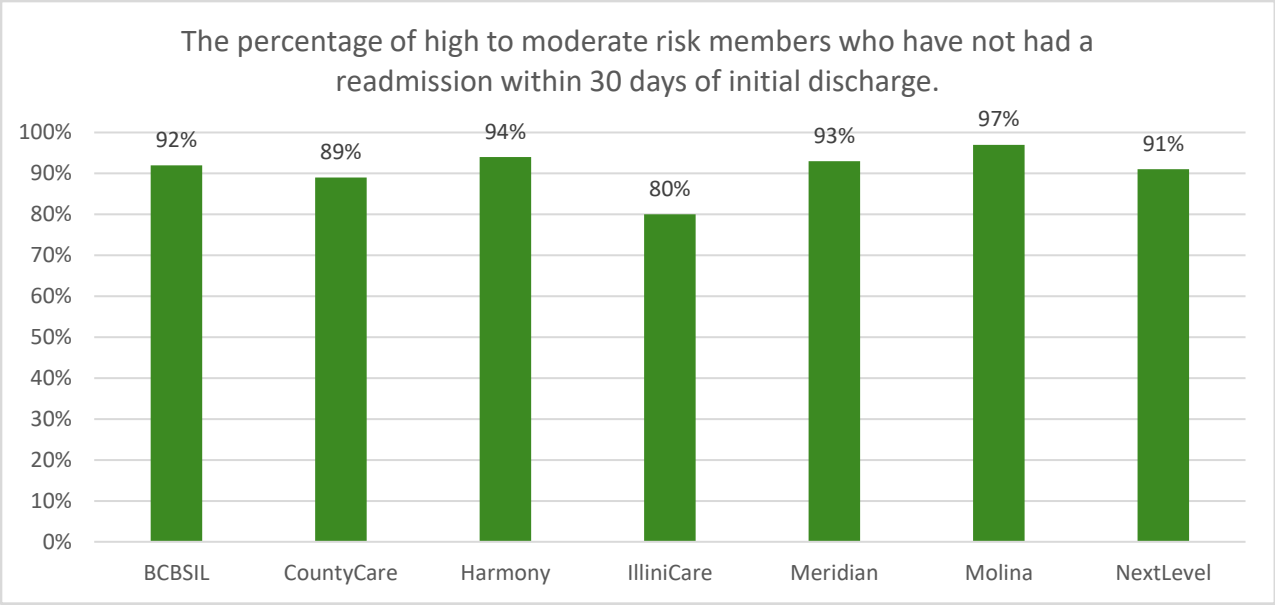


Figure 4-2—SFY 2018 Study Indicator 2 Results for FHP/ACA Health Plans for Care Coordination PIP

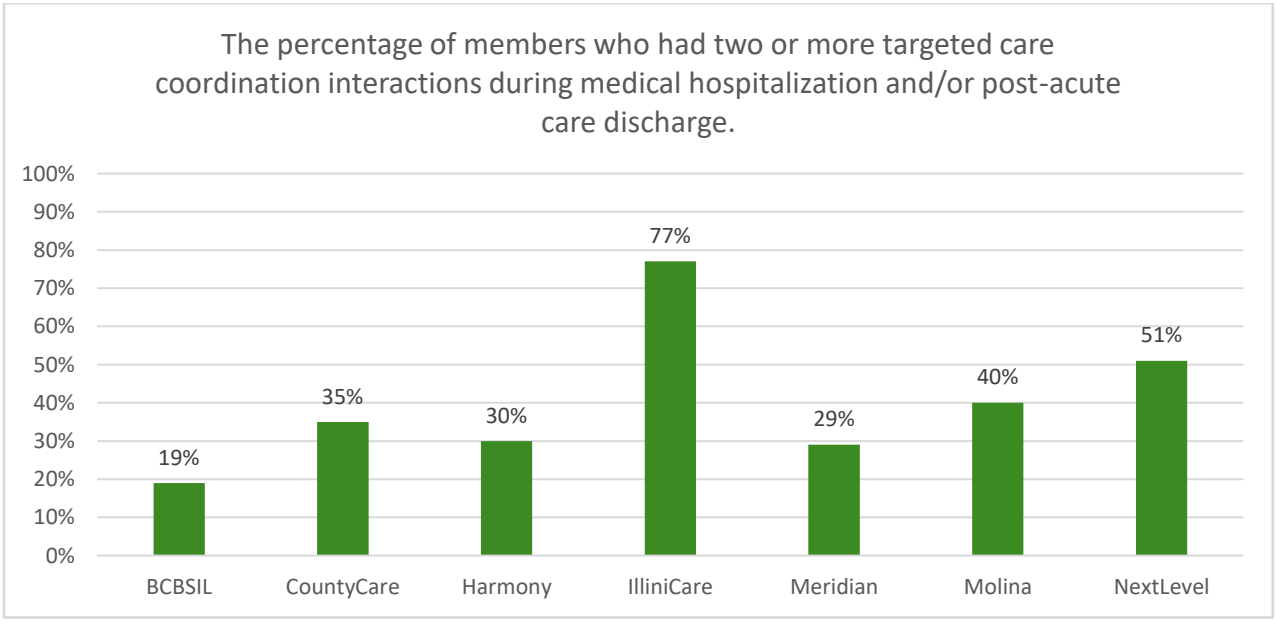
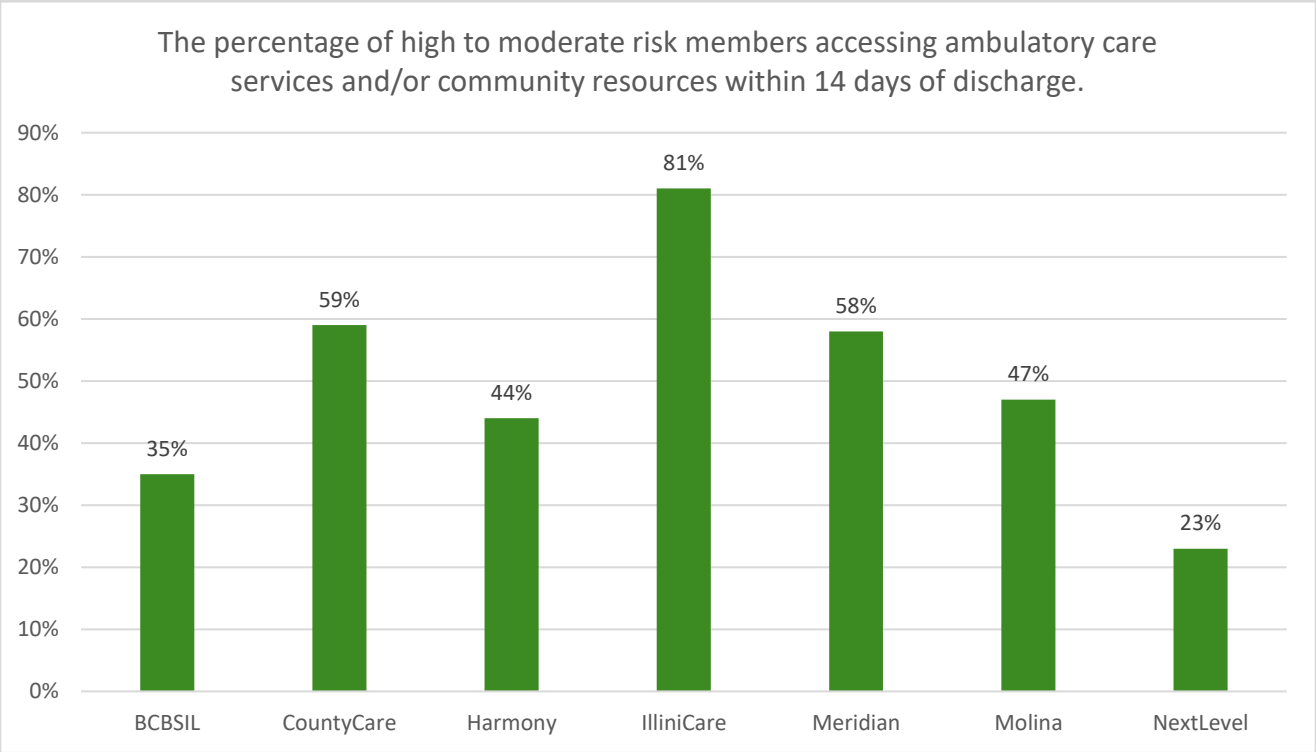


Figure 4-3—SFY 2018 Study Indicator 3 Results for FHP/ACA Health Plans for Care Coordination PIP



2018 FHP/ACA Summary

Notable

- Five of the seven health plans realized rates of over 90 percent for Study Indicator 1 (the percentage of high-to-moderate risk members who have not had a readmission within 30 days of initial discharge).

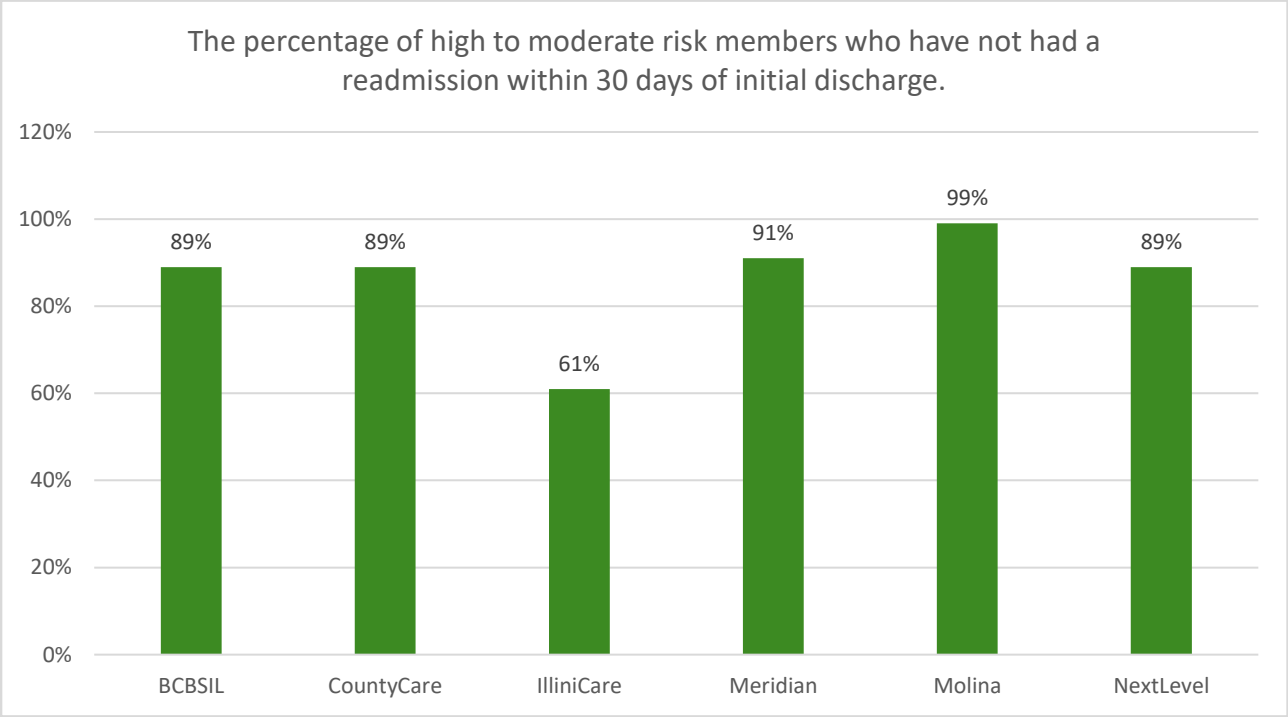
Needs Work

- Overall, the health plans averaged 40 percent for Study Indicator 2 (the percentage of members who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge). Four of the seven health plans performed at rates less than the overall overage.
- Overall, the health plans averaged 50 percent for Study Indicator 3 (the percentage of high-to-moderate risk members accessing ambulatory care services and/or community resources within 14 days of discharge). Four of the seven health plans performed at rates less than the overall average.

ICP Outcomes

SFY 2018 was the third year of participation for all ICP health plans, except for NextLevel, which completed its second year of participation.[4-3] Trended results are presented in Appendix H of this report. Figure 4-4, Figure 4-5, and Figure 4-6 display the SFY 2018 results for each study indicator for the Care Coordination PIP for each ICP health plan.

Figure 4-4—SFY 2018 Study Indicator 1 Results for ICP Health Plans for Care Coordination PIP



[4-3] NextLevel became a managed care community network (MCCN) on January 1, 2016; therefore, no baseline results were reported for SFY 2016.

Figure 4-5—SFY 2018 Study Indicator 2 Results for ICP Health Plans for Care Coordination PIP

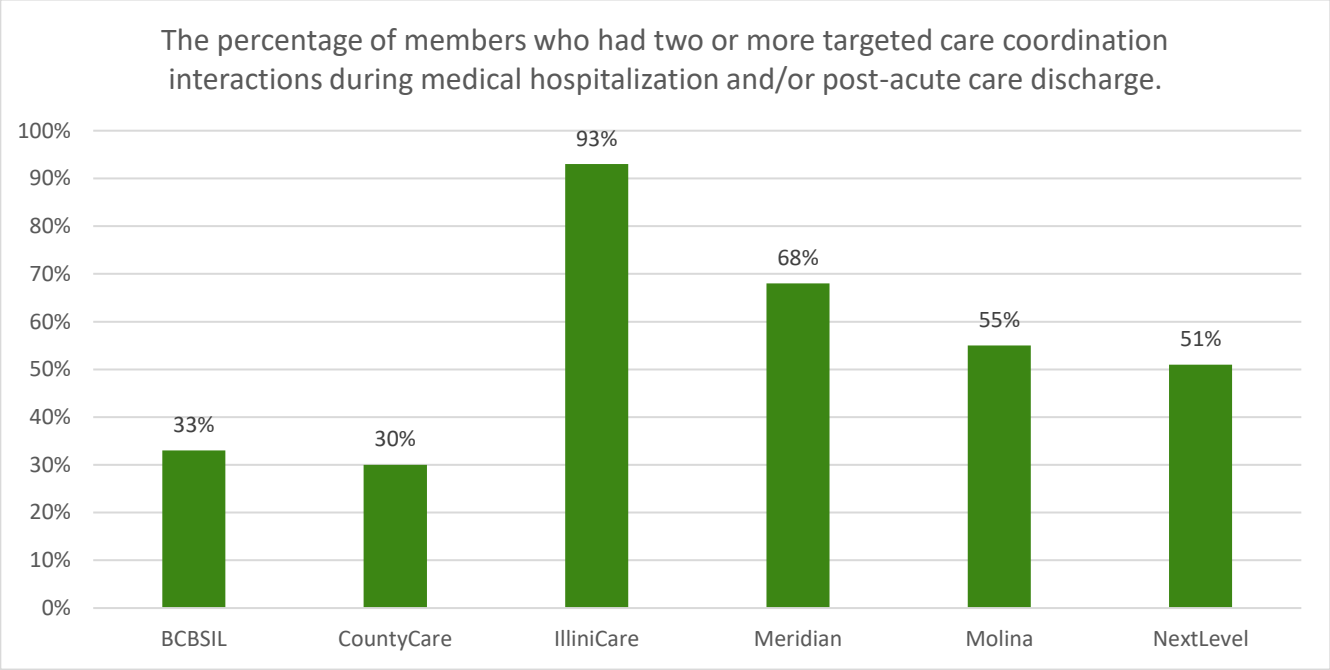
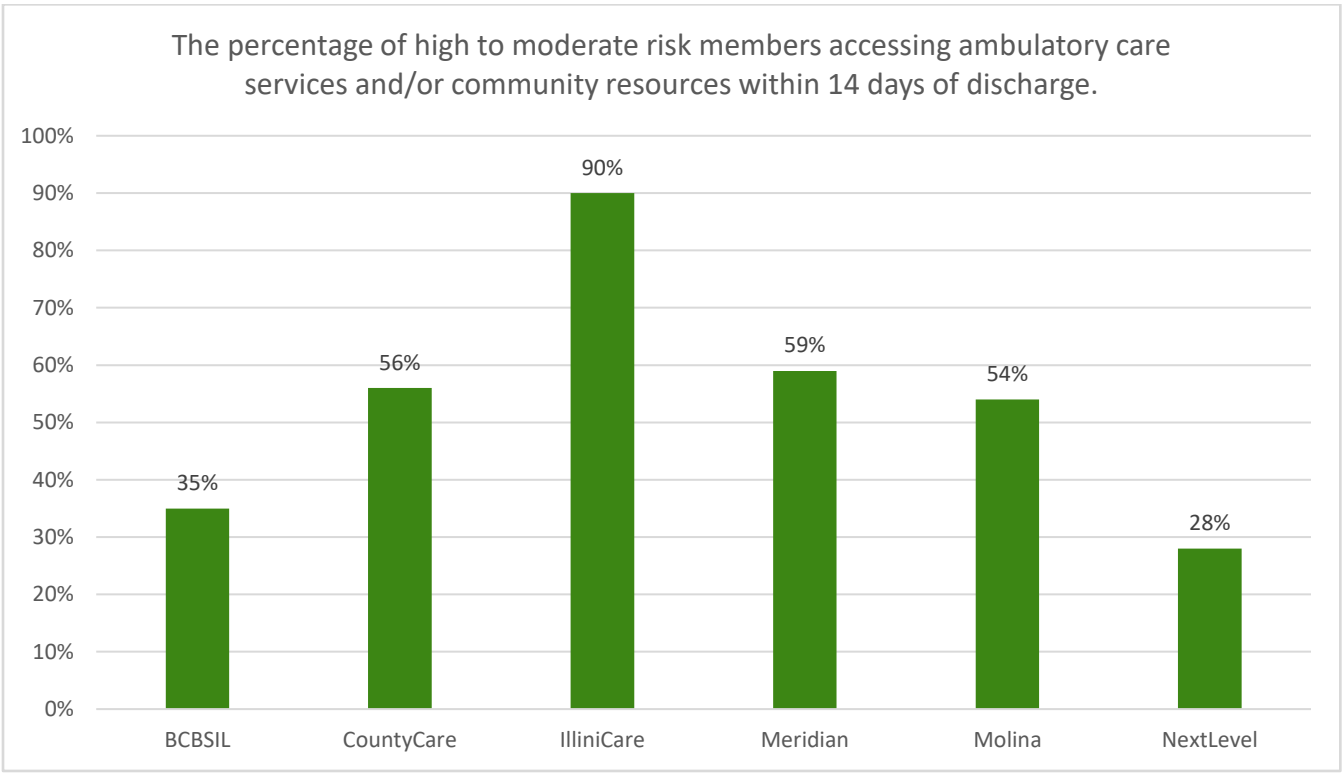


Figure 4-6—SFY 2018 Study Indicator 3 Results for ICP Health Plans for Care Coordination PIP



2017 ICP Summary

Notable

- Two of the six health plans realized rates of over 90 percent for Study Indicator 1 (the percentage of high-to-moderate risk members who have not had a readmission within 30 days of initial discharge).

Needs Work

- Overall, the health plans averaged 55 percent for Study Indicator 2 (the percentage of members who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge). Four of the six health plans performed at rates less than or equal to the overall overage.
- Overall, the health plans averaged 54 percent for Study Indicator 3 (the percentage of high-to-moderate risk members accessing ambulatory care services and/or community resources within 14 days of discharge). Three of the six health plans performed at rates less than or equal to the overall average.

Barriers/Interventions

The health plans collaborated to identify barriers through a fishbone diagram brainstorming session. Barriers were categorized by members, facilities/providers, and health plan, and were assumed the same for both the FHP/ACA and ICP populations.

Members

- Member did not receive or does not understand discharge plan.
- Member refuses to follow the discharge plan or socioeconomic concerns overwhelm member's ability to execute discharge plan.
- Member refuses to follow up with provider.
- Member refuses to work with health plan care coordination staff.
- Member refuses to take medications as prescribed.
- Member perceives a lack of transportation and/or isn't aware of transportation covered service.
- Member does not understand his/her condition, warning signs, and/or have an appropriate action plan for worsening conditions.
- Member unaware of potential eligibility for long-term services and supports.

Facility/Provider

- Lack of communication between hospital staff and health plan staff.
- Untimely notification to health plan of member admission and/or discharge.
- Hospital staff provides minimal support to member in executing their discharge plan.

- Lack of communication between hospital staff and member's PCP in transitioning member back to primary care.
- Incorrect billing and/or coding.

Health Plan

- Lack of timely follow-up following an inpatient hospital stay.
- Lack of ability to obtain adequate discharge plan information from hospitals during post-discharge UM review.
- Ineffective processes to receive inpatient information from hospitals after member has been discharged.
- Unable to contact member due to bad phone numbers and/or addresses.
- Staff turnover.
- Lack of training and/or staff protocols.
- Caseloads prevent exhaustive search efforts to locate members.
- Caseloads prevent quality time spent in assisting members in executing their discharge plan.
- Lack of continuity with follow-up discharge calls between care management and utilization management staff.

The following are interventions common across all health plans:

- Developed and conducted training and education to clinical staff and network providers.
- Developed a transition of care system program to identify member(s) in the hospital prior to discharge so outreach could be conducted.
- Established a partnership and collaborated with hospitals/inpatient facilities, including embedding care coordinators in high-volume facilities.
- Implemented and revised current programs for high-risk population(s).
- Participated in community outreach events to have face-to-face outreach with members.

Behavioral Health PIP Results

Validation

SFY 2018

Table 4-2 displays the overall SFY 2018 validation results for each health plan for the Behavioral Health PIP.

Table 4-2—SFY 2018 Validation Results Across All Health Plans for Behavioral Health PIP

Health Plan	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Validation Status
BCBSIL	85%	100%	*Met*
CountyCare	93%	100%	*Met*
Harmony	85%	100%	*Met*
IlliniCare	85%	100%	*Met*
Meridian	93%	100%	*Met*
Molina	85%	100%	*Met*
NextLevel	88%	100%	*Met*

For the SFY 2018 validation of the Behavioral Health PIP, all seven health plans received an overall *Met* validation status and a 100 percent *Met* score for all applicable critical evaluation elements. Like the Care Coordination PIP, health plans were generally able to meet the documentation requirements of the PIP; however, lack of improvement in the study indicator outcomes contributed to a lower percentage score of evaluation elements *Met*.

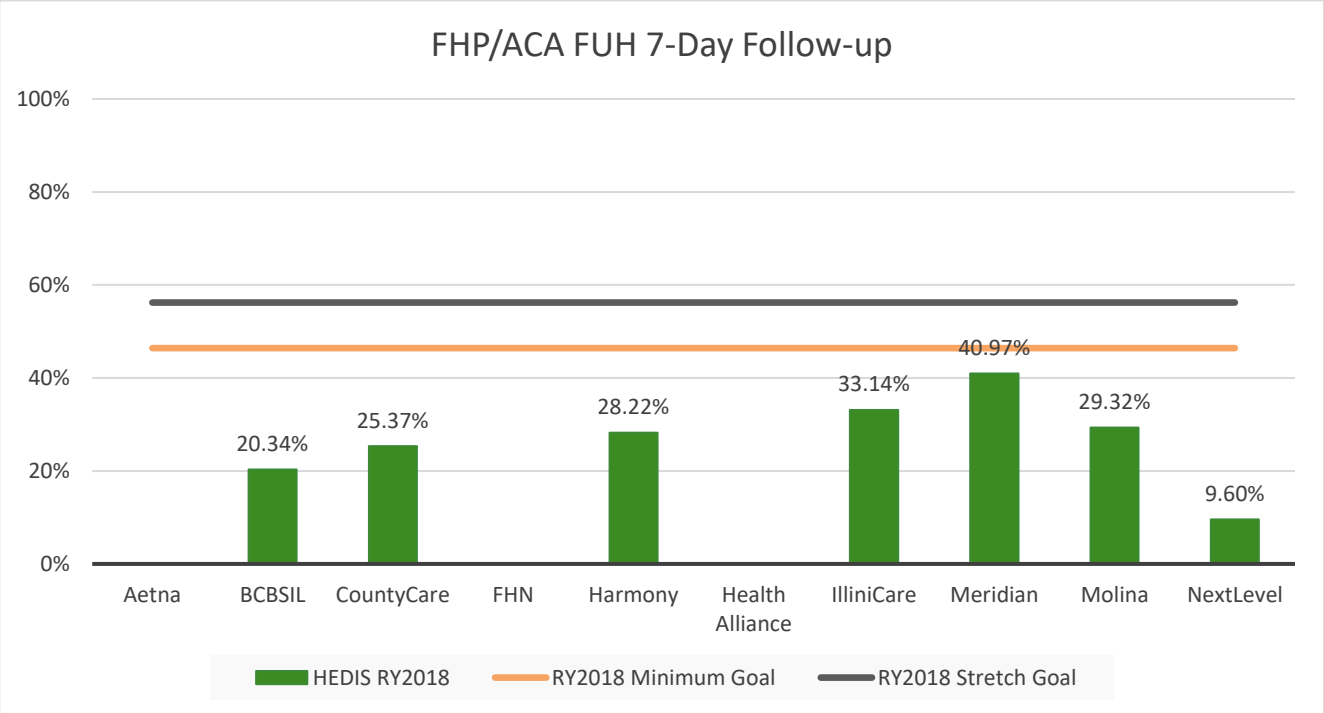
Outcomes

Two study indicators for this PIP tracked health plan performance on HEDIS measures that assess the rate of beneficiaries receiving follow-up appointments within seven days (Study Indicator 1) and 30 days (Study Indicator 2) of discharge from an inpatient stay for mental health treatment (*FUH*). The PIP goal for both HEDIS measures was to achieve at least the 50th percentile based on HEDIS benchmarks. SFY 2018 was the third year of participation in this PIP for all health plans with the exception of NextLevel, which completed its second year of participation.[4-4] FHP/ACA and ICP results are presented separately. Trended results are included in Appendix H of this report.

FHP/ACA Outcomes

Figure 4-7 and Figure 4-8 display the results for each study indicator for the Behavioral Health PIP for the FHP/ACA health plans for SFY 2018.

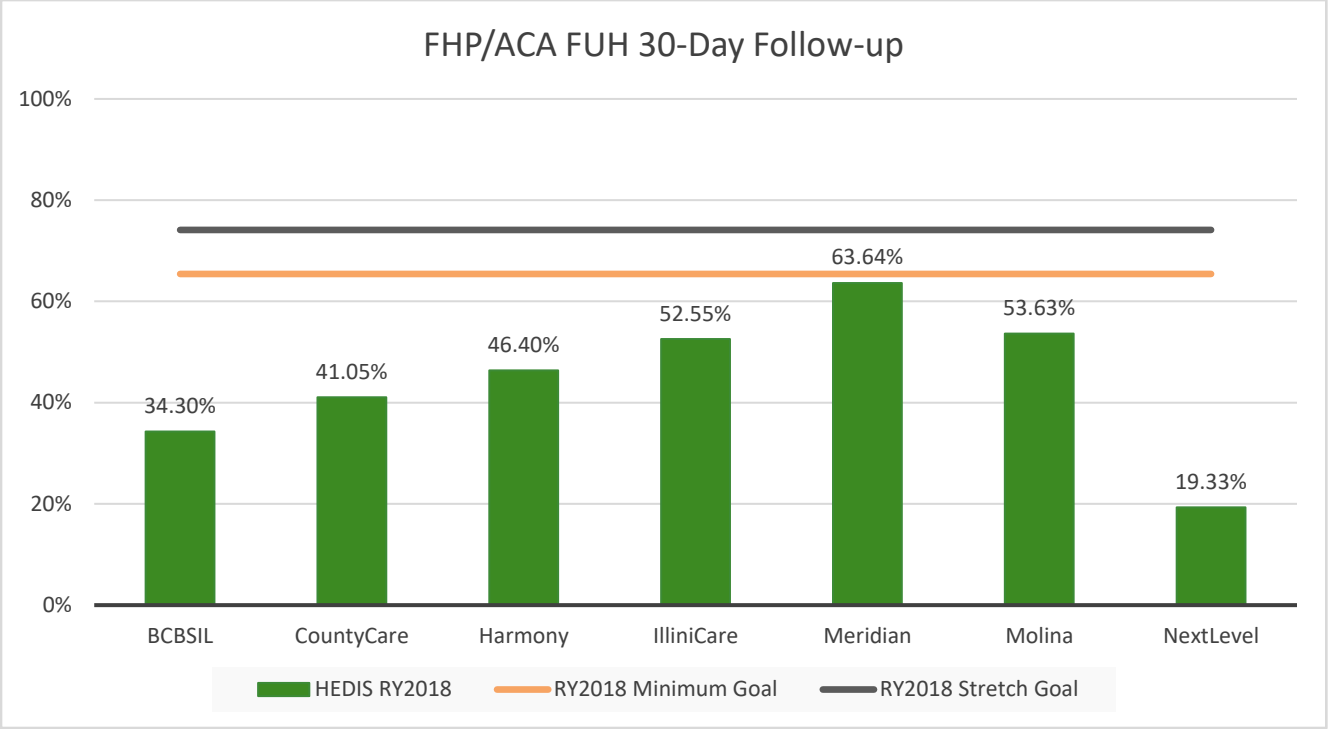
Figure 4-7—SFY 2018 Study Indicator 1 Results for FHP/ACA Health Plans for Behavioral Health PIP



Remeasurement year (RY)

[4-4] NextLevel became a MCCN on January 1, 2016; therefore, no baseline results were reported for SFY 2016.

Figure 4-8—SFY 2018 Study Indicator 2 Results for FHP/ACA Health Plans for Behavioral Health PIP



Remeasurement year (RY)

SFY 2018 FHP/ACA Summary

Notable

- Two of the seven health plans realized an improvement in performance for Study Indicator 1 (7-day follow-up) compared to SFY 2017.
- Four of the seven health plans realized an improvement in performance for Study Indicator 2 (30-day follow-up) compared to SFY 2017.

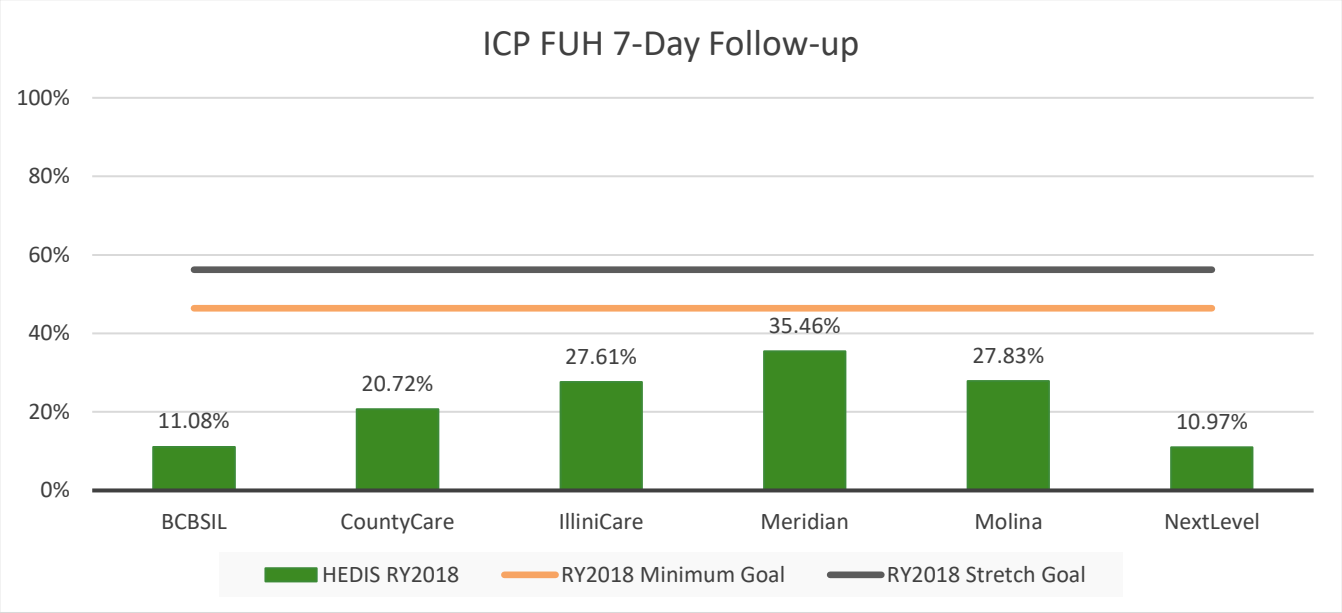
Needs Work

- Overall, the health plans averaged 27 percent for Study Indicator 1: (7-day follow-up). All seven health plans performed below the minimum goal.
- Overall, the health plans averaged 44 percent for Study Indicator 2 (30-day follow-up). All seven health plans performed below the minimum goal.

ICP Outcomes

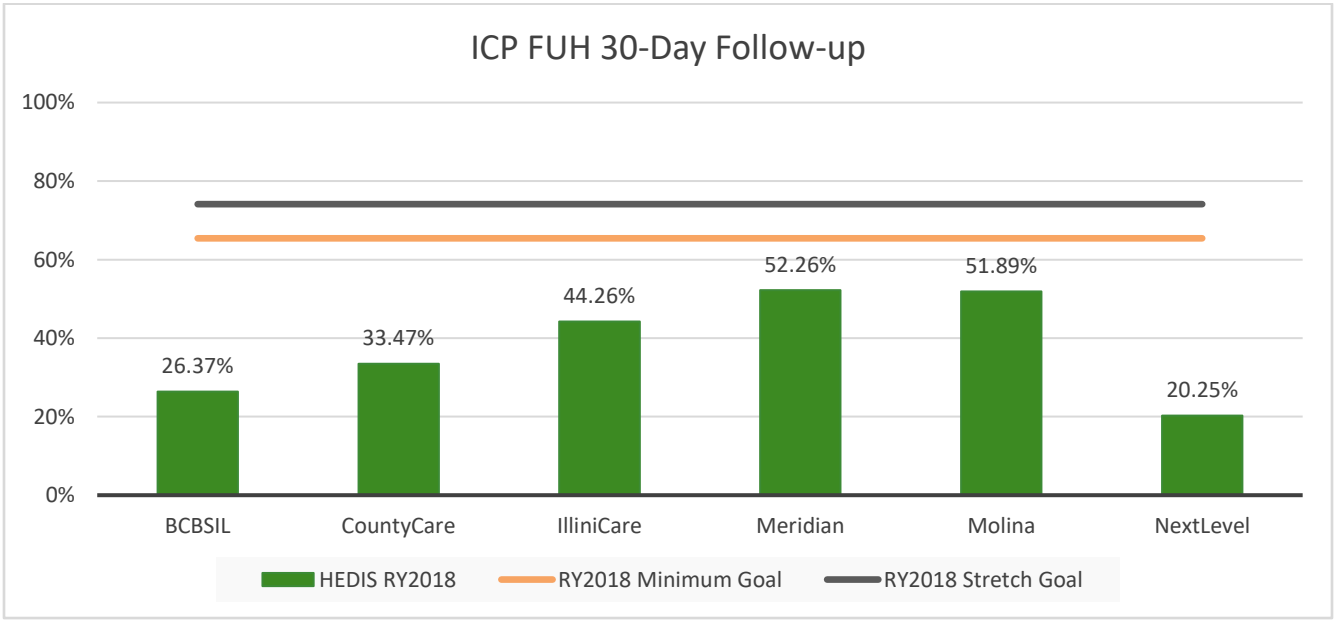
Figure 4-9 through Figure 4-10 display the results for each study indicator for the Behavioral Health PIP for the ICP health plans.

Figure 4-9—SFY 2018 Study Indicator 1 Results for ICP Health Plans for Behavioral Health PIP



Remeasurement year (RY)

Figure 4-10—SFY 2018 Study Indicator 2 Results for ICP Health Plans for Behavioral Health PIP



Remeasurement year (RY)

SFY 2018 ICP Summary

Notable

- Three of the six health plans realized an improvement in performance for Study Indicator 1 (7-day follow-up) compared to SFY 2017.
- Three of the six health plans realized an improvement in performance for Study Indicator 2 (30-day follow-up) compared to SFY 2017.

Needs Work

- Overall, the health plans averaged 22 percent for Study Indicator 1 (7-day follow-up). All six health plans performed below the minimum goal.
- Overall, the health plans averaged 38 percent for Study Indicator 2 (30-day follow-up). All six health plans performed below the minimum goal.

Barriers/Interventions

The following are barriers that were common across all health plans:

- Aftercare planning is not occurring early in the members' inpatient stay.
- The behavioral health network may not be adequate to meet the timeliness requirements of the 7- and 30-day performance measures.
- Workflow processes need to be assessed and redirected to ensure there are adequate clinical resources available to address timely aftercare discharge planning.
- Coordination between hospital facility staff and the health plan related to discharge planning. The identification of, and access to, hospital discharge staff could be streamlined with a single point of entry or contact.
- Network practitioners, providers, and facilities are unaware of the *FUH* measure requirements.
- Network providers do not prioritize follow-up or walk-in appointments for discharged members.
- Members lack an understanding for the importance of follow-up care and how to address physical barriers (i.e., lack of transportation).
- Members may not have an established mental health provider.
- Members with co-morbid/co-occurring mental health and substance use disorders or issues may be more treatment-ambivalent due to the comorbidity illness and their current stage of change.
- Members' lack of adherence to their psychotropic medication regimen due to the side effects experienced.

The following are interventions common across all health plans:

- Established multiple connections with community agencies to support access to behavioral health care, including pre-discharge community agency connection and in-home assessments.
- The Behavioral Health Care Transitions Teams worked with hospitals/inpatient facilities to have hospital discharge staff start the discharge coordination planning process early in the member's inpatient stay.
- Educated providers, inpatient facilities, and community agencies on the *FUH* HEDIS measure and its standards.
- Held community events to promote healthy behaviors and self-management of illness.
- Conducted member outreach to educate on the importance of post-hospital discharge follow-up, medication adherence, and self-management of behavioral health illness.

Recommendations

Due to a lack of progress/value added and a lack of causality between PIP study indicators, HSAG recommends that the Care Coordination PIP be retired. Due to the lack of improved performance related to the Behavioral Health PIP indicators, HFS may consider implementing the Institute for Healthcare Improvement's (IHI's) rapid-cycle performance improvement approach[4-5] for the PIP, which places greater emphasis on improving outcomes using quality improvement science.

[4-5] Institute for Healthcare Improvement. Science of Improvement: How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx. Accessed on: Mar 27, 2018.

5. New Mandatory Activities

The Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F) in 2016, which outlined new requirements for states. This section presents a brief description of the activities Health Services Advisory Group, Inc. (HSAG), conducted to assist the Illinois Department of Healthcare and Family Services (HFS) in meeting new external quality review (EQR) requirements.

Section Contents

Validation of Health Plan Network Adequacy

Introduction

In fiscal year (FY) 2017–2018, HFS requested that HSAG conduct readiness reviews and post-implementation reviews of the HealthChoice Illinois Medicaid managed care program, effective April 1st, 2018. On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, which serves approximately 2.5 million residents. Under the managed care program reboot, seven health plans were contracted by HFS to provide care for 80 percent of all Medicaid enrollees statewide. The key objectives of the reboot were to reduce Medicaid program costs, more efficiently manage utilization of healthcare services, and improve healthcare quality and outcomes. The managed care program prior to January 1, 2018, was designed to operate in 30 counties; as of April 1, 2018, expansion included all 102 counties statewide. Five of the seven HealthChoice Illinois managed care health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only.

The provider network readiness review activities began on September 2017 and continued post-implementation until June 30th, 2018. The purpose of the network reviews was to evaluate and report on the capacity of the health plan provider network in 102 counties (72 expansion counties and 30 mandatory counties). HFS maintained authority to approve the sufficiency of the health plans' provider networks in accordance with the Medicaid model contract.

Methodology

HSAG established a process for health plans to submit monthly provider network data for each of their service areas. HSAG used the provider network submissions to identify potential network gaps and to monitor the health plans' contracting progress towards establishing an adequate provider network for enrollees. The readiness review conducted by HSAG consisted of three processes: Network Data Submission, Data Validation, and Reporting and Communication.

Network Data Submission Process

HSAG developed a Provider Network Data Submission Instruction Manual (manual) to provide health plans with detailed guidance for the monthly completion and submission of accurate network capacity data. The health plans were required to follow the instructions and definitions for provider types within the manual to submit monthly network capacity data in a standardized Provider File Layout (PFL), Microsoft (MS) Excel workbook. The manual included the following sections:

- Section 1—Introduction, describes the purpose of the manual and its organization and provides an overview of the PFL.
- Section 2—PFL Instruction, provides detailed guidance on properly completing the PFL, including the file naming conventions, provider type specifications and definitions, and a description of the data submission elements needed to complete each field of the PFL.

- Section 3—Submission Process, describes the procedure managed care organizations (MCOs) follow to submit the provider network data.
- Appendix A—Data Dictionary, contains definitions for all provider types required for submission.
- Appendix B—Home- and Community-Based Services (HCBS) Waiver Definitions, defines HCBS service types required for submission.
- Appendix C—PFL MS Excel workbook template.

Health plans were required to upload their monthly provider network data files to a secure HSAG file transfer protocol site. These files included primary care providers (PCPs), specialists, pediatric providers, dental providers, hospitals, facilities, pharmacies, HCBS and Managed Long Term Services and Supports (MLTSS) providers (including substance abuse providers), federally qualified health centers (FQHCs), community mental health centers (CMHCs), rural health clinics (RHCs), nursing facilities, supportive living facilities (SLFs), exceptional care providers, and transportation providers within each managed care expansion area.

In addition to the monthly provider network data files, health plans were required to submit a hospital contracting workbook that identified the status of the health plans' contracting efforts with all hospital types in the expansion counties, as well as in contiguous counties, if applicable. The purpose of the hospital contracting workbook was to track the health plans' outreach attempts with hospitals and monitor the execution of contracts with major hospital groups. This allowed HFS and HSAG to prioritize and focus on the health plans' contracting progress with large hospital groups in the expansion counties.

Data Validation Process

Following the monthly submission of the health plans' provider network data, HSAG conducted a validation process that included:

- A review of the accuracy and completeness of required data fields.
- Identification of duplicate data.
- Categorization of providers to the correct provider group.
- Verification of provider contract status.
- Verification of open and closed panel status.
- Comparison of the number of data records between the prior and current data submissions.
- Verification of provider types.

After completion of HSAG's validation checks, the health plan provider data was loaded to a secure MS Access database containing programmed queries that generated network reports. As an additional validation check, the data generated by the source programming code was validated against the health plan data files to verify the accuracy of the network reports.

HSAG produced health plan-specific and comparative network reports to identify the number of provider types within each county across the state. HSAG monitored the health plans' network

development in the expansion counties by including counts of current contracted providers, pending providers, and the future network when all providers are contracted and loaded into the health plan provider database.

Reporting and Communication

During the network readiness reviews and post-implementation reviews, HSAG maintained ongoing communication with the health plans and HFS regarding any findings and recommendations identified during HSAG's monthly analysis of the health plans' provider networks. Network gaps were communicated to HFS; health plans were required to respond to all identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps. In addition, HSAG provided technical assistance sessions to each health plan to improve the data collection and submission process for accurate reporting.

HSAG collaborated with HFS to develop monthly provider network capacity reports to ensure compliance with HFS' specifications. The monthly provider network capacity reports included:

- Regional Dashboard Report—review of the health plans' contracting status with hospitals, FQHCs, CMHCs, and RHCs in the expansion counties, as well as contiguous counties, if applicable.
- Hospital Analysis Report—hospitals listed by name and region to show contracted and pended hospitals across health plans.
- HealthChoice Illinois Network Development—snapshot of the health plans' network development progress each month.
- PCP Network Capacity Report—review of each health plan's PCP capacity within each county and region.
- PCP Open & Closed Panels—number and percent of PCPs with open and closed panels by health plan.
- No Contracted Providers Across Statewide Health Plans—review of provider types the health plans were least successful contracting in the expansion counties.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.
- Division of Alcoholism and Substance Abuse (DASA) Provider Network Review—high-level review of each health plan's current and future network for DASA providers within each region.

Findings

The following section includes findings that resulted from the network readiness review for the statewide expansion:

- All health plans demonstrated adequate network capacity in the Cook and the collar counties (five counties that border Cook) at the time of Statewide expansion.
  - To validate network capacity a time and distance study was completed using the April network provider data and enrollment file. The findings for the providers included in the study identified compliance with time and distance requirements for the Cook and the collar counties.

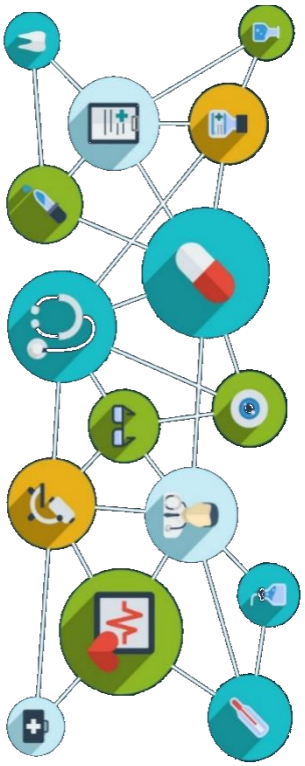
- HFS determined that the provider network capacity for IlliniCare Health Plan, Inc. (IlliniCare), Meridian Health Plan, Inc. (Meridian), and Molina Healthcare of Illinois, Inc. (Molina), was adequate at the time of the statewide expansion across all regions.
- HFS determined that Blue Cross Blue Shield of Illinois' (BCBSIL's) and Harmony Health Plan of Illinois, Inc.'s (Harmony's), provider network was not adequate, which resulted in an enrollment hold and restriction of the auto assignment algorithm for BCBSIL and Harmony.
- Due to delays in the implementation of the HealthChoice Illinois contract, the health plans' time frame for engaging and contracting with providers was limited for the statewide expansion.
  - Limited time for contracting directly impacted providers by restricting the time needed for review and execution of provider contracts.
  - Processing large numbers of provider contracts and subsequent entry into the health plan provider database caused significant resource challenges for the health plan provider network staff.
- Capacity of some regions required inclusion of providers in contiguous states due to limited provider capacity in these regions.
- Providers in the expansion counties initially limited contracting opportunities for two to three of the five Medicaid managed care plans. HFS intervened on behalf of the health plans by encouraging providers to contract with all Medicaid managed health plans.
- Capacity of the HCBS network identified the need for the health plans to focus their efforts on contracting with HCBS providers in the expansion regions.

Recommendations

The following recommendations are based on the findings for the statewide expansion network capacity readiness review.

- Continue monitoring health plans' contracting efforts and network development through a review of the provider data and hospital contracting workbook.
- Enhance the accuracy of reporting for all pediatric providers.
- Evaluate resources and systems to more efficiently complete the loading process for newly contracted providers.
- Improve the accuracy of reporting individual providers within provider/physician groups, hospitals, CMHCs, FQHCs, and RHCs.
- Evaluate the frequency of online and paper provider directories audits for compliance with directory requirements.
  - Examine the process and timeliness of completing updates to the provider directory.
  - Include audits of the delegated online directories for compliance with directory requirements; for example, dental and vision provider directories.
- Establish timely single-case agreements with out of network providers until a qualified in-network provider is contracted/available.
- Continue contracting efforts with HCBS providers in the expansion regions for existing enrollment and for the future implementation of the MLTSS program.

Time/Distance Analysis



As part of its provider network adequacy monitoring activities, HFS requested its external quality review organization (EQRO), HSAG, conduct a time/distance analysis between enrollees and providers in the HealthChoice Illinois health plan networks. Specifically, the purpose of the state fiscal year (SFY) 2018 time/distance analysis was to evaluate the degree to which health plans comply with the network standards outlined in the Illinois Department of Healthcare and Family Services—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol has not yet been released, the time/distance analysis described in this report aligns with current federal regulations and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect.

This time/distance analysis includes two phases. The first phase, presented in this report, was conducted in the middle of 2018 and included seven HealthChoice Illinois health plans. Details about the submission process and submission guidance are included in Appendix I of this report.

HSAG was also contracted to conduct an analysis of the health plans' provider networks as a key component of pre- and post-implementation readiness reviews. The purpose of the provider network review prior to implementation is to evaluate the progress of each health plan in contracting and credentialing providers to ensure sufficient network capacity to serve enrollees in the expansion areas. The network analysis allows HFS to evaluate the provider network across the health plans using a standardized approach. This process ensures that the health plans' networks are reviewed with a consistent methodology that allows for fair comparisons, and that each health plan has a broad range of PCPs, specialists, outpatient facilities, and hospitals to provide access to care and services to its enrollees.

Regions

The managed care program prior to January 1, 2018, was designed to operate in 30 counties; as of April 1, 2018, expansion included all 102 counties statewide. Five of the seven HealthChoice Illinois managed care health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. Time/distance standards limit how long and/or how far an enrollee must travel to access a specified type of provider. Time/distance requirements are a common metric for measuring the adequacy of a plan's provider network.

Geographic network distribution analyses assess whether enrollees in each county are required to travel a reasonable amount of time or distance to reach the nearest provider. HFS established access standards

by provider category for the maximum allowable distance or time an enrollee should be required to travel to receive care and established five regions within the state for the purposes of analysis. The percentage of enrollees living within the time/distance standards statewide and for each region and health plan was calculated as well as the percentage of counties per region meeting the contract requirements as defined by the HealthChoice Illinois Medicaid model contract.

Findings

Overall results of the time and distance study for all five regions are summarized below:

- All seven health plans were compliant with the time and distance requirements for all provider categories in Region 4 (Cook County).
- CountyCare Health Plan and NextLevel Health Partners, LLC, were compliant with the time/distance standards for all provider categories in Cook County.
- Molina was compliant with 97.2 percent of provider categories within the time/distance standards across all regions.
- Across all regions, IlliniCare was compliant with 90.3 percent of provider categories in urban counties and 93.1 percent in rural counties.
- Across all regions, Meridian was compliant with 88.9 percent of provider categories in urban counties and 94.4 percent in rural counties.
- Across all regions, Harmony was compliant with 83.3 percent of the provider categories in urban counties and 97.2 percent in rural counties.
- Across all regions, BCBSIL was compliant with 86.1 percent of the provider categories in urban counties and 88.9 percent in rural counties.

Recommendations for HFS and Health Plans

Based on the results and conclusions of the time and distance study, HSAG recommended the following for HFS and the health plans to strengthen the HealthChoice Illinois Medicaid managed care provider networks and ensure enrollees' timely access to healthcare services:

- HFS and the health plans should continue to work with their EQRO to ensure that provider data submitted by the health plans accurately reflects the services provided and the populations served by the providers, especially regarding pediatric providers. It is important to ensure that these providers are accurately represented in the health plans' networks so that analysis of time/distance standards may provide the most robust results for the unique needs of the pediatric population.
- HFS should continue to collaborate with the health plans to ensure that enrollees' address data are complete and accurate. It is important to ensure that address information used in the time/distance analysis reflects each enrollee's current address with accurate county information.
- HFS should continue to collaborate with the health plans to contract with additional providers, if available, in the areas identified as having excessive travel times or travel distances. Provider

categories of concern include pediatric behavioral health service provider, pediatric dentist, endocrinology, and oral surgery.

- HFS should conduct an in-depth review of provider categories in which each plan did not meet the access standards, with the goal of determining whether the health plan's failure to meet the time/distance network access standard(s) was the result of a lack of providers or an inability to contract with providers in the geographic area. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories in which providers may not be available or willing to contract with the health plans.
- As the time/distance analyses represent the potential distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should consider using appointment availability and utilization analyses to evaluate providers' availability and enrollees' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess enrollees' use of services and potential gaps in access to care resulting from inadequate provider availability.
- HFS should continue to develop requirements for Long-Term Services and Supports (LTSS) providers that require the enrollee to travel to the provider. LTSS network requirements are included in the new requirements governing network adequacy in the 2016 Medicaid Managed Care Rule.

Quality Rating System

Overview

§438.334 requires the development of a Medicaid managed care quality rating system. In SFY 2018, HFS updated its consumer quality comparison tool, called the HealthChoice Illinois Plan Report Card, to reflect the performance of each of the seven HealthChoice Illinois health plans.

HSAG was tasked with developing a report card to evaluate the performance of seven health plans serving the Integrated Care Program (ICP) and Family Health Plan/Accountable Care Act (FHP/ACA) populations. The report card was targeted toward a consumer audience; therefore, it was user friendly, easy to read, and addressed areas of interest for consumers. As part of the EQRO contract, HSAG analyzed 2018 Healthcare Effectiveness Data and Information Set (HEDIS) results, including 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) data from seven Illinois health plans.

HSAG created two report cards that included the combined ICP and FHP/ACA populations. The Cook County report card included an analysis of the seven plans that are available to Medicaid beneficiaries in Cook County. A non-Cook County report card included an analysis of the five plans that are available statewide to Medicaid beneficiaries (i.e., the two plans that are only available in Cook County will be excluded from the analysis). The calendar year (CY) 2017 Combined Report Card analyses helped support HFS' public reporting of MCO performance information.

Reporting Measures and Categories

Health plan performance was evaluated in six separate reporting categories, identified as important to consumers.[5-1] Each reporting category consisted of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the measures they contain were:

- **Doctors' Communication and Patient Engagement:** Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate and shared decision making, as well as overall ratings of personal doctors. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access to Care:** Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes

[5-1] National Committee for Quality Assurance. *Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports For Consumers*. Oct 1998.

HEDIS measures that assess adults' access to care and whether adults had their body mass index (BMI) documented.

- **Women's Health:** Includes HEDIS measures that assess how often women-specific services are provided (e.g., breast cancer, cervical cancer, chlamydia screenings, and prenatal and postpartum care).
- **Living With Illness:** Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions, such as asthma, diabetes, and hypertension. In addition, this category includes HEDIS measures that assess if members on persistent medications receive appropriate metabolic monitoring.
- **Behavioral Health:** Includes HEDIS measures that assess if members with behavioral health conditions received appropriate follow-up after hospitalization. In addition, this category includes a HEDIS measure for the initiation and engagement of alcohol and other drug dependence treatment.
- **Keeping Kids Healthy:** Includes HEDIS measures that assess how often preventative services are provided (e.g., child and adolescent immunizations, well-child visits, and weight assessment and counseling for children/adolescents).

Measures Used in Analysis

HFS, in collaboration with HSAG, chose measures for the report card based on several factors, such as using measures that best approximate the reporting categories that are useful to consumers; using available data; and using nationally recognized, standardized measures of Medicaid and/or managed care.

Thirty-nine measures were chosen, 13 CAHPS and 26 HEDIS, as well as their associated weights. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contributed equally to the derivation of the results.

Comparing Plan/Plan Category Performance to National Benchmarks

HSAG presented measure-level ratings on the selected HEDIS and CAHPS measures based on comparisons to national Medicaid benchmarks. A five-level rating scale was used to report how HEDIS measures compared to the 2017 Quality Compass national Medicaid benchmarks and how CAHPS measures compared to NCQA's 2018 Benchmarks and Thresholds for Accreditation. In addition, HSAG provided consumers with category-level trending information for the selected categories (Doctor's Communication and Patient Engagement, Access to Care, Women's Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy) to indicate whether the health plan's average rating in each category improved, declined, or stayed the same from 2017 to 2018 based on comparisons to national Medicaid benchmarks. HSAG computed six reporting category summary scores for each MCO. HSAG compared each measure to national benchmarks and assigned star ratings for each measure.

A copy of the most recently published report card for all counties excluding Cook County can be found at https://enrollhfs.illinois.gov/sites/default/files/content-docs/2017%2011%2021%20HealthChoice%20Illinois%20Report%20Card%20EN.pdf.

Responding to Illinois Legislation

Illinois Public Act 099-0725 set forth requirements for the Medicaid quality rating system. HSAG and HFS worked together to tailor the report card to meet the requirements of the legislation. In response, HSAG is assisting HFS in designing an online, interactive version of the report card.

Evaluation of Quality Strategy

HSAG understands that HFS must update its Quality Strategy as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authorities; and/or significant changes to the programmatic structure of the Medicaid program.

To assist with Quality Strategy development, HSAG facilitated stakeholder meetings, monitored project progress according to the proposed time frames to ensure the Quality Strategy was completed on time for CMS submission, provided feedback and guidance on drafts, and assisted with graphic design and editing. This technical assistance (TA) helps HFS design a Quality Strategy that provides an effective framework to accomplish HFS' goals and objectives.

HSAG stays abreast of CMS requirements for states' Quality Strategy and advised HFS on the development of its Quality Strategy in accordance with CMS' *Quality Strategy Toolkit for States*.[5-2] In addition, HSAG prepared presentations and briefs to update states on new regulations affecting the Quality Strategy.

In accordance with §438.340(c)(2)(i), HFS conducted an evaluation of its Quality Strategy with the assistance of HSAG. As a result, HFS published a fully revised and restructured Quality Strategy in 2018.

[5-2] Centers for Medicare & Medicaid Services. *Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Mar 19, 2018.

6. Structure and Operations

This section presents a brief description of the activities Health Services Advisory Group, Inc. (HSAG), conducted to assess and monitor the health plans' structure and operations as required by federal regulations and by request of the Illinois Department of Healthcare and Family Services (HFS) as well as a high-level summary of the results of those activities.

Section Contents

Compliance and Readiness Reviews

Introduction

The Code of Federal Regulations (CFR) at 42 CFR Part 438 Subpart E requires that specific review activities be performed by an external quality review organization (EQRO) related to required external quality reviews of a health plan's compliance with state and federal standards. The Illinois Department of Healthcare and Family Services (HFS) issued a request for proposals (RFP) on February 27, 2017, to rebid most of the State's existing Medicaid managed care program contracts, consolidate multiple programs into a single streamlined program, and expand managed care statewide. The RFP consolidated the Family Health Plans/Affordable Care Act (FHP/ACA) program, the Integrated Care Program (ICP), and the Managed Long-Term Services and Supports (MLTSS) program into a single contracting approach, while reducing the number of contracted Medicaid managed care health plans (health plans) to seven. HealthChoice Illinois—the State's rebooted Medicaid managed care program—launched on January 1, 2018, to serve almost 2.7 million residents.

In the prior external quality review (EQR) reporting years, HSAG conducted an administrative compliance review in accordance with §438.358 on a subset of standards selected by HFS. In state fiscal year (SFY) 2018, HSAG completed the administrative compliance reviews by assessing the remaining standards for the five health plans that were exiting the Illinois Medicaid market, and including review of the remaining standards in the readiness review process for the seven health plans serving HealthChoice Illinois.

Federal regulations at 42 CFR §438.66(d)(2) require states to conduct comprehensive readiness reviews to verify whether contracted health plans are prepared to provide services prior to enrolling Medicaid beneficiaries into managed care. As part of implementation of the HealthChoice Illinois program, HFS contracted with its EQRO, HSAG, during SFY 2017 to conduct readiness reviews of each of the health plans selected to participate in HealthChoice Illinois. These reviews included assessing health plan readiness to serve members using MLTSS waivers. Under the waiver, in specified geographies, dual eligible beneficiaries who receive institutional services (except those receiving developmental disability institutional services) or community-based long-term services and supports (through five of the State's 1915(c) waiver programs) were required to enroll in managed care, unless they met another exclusion. The covered geography will be expanded statewide when MLTSS and waiver services are incorporated into HealthChoice Illinois, scheduled for January 1, 2019.

Under HealthChoice Illinois, children in the care of the Department of Children and Family Services (DCFS) will be served by IlliniCare Health Plan, Inc. (IlliniCare). HSAG will conduct a readiness review process in SFY 2018 specific to the DCFS population to assess IlliniCare's processes, care coordination, staffing, contract oversight, and systems to ensure the capacity to serve new DCFS enrollment.

Administrative Compliance Reviews

Background

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states contract with an EQRO to conduct an evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs'/PIHPs' compliance with standards related to access, measurement and improvement, structure and operations, and program integrity. The U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), regulates procedures for EQR. Oversight activities of the EQRO focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries.

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards for quality healthcare is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The CMS Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans Version 2.0, September 1, 2012, describe the second step.

Since June 2002, HSAG has served as the EQRO for the Illinois Department of Healthcare and Family Services (HFS, or the Department).

Objectives for Conducting the Administrative Compliance Audit

The primary objective of HSAG's review was to provide meaningful information to HFS and the MCOs regarding the MCOs' compliance with federal managed care regulations and contract requirements. The review areas selected included the remaining standards that were not included in calendar year (CY) 2015 Focused Administrative Review and are listed below under the three areas of Access, Structure and Operations, and Measurement and Improvement. The SFY 2018 completed all standards that are required to complete a comprehensive readiness review for the MCOs.

To complete the readiness 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 the report of its findings.

To accomplish its objective and based on the results of collaborative planning with HFS, HSAG revised and updated the standardized data collection tool and processes to access and document each MCO's compliance with federal Medicaid managed care regulations, State rules, and the associated HFS

contract requirements. The 2018 administrative review tool included requirements that addressed the following operational areas.

2018 Standards

Access Standards

- Standard IV—Coverage and Authorization of Services
- Standard V—Credentialing and Recredentialing
- Standard VI—Children's Mental Health System

Structure and Operations Standards

- Standard VIII—Enrollee Information/Enrollee Rights
- Standard IX—Confidentiality
- Standard X—Enrollment and Disenrollment
- Standard XI—Grievance and Appeal Process

Measurement and Improvement Standards

- Standard XII—Quality Assessment and Performance Improvement Program

Program Integrity

- Standard XVI—Fraud Waste and Abuse

Surveyor Training and Oversight

To ensure interrater reliability, HSAG surveyors conferred on review methodology and collaborated with HFS on the development of the standardized readiness review tools. Ongoing communication and coordination between the team members ensured uniformity of review. The team leader reviewed all standard designations and reports to ensure consistency. The surveyors also reviewed each other's completed section reviews to ensure consistency in terminology and designation assignments.

HSAG validated all surveyor-completed tools against the final report to ensure accuracy of the information. Discrepancies were reported to the team leader, discussed among the survey team members, addressed, and rectified.

Evaluation of Compliance

HSAG's findings of the SFY 2018 readiness review were determined from its:

- Desk review of the health plan documents submitted to HSAG prior to the on-site portion of the readiness review.
- On-site activities, which included reviewing additional documents and records, observing systems demonstrations, and interviewing key health plan administrative and program staff members.

Based on the results from the comprehensive readiness review tool and conclusions from the review activities, HSAG assigned each element within the standards in the compliance monitoring tool a score of *Met*, *Not Met*, or *Not Applicable (NA).*

HSAG used scores of *Met* and *Not Met* to indicate the degree of compliance with the requirements by the ICPs. HSAG used a designation of *NA* when a requirement was not applicable to an organization during the period covered by the review. This scoring methodology was consistent with CMS' final 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., February 11, 2003.[6-1]

Met indicates full compliance defined as both of the following:

- All documentation listed under a regulatory provision or component thereof is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as the following:

- Not all documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

For any element assigned a *Not Met* finding, the health plan was required to develop a corrective action plan (CAP) to identify how it would become compliant with the required element.

[6-1] Centers for Medicare & Medicaid Services. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations.* Available at: http://www.ldh.la.gov/assets/docs/RFP2/StandardsReviewProtocol.pdf. Accessed on: Feb 12, 2019.

Administrative Compliance Audit Results

Figure 6-1 and Figure 6-2 display the overall SFY 2018 initial and final compliance audit results for each standard under the scope of the review for each health plan. As a result of the timing of the 2019 statewide expansion of Medicaid managed care, the administrative review standards were reviewed at the same time as the 2018 HealthChoice Illinois Readiness Reviews in preparation for expansion.

The initial scores in the tables below represent the performance on each of the standards prior to remediation of any non-compliant findings from the desk and on-site administrative reviews.

Figure 6-1—FHP/ACA Audit Initial-Final Scoring Comparison

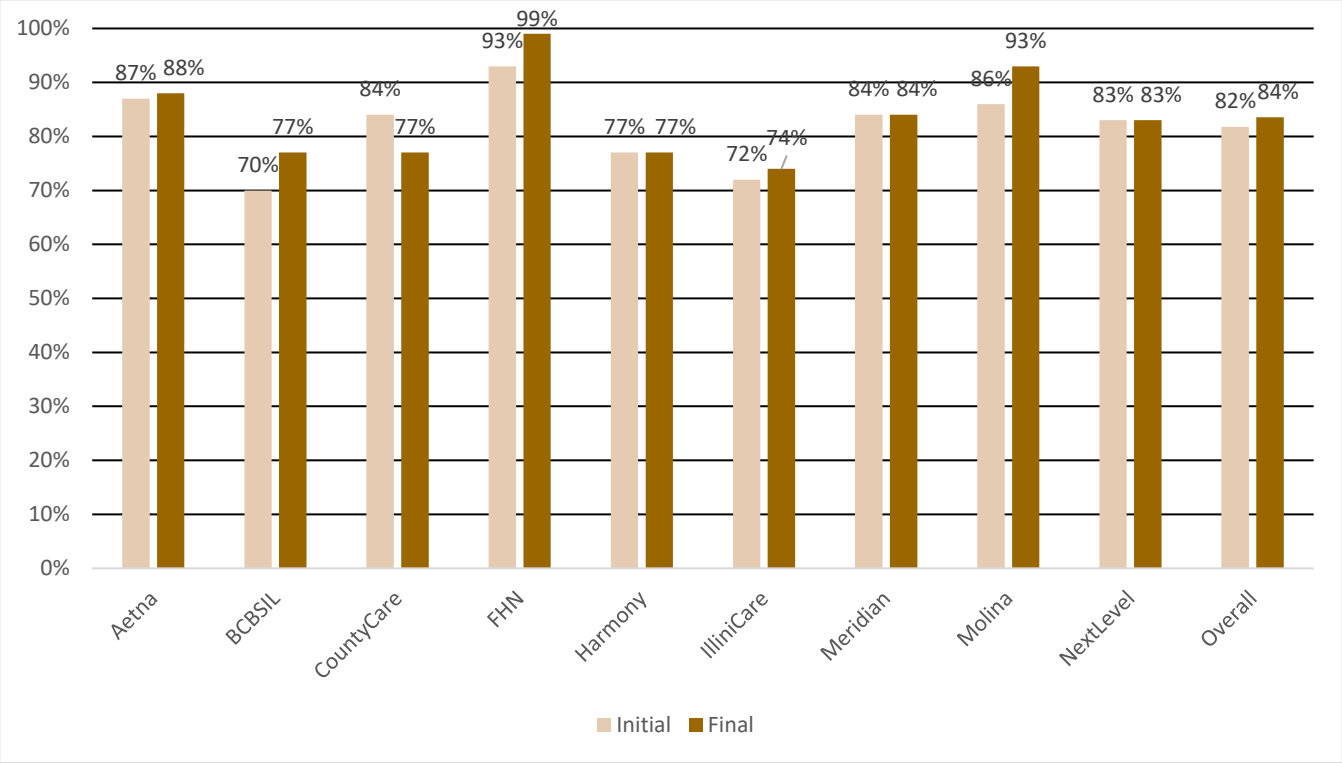
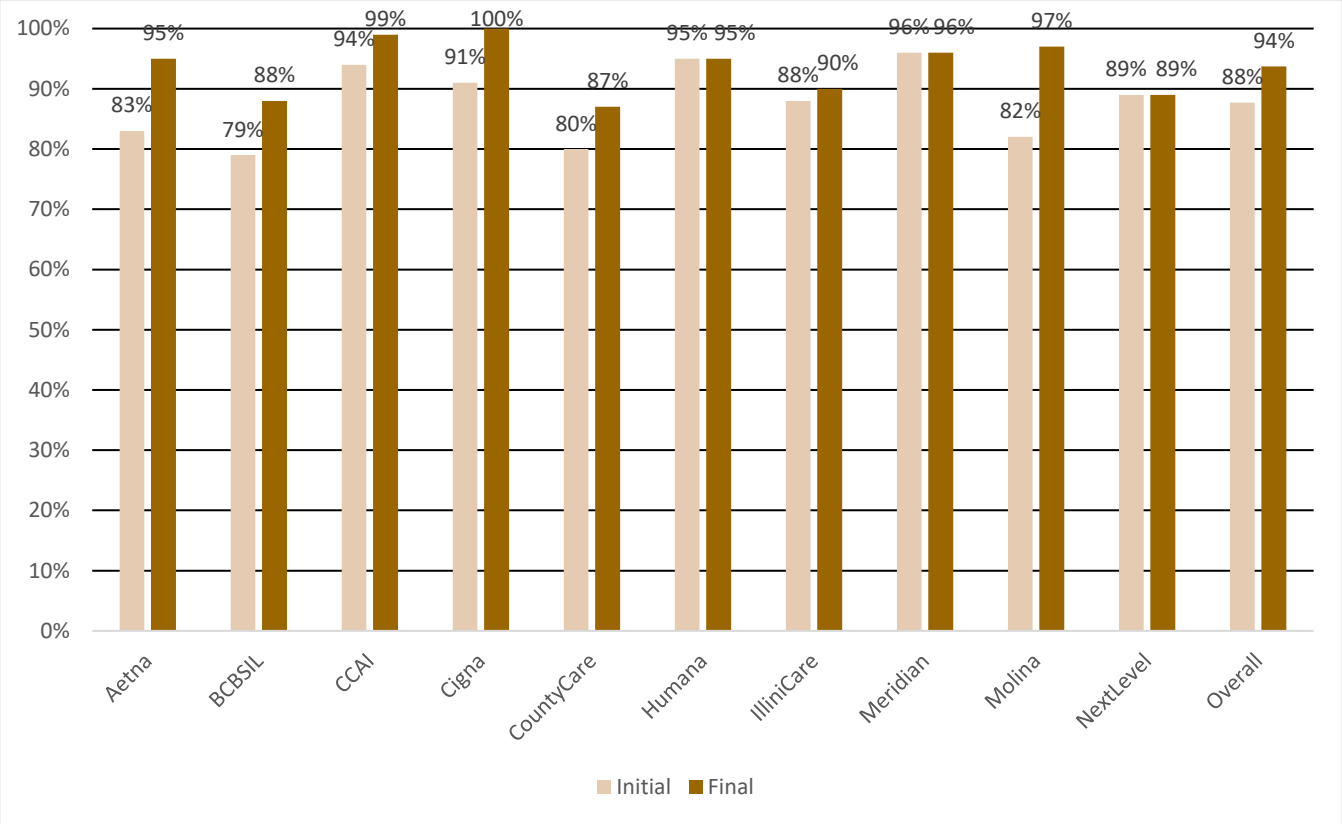


Figure 6-2—ICP Audit Initial-Final Scoring Comparison



Findings and Conclusions

Of the nine standards reviewed during the administrative review process, most health plans demonstrated overall compliance with the Standard X—Enrollment and Disenrollment; Standard IX—Confidentiality; Standard XI—Grievance and Appeal System; Standard XIII—Fraud, Waste and Abuse; and Standard XVIII—Quality Assessment and Performance Improvement Program.

The area with the greatest opportunity for improvement for administrative review standards was Standard IV—Children's Mental Health System. The results for this standard across all health plans identified a lack of compliance with inclusion of all program requirements in policies and procedures and oversight of the contracted vendor Chrysalis, a state contracted vendor for the Crisis and Referral Entry Services (CARES) line which is the dedicated Behavioral Health Crisis line for enrollees and family members. As this standard was included in the readiness review follow-up, remediation of non-compliance was documented as part of the readiness review.

Readiness Review Process for HealthChoice Illinois

Background

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). P.A. 096-1501 (also known as "Medicaid Reform") required that 50 percent of Medicaid clients be enrolled in care coordination (managed care) programs by 2015. In January 1, 2018, HFS launched HealthChoice Illinois to provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. The former FHP/ACA and ICP populations were combined and served under a new HealthChoice Illinois model contract. Beginning in January, the seven health plans chosen to serve HealthChoice Illinois began serving the new combined population in the counties in which they had previously operated. On April 1, 2018, health plans expanded coverage to all counties. This resulted in all of Illinois' 102 counties being covered under Medicaid managed care.

HFS contracted with HSAG to conduct HealthChoice Illinois program readiness reviews to assess the health plans' processes, care coordination, provider network, staffing, contract oversight, and systems to ensure the capacity to serve new enrollment.

Scope of the Readiness Reviews

The readiness review consisted of two phases as outlined below.

Phase I: On-site Review

The on-site review included reviewing documents and records, observing systems demonstrations, and interviewing key health plan staff. The following components were included in the on-site review:

- High-level critical components of key operational areas
- Overall project/implementation plan
- Enrollee transition plans
- Staffing plans
- Claims Systems Testing Review
- Provider Network Capacity Review—refer to Section 5 of this report for findings of the provider network readiness reviews.

Critical Elements

Critical elements were identified for readiness and health plans were required to pass all critical elements prior to accepting enrollment. Ongoing monitoring will be conducted by HFS and HSAG to

assess health plan performance and their ability to Medicaid beneficiaries. Critical elements included the following elements:

Operations and Administration

- Organizational structure and staffing and transition team
- Delegated vendors and oversight
- Enrollee and provider communications
- Grievance and appeals
- Member services and outreach
- Provider network management
- Program integrity/compliance

Service Delivery

- Utilization management
- Care management/care coordination
- Quality assessment and performance improvement
- Program integrity and confidentiality

Systems Management

- Enrollment processing
- Systems and operations
- Claims processing
- Care management software system

Phase II: Desk Review and Follow-Up On-Site Review

The scope of the Desk review and on-site review included 18 standards from the 2018 Model Medicaid Managed Care Contract as follows:

I. Availability of Services
II. Assurance of Adequate Capacity and Services
III. Coordination and Continuity of Care (Including Transition of Care)
IV. Coverage and Authorization of Services
V. Credentialing and Re-credentialing
VI. Children's Behavioral Health Services
VII. DCFS Youth
VIII. Enrollee Information/Enrollee Rights
IX. Confidentiality
X. Enrollment and Disenrollment
XI. Grievance and Appeal Systems

XII. Organization and Governance
XIII. Fraud, Waste, and Abuse
XIV. Health Information System
XV. Subcontractual Relationship and Delegation
XVI. Critical Incidents
XVII. Practice Guidelines and Required Minimum Standards of Care
XVIII. Quality Assessment and Performance Improvement Program

The objectives and procedures for the readiness review process and data collection and analysis are detailed in Appendix I. The readiness review also included a separate network validation review. Refer to Section 5 of this report for the results of the provider network readiness review. The readiness review tools addressed key areas that directly impact a client's ability to receive services including, but not limited to, assessment processes, care coordination, provider network, staffing, and systems to ensure that the organization has the capacity to manage the increase in enrollment due to the statewide Medicaid managed care expansion.

Enrollment Distribution

As a result of five health plans exiting the market, the seven HealthChoice Illinois health plans were required to absorb additional enrollment. The table below demonstrates the enrollment distribution that occurred for the HealthChoice Illinois transition. HSAG's readiness reviews focused on determining if health plans acquiring significant enrollment were prepared to deliver high quality care to the increased enrollment. Table 6-2 below demonstrates the transition of enrollment between health plans as a result of the transition to HealthChoice Illinois.

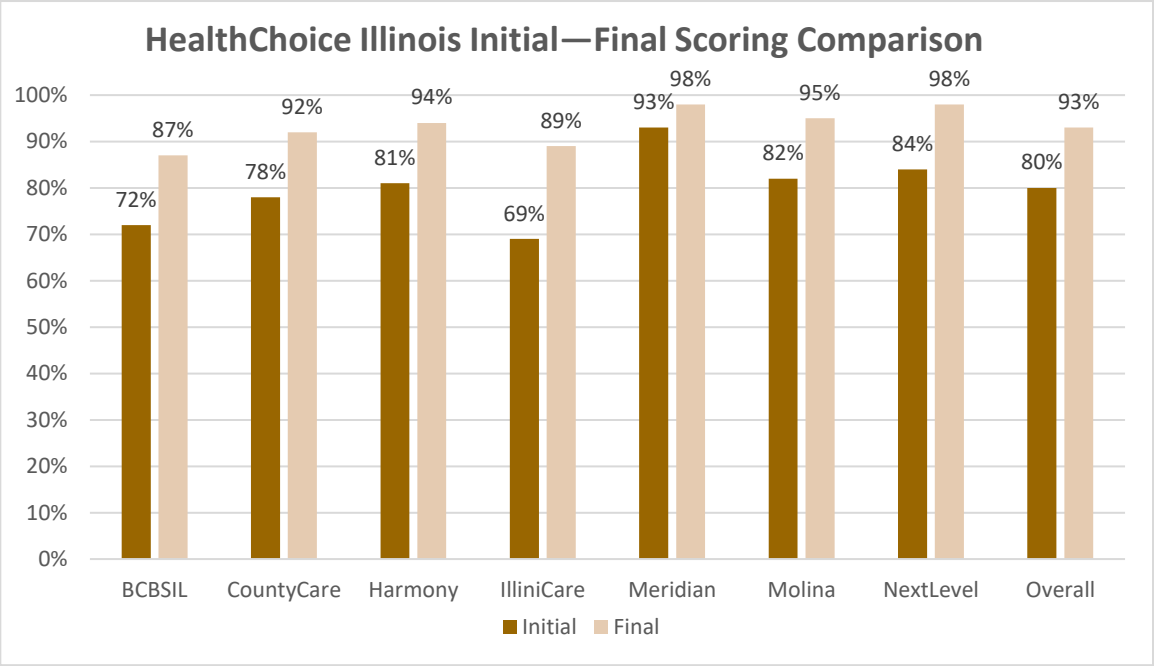
Table 6-2—Transition of Enrollment from Exiting Plans to HealthChoice Illinois

Exiting Plan	Program	New Plan	Enrollment Transferred 7/1/2017	Enrollment Transferred 1/1/2018
Cigna-HealthSpring of Illinois (Cigna)	ICP	Humana Health Plan, Inc. (Humana)	560	N/A
		CountyCare HealthPlan (CountyCare)	672	N/A
		NextLevel Health Partners, LLC (NextLevel)	232	N/A
		Aetna Better Health (Aetna)	864	N/A
		Blue Cross Blue Shield of Illinois (BCBSIL)	842	N/A
		IlliniCare	831	N/A
		Meridian Health Plan, Inc. (Meridian)	852	N/A
	Medicare-Medicaid Alignment Initiative (MMAI)	Membership transferred to HealthChoice Illinois Plans	N/A	3,089
Family Health Network (FHN)	FHP/ACA	CountyCare (Cook only)	159,833	N/A
		IlliniCare	N/A	47,077
Community Care Alliance of Illinois (CCAI)	ICP	CountyCare (Cook only)	6,028	N/A
		IlliniCare	N/A	1,601
Humana	ICP	Membership transferred to HealthChoice Illinois Plans	N/A	5,588
	MMAI	Humana	N/A	6,949 (Humana in MMAI)
Aetna	FHP/ACA	CountyCare (Cook only)	N/A	98,577
	FHP/ACA	Meridian	N/A	91,251
	ICP	CountyCare (Cook only)	N/A	19,978
	ICP	Meridian	N/A	8,617
	MLTSS	CountyCare (Cook only)	N/A	6,371
	MLTSS	Meridian	N/A	898
	MMAI	Aetna	N/A	6,700 (Aetna in MMAI)

Readiness Review Findings

HSAG summarized the findings of the 2017 on-site and desk readiness review for the seven HealthChoice Illinois managed care plans. HSAG applied a pass/fail methodology to the assessment of each health plan's ability and capacity to perform in each of the key readiness review standards as outlined in 42 CFR §438.66. For purposes of reporting the readiness review status, HSAG summarized the findings of the review in a dashboard format to allow for a high-level summary of each health plan's performance and readiness to implement the 2018 model contract requirements on January 1, 2018. Table 6-3 below represents the initial and final overall scores for all standards across all HealthChoice Illinois health plans.

Table 6-3—Readiness Review Review—Initial-Final Findings



Findings and Conclusions

All health plans were non-compliant for oversight of the contracted vendor Chrysalis, who is the State contracted vendor for the CARES line, a dedicated behavioral health crisis line for enrollees and family members. The health plans did not have delegated contracts or oversight of the crisis line in place at the time of the readiness reviews. Continued follow-up by the EQRO identified continued non-compliance with the Medicaid model contract requirements. HFS is working with the health plans to clarify the requirements and expectations for oversight of the crisis line and compliance with requirements will be reviewed during the post-implementation review.

Other areas requiring follow-up across all health plans included a focused review of compliance with the cultural competence plan, provider directory for dental and vision providers, and the provider complaint and resolution process. All plans demonstrated the ability to remediate deficient elements and follow-up

on implementation of remediation actions which will be assessed in the 2019 post-implementation on-site review.

Finally, due to the compressed timeline for implementation of statewide managed care, HFS required HSAG to continue frequent monitoring of the provider network for all plans for several months following statewide expansion and time distance analysis is scheduled to be conducted in the third and fourth quarter of 2019.

BCBSIL

Of the 17 standard areas reviewed, BCBSIL demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract for the majority of the standards. BCBSIL was not able to demonstrate compliance with an adequate network of contracted providers in the expansion counties, the capacity to comply with timely processing of grievances and appeals, or provide oversight of delegated vendors.

As indicted above, the areas with the greatest opportunity for improvement within the quality assessment and performance improvement (QAPI) program standards were related to Standard II—Assurances of Adequate Capacity and Services, specifically to the adequacy of contracting an adequate provider network in the expansions counties, Standard X—Grievance and Appeal System, specific to the timely processing of grievances and appeals, Standard XV—Subcontractual Relationships and Delegation, specific to the oversight of delegated vendors, and Standard XVIII—Quality Assessment and Performance Improvement Program, related to the lack of oversight by the designated quality committee and compliance officer and failure to remediate continued operational non-compliance related to grievances and appeals, and delegation oversight.

BCBSIL was not able to remedy deficient elements and therefore could not demonstrate compliance with operational, structural, or system deficiencies, which impeded the plan's ability and capacity to satisfactorily perform the managed care responsibilities outlined in its contract. HFS issued a formal notice of provider capacity non-compliance in January 2018.

CountyCare

Of the 17 standard areas reviewed, CountyCare demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract. CountyCare achieved 100 percent compliance on five of the 17 standards. The areas with the greatest opportunity for improvement within the QAPI program standards were related to Standard XV—Subcontractual Relationships and Delegation, specific to oversight and monitoring of its multiple delegated vendors.

While several items were found to be incomplete during CountyCare's readiness review, for which a remediation plan was submitted to and approved by HFS to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the plan's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with HFS.

None of the incomplete elements that resulted from HSAG's operational readiness review required a delay in implementation.

Harmony

Of the 17 standard areas reviewed, Harmony demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract. Harmony achieved 100 percent compliance on seven of the 17 standards. The areas with the greatest opportunity for improvement within the QAPI program standards were related to Standard II—Assurances of Adequate Capacity and Services, specific to the building and monitoring of the provider network and Standard XV—Subcontractual Relationships and Delegation, specific to oversight and monitoring of its delegated vendor Independent Living Systems.

While several items were found to be incomplete during Harmony's readiness review, for which a remediation plan was submitted to and approved by HFS to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the plan's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with HFS. None of the incomplete elements that resulted from HSAG's operational readiness review required a delay in implementation; however, frequent monitoring of the capacity of the provider network continued following statewide expansion.

IlliniCare

Of the 17 standard areas reviewed, IlliniCare demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract. IlliniCare achieved 100 percent compliance on nine of the 17 standards. The areas with the greatest opportunity for improvement within the QAPI program standards were related to Standard II—Assurances of Adequate Capacity and Services, specific to around the building of the provider network and Standard X—Grievance and Appeal System, specific to correctly identifying and reporting grievances.

While several items were found to be incomplete during IlliniCare's readiness review, for which a remediation plan was submitted to and approved by HFS to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the plan's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with HFS. None of the incomplete elements that resulted from HSAG's operational readiness review required a delay in implementation; however, frequent monitoring of the capacity of the provider network continued following statewide expansion.

Meridian

Of the 17 standard areas reviewed, Meridian demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract. Meridian achieved 100 percent compliance for 12 of the 17 standards. The area with the greatest opportunity for improvement within the QAPI program standards was related to Standard III—Coordination and Continuity of Care (Including Transition of Care), specific to qualifications of staff managing the Human Immunodeficiency/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver enrollees without the required qualifications and to staff managing HIV/AIDS and/or brain injury (BI) waiver caseloads that exceeded the requirements. In addition, Meridian did not comply with the weighted caseload requirements or caseload volume standards for high and moderate risk enrollees.

While several items were found to be incomplete during Meridian's readiness review, for which a remediation plan was submitted to and approved by HFS to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the plan's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with HFS. None of the incomplete elements that resulted from HSAG's operational readiness review required a delay in implementation; however, frequent monitoring of the capacity of the provider network continued following statewide expansion.

Molina

Of the 17 standard areas reviewed, Molina demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract. Molina achieved 100 percent compliance on eight of the 17 standards. The areas with the greatest opportunity for improvement within the QAPI program standards were related to Standard II—Assurances of Adequate Capacity and Services, specific to contracting and building of the provider network, Standard III—Coordination and Continuity of Care (Including Transition of Care), specific to the qualifications of staff managing HIV/AIDS waiver enrollees without the required qualifications and to staff managing HIV/AIDS and/or BI waiver caseloads that exceeded the requirements, and Standard XIV—Health Information Systems, specific to the enrollee portal.

While several items were found to be incomplete during Molina's readiness review, for which a remediation plan was submitted to and approved by HFS to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the plan's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with HFS. None of the incomplete elements that resulted from HSAG's operational readiness review required a delay in implementation; however, frequent monitoring of the capacity of the provider network continued following statewide expansion.

NextLevel

Of the 17 standard areas reviewed, NextLevel demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the HealthChoice Illinois Medicaid managed care contract. NextLevel achieved 100 percent compliance on 10 of the 17 standards. The areas with the greatest opportunity for improvement within the QAPI program standards were related to Standard XV—Subcontractual Relationships and Delegation, specific to oversight of delegated vendors, Standard VIII—Enrollee Information and Enrollee Rights, specific to requirements around the mailing of new enrollee packets and non-compliance with call center metrics, and Standard III—Coordination and Continuity of Care (Including Transition of Care), specific to care management systems and resources.

While several items were found to be incomplete during NextLevel's readiness review, for which a remediation plan was submitted to and approved by HFS to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the plan's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with HFS. None of the incomplete elements that resulted from HSAG's operational readiness review required a delay in implementation.

Care Coordination/Care Management

Care Coordination Staffing Reviews

HSAG was contracted by HFS to conduct a care coordination/care management (CC/CM) staffing, qualifications, and training review of state-selected requirements for the Medicaid managed care plans and their delegates, as applicable. The CC/CM staffing, qualifications, and training evaluation included review of the contract requirements for the HealthChoice Illinois and MMAI waiver and non-waiver programs. These requirements are included in Appendix I of this report.

HSAG reviewed the educational qualifications, related experience, full time equivalency (FTE) allocation, caseloads, and annual training of CC/CM staff serving the Medicaid managed care population against the HealthChoice Illinois, MMAI, and CMS HCBS contract requirements. Caseloads, training, and qualifications categories were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

Staffing Findings and Recommendations

During SFY 2018, the staffing review identified that, for most health plans, staff providing care coordination services to waiver enrollees did not meet the education, experience, and qualifications requirements, and that health plans did not comply with HIV/AIDS and BI waiver caseload maximums.

- Six of the nine health plans, or their delegates, employed staff who did not have the credentials/qualifications required to manage waiver caseloads.
- Three of the nine health plans, or their delegates, employed staff who did not have the related experience required to manage HIV waiver caseloads.

- Six of the nine health plans, or their delegates, had staff managing HIV and/or BI waiver caseloads with a total caseload of over 30.

During SFY 2018, the staffing review also identified that most health plans were in compliance with caseload requirements. The review identified the following:

- Three of the nine health plans, or their delegates, had staff with caseloads exceeding the weighted maximum of 600.
- Three of the nine health plans, or their delegates, had staff with caseloads exceeding the total allowed for high risk or moderate risk enrollees.

Based on the findings of the staffing analysis across health plans, HSAG identified the following recommendations for HFS:

- Follow up with those health plans employing CC/CM staff who do not meet qualification requirements for managing waiver caseloads.
- Follow up with health plans employing CC/CM staff who do not meet the related experience requirements for staff managing HIV/AIDS waiver caseloads.
- Provide direction to the health plans related to caseload requirements for CC/CMs managing HIV and BI waiver members. Discussion with health plans identified that the health plans interpret the contract to mean that the 30-caseload limit pertains only to HIV and/or BI caseloads, as opposed to CC/CM total caseload (which may include other waiver and non-waiver cases).
- Follow up with health plans with noncompliant findings related to managing weighted caseloads above 600.
- Follow up with health plans with noncompliant findings related to caseload volumes.
- Provide direction to health plans related to caseload limits for CC/CM staff who manage beneficiaries across multiple product lines.

Training Findings

During SFY 2018, the training review identified that, for most health plans, training materials and completion of mandatory training did not meet contract requirements. The training review identified that:

- Five of the nine health plans, or their delegates, did not have general training content developed to meet contract requirements.
- Four of the nine health plans, or their delegates, did not have waiver training content developed to meet contract requirements.
- Seven of the nine health plans, or their delegates, had staff managing Elderly (ELD) waiver caseloads without evidence of ELD waiver-required training.
- Four of the nine health plans, or their delegates, had staff managing BI waiver caseloads without evidence of BI waiver-required training.

- Five of the nine health plans, or their delegates, had staff managing HIV waiver caseloads without evidence of HIV waiver-required training.
- Eight of the nine health plans, or their delegates, had staff managing Supported Living Facility (SLF) waiver caseloads without evidence of SLF waiver-required training.
- Seven of the nine health plans, or their delegates, had staff managing waiver caseloads without evidence of the required 20 hours (or prorated based on hire date) of annual training.

In addition, HSAG identified that, for most health plans, there was opportunity to ensure that all care coordination staff received annual required general and waiver topic-based training.

Based on the findings of the training analysis across health plans, HSAG identified the following recommendations for HFS:

- Follow up with those health plans who had not yet developed all required training content, both general and waiver-specific.
- Follow up with health plans who have CC/CMs without evidence of required general training.
- Follow up with health plans who have CC/CMs without evidence of required waiver-specific training.
- Follow up with health plans who have CC/CMs without evidence of the required annual waiver training hours.
- Consider requesting that health plans develop an audit process to ensure that required annual trainings, including general, waiver-specific, and waiver-specific hours, are completed for all staff.

Key Leadership Positions

HealthChoice Illinois Key Leadership Position Analysis

HSAG analyzed each health plan's compliance with contract requirements in the areas described below:

- Key leadership positions occupied
- Residency requirements
- FTE requirements
- Licensure/credentials requirements

For SFY 2018, six of the seven health plans reviewed had a deficiency in one or more key leadership positions, such as noncompliance with FTE requirements.

Findings and Recommendations

Based on the findings of the staffing analysis across health plans, HSAG identified the following recommendations for HFS:

- Review contractual licensure requirements to identify whether revisions are needed for specific key leadership positions (e.g., quality management coordinator).
- Examine implications for health plans not meeting requirements for key leadership positions.
- Follow up with those health plans employing CC/CM staff who do not meet qualification requirements for managing waiver caseloads.
- Follow up with health plans employing CC/CM staff who do not meet the related experience requirements for staff managing HIV/AIDS waiver caseloads.
- Provide direction to the health plans related to caseload requirements for CC/CMs managing HIV and BI waiver members. Discussion with health plans identified that the health plans interpret the contract to mean that the 30-caseload limit and/or BI caseloads, as opposed to CC/CM total caseload (which may include other waiver and non-waiver cases).
- Follow up with health plans with noncompliant findings related to managing weighted caseloads above 600.
- Follow up with health plans with noncompliant findings related to caseload volumes.
- Provide direction to health plans related to caseload limits for CC/CM staff who manage beneficiaries across multiple product lines.
- Follow up with health plans who have delegate(s) with noncompliant findings related to CC/CM staffing to ensure appropriate follow-up of expectations related to caseload limits.
- Review staffing analysis findings against other available data to determine additional improvement opportunities for specific health plans.

Monthly and Quarterly Managed Care Meetings

HSAG met regularly with HFS throughout the term of its EQRO contract to partner effectively and efficiently with the State. HSAG assisted and attended HFS' on-site quarterly meetings with the health plans as well as the monthly teleconference meetings. The purpose of these meetings was 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 included discussion of compliance with the State's quality strategy, ongoing monitoring of performance of Medicaid programs, program changes or additions, readiness reviews, and future initiatives. In addition, the on-site quarterly meetings served as a forum for review of the health plans' progress in managing their QAPI programs, as well as provided time for technical assistance (TA) and training sessions provided by HSAG.

For both monthly and quarterly meetings, HSAG was 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 included worksheets, Microsoft PowerPoint presentations, slide handouts, or technical demonstrations. Subject matter experts, including clinical and analytical staff as required, were involved in the development of meeting content; and appropriate staff provided the instruction and/or facilitation, as appropriate. Following each meeting, HSAG prepared meeting minutes and, upon HFS' approval, forwarded them to all meeting participants. As part of this process, HSAG created an action item list and then followed up with the health plans and HFS to ensure timely completion of those items. HSAG provided status updates to HFS so it could track health plan progress on completing follow-up items.

Quality Forums

In addition to monthly and quarterly meetings, focused areas for improvement were considered for quality forums. During SFY 2018, HFS selected breast cancer screening as its focus for innovation in practice, with goals to:

- Realize an improvement in the number of Medicaid women screened for breast cancer.
- Identify and reduce or eliminate identified disparities and barriers to screening and follow-up through engagement of community partners and Medicaid members.
- Improve appropriate and efficient follow-up treatment for improved outcomes.
- Identify successful quality improvement initiatives that improve screening and follow-up and implement those initiatives statewide.

The purpose of the quality forum was to build a partnership for improvement through communication and collaboration and enact strategies that would improve breast cancer screening for women at risk. The forum included expert clinician, community partner, and survivor presentations, and provided the health plans the opportunity to collaborate on best practices, barrier identification, and targeted solutions.

HSAG, in collaboration with HFS, developed an intervention work plan to assist the health plans with their performance improvement initiative. The work plan included actions following the Plan-Do-Study-Act quality framework, culminating in a remeasurement of screening rates to evaluate the effectiveness of the interventions, with reporting at the October 2018 quality forum.

Technical Assistance (TA) to HFS and Health Plans

At the State's direction, the EQRO may provide technical guidance to Medicaid agencies and health plans as described at 42 CFR §438.358(d). HSAG has provided a variety of TA to HFS that has led to quality outcomes, including TA in the following areas: PIPs, grievance and appeals process, care management/ HealthChoice Illinois programs, Consumer Assessment of Healthcare Providers and Systems (CAHPS) sampling and development of CAHPS supplemental questions, pay-for-performance (P4P) program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS waiver program requirements, and much more.

HSAG understood the importance of providing ongoing and specific TA to each health plan, as needed, and provided consultation, expertise, suggestions, and advice to assist with decision making and strategic planning. HSAG worked in partnership and collaboration with HFS and health plans to ensure that it delivered effective technical support that facilitated the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG continued to provide technical guidance to the health plans to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). In addition, the following TA activities were conducted in SFY 2018.

Designing New Pay-for-Performance (P4P) Program

HFS contracted with HSAG to develop a scoring mechanism for the managed care P4P Program. For the P4P, each plan is evaluated on several Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS measures. The P4P calculation methodology and measures for HEDIS reporting years 2020 and 2021 describes the mechanism through which HealthChoice Illinois Managed Care Health Plans' (HealthChoice's) performance will be evaluated and scored and final payments calculated. HSAG conducted a thorough analysis to recommend a measure set, which was refined by HFS, and then reviewed by the health plans. The P4P measures selected included alignment with 10 Integrated Health Home (IHH) outcome-based payment measures and HFS priority measures, and are representative of the HealthChoice Illinois managed care populations.

Performance Measures

In SFY 2020, the HealthChoice health plans will be subject to P4P payments or withholds based on measure rate performance collected during CY 2019 and HEDIS reporting year (RY) 2020 and data collection CY 2020 and HEDIS RY 2021. The following measures, both HEDIS and non-HEDIS, are included in the P4P model.

HEDIS Measures

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Eye Exam*
- *Comprehensive Diabetes Care—Nephropathy*
- *Childhood Immunization Status—Combo 3*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Timeliness of Prenatal Care*
- *Postpartum Care*
- *Well Child Visits in the First 15 Months of Life—6+ Visits*
- *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Initiation and Engagement of Alcohol and Other Drug [AOD] Dependence Treatment—Initiation of AOD Treatment*
- *Initiation and Engagement of Alcohol and Other Drug [AOD] Dependence Treatment—Engagement of AOD Treatment*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile documentation*
- *Medication Management for People with Asthma—50%*
- *Medication Management for People with Asthma—75%*
- *Follow-Up After Hospitalization for Mental Illness—Percentage of discharges for which the member received follow-up within 30 days of discharge*
- *Follow-Up After Hospitalization for Mental Illness—Percentage of discharges for which the member received follow-up within 7 days of discharge*
- *Ambulatory Care—ED [Emergency Department] Visits*
- *Adult BMI Assessment*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment*

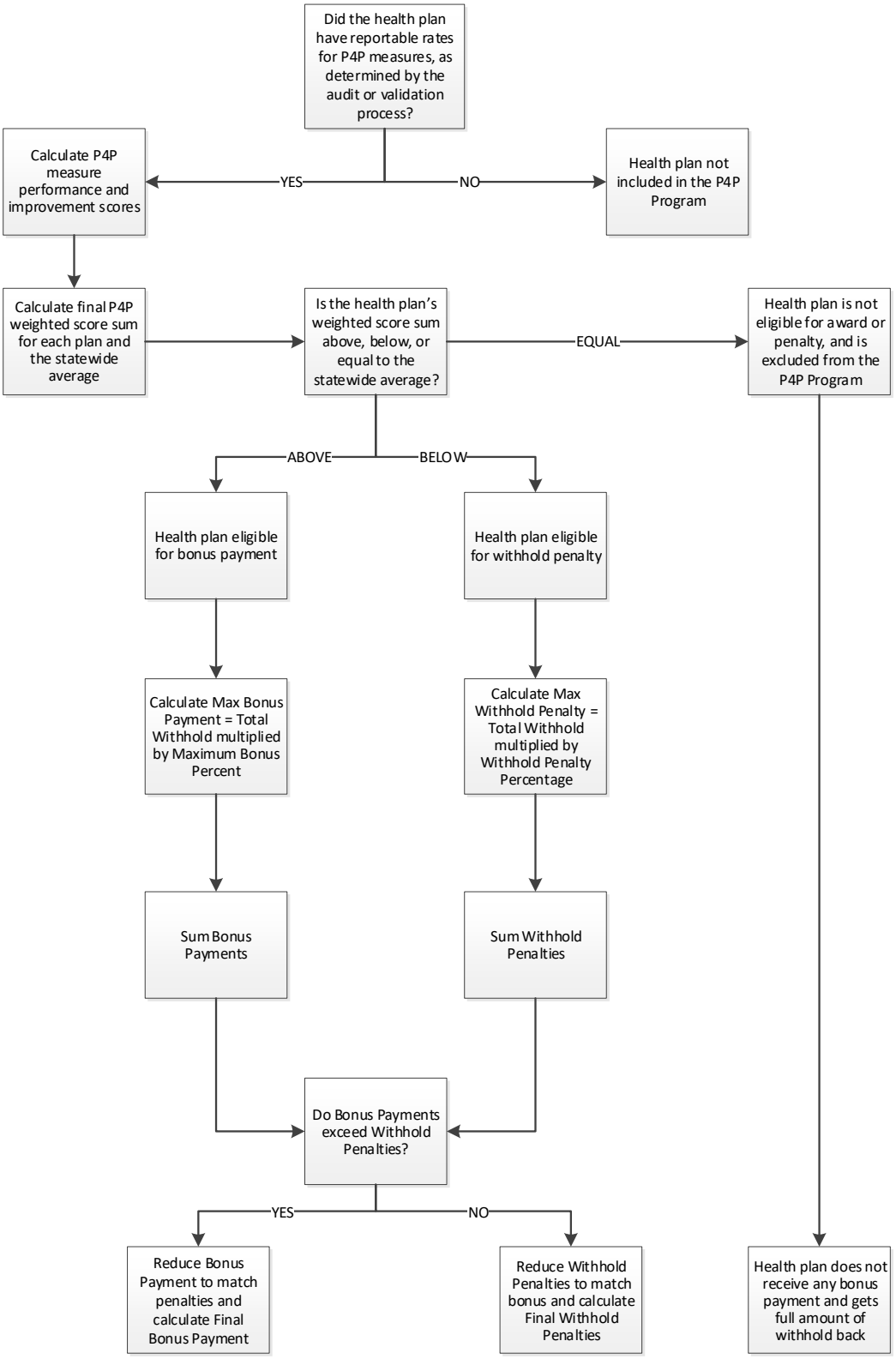
NON-HEDIS Measures

- *Screening for Clinical Depression and Follow-Up Plan*
- *Chronic Condition Hospital Admission Composite—PQI [Prevention Quality Indicator]*

Scoring and Funds Allocation Models

HSAG provided significant technical assistance in developing the P4P scoring and payment model. Each measure will be scored and weighted appropriately prior to calculating withhold earn back percentages and bonus payments for each health plan. The positive or negative funds allocation model will use the health plan's weighted score sum to allocate funds among health plans. In addition, the funds allocation model was developed to ensure the total dollar amount for bonus payments will always be equal to the total withhold amounts that are not earned back to ensure budget neutrality for HFS. The health plan's average weighted total score is used to determine the withhold earn back percentage and bonus payment for each health plan. If a health plan's average weighted total score is above the Illinois average, it will earn back 100 percent of its withhold and be eligible for a bonus payment. If a health plan's average weighted total score is below the Illinois average, it will earn back less than 100 percent of its withhold and will not be eligible for a bonus payment. If a health plan's average weighted total score is equal to the Illinois average, then the health plan will earn back 100 percent of its withhold but will not be eligible for a bonus payment. The amount of the award or penalty is independent of the Illinois average, and is instead based on the percentage of the Maximum Possible Average Score (i.e., the highest possible measure score = 5) a health plan achieved. If the total of the maximum bonus payments exceeds the withhold amounts that have not been earned back, then the bonus pool does not fully fund the bonus payments and excess bonus payment amounts will need to be reduced to achieve budget neutrality. If bonus payments are reduced; each health plan will receive an award that is the same percentage of the newly reduced amount as they would have received had the full bonus payment amount been budget neutral. If the bonus pool amounts exceed the total maximum bonus payments, then the bonus payments do not fully claim the withhold amounts that were not earned back and the withhold earn backs will need to be increased to achieve budget neutrality. If withhold percentages need to be increased, each health plan that had a maximum withhold percentage less than 100 percent will be adjusted so that the health plan's withhold amount that is unearned is the same percentage as they would have paid into the bonus pool had the total bonus payments been budget neutral. The following figure presents an overview of the payment calculation process for the P4P program.

Figure 6-1—P4P Program Flow Chart



Developing Annual Health Plan Report Template

To align with HealthChoice Illinois implementation, HFS contracted with HSAG to update the template for the Quality Assurance/Utilization Review/ Peer Review (QA/UR/PR) Annual Report that health plans are contractually required to submit to HFS. HSAG conducted a crosswalk of the HealthChoice Illinois model contract requirements and the National Committee for Quality Assurance (NCQA) 2018 standards and guidelines for health plan accreditation and designed a recommended outline for the annual report. After consultation with HFS, HSAG finalized a report template and developed an annual report evaluation tool that will be used to assess each health plan's compliance with the template.

Medicaid Managed Care Final Rule Training

On May 5, 2016, CMS published the federal Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) requiring states to make a number of changes to the oversight of managed care. HSAG conducted an analysis of the final rule and created an overview for HFS that identified all provisions of the final rule and their effective date. HSAG also conducted training sessions to assist key HFS staff in staying abreast of final rule requirements and timelines.

NCQA Accreditation Tracking

The 2010 federal Affordable Care Act (ACA) called for the use of accreditation to ensure quality in the managed healthcare sector. The ACA requires that, beginning in 2014, all health plans offered through state insurance exchanges "…must be accredited with respect to local performance on clinical quality measures … by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans…" The NCQA's Health Plan Accreditation is considered the industry's gold standard to provide a current, rigorous and comprehensive framework for essential quality improvement and measurement. Illinois implemented legislation that requires all HealthChoice Illinois plans to achieve NCQA accreditation. HSAG designed several tools to assist HFS in monitoring plan accreditation status. The NCQA tracking spreadsheet displays each health plan's accreditation eligibility date, accreditation dates, date of final NCQA decision letter and summary report, accreditation expiration date, accreditation status, and NCQA health insurance plan ratings and accreditation star ratings. HSAG updates the spreadsheet periodically.

In addition, HSAG developed HealthChoice Illinois Managed Care Program National Committee for Quality Assurance (NCQA) Medicaid Healthcare Maintenance Organization Accreditation status sheet which succinctly displays each health plan's accreditation date and status along with a description of the NCQA accreditation levels. HFS features this status sheet on its website to make the information public. The most recent version can be accessed at https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2018HFSWebsiteNCQAAccreditationDoc052218.pdf.

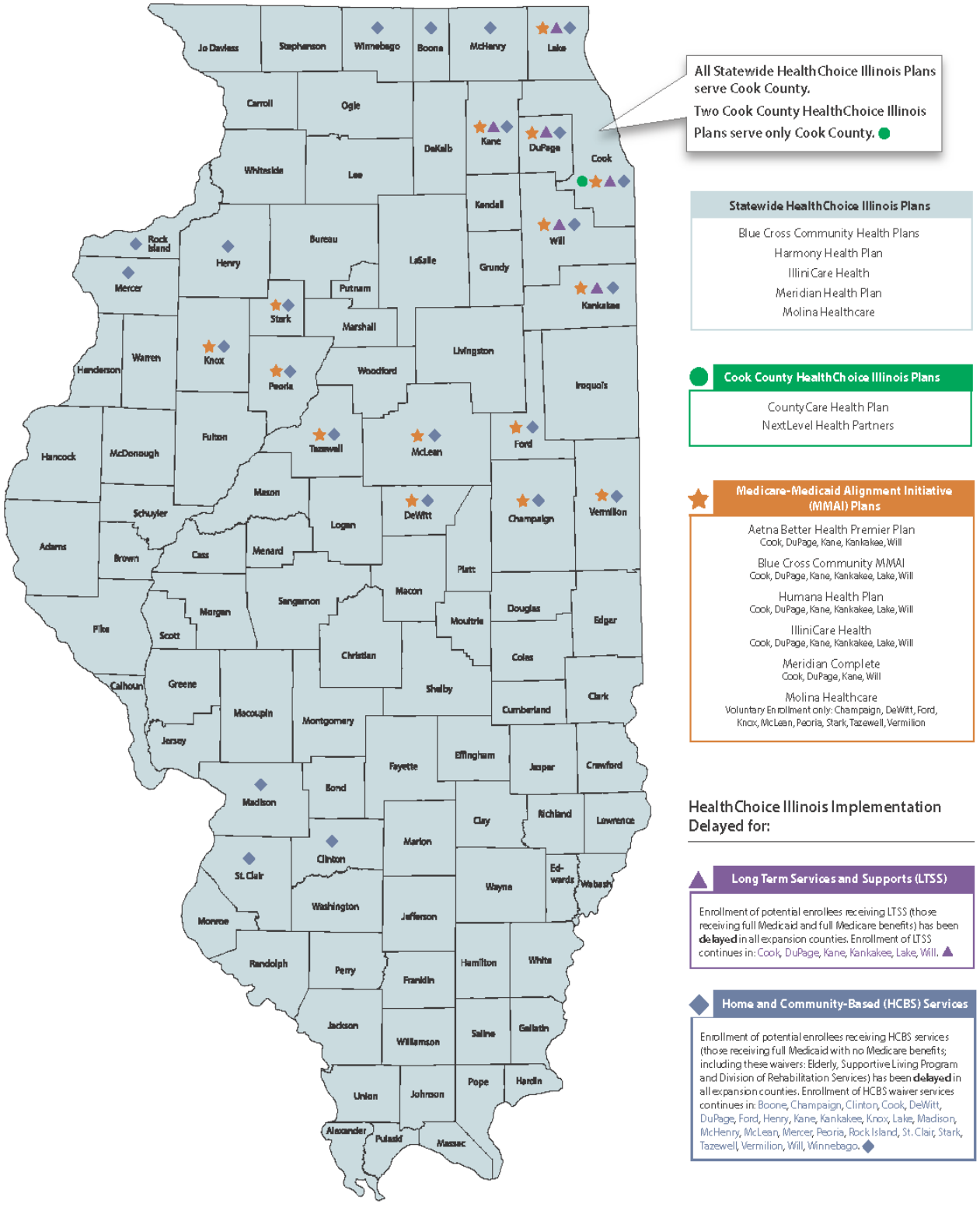
P4P Bonus Calculations

In SFY 2018, HSAG continued to calculate the P4P bonuses for Illinois' health plans. Spreadsheets were created for both the FHP/ACA and ICP populations that detail each health plan's performance on each P4P measure in comparison to national Medicaid HEDIS percentiles, indicate whether each health plan met or did not meet the withhold, and list performance on all HFS priority measures. SFY 2018 is the final year that P4P bonuses will be calculated for separate populations. Moving forward, P4P will be calculated for the combined HealthChoice Illinois population.

Expansion Map

Given the significant expansion in Illinois, HFS requested HSAG to design a graphical depiction of expansion efforts that could be shared with stakeholders. As a result, HFS and HSAG created the Care Coordination Expansion Map, which demonstrates which health plans are operating across the State of Illinois, and in which programs those plans participate. HFS used the map to inform stakeholders and legislators of expansion progress, and it was displayed publicly on the HFS website. Throughout SFY 2018, HSAG provided ongoing TA to periodically update the map to reflect up-to-date expansion. Figure 6-2 represents the map as of April 1, 2018.

Figure 6-2—Illinois Medicaid Managed Care Expansion Map



Follow-Up on Prior Year EQR Recommendations

In accordance with CFR §438.364(a)(5), this technical report includes an assessment of the degree to which each health plan effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

This section reports on follow-up to the EQR recommendations from SFY 2017.

New Statewide Follow-up Procedure

In SFY 2017, HFS worked with HSAG to redesign the EQR Technical Report to facilitate tracking of performance, comparison to Quality Strategy goals, and follow-up on EQR recommendations from year to year. Following the report's publication, HSAG worked with HFS to design a new EQR follow-up procedure with the health plans.

Transition of care (TOC) was chosen as the Phase I quality improvement focus. HSAG and HFS established the following recommendations:

1. Establish TOC evaluation measures.
2. Improve communication with hospitals to improve transitions of care.
3. Enhance discharge communication between utilization and care management departments.
4. Implement dedicated TOC teams to manage transitions of care for members with behavioral health/complex healthcare needs.

For each recommendation, health plans were required to submit specific goals for improvement, proposed improvement initiatives, and implementation timelines. HSAG conducted TA sessions with HFS' account managers to establish procedures for monitoring and follow-up with health plans. HSAG designed a tracking grid that summarized all health plan efforts and facilitated monthly or bi-weekly monitoring by account managers.

Specific Health Plan Follow-Up

In the SFY 2016–2017 EQR report, HSAG also provided recommendations for improving performance measure and PIP results, compliance, and consumer satisfaction rates. In their annual reports, health plans reported on follow-up improvement efforts.

Aetna

Initiatives to improve performance included the following:

- System and software enhancements included improved assessment due date tracking, improved accessibility to medication tracking, timeliness of assessment and care planning reporting, enhancements to the Health Care Equity assessment tool, and modifications to the forms, which allowed for proper transition when members disenrolled from and enrolled in a new health plan.
- Telemonitoring was used to manage chronic health conditions, such as heart failure, diabetes, COPD, and asthma, among other chronic conditions. The telemonitoring program provided members with tools to monitor and manage their chronic conditions, which increased members' sense of autonomy in managing aspects of their or their loved ones' conditions and provided an opportunity for early intervention should problems arise.
- In addition to having behavioral health expertise at the plan level, external partnerships were vital to the successful TOC for the members that experienced a behavioral health admission. Such partnership included ongoing evaluation of community partners/providers which provided enhanced behavioral health services in primary care settings supplemented by behavioral health providers.
- The Plan facilitates an Emergency Department (ED) Diversion workgroup which aims to engage members and reduce ED visits. Case managers work to locate members and educate them about their benefits and health conditions while linking them with appropriate ambulatory care.
- Implemented the "Change in Condition" Pilot Program with a partner, Addus, which has the goal of improving shared member/client health outcomes through a collaborative approach using a time-sensitive communication effort with a focus on earlier intervention and/or use of health services. Reports indicate a decline in 30-day readmissions for the pilot group members and an improvement increase in the primary care physician (PCP) follow-up after both ED visit and inpatient discharge.
- Implemented supportive strategies to address the transient nature of the MMAI membership with a focus on helping members that are currently experiencing homelessness prepare for potential participation in the Better Health Through Housing Program in partnership with AFC.

BCBSIL

Initiatives to improve performance included the following:

- System Updates—implemented a new care management system (Altruista Guiding Care) and a new utilization management system (Smart UM), a new care gap database for a portion of the Illinois Providers, and engaged providers from the expansion areas as members of the quality committees.
- A population health strategy—developed to identify the needs of members through the analysis of stratified member populations, social determinants of health, assessing health risk from claims data, and examining how programs and services address the health needs of members.
- Diabetic HEDIS—BCBSIL partnered with Welch Allyn, who distributed RetinaVue 100 Imager to six federally qualified health centers (FQHCs) in the Chicago area to improve dilated retinal screening. BCBSIL used the Living365 program to send educational pamphlets to newly diagnosed

diabetics, educating members about their condition and the importance of taking their medications. BCBSIL pharmacists met with provider groups about their members' medication adherence and other pharmacy issues. BCBSIL engaged with community pharmacists through the PAVE® program, which uses community pharmacists to talk to non-adherent patients about taking their medications as prescribed and the importance of refilling their medications.

- Member Engagement—incorporation of an in-house BCBSIL employment specialist to assist members with overcoming barriers involving entry into the workforce. The employment specialist supports members' attempts to enter the workforce to help maximize their quality of life. During the first six months of the program, the employment specialist received 310-member referrals, of which 63 (5 percent) were for employment and offered career coaching techniques. These career coaching techniques included resume development, interviewing skills, and job training assistance.
- Transition of Care—Facility Liaison and Recovery Support Assistant positions were created and have since been expanded to 12 facilities to establish relationships with hospitals and homeless shelters to improve engagement with members. The Facility Liaison and Recovery Support Assistant regularly visits hospitals and shelters to engage members and address barriers including linking members to outpatient services and offering support navigating available benefits. The TOC team provides telephonic transition support to members who are admitted to hospitals where on-site presence is not established. The TOC care coordinator assists with discharge planning, completes assessments (i.e., completes/updates HRS, health risk assessments (HRAs), discharge assessments, depression screenings), ensures that all discharge needs have been met (i.e., durable medical equipment (DME) ordered, Home Health in place, PCP follow-up appointment scheduled) and transitions the case back to the TOC care coordinator once post-discharge call and assessments are complete.
- Utilization Management Enhancements—implementation of a new health management platform; increased clinical and non-clinical staffing; specialized UM Rounds for outpatient, neonatal intensive care unit (NICU), and acute teams; ongoing partnership and provider engagement with high volume providers; acute facility designation and concurrent review process; ongoing training of review staff on MCG Optimized Review Process; partnership with TOC Case Management team for coordination of care and discharge planning; enhanced Care Management (CM) referral and escalation process for members identified with complex needs and urgent intervention; and NICU level of care focused reviews.

CountyCare

Initiatives to improve performance included the following:

- Transition of Care—built a standardized TOC "bundle" of workflows and resources that guides both remote and on-site transition contacts through post-acute care and discharge home. CountyCare also implemented a Pilot Behavioral Health Transition program, embedding a behavioral health agency at a high volume behavioral health hospital. Transition coordinators arrange and connect members with outpatient services and maintain contact with members following discharge to improve follow-up.
- Data Reporting and Analysis—built a suite of new reports for consistent overall oversight and to guide health plan management, including a Master Performance Report which encompasses health

plan financial, utilization, and quality data and allows for analysis across various areas of the network, lines of business, and clinical factors to develop targeted assessments and initiatives.

- System Developments—development of standardized file formats, file exchange schedules, and quality control mechanisms for all data exchanges with trading partners. This allows CountyCare to leverage all the advantages of partner software systems while ensuring consistent, timely, and accurate data reporting to the State, governance and oversight committees, and delegated vendor oversight.
- Transportation Fleet Investments—the Cook County Health and Hospital System (CCHHS) Transportation Fleet began transporting CountyCare members to CCHHS facilities and select Behavioral Health Consortium sites in September 2017 and has continued to increase capacity to accommodate membership needs. The addition of a nearly 50-car fleet, now handling approximately 25 percent of the overall trip volume, has helped to improve transportation services overall for the CountyCare membership. This resource aligns drivers and vehicles with regular facilities and reduces the demand on CountyCare's primary vendor.

Harmony

Initiatives to improve performance included the following:

- Development of specialized behavioral health programs to target the highest utilizing members in partnership with several community based mental health centers. Results showed an overall decrease in utilization, with a net savings of $230 per member/per month.
- Establishment of direct data feeds from physician practice electronic medical record (EMR) systems, which supports the providers in the Pay-For-Quality (P4Q) program and ultimately improves member outcomes.
- A focus on integrated recovery efforts by contracting with The Boulevard, a medical respite center for the homeless, which allows for Harmony Health Plan of Illinois, Inc. (Harmony) to refer members with dual physical and behavioral health needs to a dedicated one bed unit.
- Transition of Care—established a partnership with 7 Hills Healthcare, where they met with members in the hospital and provided follow up care in the member's home. Additionally, continued to assign transitional care managers to five of the high-volume facilities. The transitional care manager engages with the member during their inpatient hospitalization to develop a relationship with the member, family, and facility discharge team.
- Partnership with the University of Illinois Coordination of Healthcare for Complex Kids (CHECK), which uses a Community-Based Medical Neighborhood (CBMN) model as a vehicle to build relationships with community organizations. It offers physical and behavioral health promotion and referrals, a mobile dental van, and relationships with schools to improve attendance, while representing the critical needs of this population. CHECK has been able to reduce overall medical costs for the Harmony population by 25 percent, reduce average length of hospital days by 31 percent and reduce ED utilization by 14 percent.

Humana

Initiatives to improve performance included:

- Continued data collection and collaboration in the Care Coordination and Utilization Management areas between medical, behavioral health, and long-term services and support, with on-going Interdisciplinary Care Team meetings and UM Rounds has allowed care partners to have access to all outpatient-ordered services at time of discharge, providing more opportunities for post-discharge care coordination.

IlliniCare

Initiatives to improve performance included the following:

- In 2018, IlliniCare Health introduced Interpreta, an innovative healthcare technology. Interpreta is a health informatics platform that continuously updates, interprets, and synchronizes clinical and genomic information from membership, pharmacy, and claims data streams. These real-time insights offer providers and IlliniCare staff patient-specific information needed to support the provision of timely preventive and chronic healthcare.
- Developed a robust diabetes management program, which included hiring a full-time nurse certified diabetic educator.
- Designed an on-site discharge planning approach to address members with behavioral health disorders, substance use disorders, and opioid-related disorders. This program focuses on members with long stays and involves face-to-face interactions with IlliniCare clinicians and telephonic interaction between IlliniCare clinicians and members.
- Launched a Long-Term Care Quality program in 2018 to optimize the quality and cost of care for members in non-acute residential settings.
- Implemented a certified Community Health Work Program. Focused initiatives included intervention for preventable readmissions with scheduled face-to-face touch points with members at key intervals during the first 30 days after discharge. Within this specific cohort, re-admissions have been reduced more than 89 percent.

Meridian

Initiatives to improve performance included the following:

- To address the identified gap in care for diabetic members, Meridian partnered with HealPros, a vendor that completes mobile eye exams in member residences. In one month, the partnership resulted in outreach to 1,016 members and 280 scheduled appointments; 76 percent (213) were successfully completed.
- Advanced Patient Care (APC) Pilot Program: program services target high risk members who experience medication burden due to multiple chronic conditions, medications, prescribers, and/or pharmacies. A contracted vendor, an APC pharmacist, completes an in-home assessment with the

member, including comprehensive medication reconciliation and education. Telephonic follow-up is conducted with members and their practitioners by both APC and Meridian to determine compliance, outcomes, and adherence.

- Implemented a new critical incident reporting and resolution process to improve efficiency and further assure member safety. The new process includes the creation of a quality of care clinical team devoted to reviewing and processing critical incidents.
- Established a complaint and resolution system for network and non-network providers. The newly established system includes a claims dispute process that allows providers to contest a payment decision after a claim has been adjudicated and a service authorization dispute process that allows providers to contest an authorization denial or a reduction, suspension, or termination of a previously authorized service.

Molina

Initiatives to improve performance included the following:

- To address emerging and major population health trends, Molina initiated a women's health workgroup, a behavioral health workgroup, and an asthma and chronic obstructive pulmonary disease (COPD) workgroup. In conjunction with those workgroups, Molina has devised population-specific interventions that include its Well Mom outreach and education program to improve perinatal and infant outcomes and the addition of a respiratory specialist to assist with discharge planning for members with asthma/COPD. To address behavioral health needs, Molina enhanced and expanded its TOC program and engaged in pilot projects with community partners to provide high-touch case management to high-risk members.
- For members who receive inpatient treatment, Molina has increased clinical involvement through a multidisciplinary card flip process that facilitates review of every inpatient admission, and for behavioral health admissions, Molina has improved and expanded its TOC program.
- The Intensive Care Coordination Program (ICCP) extended intensive care management to the community for members with high-risk indicators, often with co-morbid medical and behavioral health conditions, who typically require wraparound care coordination services to improve or maintain their mental and physical health. Through the ICCP, a Molina personal service coordinator engaged these high needs members and their families up to three times per week, in person and telephonically. Along with providing intensive care coordination, the personal service coordinators re-engaged members with their local community mental health agency, PCP, housing assistance, or other in-network providers, with the goal of increasing connections to community supports so that intensive care coordination becomes unnecessary. Outcomes from this program during the first three months were dramatic: members included in the program saw a 78 percent decrease in inpatient admissions, a 40 percent decrease in ED visits, and 62 percent reduction in per member per month expenditures.
- Molina has formed a dedicated team, the Strategic Triage Assessment Team (STAT), comprised of nurse care coordinators and member health assessors, to engage, assess, and create care plans for high-risk and potentially high-risk members.

NextLevel

Initiatives to improve performance included the following:

- Launched the Tiger Team in 2017 to address members with high inpatient and/or ED utilization who would benefit from enhanced case management. In 2018, this team evolved into a unit of embedded care managers located at acute inpatient facilities conducting daily rounds on current census information.
- Migration to a new utilization management platform that allows for more robust data sharing capabilities.
- Developed a Ready Response Team, Children's Behavioral Health, and Maternal-Child Health teams to further improve the member experience of quality of care and care coordination, improve the health of populations, and decrease healthcare costs.
- Launched WeCare, a program to address the needs of members who have high inpatient admissions and high number of ED visits related to behavioral health conditions.

Appendix A1. Summary of Performance Measure Results

Performance Measures

Table A1-1 displays a snapshot of health plan performance for measures selected by the Illinois Department of Healthcare and Family Services (HFS) in domains of care that it prioritizes for improvement. The data have been combined for the Family Health Plan/Affordable Care Act (FHP/ACA) and Integrated Care Program (ICP) health plans where appropriate and possible, by calculating a weighted average based on the size of the eligible population. Performance for Healthcare Effectiveness Data and Information Set (HEDIS) 2018 measures is compared to the National Committee for Quality Assurance's (NCQA's) Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2017, when available, which is an indicator of health plan performance on a national level. For most measures, two years of data (HEDIS 2017 and HEDIS 2018) are trended. Due to changes in the technical specifications for some measures in HEDIS 2018 (e.g., *Breast Cancer Screening*), NCQA does not recommend trending between 2018 and prior years or comparisons to benchmarks; therefore, these measures are not displayed below. Additionally, *Ambulatory Care* is a utilization measure and is provided for information only. As noted previously, performance measure results are shown for only the seven health plans that will continued to serve Illinois Medicaid beneficiaries in 2018. A key and notes for Table A1-1 are listed in the table below.

Table A1-1—Summary of Performance Measures Results

P4P 2018	Measure	# Plans Reporting 2018	Plan Performance 2018				Statewide Avg. 2018/Trended 2017–2018	Improved Performance 2017–2018	Quality (Q) Timeliness (T) Access (A)
			<25th	25th–49th	50th–74th	≥75th			
Access/Utilization of Care									
Adults' Access to Preventive/Ambulatory Health Services									
—	*Total*	7	4	3	0	0	<25th ↓	2 of 7 plans	A
Ambulatory Care (per 1,000 Member Months)									
—	*ED Visit—Total*	7	0	3	4	0	25th–49th ↓	3 of 6 plans	Not Applicable
—	*Outpatient Visit—Total*	7	4	1	0	2	25th–49th ↓	3 of 6 plans	Not Applicable
Preventive Care									
Adult BMI Assessment									
—	*Adult BMI Assessment*	7	3	2	1	1	<25th ↓	5 of 6 plans	Q

Summary of Performance Measure Results

P4P 2018	Measure	# Plans Reporting 2018	Plan Performance 2018				Statewide Avg. 2018/Trended 2017–2018	Improved Performance 2017–2018	Quality (Q) Timeliness (T) Access (A)
			<25th	25th–49th	50th–74th	≥75th			
Child & Adolescent Care									
Childhood Immunization Status									
—	*Combination 2*	7	4	1	2	0	<25th ↓	3 of 6 plans	Q
—	*Combination 3*	7	4	2	1	0	<25th ↓	3 of 6 plans	Q
Immunization for Adolescents									
—	*Combination 1 (Meningococcal, Tdap)*	7	1	1	3	2	50th–74th/ Not Applicable	Not Applicable	Q
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents									
P4P	*BMI Percentile Documentation—Total*	7	1	2	2	2	25th–49th ↑	6 of 6 plans	Q
P4P	*Counseling for Nutrition—Total*	7	2	2	1	2	25th–49th ↑	6 of 6 plans	Q
P4P	*Counseling for Physical Activity—Total*	7	1	2	1	3	25th–49th ↑	6 of 6 plans	Q
Well-Child Visits in the First 15 Months of Life									
P4P	*Six or More Well-Child Visits*	7	2	2	1	2	50th–74th ↑	5 of 6 plans	Q
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life									
P4P	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	7	1	0	4	2	50th–74th ↑	3 of 6 plans	Q
Women's Health									
Cervical Cancer Screening									
P4P	*Cervical Cancer Screening*	7	1	2	2	2	50th–74th ↑	5 of 7 plans	Q
Chlamydia Screening in Women									
—	*Total*	7	0	2	4	1	50th–74th ↓	4 of 7 plans	Q
Prenatal and Postpartum Care									
P4P	*Timeliness of Prenatal Care*	7	2	3	2	0	25th–49th ↓	4 of 7 plans	Q, T, A
P4P	*Postpartum Care*	7	1	3	2	1	50th–74th ↓	3 of 7 plans	Q, T, A

Summary of Performance Measure Results

P4P 2018	Measure	# Plans Reporting 2018	Plan Performance 2018				Statewide Avg. 2018/Trended 2017–2018	Improved Performance 2017–2018	Quality (Q) Timeliness (T) Access (A)
			<25th	25th–49th	50th–74th	≥75th			
Appropriate Care									
Annual Monitoring for Patients on Persistent Medications									
—	*ACE Inhibitors or ARBs*	7	4	0	3	0	25th–49th ↑	5 of 7 plans	Q
—	*Diuretics*	7	4	1	2	0	25th–49th ↑	6 of 7 plans	Q
Comprehensive Diabetes Care									
P4P	*HbA1c Testing*	7	1	1	5	0	50th–74th ↑	6 of 7 plans	Q
P4P	*Eye Exam (Retinal) Performed*	7	3	1	3	0	50th–74th ↑	5 of 7 plans	Q
P4P	*Medical Attention for Nephropathy*	7	1	2	3	1	50th–74th ↑	4 of 7 plans	Q
Controlling High Blood Pressure									
—	*Controlling High Blood Pressure*	6	3	2	1	0	<25th ↑	4 of 6 plans	Q
Medication Management for People With Asthma									
—	*Medication Compliance 50%—Total*[1]	7	2	3	0	2	25th–49th ↑	2 of 6 plans	Q
—	*Medication Compliance 75%—Total*	7	3	2	0	2	25th–49th ↑	2 of 6 plans	Q
Statin Therapy for People With Diabetes									
—	*Received Statin Therapy*	7	1	2	1	3	≥75th ↑	5 of 6 plans	Q
—	*Statin Adherence 80%*	7	2	2	1	2	25th–49th ↓	1 of 6 plans	Q
Behavioral Health									
Metabolic Monitoring for Children and Adolescents on Antipsychotics									
—	*Total*	6	0	3	3	0	50th–74th ↑	4 of 6 plans	Q

— indicates the measure was not a required measure for the P4P incentive bonus for 2018.

P4P indicates the measure was required for the P4P incentive bonus for 2018 for the FHP/ACA and/or ICP health plans.

↑ indicates performance improved from HEDIS 2017 to HEDIS 2018.

↓ indicates performance declined from HEDIS 2017 to HEDIS 2018.

[1] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

Appendix A2. Executive Summary Appendix

Federal Requirements for External Quality Review (EQR) Technical Report

This report addresses the following for each EQR-related activity conducted in accordance with the Code of Federal Regulations (CFR) at Title 42, Section (§)438.358:

- Objectives.
- Technical methods of data collection and analysis.
- Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii).
- Conclusions drawn from the data.

As described in the CFR, the report also offers:

- An assessment of each health plan's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each health plan, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all health plans, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each health plan has effectively addressed the recommendations for quality improvement made by the external quality review organization (EQRO) during the previous year's EQR.

This report also offers recommendations for improving the quality of healthcare services furnished by each health plan, makes comparisons of plan performance, and describes performance improvement efforts. Information released in this technical report does not disclose the identity of any beneficiary, in accordance with §438.350(f) and §438.364(a)(b).

Scope of Report

Mandatory activities for state fiscal years (SFY) 2018 included:

- Compliance Monitoring—As set forth in 42 CFR §438.358, the state or its designee conducts a review within the previous three-year period to determine the health plan's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.
- Validation of Performance Measures—In accordance with §438.358(b)(2), the EQR technical report must include information on the validation of health plan performance measures (as required by the state) or health plan performance measures calculated by the state during the preceding 12 months.
- Validation of Performance Improvement Projects (PIPs)—Health Services Advisory Group, Inc. (HSAG) validated PIPs conducted by the health plans regarding compliance with requirements set forth in 42 CFR §438.330(b)(1).
- Validation of network adequacy as described in §438.358(b)(1)(iv). As described in §438.68, states must develop and enforce network adequacy standards consistent with this section. The Illinois Department of Healthcare and Family Services (HFS) contracted HSAG to evaluate and monitor health plans' progress of contracting and credentialing providers to ensure sufficient network capacity. HSAG also used the provider network data to identify potential network gaps and to monitor each health plan's progress towards establishing an adequate provider network for members.

Optional activities for SFY 2018 included:

- Development of a Medicaid managed care quality rating system as set forth in §438.334.
- Evaluation of the Managed Care State Quality Strategy (Quality Strategy) as described in §438.340(c)(2)(i).
- Validation of Performance Measures—HSAG conducted a review of the Primary Care Case Management (PCCM) and Children's Health Insurance Program Reauthorization Act (CHIPRA) programs for a select set of performance measures, following the Performance Measure Validation protocol outlined by the Centers for Medicare & Medicaid Services (CMS).[A2-1]
- CMS Home- and Community-Based Services (HCBS) Waiver Performance Measures Record Reviews—To monitor the quality of services and supports provided to the HCBS waiver program enrollees, HSAG continued on-site record reviews for Integrated Care Program (ICP) and Medicare-Medicaid Alignment Initiative (MMAI) health plans to monitor performance on the HCBS waiver performance measures and began conducting reviews for Family Health Plan/Affordable Care Act (FHP/ACA) health plans.

[A2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Mar 13, 2018.

Medicaid Managed Care Programs

Medicare-Medicaid Alignment Initiative (MMAI)

The MMAI was a groundbreaking joint effort to reform the way care is delivered to clients eligible for both Medicare and Medicaid Services (called "dual eligibles"). The MMAI demonstration project began providing coordinated care to Medicare-Medicaid enrollees in the Chicagoland area and Central Illinois beginning in March 2014. The MMAI program continues to operate under a separate three-way contract between HFS, the federal CMS, and the health plans and was not expanded to additional counties in 2018.

Managed Long Term Services and Supports (MLTSS)

MLTSS and waiver services (including Elderly waiver and Supportive Living program and Division of Rehabilitation waiver services) will be expanded as part of HealthChoice Illinois, scheduled for statewide expansion in 2019. The HealthChoice Illinois MLTSS program will provide waiver and other services to individuals who qualify for both Medicare and Medicaid, but who are not part of the Medicare-Medicaid Alignment Initiative.

Home and Community-based Services (HCBS)

Dual-eligible adults who are receiving long-term services and supports (LTSS) in an institutional care setting or through a HCBS waiver, excluding those receiving partial benefits who are enrolled in the MMAI, are served through HealthChoice Illinois. All HealthChoice Illinois health plans serve HCBS enrollees.

Department of Children and Family Services (DCFS) Youth

Children in the care of the DCFS, including those formerly under this care who have been adopted or who entered into a guardianship, will be covered under statewide managed care Medicaid expansion. DCFS Youth will be enrolled in the IlliniCare Health Plan as part of HealthChoice Illinois. Implementation is expected for 2019.

Integrated Health Homes (IHHs)

Building on a managed care system that carved behavioral health into the medical program, HFS aims to enhance true integration of behavioral and physical healthcare through an ambitious integrated behavioral and physical health home program (integrated health homes or IHHs) that promotes accountability, rewards team-based integrated care, and shifts toward a system that pays for value and outcomes. The IHH program is a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. Each member in the Medicaid population will be linked to an IHH provider based on their level of need and the provider's ability to meet those needs. The IHH will be

responsible for care coordination for members across their physical, behavioral, and social care needs. The development of IHHs and the payment model to sustainably support them is a significant but challenging step. HealthChoice Illinois recognizes that these IHHs will not materialize without considerable planning and appreciates that different providers are at different stages in their evolutions toward becoming IHHs, so HFS is allowing for a phased approach under which all providers are encouraged to make progress by creating greater incentives for those who can move more quickly toward a higher degree of integration.

HealthChoice Illinois Health Plans

HFS contracted with seven health plans to provide healthcare services to Medicaid managed care beneficiaries. **Error! Reference source not found.** identifies the health plans, their counties of operation, and the SFY 2018 enrollment for each health plan.

Table A2-1—HealthChoice Illinois Health Plans for SFY 2018

Health Plan Name	Abbreviation	Counties	June 2018 Enrollment
Blue Cross Blue Shield of Illinois	BCBSIL	All Counties	447,020
CountyCare Health Plan	CountyCare	Cook County	330,576
Harmony Health Plan of Illinois, Inc.	Harmony	All Counties	254,463
IlliniCare Health Plan, Inc.	IlliniCare	All Counties	335,539
Meridian Health Plan, Inc.	Meridian	All Counties	593,151
Molina Healthcare of Illinois, Inc.	Molina	All Counties	219,107
NextLevel Health Partners, LLC	NextLevel	Cook County	57,459
Total			**2,237,315**

Quality Strategy

The Quality Strategy provides a framework to accomplish HFS' mission of empowering individuals enrolled in the Medicaid program to improve their health status while simultaneously containing costs and maintaining program integrity. HFS worked with stakeholders and identified the following goals for quality improvement.[A2-2]

Better Care

1. Improve population health.
2. Improve access to care (including community based long-term services and supports).
3. Increase effective coordination of care.

Healthy People/Healthy Communities

4. Improve participation in preventive care and screenings.
5. Promote integration of behavioral and physical health care.
6. Create consumer-centric healthcare delivery system.

Affordable Care

7. Transition to value- and outcome-based payment.
8. Deploy technology initiatives and provide incentives to increase adoption of electronic health records and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

Performance Domains

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which a managed care organization (MCO) or prepaid impatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, through the

[A2-2] Illinois Department of Healthcare and Family Services. FY 2016 Annual Report: Medical Assistance Program; March 31, 2017. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/HFS2016AnnualReportFINAL33117.pdf. Accessed on: Mar 19, 2018.

provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement.[A2-3]

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).[A2-4]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A2-5] In the final 2016 federal healthcare managed care regulations, CMS recognizes the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206(a) and by requiring states, at 42 CFR §438.68(b), to develop time and distance standards for network adequacy.

Performance Measure Domains

Table A2-2 shows HSAG's assignment of the Healthcare Effectiveness Data and Information Set (HEDIS) 2018 performance measures HFS prioritized for improvement into the domains of quality, timeliness, and access. *Ambulatory Care* does not fall into these domains, as this is a utilization measure; therefore, this measure is not included in the table below.

Table A2-2—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measure	Quality	Timeliness	Access
Access/Utilization of Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Preventive Care			
Adult BMI Assessment	✓		

[A2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

[A2-4] Ibid.

[A2-5] National Committee for Quality Assurance. 2013 Standards and Guidelines for Managed Behavioral Health Organizations (MBHOs) and MCOs.

Performance Measure	Quality	Timeliness	Access
Child & Adolescent Care			
Childhood Immunization Status—Combination 2 and *Combination 3*	✓		
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Appropriate Care			
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Diuretics, and *Total*	✓		
Comprehensive Diabetes Care—HbA1c Testing, Eye Exam (Retinal) Performed, and *Medical Attention for Nephropathy*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	✓		
Statin Therapy for People With Diabetes—Received Statin Therapy and *Statin Adherence 80%*	✓		
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and *30-Day Follow-Up*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total and *Engagement of AOD Treatment—Total—Total*	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	✓		

Performance Snapshot

Performance Measures

Twenty-five measure rates were compared to national benchmarks for HEDIS 2018. Overall, 11 of 25 measure rates (44.0 percent) ranked above the national Medicaid 50th percentile for the statewide average. Conversely, 5 of 25 measure rates (20.0 percent) fell below the national Medicaid 25th percentile for HEDIS 2018.

Quality Measures

Within the quality domain, 11 of 24 measure rates (45.8 percent) ranked above the national Medicaid 50th percentile for the statewide average, with one rate (*Statin Therapy for Patients With Diabetes—Received Statin Therapy*) exceeding the national Medicaid 75th percentile. Conversely, four rates (*Adult BMI Assessment, Childhood Immunization Status—Combinations 2* and *3,* and *Controlling High Blood Pressure*) fell below the national Medicaid 25th percentile. Additionally, seven of 24 measure rates (29.2 percent) with two years of data demonstrated a decrease in performance from HEDIS 2017 to HEDIS 2018. Despite slight increases in performance, several measure rates within the Child & Adolescent Care domain continued to perform below the national Medicaid 50th percentile, indicating that health plans should focus their quality improvement efforts on ensuring young members receive necessary vaccinations and counseling/monitoring services.

Timeliness Measures

For the two measure rates within the timeliness domain that were comparable to benchmarks, *Prenatal and Postpartum Care—Postpartum Care* ranked above the national Medicaid 50th percentile, while *Timeliness of Prenatal Care* decreased in performance, fell below the national Medicaid 50th percentile for the statewide average. Health plans should focus their improvement efforts on increasing the number of essential services for female members during their pregnancy.

Access Measures

For the access domain, one of three measure rates (33.3 percent) ranked above the national Medicaid 50th percentile for the statewide average (*Prenatal and Postpartum Care—Postpartum Care*). Of note, the statewide average for *Adults' Access to Preventive/Ambulatory Health Services—Total* continued to fall below the national Medicaid 25th percentile, indicating members may not have access to preventive care.

Pay-for-Performance (P4P) Measures

HFS identifies pay-for-performance (P4P) measures with specific, performance-driven target objectives. P4P measures create an incentive for health plans to spend money on care that produces valued outcomes. For this reporting year, there were eight FHP/ACA P4P bundled measures and five ICP P4P bundled measures. To determine if the health plans met the P4P performance target for SFY 2018, the results for the P4P measures were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018. A summary of the health plans' performance is provided below.

P4P MEASURES AND METHODOLOGY

FHP/ACA & ICP Measures*

a) *BCS*
b) *CCS*
c) *CDC—HbA1c Testing*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*
d) *FUH—30-Day Follow-Up*
e) *IET—Initiation of AOD Treatment—Total—Total* and *Engagement of AOD Treatment—Total—Total*

FHP/ACA Measures*

f) *WCC—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
g) *W15—Six or More Well-Child Visits* and *W34*
h) *PPC—Timeliness of Prenatal Care* and *Postpartum Care*

HFS applies withholds (a percentage of total capitation rates each month) of:

- 1% in the first measurement year
- 1.5% in the second measurement year
- 2% in the third and subsequent measurement years

The Contractor may earn a percentage of the withhold based on:

- Quality metrics
- Operational metrics
- Achievement of implementation goals

2018 PAYOUT

FHP/ACA

Measure	a	b	c	d	e	f	g	h
Met	0	4	1	0	1	2	1	4

ICP

Measure	a	b	c	d	e
Met	0	0	3	0	0

# of plans that met performance goal FHP/ACA: 9 plans reported ICP: 10 plans reported

* The full measure names are as follows:

a) *Breast Cancer Screening (BCS)*
b) *Cervical Cancer Screening (CCS)*
c) *Comprehensive Diabetes Care (CDC)*
d) *Follow-Up After Hospitalization for Mental Illness (FUH)*
e) *Initiation and Engagement (IET) of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment*
f) *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* and *Body Mass Index (BMI)Percentile Documentation*
g) *Well-Child Visits in the First 15 Months of Life (W15)* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
h) *Prenatal and Postpartum Care (PPC)*

Operational Readiness and Administrative Reviews

Administrative Compliance Review

The primary objective of HSAG's review was to provide meaningful information to HFS and the MCOs regarding the MCOs' compliance with federal managed care regulations and contract requirements. In SFY 2018 all standards were completed that are required to complete a comprehensive readiness review for the MCOs. The areas selected for compliance review included standards listed below under the areas of Access, Structure and Operations, Measurement and Improvement, and Program Integrity. For the nine standards reviewed during the administrative review, the health plans demonstrated overall compliance with coverage and authorization; confidentiality; enrollment and disenrollment; the grievance and appeal system; fraud, waste, and abuse; and the quality assessment and performance improvement program. See more detailed recommendations for achieving improvement in each area in Section 6 and Appendix I.

Access Standards

- Standard IV—Coverage and Authorization of Services
- Standard V—Credentialing and Recredentialing
- Standard VI—Children's Mental Health System

Overall improvement opportunities identified for all health plans included:

- The area with the greatest opportunity for improvement for the access standards was Standard IV—Children's Mental Health System. The results for this standard across all health plans identified a lack of compliance with inclusion of all program requirements in policies and procedures and oversight of the contracted vendor Chrysalis, a state contracted vendor for the CARES line, which is the dedicated Behavioral Health Crisis line for enrollees and family members. As this standard was included in the readiness review follow-up, remediation of non-compliance was documented as part of the readiness review.

Structure and Operations Standards

- Standard VIII—Enrollee Information / Enrollee Rights
- Standard IX—Confidentiality
- Standard X—Enrollment and Disenrollment
- Standard XI—Grievance and Appeal Process

Overall improvement opportunities identified for all health plans included the following:

- The area with the greatest opportunity for improvement for the Structure and Operations standards was Standard IX—Grievance and Appeals Process. As this standard was included in the readiness review follow-up, remediation of non-compliance was documented as part of the readiness review.

Three plans, Aetna, IlliniCare, and BCBSIL had findings in the Grievance and Appeal Standard specific to the processing of grievances and appeals. Aetna and IlliniCare remediated the findings; however, one health plan, BCBSIL, was placed on a focused corrective action plan for significant non-compliance with timely acknowledgement and resolution of both grievances and appeals, as well as oversight of their delegated vendors contracted to process appeals. Details of the corrective action plan monitoring for BCBSIL will be reported in the SFY 2018–2019 EQR Report.

Measurement and Improvement Standards

- Standard XII—Quality Assessment and Performance Improvement (QAPI) Program

Overall improvement opportunities identified for all health plans included the following:

- The area with the greatest opportunity for improvement for QAPI for all plans was compliance with cultural competence plan requirements. HSAG conducted follow-up on the plans' remediation actions and the review identified that all plans were fully compliant following remediation. In addition, findings for BCBSIL identified a lack of oversight by the designated quality committee and compliance officer of continued non-compliance and failure to remediate operational issues related to the processing of grievances and appeals and to oversight of delegated vendors.

Program Integrity

- Standard XVI—Fraud, Waste, and Abuse

Overall improvement opportunities identified for all health plans included the following:

- No areas for improvement were noted for Program Integrity. HSAG conducted a focused review of each health plans' Fraud, Waste, and Abuse Plan and found all plans to be in compliance with the requirements.

Consumer Satisfaction Measures

In SFY 2018, health plans were responsible for obtaining a Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor to administer the CAHPS surveys and forward results to HSAG for analysis. For the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS.

CAHPS surveys indicated adult members' satisfaction with their overall health plan is improving, since the 2018 score for one global rating (*Rating of Health Plan*) was statistically significantly higher than the 2017 score. However, the 2018 score for this measure fell below the 50th percentile compared to national Medicaid benchmarks, along with four other measures (*Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*). Adult members showed greatest satisfaction with the *How Well Doctors Communicate* composite measure, as this measure scored at or above the 90th percentile compared to national Medicaid benchmarks.

Similar to the adult aggregate results, the child aggregate results of all FHP/ACA health plans combined showed that the 2018 score for the *Rating of Health Plan* global rating was statistically significantly higher than the 2017 score. Furthermore, three of the same composite measures (*Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*) scored below the 50th percentile compared to national Medicaid benchmarks, indicating that adult members and parents/caretakers of child members were less satisfied with these measures. However, parents/caretakers of child members showed greater satisfaction with all of the global ratings (i.e., *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*), as these measures scored at or above the 75th percentile compared to national Medicaid benchmarks.

When the 2018 scores for the general child population for the Illinois Statewide Program Aggregate were compared to national benchmarks, three measures (*Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) scored at or above the 90th percentiles; however, four measures (*Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Health Plan*) performed poorly, falling below the 50th percentiles compared to national Medicaid benchmarks. When comparing the 2018 top-box rates to 2017 for the continuum of care center (CCC) population for the Illinois Statewide Program Aggregate, none of the measures increased or decreased substantially.

Based on these results for both the adult and child populations, FHP/ACA and ICP health plans and the Illinois Statewide Program Aggregate have opportunities for improvement regarding members' access to and timeliness of care and customer service skills. Improvements in these areas may increase members' overall rating of their health plan.

Refer to Section 3 and Appendix G of this report for additional details on consumer satisfaction performance ratings.

Home- and Community-Based Services (HCBS) Waiver Record Reviews

As a result of HFS's commitment to continuous quality improvement, the HCBS waiver review process was revised during SFY 2018. Three CMS performance measures were added, resulting in an increase from 12 to 15 measures abstracted from health plan records. As a result, overall data from previous years was not comparable.

HealthChoice Illinois

Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois Managed Care Program (HealthChoice), on January 1, 2018, which combined the FHP/ACA and ICP populations into one managed care program. HCBS data continued to be collected and reported via separate FHP/ACA and ICP populations through the end of SFY 2018 to maintain consistency. Successes were identified for both the FHP/ACA and ICP populations. For the FHP/ACA population, 12 of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018, and six of the nine health plans averaged 90 percent or greater overall compliance. For the ICP population, 11 of the 15 CMS performance measures averaged 90 percent or greater compliance in SFY 2018, and four of the ten health plans averaged 90 percent or greater overall compliance.

MMAI

As with the FHP/ACA and ICP populations, the MMAI program also realized successes. Ten of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018, and five of the seven health plans averaged 90 percent or greater overall compliance.

Refer to Section 2 and Appendix F of this report for additional details on HCBS waiver record reviews.

Recommendations for Improvement

The summary tables below identify focused populations and key areas for improvement based on health plan performance on HEDIS measures, consumer satisfaction, and compliance with Medicaid managed care requirements. Focused populations and areas for improvement are categorized into improvement domains, rationale for inclusion, plan performance on key indicators, current interventions, recommendations for improvement, and alignment with the State Quality Strategy.

Behavioral Health (BH)

Domain(s)	Quality, Access, and Timeliness
Issue Brief	**Cost** ▪ Illinois Medicaid members with BH conditions make up 25 percent of the Medicaid population, but they account for 56 percent of Medicaid spending when factoring in both behavioral and medical costs.[i] ▪ The costliest 10 percent of Medicaid BH members account for more than 70 percent of all Medicaid spending on BH in the State.[i] **Improvement Strategies** Given the prevalence of BH conditions in the Medicaid population, the high level of Medicaid spending on BH care, and the adverse impact that uncoordinated care can have on people's health, initiatives to integrate physical and mental health are a top priority for Medicaid agencies. Integrated care approaches have been shown to improve health outcomes for individuals with BH conditions. Effective integrated care can also enhance patient engagement and activation, which has been shown to be associated with increased treatment adherence, improved patient satisfaction, better quality of life, and increased mental and physical health.[ii] **Alignment with State Strategies** Establish guidelines for care coordination, quality measures, and beneficiary access.

Plan Performance	
2017–2018 HEDIS Performance Measures	*Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; however, improving performance on this measure is a priority for HFS.* ▪ *Follow-Up After Hospitalization (FUH) for Mental Illness* o *7-Day Follow-Up* o *30-Day Follow-Up*
2017–2018 Administrative Reviews	Findings identified the need to: ▪ Improve care coordination programs for beneficiaries with BH conditions. ▪ Continue to evaluate care transition programs to determine effectiveness of care transitions. ▪ Continue to improve communication between health plan utilization management and care management programs to improve transitions and care coordination. ▪ Continue efforts to develop stronger communication and collaboration with hospitals to improve discharge planning communication and handoffs. ▪ Evaluate the capacity of the BH provider network.

Plan Interventions
Collaborative BH PIP ▪ Goal: Improve the rate of beneficiaries receiving follow-up appointments within 7 days and 30 days of discharge from an inpatient stay for BH treatment. ▪ Health plans are implementing rapid cycle PIPs in 2018–2019. ▪ Development of specialized behavioral health programs targeting high utilizers.
State Strategy
1115 Demonstration Waiver ▪ Illinois BH transformation waiver for physical and mental health integration. ▪ HFS required the health plans to implement quality improvement plans to improve transitions of care for members with BH conditions.

Recommendations for Health Plans

- Continue to evaluate the effectiveness of health plan transition of care programs to determine the effectiveness of transitions of care from inpatient settings to home- and community-based settings.[iii]
  - Establish transition of care evaluation measures.
  - Evaluate compliance with standardized forms, tools, and methods for transitions of care.
  - Utilize surveys and data collection tools and engage consumer advisory committees to identify root causes of ineffective transitions and patient/member satisfaction with transitions including an understanding of the care plan.
  - Consider dedicated transition of care teams to manage transitions of care for beneficiaries with BH/complex healthcare needs.
  - Include evaluation of readmission rates and emergency department (ED) utilization in evaluation of the effectiveness of transition of care and care coordination programs.
- Continue to evaluate care coordination/care management (CC/CM) programs to determine the effectiveness of care coordination for beneficiaries with complex healthcare needs.
- Continue collaboration efforts with community BH organizations.
- Provide easy access to prior-authorization, pharmacy, and claims data for CC/CM staff. These data are critical for the CC/CM to understand the health status, medication compliance, receipt of services, risks, and needs of members assigned to care management.

Other Considerations for Health Plans and HFS

- Health plans may consider evidence-based transition of care models to improve patient outcomes (see references).
- Health plans should utilize their consumer advisory committees to determine opportunities to improve transition of care programs and beneficiary satisfaction with transitions.
- Health plans may consider programming online databases/programs to flag members who need medical/BH visits, high ED utilizers, and hard-to-reach members.
  - Allows member services, the nurse advise line, and care managers to address the flag during contact with the member.
- Health plans should continue to strengthen linkages with community-based services and resources through partnerships with community mental health centers (CMHCs), psychiatric hospitals, and State initiatives to develop a culture of shared accountability.
- Continue to focus on ancillary services (e.g., transportation and housing).
- HFS should continue to build a collaborative learning environment between State agencies and health plans to leverage best practices.
- Explore options for telemedicine which can remove access barriers by allowing patients to receive access to specialists, regardless of their location.
- HFS may consider identifying integrated care measures that support the State's performance outcome goals in improving physical and mental health integration. Consider data collection and measurement strategies.

Barriers to Improvement Identified by Health Plans

The following barriers to improvement were identified by the health plans:

- Aftercare planning is not occurring early in the beneficiaries' inpatient stay.
- The BH network may not be adequate to meet the timeliness requirements of the 7- and 30-day performance measures.
- Workflow processes need to be assessed and redirected to ensure there are adequate clinical resources available to address timely aftercare discharge planning.
- The identification of, and access to, hospital discharge staff needs to be streamlined with a single point of entry or contact.
- Network practitioners, providers, and facilities are unaware of the HEDIS *FUH* measure requirements.
- Members lack an understanding for the importance of follow-up care and how to address physical barriers.
- Members with comorbid/co-occurring mental health and substance use disorders may be more treatment-ambivalent due to the comorbidity illness and their current stage of change.
- Members' lack of adherence to their psychotropic medication regimen due to side effects.

Current Health Plan Initiatives

- Established multiple connections with community agencies to support access to BH care, including pre-discharge community agency connection and in-home assessments.
- BH transitions teams work with hospitals/inpatient facilities to have hospital discharge staff initiate the discharge coordination planning process early in the member's inpatient stay.
- Educated providers, inpatient facilities, and community agencies on the *FUH* HEDIS measure standards.
- Conducted member outreach to educate on the importance of post-hospital discharge follow-up, mediation adherence, and self-management of BH illness.
- Held community events to promote healthy behaviors and self-management of illness.

Current State Initiatives

- Application for an 1115 Waiver
  - "Our [HHS'] transformation puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care to keep them more closely connected with their families and communities."[iv]
  - Consistent with the IHI Triple Aim, the HHS transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes: [v]
    - Prevention and population health
    - Paying for value, quality, and outcomes
    - Rebalancing from institutional to community care
    - Data integration and predictive analytics
    - Education and self-sufficiency

i. Illinois Department of Healthcare and Family Services. "Illinois' Behavioral Health Transformation: Section 1115 Demonstration Waiver." Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/20160902_1115_Waiver_for_Public_Comment_vF.pdf. Accessed on: Mar 14, 2018.

ii. E. Edwards, *Assessing Changes to Medicaid Managed Care Regulations: Facilitating Integration of Physical and Behavioral Health Care*. The Commonwealth Fund, October 2017. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2017/oct/medicaid-managed-care-behavioral-health. Accessed on: Mar 14, 2018.

iii. The Joint Commission. "Hot Topics in Health Care. Transitions of Care: The need for a more effective approach to continuing patient care." Available at: https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf. Accessed on: Mar 14, 2018.

iv. Illinois.gov. HHS Transformation. Available at: https://www2.illinois.gov/sites/hhstransformation/overview/Pages/default.aspx. Accessed on: Mar 14, 2018.

v. Illinois Department of Healthcare and Family Services. Frequently Asked Questions (FAQs): Illinois' Behavioral Health Transformation. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/20160826_FAQs_vF.pdf. Accessed on: Mar 14, 2018.

Consumer Satisfaction with Customer Service, Health Plan, and Overall Health Care

Domain(s)	Quality

Issue Brief

- In 2018, Medicaid health plan members reported that they were generally dissatisfied with their health plan customer service and whether the plan's customer service gave them the information or help they needed.[i]
- Better service translates into higher satisfaction for the patient, and dissatisfied members can generate potential new costs since they may be less likely to follow clinical advice (and develop worse outcomes) and are likely to share their negative stories with friends and family members.[i]
  - Marketing studies confirm that only 50 percent of unhappy customers will complain to the service organization, but 96 percent will tell at least nine friends about their bad experience.[i]

Plan Performance

CAHPS
2018 FHP/ACA Child and Adult and ICP Adult Survey Results

≤ 50th National Medicaid Percentile

- Adult CAHPS Aggregate Results—*Customer Service*, and *Rating of Health Plan*
- Adult and Child CAHPS Aggregate Results—*Customer Service*

2017–2018 Administrative Reviews and Readiness Reviews

Findings identified the need to:

- Improve staffing resources, qualifications and training for CC/CM department.
- Improve training of customer service and grievance and appeals staff on handling member complaints/grievances.
- Continue to improve processing and timeliness of resolution of grievances.
- Establish a consistent process to track the source of the complaints/grievances to identify the correct improvement strategies.

Plan Interventions

- Call center service-level monitoring to design interventions to improve member satisfaction with the health plan.
- Conduct call center satisfaction survey- survey members within days of their calling customer service to assess their recent experience.
- Implement a service recovery program so that call center representatives have guidelines to follow for problem resolution.
- Promote a health plan culture that customer service is the responsibility of all staff throughout the organization.

HFS Interventions

Consumer Report Card

- According to 42 CFR §438.334, produced the Illinois Report Card using Illinois Medicaid plans' HEDIS performance measure data and CAHPS survey results.[ii]

Recommendations[iii] for Health Plans
▪ Evaluate the need for a service recovery program. National experts in service recovery recommend a well-tested process for service recovery. This will allow call center representatives have guidelines to follow for problem resolution and atonement. "Excellent service recovery programs are an effective tool for retaining members or patients and improving their level of satisfaction. Good service recovery programs can turn frustrated, disgruntled, or even furious patients or members into loyal ones."[iv]
▪ Conduct a Call Center Satisfaction Survey.
▪ Implement a short interactive voice response (IVR) survey to members within a short time of their interaction with customer service to assess their recent experience.
▪ Evaluate complaints/grievances tracking systems/database. The system should have the capacity to track timelines and generate regular reports to operational staff and management.
▪ Evaluate complaints/grievances data to identify failure points that are root causes of low satisfaction.
▪ Track trends and use information to improve service processes.
▪ Evaluate standards and service-level reporting for customer service.

Other Considerations
▪ Health plans could analyze data for gender or age differences to determine if targeted outreach might affect satisfaction.
▪ Health plans may reexamine population needs to determine if additional care coordination programs may be warranted to assist membership with access to care and satisfaction.
▪ Health plans might utilize their consumer advisory committees to determine opportunities to improve overall satisfaction with the health plan, including benefits or incentives offered.

Current State Initiatives
HFS developed a **consumer report card** to support HFS' public reporting of plan performance information to be used by individuals to make informed decisions about their healthcare. The report card evaluated individual plan performance in key areas (e.g., how well doctors involved members in decisions about their care, if children regularly received checkups and important shots that helped protect them against serious illness), allowing beneficiaries the opportunity to be better informed when making decisions about their healthcare. For example, if a member has a chronic condition, the member may use the *Access to Care* and *Living With Illness* performance areas to determine which plan had the best performance to help determine which plan is best for them. The report card, which was made publicly available in November 2016 and again in 2018, included an overview, description of the performance areas, and plan-specific results including trended performance from the prior year as well as background information for assisting individuals in choosing a Medicaid plan.

i. Agency for Healthcare Research and Quality. The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience; December 2017. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/cahps-ambulatory-care-guide-full.pdf. Accessed on: Mar 14, 2018.
The Illinois Report Card may meet the requirement for a quality rating system (QRS) with CMS approval. The report card presents an easy-to-read "picture" of quality performance across the plans in the following key performance areas: Doctors' Communication and Patient Engagement, Access to Care, Women's Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy.

ii. The report card presented results for each plan using a five-level rating scale that clearly emphasized differences between plans (i.e., from a level one rating up to a level five rating) in the above key performance areas to assist members when selecting a plan. The report card was developed to support HFS' public reporting of plan performance information to be used by members to make informed decisions about their healthcare. Because the report card evaluated individual plan performance in key areas (e.g., how well doctors involved members in decisions about their care, if children regularly received checkups, and important shots that helped protect them against serious illness), members have an opportunity to be better informed when making decisions about their healthcare.

iii. Agency for Healthcare Research and Quality. The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience; December 2017. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/cahps-ambulatory-care-guide-full.pdf. Accessed on: Mar 14, 2018.

iv. Ibid.

Appropriate Care—Chronic Conditions
Controlling High Blood Pressure and *Adult BMI* Measures

Domain(s)	Quality
Issue Brief	**Cost** ▪ Studies have shown that one-third of adults have hypertension, which is associated with an increased risk of a first heart attack, first stroke, chronic heart failure, and kidney disease. Additionally, treating high blood pressure costs approximately $46 billion annually, showing that this is a high-impact area for improvement.[i] **Facts** ▪ When compared to the United States, Illinois has a higher prevalence for the risk factors of high cholesterol, obesity, poor nutrition, and excessive alcohol use. Illinois has a lower prevalence of the risk factors of high blood pressure, smoking, and physical inactivity than the United States.[ii] ▪ Team-based care is a central pillar of the Million Hearts initiative, launched by the Department of Health and Human Services in September 2011. Million Hearts is a national, public-private initiative of the Department of Health and Human Services to prevent 1 million heart attacks and strokes over five years. The initiative is aligned with the Healthy People 2020 goal to reduce the proportion of persons in the U.S. population with high blood pressure. Specifically, team-based care is an evidence-based model that incorporates the contributions of a variety of team members, such as pharmacists, nurses, and others, working with providers and patients to support healthy behaviors and appropriate use of medications to address cardiovascular risk factors such as high blood pressure. Blood pressure control is one of four health behaviors targeted by the initiative—the others are aspirin as appropriate, cholesterol management, and smoking cessation—to achieve the goal of preventing 1 million heart attacks and strokes by 2017.[iii] ▪ A review of 77 studies of team-based care showed that patients' control of blood pressure improved when their care was provided by a team of health professionals—a primary care provider (PCP) supported by a pharmacist, nurse, dietitian, social worker, or community health worker—rather than by a single physician.[iv] ▪ The prevalence of adult BMI greater than or equal to 30 kg/m2 (obese status) has greatly increased since the 1970s. Recently, however, this trend has leveled off, except for older women. Obesity has continued to increase in adult women who are 60 years of age and older.[v] People who have obesity are at an increased risk for many diseases and health conditions.

Executive Summary Appendix

Plan Performance	
2017–2018 HEDIS Performance Measure	Between the 25th and 50th National Medicaid Percentile ▪ *Controlling High Blood Pressure* ▪ *Adult BMI Assessment*
2017–2018 Administrative Reviews	Findings identified the need to: ▪ Improve staffing resources, qualifications, and training for CC/CM department. ▪ Evaluate disease management programs to determine effectiveness of disease management for individuals with chronic diseases.

Plan Interventions

- Targeted care coordination outreach to members not enrolled in care coordination.
- Evaluate the effectiveness of CC/CM programs managing members with hypertension and obesity.
- Collaborate with the Illinois Department of Public Health (IDPH) in current Healthy Heart initiatives with local health departments, rural health clinics, and federally qualified health centers (FQHCs).

HFS Interventions

IDPH Healthy Heart Project.

Recommendations for Health Plans

- Evaluate the effectiveness of chronic disease management programs to determine effectiveness of educational materials for blood pressure control.
- Evaluate the effectiveness of integrated CC/CM for members with hypertension – consider the use of a multidisciplinary team to improve the quality of hypertension care for member. The team should include the PCP, nurse, pharmacist, dietitian, social worker, and community health workers.
  - Evaluate patient-centered outcomes of satisfaction with care and adherence to behavioral change activities.
  - Use health plan consumer advisory committees to identify barriers to care and factors that motivate beneficiaries to seek diabetes care.
- For the *Controlling High Blood Pressure* measure, health plans could consider a focused project to analyze commonalities and/or barriers to achieving hypertension control. For instance, they may consider focused outreach to those members without hypertensive medications prescribed, or outreach to providers to determine barriers to achieving success with this measure.

Current State Initiatives

Illinois Healthy Heart Project

- IDPH is committed to preventing cardiovascular disease in communities across the state. These prevention efforts are also an integral part of the Illinois State Health Improvement Plan.

i. Illinois Department of Public Health. The Burden of Diabetes in Illinois: Prevalence, Mortality, and Risk Factors 2012. Available at: http://www.idph.state.il.us/diabetes/pdf/8-27-12_Diabetes_Burden.pdf. Accessed on: Apr 16, 2018.

i. Illinois Department of Public Health (IDPH) Healthy Hearts Project. Available at: http://dph.illinois.gov/topics-services/prevention-wellness/patient-safety-quality/healthy-hearts-project. Accessed on April 25, 2019.

ii. HealthyPeople.gov. Overarching Goals. Available at: https://www.healthypeople.gov/2020/About-Healthy-People. Accessed on: Mar 14, 2018.

iii. CDC Newsroom Press Release. Available at: https://www.cdc.gov/media/releases/2012/p0515_bp_control.html. Accessed on April 25, 2019.

iv. CDC Healthy Weight: About Adult BMI. Available at: https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html. Accessed on April 25, 2019.

Access to Care—Preventive Ambulatory Health Services

Domain(s)	Access
Issue Brief	**Cost** ▪ From the Agency for Healthcare Research and Quality's (AHRQ's) *2011 National Healthcare Disparities Report*, "People with a usual source of care (a provider or facility where one regularly receives care) experience improved health outcomes and reduced disparities (smaller differences between groups) (Starfield & Shi, 2004) and costs (De Maeseneer, et al., 2003)."[i] **Facts** ▪ The 2010 AHRQ State Snapshot for Ambulatory Care Quality includes measures that assess the quality of care provided to patients with specific conditions when they are treated in doctors' offices, clinics, and other sites of walk-in care. This measure is reported as weak for Illinois when compared to other states.[ii] ▪ Efforts that combine targeted access to preventive services with more comprehensive programs to improve community health may yield significant cost savings. An investment of $10 per person per year for proven community-based disease prevention programs that improve physical activity and nutrition and lower smoking rates in communities could save Illinois Medicaid $120 million annually in the first one to two years, some $700 million annually within five years, and more than 7.5 million annually in 10 to 20 years. Early detection and prompt intervention to control a problem or disease and minimize the consequences of a disease are more cost effective if they are targeted to at-risk populations. Physical activity, nutrition, and smoking are three of the most important areas to target for prevention to generate a significant return both in terms of health and financial savings.[iii] ▪ Medicaid beneficiaries use the ED at an almost two-fold higher rate than the privately insured. Non-urgent visits comprise only about 10 percent of all ED visits by Medicaid beneficiaries, and suggest that higher utilization may be in part due to unmet health needs and lack of access to appropriate settings. In this context, as most states have recognized, efforts to reduce ED use should focus not on merely reducing the number of ED visits, but also on promoting continuous coverage for eligible individuals and improving access to appropriate care settings to better address the health needs of the population.[iv]

Plan Performance

2017–2018 HEDIS and CAHPS Performance Measures

≤ 25th National Medicaid Percentile

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
  - Statewide average decreased from 2017–2018 for in five of the seven health plans.
- Adult and Child CAHPS Aggregate Results—*Getting Needed Care* and *Getting Care Quickly* satisfaction survey results.
- Performance across the access domain (as demonstrated by HEDIS and CAHPS rates noted above) suggests that beneficiaries may have a difficult time obtaining necessary preventive care services. Additionally, the high utilization rates seen in the *Ambulatory Care—ED Visits* measure indicator further quantify that members may not be using services appropriately, either due to lack of access to preventive care or lack of understanding of the appropriate location to receive care.

Executive Summary Appendix

Plan Performance		Plan Interventions
2017–2018 Administrative Reviews	Findings identified the need to: ▪ Evaluate grievances related to access to care to identify opportunities for improving access to care. ▪ Conduct training with grievance and appeal staff to appropriately assist beneficiaries with resolution of access grievances (for example, assisting with scheduling appointments and locating a provider). ▪ Conduct an annual access and availability survey to evaluate provider compliance with appointment and after-hours access. o Follow up with noncompliant providers. ▪ Monitor provider open and closed panels and update the online provider directory. ▪ Improve the frequency of directory audits and timeliness of updates to improve the accuracy of the online provider directories. ▪ Evaluate unable-to-reach programs, as plans report the location rate continues to be low.	▪ Member education on appropriate treatment alternatives to use of the ED for nonemergent conditions. ▪ Care coordination programs for high utilizers including post-ED visit assessments. ▪ Delegated care coordination for children with complex needs to La Rabida Children's Hospital and reduced ED visits and inpatient admissions. ▪ Electronic connection with hospital systems to obtain admission, discharge, and ED data to equip providers and care teams with real-time information. ▪ ED diversion programs: Six health plans reported on their ED programs in their annual reports. ▪ Unable-to-reach programs.

Recommendations for Health Plans

- Conduct a root cause analysis of beneficiaries who do not access preventive care services to determine barriers to obtaining appointments.
- Consider targeted outreach campaigns for members who have not accessed preventive care services.
- Evaluate the effectiveness of the health plans' "Gaps in Care" programs and the role of the PCP in closing care gaps.
- Utilize health plan consumer advisory committees to identify barriers to care and motivating factors to obtaining preventive care services.
- Identify frequent/high ED users and connect them with CC/CM programs.
  - Share high utilizer information with the beneficiaries' PCPs.
- Utilize the results of the annual access and availability survey to evaluate provider compliance with appointment availability and after-hours telephone access and follow up with providers who are noncompliant with appointment standards.
- Share best practices for improving preventive care visits and ED diversion programs.
- Work with hospital systems to gain access to real-time ED visit information to allow for timely follow-up with members accessing the ED.
- Provide easy access to prior authorization, pharmacy, and claims data for CC/CM staff. These data are critical for understanding the health status, medication compliance, receipt of services, risks, and needs of members assigned to CC/CM.
- Enhance discharge communication between the utilization and care management departments through real-time alerts to facilitate transitions of care and appointment follow-up after an inpatient admission.
- Evaluate unable-to-reach programs to identify innovative strategies to improve outreach to locate hard-to-reach members.
  - Enhance outreach efforts through claims, utilization data, and obtaining beneficiary contact information from local community organizations.
  - Consider the use of health navigators who live in the community and who may be better equipped to find hard-to-locate members, gain trust, and build relationships.
  - Send staff to last known address for the member.

Other Considerations for HFS and Health Plans

- HFS may consider including *Adults' Access to Preventive/Ambulatory Health Services—Total* as part of its P4P incentive program in future years, as the rates for this measure are low and contribute to the well-being of members across multiple domains of care.
- HFS may consider enhancing the validation of the adequacy of the health plan provider networks through analysis of time/distance standards, open and closed panels, and accuracy of the online provider directories.
- Health plans may consider programming online databases/systems to flag high ED utilizers, members who need preventive care visits, and hard-to-reach members.
  - Allows member services, nurse advise line staff, and care managers to address the reasons for flagging during contact with the member.
- Health plans may consider the use of mobile technology, including text messaging.

Barriers to Improvement Identified by Health Plans

- Limited same-day, after-hours, and weekend appointments.
- Significant barriers to locating members, which is even more difficult with the homeless and BH populations. (See resource for outreach strategies.[v])
- Lack of housing resources available for homeless members.

Current State Initiatives

The Illinois Health and Human Services (HHS) Transformation places a strong focus on prevention and public health.[vi]

i. Agency for Healthcare Research Quality. *2011 National Healthcare Disparities Report*. Available at: https://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap9.html#. Accessed on: Mar 1, 2018.
ii. Agency for Healthcare Research Quality. AHRQ State Snapshot for Ambulatory Care Quality. Available at: https://statesnapshots.ahrq.gov/snaps10/settingsofcare.jsp?menuId=13&state=IL&level=7. Accessed on: Mar 1, 2018.
iii. Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. Available at: http://healthyamericans.org/reports/prevention08/Prevention08.pdf. Accessed on: Mar 2, 2018.
iv. CMS Informational Bulletin: Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf. Accessed on: Mar 1, 2018.
v. Center for Health Care Strategies, Inc. Contacting Hard-to-Locate Medicare and Medicaid Members: Tips for Health Plans. Available at: https://www.chcs.org/media/PRIDE-Tips-for-Contacting-Hard-to-Locate-Members_121014_2.pdf. Accessed on: Mar 2, 2018.
vi. Illinois.gov. Health and Human Services (HHS) Transformation website. Available at: https://www2.illinois.gov/sites/hhstransformation. Accessed on: Mar 2, 2018.

Appendix B. 2017–2018 Performance Measure Methodology

NCQA HEDIS Compliance Audit

Objectives

This section describes the evaluation of the Medicaid managed care health plans' (health plans') ability to collect and report on the performance measures accurately. The Healthcare Effectiveness Data and Information Set (HEDIS) performance measures are a nationally recognized set of performance measures developed by National Committee for Quality Assurance (NCQA). Healthcare 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 healthcare services is the ability to provide easily understood, comparable information on the performance of the health plans. 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 health plan 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 Illinois Department of Healthcare and Family Services (HFS) requires the health plans to monitor and evaluate the quality of care using HEDIS and HFS-defined performance measures. The health plans must establish methods to determine if the administrative data are accurate for each measure. In addition, the health plans 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 health plans 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 indicates the extent to which health plans 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, data integrity, compliance with HEDIS specifications, and analytic file production.

Technical Methods of Data Collection and Analysis

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's measurement year (MY) 2017 data. HFS contracted with Health Services Advisory Group, Inc. (HSAG) to conduct an audit for each Family Health Plan/Affordable Care Act (FHP/ACA) and Integrated Care Program (ICP) health plan. The audits were conducted in a manner consistent with NCQA's *HEDIS 2018, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The audit incorporated two main components:

- A detailed assessment of the health plan's information systems (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.
  - Supplemental database review.
  - Databases and files used to store HEDIS information.
  - Medical record abstraction tools and abstraction procedures used.
  - Any manual processes employed for MY 2017 HEDIS data production and reporting.

The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the health plan's oversight of these outsourced functions.

A specific set of performance measures were selected by HFS for validation by HSAG based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. The measures selected for validation through the NCQA HEDIS Compliance Audits were the following:

Table B-1—FHP/ACA Measures Selected for Validation

HEDIS 2018 FHP/ACA Performance Measures Selected by HFS			
Measure Name		**Acronym**	**Method**
1	*Breast Cancer Screening*	*BCS*	Admin
2	*Immunizations for Adolescents*	*IMA*	Hybrid
3	*Medication Management for People with Asthma*	*MMA*	Admin
4	*Well-Child Visits in the First 15 Months of Life*	*W15*	Hybrid
5	*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*	*W34*	Hybrid

Table B-2—ICP Measures Selected for Validation

HEDIS 2018 ICP Performance Measures Selected by HFS			
Measure Name		**Acronym**	**Method**
1	*Adult BMI Assessment*	*ABA*	Hybrid
2	*Ambulatory Care*	*AMB*	Admin
3	*Cervical Cancer Screening*	*CCS*	Hybrid
4	*Follow-Up After Hospitalization for Mental Illness*	*FUH*	Admin
5	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	*IET*	Admin

HSAG used several different methods and information sources to conduct the audits, including:

- Teleconference calls with health plan personnel and vendor representatives, as necessary.
- Detailed review of each health plan's completed responses to the HEDIS 2018 Record of Administration, Data Management and Processes (Roadmap) published by NCQA as Appendix 2 to NCQA's *HEDIS 2018, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures,* and updated information communicated by NCQA to the audit team directly.
- On-site meetings in the health plans' 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, an abstraction of a sample of medical records selected by the auditors was compared to the results of the health plan's review determinations for the same records.
- If supplemental data were used, primary source verification (PSV) of a sample of records was conducted from any nonstandard supplemental data sources.
- Requests for corrective actions and modifications to the health plan'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 submitted by the health plans.
- A variety of interviews with 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 calculated HEDIS 2018 (and earlier) performance measure data may also have been interviewed and asked to provide documentation of their work.

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the NCQA categories listed below in Table B-3.

Table B-3—Performance Measure Audit Results and Definitions

Result	Definition
R	*Reportable.* A reportable rate was submitted for the measure.
NR	*Not Reported*. The organization chose not to report the measure.
NA	*Small Denominator*. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate. a. For Effective ness of Care (EOC) and EOC-like measures, when the denominator is <30; and for *Standardized Healthcare-Associated Infection Ratio (HAI)*, when Total Inpatient Discharges is <30. b. For utilization measures that count member months, when the denominator is <360 member months. c. For all risk-adjusted utilization measures, except Plan All-Cause Readmissions (PCR), when the denominator is <150.

Result	Definition
NB	*No Benefit.* The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NQ	*Not Required.* The organization was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., Board Certification).

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.)

For some measures, more than one rate is required for HEDIS reporting (e.g., *Medication Management for People with Asthma and Initiation* and *Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*). It is possible that the health plan prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the health plan would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive a *BR* result, where appropriate.

Upon completion of the audit, HSAG submitted a final audit report to HFS and each health plan that included a completed and signed final audit statement.

For the medical record review validation (MRRV) portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the medical record review (MRR) processes employed by the health plan, including MRR staff qualifications, training, data collection instruments/tools, accuracy of data collection, vendor oversight, and the method used for combining MRR data with administrative data; and (2) complete MRRV, which involves the validation of the health plan's abstraction accuracy for a sample of cases across the NCQA-designated measure groups and a comparison of HSAG's validation results to the health plan's abstraction results.

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

HSAG completed the MRRV process and reabstracted sample records across the appropriate measure groups and compared the results to each health plan's findings for the same medical records. This process provided an assessment of actual reviewer accuracy. HSAG randomly selected 16 cases from the MRR numerator positives as identified by each health plan. If fewer than 16 medical records were found to meet numerator compliance, all records were reviewed or additional records from another measure within the same group were added to equal 16 cases. If an abstraction discrepancy was noted, only critical errors were considered errors. A critical error is 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). If one critical error was noted, HSAG was required to retest a second sample of 16 records that did not

include the original sampled records. If the second sample was free of errors, the measure and measure group passed. If one or more errors were detected, the measure and measure group did not pass validation and could not be reported until all errors were corrected and reviewed by the auditor. If there was not enough time to correct all errors, the health plan was not allowed to report the measure via the hybrid methodology.

Plan-Specific Findings for HealthChoice Illinois Health Plans

NCQA HEDIS Compliance Audit Results for BCBSIL

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Blue Cross Blue Shield of Illinois' (BCBSIL's) FHP/ACA and ICP populations. The audit indicated that BCBSIL was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B-4—BCBSIL 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	**Medical Services Data**	**Provider Data**	**Data Integration**	**Medical Record Data**	**Supplemental Data**	All selected HEDIS measures received an *R* designation.*
Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an *NA* for the 13–17 years of age stratification as there were no members in the eligible population; however, all other age stratifications and the total rates received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving managed care organization (MCO) processes were also identified.

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

BCBSIL used TMG Health as a third-party administrator to process medical services data. During 2017, TMG Health was purchased by Cognizant. Much of the TMG Health processes were unchanged; however, the EverCore application for linking prior authorizations with claims was implemented. TMG Health used Facets to process claims. TMG Health received both electronic data interchange (EDI) (95 percent) and paper (5 percent) claims. Paper claims were imaged and converted into standard format for processing. For 2017, the auto-adjudication rate was 64 percent. The most common types of claims that were not auto-adjudicated included home health services, duplicate claims, and claims for which authorizations were not linked to a claim. During 2017, the implementation of the Evercore system created additional issues for the processing of claims that required prior authorization which played a role in the claims processing delays during the year. During 2017, improvements were implemented to improve the claims data completeness including the capture of rendering provider data for Federally Qualified Health Centers (FQHCs) claims and the ability to pass provider specialty taxonomies to the Enterprise Data Warehouse (EDW) from the Facets system.

TMG Health's Quality Team conducted audits on a random sample of claims to monitor processor proficiency and accuracy. During the on-site, TMG Health indicated a statistically determined sample of claims it selected for routine audits. The claims selected for the audit were stratified by categories (i.e., denied, paid, manually processed). The audits assessed timeliness, compliance with State processing requirements, potential fraud and abuse, technical accuracy, and financial accuracy. For 2017, the audit results for financial accuracy were approximately 98 percent and 99 percent for technical (non-financial) accuracy. BCBSIL reimbursed providers for services covered by the FHP/ACA and ICP products on a fee-for-service basis. The health plan reinforced this point during the on-site.

During the on-site, TMG Health provided a system walk-through to demonstrate the ability of the Facets system to capture data elements required to support HEDIS reporting. The walk-through confirmed that Facets had processes to validate procedure codes, diagnosis codes, eligibility, and provider affiliation.

Pharmacy data were received through the Prime Therapeutics and were thoroughly monitored. BCBSIL had a very rigorous oversight process and analytic structure in place to monitor pharmacy data and utilization.

BCBSIL was fully compliant with IS Standard 1.0.

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

BCBSIL received daily enrollment files with additions, terminations, and primary care practitioner (PCP) information. Separate daily files were received for each product (i.e., FHP/ACA, ICP). Approximately 95 percent of the records contained in the State files loaded without any issues. The most common issues causing records to require correction were related to discrepancies in member contact information (i.e., name, phone number). The TMG Quality Team monitored the accuracy of the enrollment data, in part, through the TMG Monthly Enrollment Recon Report and audits of approximately 10 percent of manually processed transactions. TMG Health reports indicated TMG met the accuracy standard for 2017. Monthly 834 audit files were also received from the State and were reconciled with the information received in the daily files and then loaded into Facets. Reports reviewed during the on-site visit indicated the monthly discrepancy was less than 1 percent.

BCBSIL conducted routine oversight of membership data processed by TMG through a set of "Absent on Recon" (AOR) with a re-review monthly. AOR identified members who failed to load into Facets. BCBSIL investigated issues and provided corrected information back to TMG for correction.

Facets enrollment screens and the process for editing enrollment data were demonstrated during the on-site. All data elements required to support HEDIS reporting were present in the Facets system. Member eligibility history was present and product-specific identifiers were confirmed during the demonstration.

BCBSIL was fully compliant with IS Standard 2.0.

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

BCBSIL maintained practitioner data in Premier Provider and Facets. Credentialing and contracting data were maintained in the Premier Provider system. Daily files were exported and transferred to TMG via a file transfer protocol (FTP) site. Weekly reports (Control 77 Premier—Facets Error Report) were produced and reviewed to ensure concordance between the two systems. The report compared the full set of practitioner data in each system. The concordance rate between the two systems was consistently over 95 percent. In 2017, both the ICP and FHP/ACA provider network grew significantly to accommodate the increase in membership and for anticipated enrollment increases in 2018. During the on-site, system demonstrations were conducted for both the Premier Provider and Facets provider systems. Two providers were reviewed in both systems to verify the concordance of the data in the systems. All data elements, including specialty and active contract segments, matched across the two systems.

BCBSIL was fully compliant with IS Standard 3.0.

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

BCBSIL sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. The medical record project configuration and data were reviewed during the on-site visit. This review included sample parameters, chase logic, and the resulting medical record project data.

BCBSIL utilized internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of Quality Spectrum Hybrid Reporter's (QSHR) abstraction tool to accurately conduct medical record reviews. HSAG reviewed BCBSIL's training manual and had no concerns.

BCBSIL maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.

Due to revisions to several measure specifications for 2017 and all new measures for BCBSIL, a convenience sample was required for the following measures:

1. *Adult BMI Assessment (ABA)*
2. *Well-Child Visits in the First 15 Months of Life (W15)—6+ Visits*
3. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
4. *Cervical Cancer Screening (CCS)*
5. *Immunizations for Adolescents (IMA)—Combo 2*

BCBSIL passed the convenience sample review for all selected measures.

BCBSIL passed the medical record review validation process for the following measures and corresponding measure groups:

- Group A: Biometrics (BMI, BP) and Maternity—*ABA*
- Group B: Anticipatory Guidance and Counseling—*W15–6+ Visits*
- Group C: Laboratory—*CCS*
- Group D: Immunizations and Other Screenings—*IMA—Combo 2*
- Group F: All MR Exclusions

No critical errors were identified and BCBCIL passed the MRRV process for all measures.

BCBSIL was fully compliant with IS Standard 4.0.

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

BCBSIL submitted documentation for two standard supplemental data sources for the purposes of reporting the FHP/ACA and ICP measures. Complete documentation was provided with the Roadmap. Both databases met the requirements to be reviewed as external, standard data. BCBSIL had sufficient processes in place to ensure these data were loaded correctly and had appropriate validation processes. Both the LabCorp and Quest Diagnostic data sources were approved to use for HEDIS 2018 reporting.

BCBSIL was fully compliant with IS Standard 5.0.

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

Claims data from TMG Healthcare and Prime Therapeutics, and supplemental data from lab vendors were maintained in the plan's EDW. The files were formatted and made available directly in the EDW as well. BCBSIL data warehouse teams followed industry standard processes for validating data transfers into the EDW.

For HEDIS 2018, BCBSIL used Inovalon's Quality Spectrum Insight (QSI) software. BCBSIL had a sound process for validating data loads into the QSI repository and tracked record counts for each data source through a simple spreadsheet referred to as the Data Quality Report. During the load process, the standard reports produced by QSI were reviewed. During the on-site, a demonstration of the process was performed and a review of the QSI load validation reports was provided. Monthly data refreshes and rate calculations were performed and reviewed for reasonability and accuracy based on prior month reports.

During the on-site visit and a subsequent conference call, on-site queries that included record tracing for members for the *FUH*, *ABA*, *BCS*, and *W34* measures were conducted. For each member, enrollment and administrative data in the QSI repository were reviewed to confirm compliance with measure specifications and then the data elements used to meet the specifications were viewed in the source systems to confirm concordance.

In addition to the on-site query review, data for three additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers, and loads into the QSI repository. Membership and enrollment data were assessed through the Query Group #1—Overall Demographics query for which BCBSIL provided monthly membership counts for 2017 by product and stratified by gender. Small and consistent monthly increases were observed in both products which was consistent with documentation provided in the Roadmap and during the on-site visit.

BCBSIL data load logs for member, provider, claims, pharmacy, and lab data were reviewed for the Query Group #2—Data Loading Checks. No records failed for the claim pharmacy and lab data. Seventeen member (<0.00 percent) and nine provider (<0.00 percent) records failed to load.

Review of native provider specialty to HEDIS provider type was assessed through the Query Group #6—Mapping Results Check. BCBSIL provided a list of native provider specialties associated with administrative numerator events for members in the *W15* measure. The list of specialties was reviewed to determine the percentage of native specialty codes that met the HEDIS definition of primary care provider. Over 96 percent of the specialties were compliant and the impact of the non-compliant codes produced a minimal impact on the reported rate.

BCBSIL was partially compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for CCAI

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Community Care Alliance of Illinois' (CCAI's) ICP population. The audit indicated that CCAI was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B-5–-CCAI 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation.*
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an *NA* for the 13–17 years of age stratification as there were no members in the eligible population; however, all other age stratifications and the total rates received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

CCAI continued to use VidaClaim and VidaCounter during the 2017 measurement year. During the previous year's review, CCAI utilized external managed service organizations (MSOs) to process claims through May 2016. There were no MSOs involved with the processing of claims in 2017.

Both the VidaCounter and VidaClaim systems captured standard Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-10) codes and neither system allowed non-standard coding. CCAI's systems did not accept non-standard claim forms.

Encounter coding and coding specificity was reviewed as part of Query Group #3, primary source verification during the on-site audit. CCAI demonstrated VidaClaim and VidaCounter's ability to distinguish between primary and secondary codes. Additionally, CCAI demonstrated VidaClaim and VidaCounter's ability to capture modifier codes.

CCAI continued to have sufficient processes in place through the end of 2017. CCAI audited the claims and encounter systems through annual audits of both financial and quality metrics. All medical claims were submitted on a fee-for-service basis in 2017 as no MSOs were involved with the claims process.

CCAI's VidaClaim system only allowed for standard claim submissions and standard coding schemes. Claims not meeting Health Insurance Portability and Accountability Act of 1996 (HIPAA) edits were rejected back to the provider for resubmission.

CCAI was able to demonstrate VidaClaim's ability to capture multiple diagnosis and procedure codes during the primary source verification process on-site. The audit team had no concerns with CCAI's ability to process claims in 2017.

CCAI was fully compliant with IS Standard 1.0.

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

CCAI continued to use its internal enrollment system, VidaBility, during 2017. CCAI received a daily and monthly enrollment file from the State. The daily and monthly files were transmitted in standard 834 format and electronically uploaded to VidaBility. There were a few circumstances where CCAI manually manipulated the enrollment files; however, this occurred in less than 1 percent of the overall enrollment capture. There were no changes to this process in 2017.

CCAI's VidaBility system captured all relevant fields outlined in the HEDIS Roadmap. CCAI had sufficient processes in place to ensure all data files were captured and processed timely. VidaBility and the general audit process ensured that members were only assigned one unique identifier. CCAI continued to validate and audit daily change files to ensure duplicate member identifiers were not created.

CCAI advised HSAG that it was ceasing operations in 2017 and that a significant amount of its membership was reassigned to other health plans in May of 2017. Through on-site queries, HSAG was able to verify that CCAI's membership dropped significantly in the middle of 2017. The termination of thousands of members had a significant impact on eligible populations and hybrid and administrative rates for all measures under review.

Although the rates were impacted by the loss of membership, CCAI's processes were fully compliant with HEDIS specifications.

Rates were not significantly above or below NCQA benchmarks; however, due to the membership loss toward the end of calendar year 2017, there were significant changes to enrollment.

Rates and eligible populations were still reasonable and reportable since the loss in membership was expected due to CCAI leaving the Medicaid market.

CCAI was fully compliant with IS Standard 2.0.

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

During the on-site audit, CCAI indicated that there were no changes to its provider data process since the previous year's review. CCAI ceased operations in the Medicaid line of business at the end of 2017; however, its providers remained static over that time. CCAI still operates in the

Medicare market and since all providers contract with CCAI for all lines of business, HSAG had no concerns with Medicaid members' access to care. CCAI did not terminate any provider contracts as the Medicaid line of business was winding down.

HSAG reviewed the provider data system, VidaPro, and determined that it captured all relevant fields required for HEDIS reporting. VidaPro was able to uniquely identify a specific servicing provider and its specialty without issue. The provider mapping document was reviewed and approved. A sample of mental health and primary care specialties was reviewed on-site and found to be compliant with respect to the credentialing process.

CCAI used Gemini Diversified Services, a Credentials Verification Organization (CVO) for credentialing. The CVO provided CCAI with the credentialing information. CCAI and the CVO set up a FTP site for submitting credentialing information daily. The daily files were reviewed and audited regularly. CCAI's internal credentialing team reviewed all files from the CVO and checked to ensure all credentialing data were present and matched the provider's education. CCAI ensured that provider data were only entered into VidaPro after the credentialing process was completed.

CCAI was fully compliant with IS Standard 3.0.

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

HSAG reviewed CCAI's IS 4 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements.

CCAI sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures.

CCAI used internal staff members to abstract data into Verscend's medical record abstraction tool. HSAG participated in a live demonstration of Verscend's tool and instructions. All fields, edits, and drop- down boxes were reviewed for accuracy against NCQA's *HEDIS 2018, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved Verscend's hybrid tool and instructions.

HSAG reviewed CCAI's abstraction training manual and found no concerns. Reviewer qualifications, training, and oversight by CCAI of its review staff were appropriate.

HSAG required a convenience sample for the *ABA* measure as no other hybrid hits were captured. *ABA* successfully passed the validation. Although the number of hybrid hits was low, CCAI conducted all chases for these members and numerator positive hits were not found. The population CCAI served were generally non-compliant members.

CCAI passed the final MRRV on May 11, 2018. Additional details regarding the MRRV results are located in Appendix B.

CCAI was fully compliant with IS Standard 4.0.

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

CCAI presented eight standard supplemental databases in its HEDIS Roadmap submission. There were no non-standard supplemental databases submitted for HEDIS reporting. The majority of the data sources were for laboratory services, with the exception of one historical claims database provided by the State. All supplemental data sources met HEDIS requirements for standard supplemental data. All file layouts met the specification guidelines and no mapping of data was required.

Standard supplemental data sources included:

- American Scientific Laboratory
- BioReference Labs
- Care Coordination Claims Data (CCCD) Historical Data
- CMSO Quest Laboratory Results
- Lab Corp
- MedStar Laboratories
- Quest Laboratory Results
- Sinai Laboratories

All standard supplemental data sources were approved to use for HEDIS 2018 reporting.

CCAI was fully compliant with IS Standard 5.0.

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

There were no changes to the data integration process from the previous year's review. All claims were processed through the VidaClaim system. Extracts to the data warehouse were pulled directly from VidaClaim and the supplemental data tables. Pharmacy data were also extracted from the internal pharmacy tables in the EDW. Extracts of all source data was provided to the certified measures software vendor in the vendor's required file layout. CCAI provided four years of claims data along with enrollment and eligibility files to complete the file loads with Verscend.

The audit team reviewed several Structured Query Language (SQL) Server tables and reviewed record counts for several sources during the on-site audit. The audit team also conducted primary source verification to determine if the data extracts matched the source system for numerator positive members. All primary source records met the numerator compliance upon review.

The audit team reviewed Roadmap tables 1.7, 2.2, 3A.2, and 3B.3 to ensure all required data elements were captured in the EDW and transferred to Verscend. No issues were found during this review.

CCAI did not use non-standard coding for any measures. CCAI did not use global billing codes for any of the measures under review.

Report production for CCAI was handled by the certified measure vendor, Verscend, and the repository structure appeared to be satisfactory.

CCAI was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Cigna HealthSpring of Illinois

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Cigna HealthSpring of Illinois (Cigna's) ICP population. The audit indicated that Cigna was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Due to Cigna terminating its ICP contract as of July 31, 2017, Cigna did not have any members that met the continuous enrollment criteria for the hybrid measures. Since there were no members in the eligible population for *ABA* and *CCS*, these measures received a designation of *NA.* All other selected HEDIS measures received an *R* designation.

Table B-6—Cigna 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	**Medical Services Data**	**Provider Data**	**Data Integration**	**Medical Record Data**	**Supplemental Data**	With the exception of *ABA* and *CCS*, all selected HEDIS measures received an *R* designation.***
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Not Applicable*	Not Applicable**	

* Due to Cigna's termination of its ICP contract as of July 31, 2017, Cigna did not have any members that met the continuous enrollment criteria for the hybrid measures under the scope of the audit; therefore, a medical record review was not applicable.

** Cigna did not use any supplemental data for measure production; therefore, supplemental data were not applicable.

*** The *IET* measure was assigned an *NA* for the 13–17 years of age stratification as there were no members in the eligible population; however, all other *IET* age stratifications and the total rates received an *R.*

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

Cigna provided services to ICP population under a managed care contract with HFS. Cigna began enrollment of its ICP population March 1, 2014 and terminated all members covered under the ICP population as of July 31, 2017.

Cigna used its centralized teams for the processing of claims and encounter data for the Illinois ICP population. The health plan operated under a fee-for-service delivery system for medical claims processing during 2017 that supported data completeness since Cigna required providers to submit claims for reimbursement. Cigna used QNXT as its claims transactional system during 2017 and there were no significant changes with QNXT or the processing of claims data between 2016 and 2017. In addition to medical service claims, Cigna processed behavioral health and vision service claims through QNXT.

Cigna only accepted the submission of industry-standard claims forms. In addition, the health plan did not accept or use any non-standard coding schemes; therefore, there was no code mapping. QNXT captured primary and secondary codes and had sufficient claims edits in place. During 2017, Cigna used All Patients Refined-Diagnosis Related Groups (APR-DRG) for inpatient services and outpatient services using Microdyn as a grouper. Through this process, all claim diagnoses and procedure codes were retained and captured for reporting. The auditor confirmed that claims detail lines were not denied in order to process payment at the header level; only true claims line denials received a denial code, which allowed all associated revenue codes to be captured for HEDIS reporting.

While the health plan used some global billing and per diem pricing schemes, all dates of services and claims detail were captured within QNXT. Global billing and per diems impacted less than 1 percent of the total claims volume.

Cigna used ChangeHealth as its paper claims scanning vendor. Paper facility and provider claims were less than 10 percent of claims received. There were no changes in the processing of paper claims between 2016 and 2017. There was adequate oversight of the scanning vendor and there were no concerns related to potential data loss. Cigna had sufficient processes in place for the processing of electronic claims submissions, which made up approximately 90 percent of both facility and professional claims.

Cigna monitored claims timeliness and no backlogs in claims processing were noted by the health plan during 2017. Cigna had adequate auditing and monitoring of its claims processing with procedural accuracy of 97 percent during 2017.

Cigna submitted a Roadmap section for Superior Vision; however, it was clarified during the on-site audit, that for the Illinois ICP population, Cigna managed and paid claims directly within QNXT and did not use Superior Vision for the Illinois ICP population in 2017.

During 2017, Cigna used Optum Rx as its pharmacy benefit manager. There were no significant changes with the handling of pharmacy encounter data. No measures under the scope of the audit utilized pharmacy data; therefore, the on-site audit did not include a pharmacy data review.

Query Group #3—Drill-Down was conducted on-site and the Cigna team demonstrated the QNXT system. The auditor reviewed five members from the *FUH* and *IET* measures and no concerns were identified.

Cigna was fully compliant with IS Standard 1.0.

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

Cigna processed enrollment files received from MAXIMUS and from HFS for its ICP population. Each 834 file was received and processed by a centralized enrollment team through an automated process. The MAXIMUS file provided member demographic information while the HFS file included the eligibility information for additions, terminations, and changes. In addition, the health

plan processed the full monthly file from HFS. While there were no issues with processing the daily enrollment files, Cigna noted that it had to manually term some members in the QNXT system for the July 31, 2017 contract termination date. The ICP had appropriate quality checks to verify that all manual processing was completed. Query Group #1—Membership by Month was reviewed on-site. This query confirmed that all ICP members were terminated as of July 31, 2017. No issues were identified.

Cigna captured enrollment information within the QNXT system, including current and historical enrollment spans, the State client identification number (CIN), as well as a secondary identification number auto generated by the health plan. For HEDIS 2018, Cigna noted that two processes were used, one included the identification through the 834 enrollment file. Secondly, the health plan indicated that Inovalon software identified members in hospice using the hospice Value Set.

The health plan conducted a systems demonstration of QNXT during the on-site audit. The health plan demonstrated the use of a group identification (ID) to designate the Illinois ICP population from other product lines. During the systems demonstration, Cigna displayed five members from the *FUH* and *IET* measures to confirm that the appropriate criteria for denominator identification was used as part of the Query Group #3—Drill-Down. No issues were identified.

Cigna was fully compliant with the IS Standard 2.0.

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

Cigna used two systems to capture provider data, CACTUS for credentialing and QNXT for claims processing. There was manual data entry of credentialing and provider information into QNXT and there was sufficient oversight of the data entry process. For provider groups delegated for credentialing, the health plan received provider data which were loaded into QNXT to capture provider specialty information.

The health plan submitted its provider crosswalk which used the provider specialty in QNXT to map to the HEDIS provider type for Inovalon. The mapping was reviewed and approved, and no concerns were identified.

Query Group #4—Mapping Results Check—Provider mapping review was performed on-site. Five members from the *FUH* measure were reviewed to confirm that the follow-up visits were performed by a mental health professional. There were no concerns identified.

Cigna was fully compliant with IS Standard 3.0.

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

For HEDIS 2018, Cigna did not report any measures using the hybrid method since there were no members that met the continuous enrollment criteria due to Cigna's termination of its ICP contract as of July 31, 2017. Therefore, IS Standard 4.0 was not applicable for Cigna for HEDIS 2018 reporting.

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

For HEDIS 2018, Cigna did not use any supplemental data for measure production; therefore, IS Standard 5.0 was not applicable for Cigna for HEDIS 2018 reporting.

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

Cigna contracted with Inovalon as its software vendor for HEDIS 2018. During the on-site audit, the health plan discussed the process flow of enrollment, provider, and claims data from QNXT for integration for measure production.

Cigna's Quality Informatics Team had robust monitoring processes in place to ensure data quality. Provider to the on-site audit, Cigna provided Query Group #2—Data Load Reports for review. There were no concerns with the data load reports.

Due to the ICP population contract terminating at the end of July 2017, only three of the five measures selected under the scope of the audit were reported with rates by Cigna: *AMB*, *FUH*, and *IET*. Cigna did not report rates for the *ABA* and *CCS* measures due to members not meeting the continuous enrollment criteria. For *ABA* and *CCS*, Cigna received an "NA" audit result indicating that the measures were produced correctly but the denominator was too small for reporting. Cigna maintained its contractual obligation for accreditation throughout 2017 based on HEDIS 2017 audit results. Due to the contract termination as of July 31, 2017, Cigna noted that it will not be submitting an accreditation submission for the ICP population for 2018 accreditation.

Anthem was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for CountyCare

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for CountyCare Health Plan's (CountyCare's) FHP/ACA and ICP populations. The audit indicated that CountyCare was fully compliant with the HEDIS IS standards for membership data, provider data, medical record data, and supplemental data. CountyCare was partially compliant with the HEDIS IS standards for medical services data and data integration; however, HSAG determined only a minimal impact to reporting. All selected HEDIS measures received an *R* designation.

Table B-7—CountyCare 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation. *
Fully Compliant	Partially Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an *NA* for the 13–17 years of age stratification; however, the 18+ stratification received an *R*.

The rationale for full or partial compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

CountyCare provided services to the Illinois FHP/ACA and ICP populations under a managed care contract with HFS. CountyCare had approximately 283,000 members covered under its FHP/ACA population and approximately 11,100 ICP members during 2017. CountyCare delegated most health plan operations during 2017 and initiated a contract for delegated health plan operations with Evolent (previously Valence). Delegated functions related to HEDIS reporting included claims/encounter data processing, enrollment data processing, provider data systems, supplemental data, data integration, and the production of HEDIS performance measure rates. CountyCare provided delegated oversight of Evolent and managed medical record review. Both CountyCare and Evolent staff members participated at the on-site audit.

Evolent used Aldera as its claims transactional system and received greater than 97 percent of claims through electronic submission for both facility and professional claims. CountyCare used a primarily fee-for-service delivery system during 2017, which provided support for data completeness. Behavioral health data were managed internally and processed in Aldera.

Evolent only accepted the submission of industry-standard claims forms. In addition, Evolent did not accept or use any non-standard coding schemes; therefore, there was no code mapping. There

was sufficient capture of codes necessary for HEDIS reporting. The Aldera system captured and retained CPT II codes and the associated modifiers, if submitted.

For the small amount of paper claims received, Evolent used Change Healthcare to scan the paper claims using optical character recognition (OCR). Paper claims were formatted into an electronic claims file for processing into Aldera. There was appropriate oversight and monitoring of the scanning process.

Evolent had appropriate edits in place at the clearinghouse level for formatting as well as member validation, code edits checks, and required field checks within the Aldera system. Aldera used a grouper for the purpose of claims payment; however, all codes submitted on the claims were retained for HEDIS reporting.

Evolent noted a backlog of claims during 2017 impacting data completeness. The Open vs. Adjudicated Claims Summary report reviewed on-site showed an estimated 50 percent of data may be missing from HEDIS reporting. The claims backlog was due to pending payment by the State to CountyCare to release payments to providers. For the measures under the scope of the HSAG review, none of the hybrid measures used claims-based denominators; therefore, there was no concern with the hybrid samples being biased. CountyCare showed that the pended data and backlog was addressed prior to the April 2018 data refresh. CountyCare provided a revised Open vs. Adjudicated Claims Summary to assess impact to rates and the pended claims volume was reasonable with minimal impact to reporting noted.

Vision services were managed by a vendor, EyeQuest, during 2017. The proprietary code mapping was reviewed and none of the internally-developed codes had an impact on HEDIS reporting; therefore, the mapping was approved. There was adequate oversight of the claims processing vendor and no concerns were identified.

Evolent provided a systems demonstration of the Aldera claims processing system and the auditor verified the capture of claims data elements necessary for reporting. During the on-site, Query Group #3—Drill-Down was performed on five members from the FHP/ACA population for the *ABA* measure to validate numerator compliance. The auditor was unable to confirm numerator compliance for one of the five members selected; therefore, Evolent provided additional clarification off-site and resolved the numerator compliance concern. In addition, the auditor reviewed inpatient claims and outpatient follow-up claims for five ICP population members for the *FUH* measure. No issues were identified.

CountyCare was partially compliant with IS Standard 1.0.

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

Evolent processed separate daily files received from HFS for the FHP/ACA and ICP populations. Each 834 file was received through an automated process and loaded into Aldera. In addition to the daily file that contained additions, terminations, and changes, Evolent received and processed a full monthly file from HFS. Valence used the Medicaid ID number provided by the State as its unique

member ID for all FHP/ACA and ICP members. Member enrollment and Medicaid ID were provided to EyeQuest and OptumRx vendors.

Evolent provided an on-site system demonstration of the Aldera enrollment environment. The auditor was able to validate the capture of required fields for HEDIS reporting, including the capture of historical enrollment spans, member demographic information, and product line identification. Evolent indicated that it did not receive a hospice identifier from the State file; therefore, it used claims data to determine hospice exclusions.

During the on-site audit, the auditor conducted Query Group #3—Drill-Down on five members who were identified as part of the denominator for *ABA*, *FUH*, and *W15* for the six or more visits indicator. There were no concerns identified for the *FUH* or *W15* measures. For the *ABA* measure, there was one of five members reviewed who did not have documentation to meet continuous enrollment criteria for the measure; therefore, Evolent provided additional clarification and documentation post-on-site and no further issues were identified.

CountyCare was fully compliant with IS Standard 2.0.

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

During 2017, CountyCare delegated credentialing to 3WON, who produced an in-load file with provider data which were loaded into the Aldera system. 3WON used standard taxonomy codes to identify provider specialty information. All provider data necessary for producing HEDIS measures were captured and no concerns were identified.

The provider type specialty crosswalk was reviewed and approved prior to the on-site; however, CountyCare and Evolent were in the process of revising the mapping to address some behavioral health providers that were not previously mapped. CountyCare submitted a revised provider mapping, which was reviewed and approved.

Query Group #6—Mapping Result Checks for the *FUH* measure was performed on-site and no issues were identified.

No issues were identified with the capture of provider data and the use of provider specialty for HEDIS reporting.

CountyCare was fully compliant with IS Standard 3.0.

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

CountyCare contracted with the medical record vendor, Change Healthcare, formerly Altegra Health, to procure and abstract medical records. HSAG participated in a live vendor demonstration of the Change Healthcare tool and instructions. In addition, HSAG reviewed Change Healthcare's MRR training manual. HSAG approved the medical record tool and MRR training manual prior to the on-site audit.

Change Healthcare created the HEDIS hybrid samples for the hybrid measures under the scope of the audit. No hybrid sample size reductions were taken and therefore, no concerns were identified. CountyCare's chart chase logic was reviewed and the auditor found the logic to be appropriate with no concerns identified.

All hybrid measures selected for HEDIS 2018 reporting were new for reporting under the scope of the audit; therefore, a convenience sample was required for all hybrid measures including the *ABA*, *CCS*, *IMA*, *W15*, and *W34* measures. The convenience sample passed the validation process.

CountyCare was responsible for the oversight of Evolent and the oversight processes were sufficient. There were no concerns with MRR processes.

Final medical record review validation showed all measure groups passed.

CountyCare was fully compliant with IS Standard 4.0.

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

CountyCare submitted three lab data sources, Mt. Sinai Hospital, Quest Diagnostics Laboratory, and Stroger Hospital, as supplemental data sources to obtain lab data and results information. The lab data files were produced using a standard file layout and there was no mapping of data. These three data sources were considered standard supplemental data. All required sections of the Roadmap were received, and no issues were identified. These standard lab data sources were approved for HEDIS 2018 reporting. The health plan provided a supplemental data impact report and no concerns were identified.

In addition to the standard supplemental data sources, CountyCare submitted a non-standard Supplemental Data Table—Master data source for HEDIS 2018 consideration. The data source contained information from electronic medical records (EMRs) from contracted Medical Homes and primary care providers. The data were manually abstracted from the EMRs and provided to CountyCare via an Excel spreadsheet. The data source was determined to be non-standard. All required Roadmap documentation was provided and code mapping was approved. Primary source verification was performed on a sample of records and the initial sample revealed some cases where the human papillomavirus (HPV) test was ordered but not performed and counted as numerator compliant for the *CCS* measure. The health plan reviewed, revised, and corrected this error across the data source and a second sample was selected and passed with no issues identified. The data source was approved for HEDIS 2018 reporting.

CountyCare was fully compliant with IS Standard 5.0.

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

CountyCare continued its contractual relationship with Change Healthcare for HEDIS 2018 measure production. All measures under the scope of the audit received measure certification.

Evolent was responsible for the management of the data warehouse. Aldera provided an automated, nightly feed of claims, enrollment, and provider data to the data warehouse. Vendor data were loaded directly to the data warehouse at regularly scheduled intervals. A quarterly data load into Change Healthcare took place during 2017 with a new production run project for HEDIS 2018 reporting. Data quality reports were reviewed to address errors and conduct data reasonability checks.

Evolent was responsible for the organization-to-vendor mapping and a review of the mapping revealed that while Aldera had the capacity to capture CPT II codes and any associated modifiers, CPT II codes and modifiers were not data elements that were stored to the data warehouse for HEDIS measure production. The auditor recommended that Evolent review the volume of CPT II codes and those that align with the HEDIS value sets to determine if bringing in these additional codes warrants future consideration. The organization-to-vendor mapping for pharmacy data raised questions related to pharmacy rejects being equal to a paid claim. Evolent provided clarification post-on-site indicating that a reversed claim cancels out a previously submitted paid claim. No further issues were identified.

Query Group #1—Member Demographics and Query Group #2—Data Load Report were conducted off-site and no concerns were identified.

Due to the claims backlog issue, CountyCare was partially compliant with the IS 7.0—Data Integration standard. The impact to reporting was minimal given the resolution of the issue during claims data refresh.

NCQA HEDIS Compliance Audit Results for Harmony

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Harmony Health Plan of Illinois, Inc.'s (Harmony's) FHP/ACA population. The audit indicated that Harmony was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B-8—Harmony 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	**Medical Services Data**	**Provider Data**	**Data Integration**	**Medical Record Data**	**Supplemental Data**	All selected HEDIS measures received an *R* designation.
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

All claims were processed through Xcelys for Harmony. HSAG reviewed Harmony's claims process during the on-site audit and determined that no significant changes occurred in Xcelys or in the overall claim process since the prior year. Documentation provided in the Roadmap tables were reviewed in Xcelys as they were in historical audits. Harmony staff indicated that there were no processing changes during the year. Harmony's Xcelys system captured primary and secondary procedure and diagnosis codes without any issues. The claims system also had the capability to capture as many codes as were billed on a claim. Paper claims transactions were mailed to a Tampa mailbox, Change HealthCare (Relay Health), where they were then captured by Imagenet. Imagenet scanned the claims, converted them to an 837 format, and verified all data were captured. Imagenet's quality control center ensured data were captured appropriately.

Harmony monitored the Imagenet claims on a daily basis to ensure all values were captured on the scanned claims. Audits were conducted on 3 percent of all claims submitted. Close to 100 percent of claims were processed offshore with exceptions. Approximately 84 percent of all claims were auto adjudicated. In addition to the edits conducted in the pre-processing steps, Harmony utilized edits within Xcelys. Xcelys looked for provider, member, and payment errors to ensure members existed and payments were accurate. Harmony indicated that there were no issues with claims processing in 2017.

Ninety-nine percent of all claims were captured within one day and 100 percent within two days. Harmony also captured encounter data from capitated vendors. Encounters included Dental, Transportation, and Vision. While these encounters were not captured in Xcelys, they underwent edits in Edifecs (Exengine) which looked for valid billing codes and member information.

Harmony was fully compliant with IS Standard 1.0.

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

Harmony received daily enrollment files from the State. This process has been in place over the last several years. Harmony received the daily enrollment files in a standard HIPAA-compliant 834 electronic format and loaded the files directly into Xcelys. Harmony reconciled the daily files with a monthly file, also provided by the State, to ensure data were accurate prior to enrolling the member. HSAG reviewed the Xcelys system during the on-site audit and confirmed that each enrollment span was captured. Additionally, HSAG reviewed several enrollment records to ensure that all HEDIS-required data elements were present and accurate. HSAG conducted on-site queries of average member enrollments and did not find any issues. The average member was continuously enrolled for approximately 11 months or more. There was a program change with the State that required members to select a plan for a full year, rather than being able to change health plans once per month.

Harmony conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority. HSAG confirmed there were no changes to Harmony's enrollment data process since the previous year's review.

Harmony was fully compliant with IS Standard 2.0.

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

Harmony utilized Xcelys to capture all of its provider data for claims processing. Harmony utilized both direct contracted and delegated entities to enroll providers. Harmony used an internal software tracking mechanism (Omniflow) to manage its provider information. Omniflow was used to send provider data to Harmony's Credentialing department for provider management prior to loading into Xcelys. Once the provider information flowed through Omniflow, the data were then loaded into Xcelys. A unique provider identifier was created along with provider specialties. Harmony's credentialing staff ensured provider specialties were appropriate by validating the provider's education and specialty assignment authorized by the issuing provider board. HSAG verified that the required HEDIS reporting elements were present in Xcelys and that provider specialties were accurate based on the provider mapping documents submitted with Harmony's Roadmap. Additionally, HSAG conducted on-site queries around provider specialties and did not find any issues.

Harmony was fully compliant with IS Standard 3.0.

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

HSAG reviewed Harmony's IS 4 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements. Harmony sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. Harmony contracted with Change HealthCare (previously Altegra) and CIOX Health, L.L.C. (a.k.a., HealthPort) to retrieve medical records. Harmony's internal staff and Change HealthCare abstracted medical records using Change Healthcare's medical record abstraction tools. HSAG participated in a live vendor demonstration of the Change HealthCare tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2018, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved the abstraction tools and instructions.

Harmony maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives. Harmony's internal staff and the Change HealthCare staff were sufficiently qualified and trained on the current year's HEDIS technical specifications and the use of the abstraction tools to conduct MRRs accurately. Based on the auditor's request for a convenience sample for select measures and since new measures were reported by Harmony, a convenience sample was required for *W34* and *IMA—Combo 1*. Harmony passed the convenience sample validation without any issues.

Final MRRV was completed for the following measures:

- Group B: *W15*
- Group D: *IMA—Combination 1*
- Group D: *IMA—Combination 2*

Harmony was fully compliant with IS Standard 4.0.

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

Harmony used several standard supplemental data sources such as laboratory (lab) results and immunization and encounter files from the State. Harmony also utilized two non-standard supplemental data source which required primary source verification. All supplemental data sources met the HEDIS requirements for supplemental data use. Harmony provided file layouts, coding transformation documents, and training documents with its HEDIS Roadmap submission. All non-standard data sources passed the proof-of-service validation with no significant errors identified. There were no changes to the supplemental data sources since the previous year's audit. Harmony invested a lot of time and effort ensuring data in the supplemental data sources were accurate and processed timely. Harmony conducted audits on its supplemental data intermittently throughout the year to ensure there were minimal errors or issues. When issues were discovered, they were promptly rectified.

HSAG did have some concerns with the Roadmap submission for supplemental data sources. Since WellCare, Harmony's parent company, completed the Roadmap Section 5, supplemental data sources were included that were not applicable to the scope of the audit. HSAG requests that for future audits, Harmony clearly indicates the supplemental data sources that are applicable to Harmony for the HSAG audit scope to make it simpler to identify all data sources being used. The audit team further recommends that like supplemental data sources be combined into one standard supplemental source. For example, Harmony has several lab vendors that can be combined into one standard supplemental source. Another example of combining sources is the CCCD files. Since all of these files come from the same State source, they should be combined into one CCCD standard supplemental data source.

All supplemental data sources applicable to the scope of the audit were approved to use for HEDIS 2018 reporting.

Harmony was fully compliant with IS Standard 5.0.

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

Harmony continued to use its internal data warehouse to combine all files for extraction into the Inovalon certified measures software. The internal data warehouse combined all systems and external data into tables for consolidation prior to loading into Inovalon's file layouts. The majority of information was derived from the Xcelys system while external data such as supplemental and vendor files were loaded directly into the data warehouse tables. HSAG conducted a review of the HEDIS data warehouse and found it to be compliant. Harmony had several staff involved with the process with many years of experience in dealing with data extractions, transformations, and loading. The warehouse was managed well and access was only granted when required for job duties.

HSAG conducted primary source verification and did not encounter any issues during the validation. Member data matched Xcelys as well as the data warehouse and Inovalon numerator events. HSAG also conducted a series of NCQA-required queries during the on-site audit and did not identify any issues. HSAG reviewed Harmony's preliminary and final rates and did not identify any immediate issues. There were no changes to Harmony's systems or data integration processes since the previous year's HEDIS review.

Harmony was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for IlliniCare

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for IlliniCare Health Plan, Inc.'s (IlliniCare's) FHP/ACA and ICP populations. The audit indicated that Harmony was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B-9—IlliniCare 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation. *
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an *NA* for the 13–17 years of age stratification; however, the 18+ stratification received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

IlliniCare received the vast majority of claims through EDI feeds, over 95 percent in 2017. Paper claims were scanned and converted to an electronic format in the CenPAS system. The process for loading the electronic claim data into AMISYS included reviews for HIPAA and business rules. During the auto-adjudication process, standard field-level, eligibility, provider, authorization, benefit, and pricing validations were performed. Approximately 90 percent of claims were auto-adjudicated during 2017. Pended claims were distributed to processors through the AWD queue system.

For the small percentage of claims needing manual intervention, the following processes were in place to ensure accuracy:

- Monthly processor audits—10 claims for each processor were reviewed daily to evaluate processing and financial accuracy.
- High dollar team reviewed 5K+ professional claims and 10K hospital claims.
- Monthly internal audit of a sample of all claims processed to validate procedural, financial, and clinical information. The sample size was variable and determined through an algorithm designed to establish a statistically valid sample size based on the volume of claims for the period.

During the fourth quarter of 2017, the internal audit reported results of 99.9 percent and 98.8 percent for financial and payment accuracy.

IlliniCare was fully compliant with IS Standard 1.0.

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

IlliniCare received daily and monthly enrollment files from the State. A separate enrollment file was provided for each product, including the ICP and FHP/ACA populations. The enrollment files were loaded into AMISYS through a combined load process. Monthly files provided complete enrollment history and were reconciled against data maintained in the AMISYS system. During the process for loading the daily and monthly files, business rule logic was applied to identify records with fatal errors or records that required review (warnings) at several points in the load process. These reports included the "Queued Error Report" which identified errors that must be corrected before the data could proceed. The volume of records with errors that were identified was small (30-100 records) with the most common reason being related to eligibility of newborns. Additional validations were performed when the data were loaded into the AMYSIS system. The "UMV-AMISYS Member Load Error Report" identified issues related to invalid dates and PCP affiliation as the data were loaded. All errors in this report had to be corrected before the automated production load job could be scheduled in the "Cypress Web" application. Successful processing was documented through an automated email that included notification that the JELG500 "Completed Normally."

IlliniCare was fully compliant with IS Standard 2.0.

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

Practitioner data used for HEDIS reporting were maintained in the Portico system. IlliniCare contracted directly with providers (70 percent) and had delegation arrangements with provider groups (30 percent). Delegated provider groups submitted monthly rosters that included new providers and terminations. In addition, groups also submitted full rosters on a quarterly basis. No substantive changes were made to the systems and processing of practitioner data during 2017. During 2017, the "Portico-to-AMISYS Comparison" reports continued to be monitored daily to identify discrepancies between data in the Portico and AMISYS systems and the "Find-a-provider" audits were performed.

During 2017, IlliniCare's provider network for the ICP product grew by approximately 16 percent. The increase was driven by IlliniCare's expansion into new counties as well as practitioners joining any-willing provider network in anticipation of IlliniCare's expanded membership under the 2018 Medicaid contract.

IlliniCare was fully compliant with IS Standard 3.0.

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

IlliniCare sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples with one exception. For the *ABA* measure, IlliniCare had initially reduced the minimum required sample size based on the prior year's rate for its combined Medicaid submission, which included its full Medicaid population. Although *ABA* was only required for IlliniCare's ICP population and this measure was not reported for its ICP population in HEDIS 2017, IlliniCare was allowed to report the rate based on the reduced sample size because *ABA* was audited and reported for HEDIS 2017 in IlliniCare's combined accreditation submission and represented the same population. Provider chase logic was reviewed and determined appropriate across the hybrid measures.

For HEDIS 2018, IlliniCare changed its processes to utilize internal staff members to conduct medical record reviews and quality assurance. IlliniCare leveraged the corporate resources of the parent company, Centene, for training and project oversight guidance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of Inovalon's QSHR abstraction tool to accurately conduct medical record reviews. HSAG reviewed IlliniCare's training manual and had no concerns.

Due to the change to an internal collection process, revisions to several measure specifications for 2018, and all new measures for IlliniCare, a convenience sample was required for the following measures:

1. *ABA*
2. *W15–6+ Visits*
3. *W34*
4. *CCS*
5. *IMA—Combo 2*

IlliniCare passed the convenience sample review for all selected measures.

IlliniCare passed the MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics (BMI, BP) and Maternity—*ABA*
- Group B: Anticipatory Guidance and Counseling—*W15—6+ Visits*
- Group C: Laboratory—*CCS*
- Group D: Immunizations and Other Screenings—*IMA—Combo 2*
- Group F: All MR Exclusions

No critical errors were identified and IlliniCare passed medical record review validation for all measures.

IlliniCare was fully compliant with IS Standard 4.0.

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

IlliniCare had a standard process for the acquisition, validation, and warehousing of supplemental data. Supplemental data, including lab data and medical record data collected throughout the year, were received in a standard, prescribed layout. An Extract, Transform, and Load (ETL) process was used to load data into the ITQI server. The process "normalized" the data and applied business logic and validations during the load process. During the site visit, IlliniCare provided a walk-through of the system. The dashboard provided easy access to counts of rows received, rows with errors, and valid rows. In addition, log files were maintained and available to document the counts and types of errors for each file. During the system demonstration, data for all supplemental data sources submitted for review were examined to ensure the availability of required data elements. On-site review of the system and data along with the submitted documentation demonstrated that all four standard supplemental data sources (LabCorp, Inc., Quest Diagnostics, Medical Diagnostic Imaging, and USMM Lab Services) met the requirements to be used for HEDIS 2018. Primary source verification was conducted for the HEDIS User Interface non-standard data source and all records met the requirements.

All standard and non-standard supplemental data sources were approved to use for HEDIS 2018 reporting.

IlliniCare was fully compliant with IS Standard 5.0.

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

IlliniCare provided a walk-through of the data integration processes and the Inovalon Quality Spectrum Insight (QSI-XL) system. The EDW was the data source from which data extracts were pulled through the various ETL steps. All data were validated prior to being loaded into the EDW. Flat files were prepared and loaded into QSI-XL and a standard reconciliation process was performed. The validations included record counts and review of QSI-XL load documentation. The corporate Centene team refreshed the QSI data and produced rates monthly. Standard validation workbooks were created with reconciliations between source and the QSI repository data as part of this process. As part of the validation, the IlliniCare team reviewed the workbooks and rates to determine if they are reasonable.

During the on-site visit, queries were conducted to trace records through the system and provide an end-to-end data validation. Ten members across four measures (*ABA*, *W34*, *FUH*, and *BCS*) were selected prior to the site visit and reviewed by the auditor on-site. For each member selected, the member enrollment and claims history in the QSI-XL repository was reviewed for compliance with the technical specification and then the relevant data elements were verified in the source data systems. No issues were identified through these queries.

In addition to the on-site query review, data for three additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers and loads into the QSI repository. Membership and enrollment data were assessed through the Query Group #1—Overall

Demographics query for which IlliniCare provided monthly membership counts for 2017 by product and stratified by gender. Small and consistent monthly decreases were observed in the ICP products and consistent member counts for the FHP/ACA product which was consistent with documentation provided in the Roadmap and during the on-site visit.

IlliniCare balancing reports comparing counts of extracted records to counts of records loaded into the QSI repository for all data sources were reviewed for the Query Group #2—Data Loading Checks query. No records failed for data sources related to measures included in the scope of this audit.

Review of native provider specialty to HEDIS provider type was assessed through the Query Group #6—Mapping Results Check. IlliniCare provided a list of providers associated with administrative numerator events for members in the *W15* measure. The list included each providers' native specialty code. The list of providers was reviewed to determine the percentage of native specialty codes that met the HEDIS definition of primary care provider. All providers were compliant.

IlliniCare was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Meridian

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Meridian Health Plan, Inc.'s (Meridian's) FHP/ACA and ICP populations. The audit indicated that Meridian was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B-10—Meridian 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation. *
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an NA for the 13–17 years of age stratification; however, the 18+ stratification received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were 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 continued to use the internally developed claims system MCS. There were no major upgrades to the system since the previous year's review. MCS was able to capture primary and secondary coding with the appropriate specificity.

Meridian does not accept nonstandard claims nor does it allow nonstandard claim forms. The auditor verified through on-site demonstrations, that nonstandard codes and claim forms were rejected back to the submitter when received. Meridian conducted audits of its claims receipts during the measurement year, which resulted in 98.3 percent accuracy of all claims adjudicated.

Meridian maintained a 74.22 percent auto-adjudication rate for 2017. Claims that failed to auto-adjudicate were usually those with attached medical records. Meridian also maintained an average of 2.32 days to process all clean claims.

Meridian had no vendors, other than electronic claims clearinghouses involved with its claims process. Clearinghouses were required to maintain HIPAA compliant edit checks prior to supplying the electronic claims to Meridian. Ninety-five percent of all claims were processed electronically.

Meridian's MCS system met all requirements for capturing HEDIS relevant information.

The auditor had no concerns with Meridian's claims processing.

Meridian was fully compliant with IS Standard 1.0.

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

Meridian continued to load Medicaid enrollment in the MCS system during 2017. Enrollment data were updated daily and audited monthly utilizing the State's enrollment files. The State continued to provide enrollment information through secure file transfer protocol (SFTP), in standard HIPAA 834 format.

Meridian continued to experience growth in Medicaid during the measurement year and did not have any backlogs that impacted enrollment. Meridian did not have any changes to its enrollment processes from the previous year's review.

The auditor reviewed the enrollment process on-site through system demonstrations. The auditor confirmed that all enrollment fields required for HEDIS reporting were present in the MCS system. MCS was able to capture both the Medicaid identification number as well as the family identification number when present. The auditor requested specific queries from Meridian demonstrating average enrollment spans for the FHP/ACA and ICP populations. The auditor reviewed the enrollment spans and cross checked the eligible populations to ensure validity. The auditor did not have any concerns with the cross checks as the eligible populations were reasonable compared to historical populations.

Meridian was fully compliant with IS Standard 2.0.

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

There were no significant changes to the provider systems and processes used during the measurement year. MCS captured all credentialing information from Meridian's providers and was able to capture primary and secondary specialties. During the on-site audit, plan staff confirmed that Neurology was a valid mental health specialty for Meridian. Meridian's MCS system captured all fields required for HEDIS reporting, as outlined in Roadmap Section 3, Table 3B.A.

Meridian began using Vistar Technology (Vistar) software to help with its credentialing during measurement year 2017. Vistar was implemented in October 2017 to assist Meridian with automation of the credentialing process.

Since Vistar was new in 2017, the auditor reviewed provider records in both MCS and Vistar to evaluate the accuracy of the two systems. The auditor randomly selected several providers and verified through cross checking both systems, that information in MCS matched information in Vistar. The auditor did not find any discrepancies between the two systems.

Meridian audited every application entered and validated 100 percent of all records during the implementation stages of Vistar to ensure accuracy. Meridian continued to create daily and weekly

reports to look for critical errors. When errors were identified, Meridian's data analytics team researched and corrected the issues.

The auditor reviewed and approved Meridian's specialty mapping in MCS as part of the query process.

Since Vistar was an NCQA accredited system, it captured all relevant fields required for HEDIS reporting. The auditor also verified required fields were present in both MCS and Vistar during the on-site demonstration.

The auditor had no concerns with Meridian's provider data and processes.

Meridian was fully compliant with IS Standard 3.0.

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

HSAG reviewed Meridian's IS 4 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements. Meridian sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across hybrid measures.

Medical record pursuit and data collection were conducted by Meridian staff using proprietary data abstraction tools. HSAG participated in a live demonstration of the hybrid tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2018, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved Meridian's hybrid tools and instructions. HSAG reviewed Meridian's abstraction training manual and found no concerns.

Due to changes to the measure specifications, a convenience sample was required for HEDIS 2018 for *ABA* and *IMA—Combo 1*. Meridian passed the convenience sample validation without any issues.

Meridian passed the final MRRV without any issues. Following are the measures selected for MRRV:

- Group A: *ABA*
- Group B: *W-15—6+ Visits*
- Group C: *CCS*
- Group D: *IMA—Combo 1*
- Group D: *IMA—Combo 2*
- Group F: All exclusions

Meridian was fully compliant with IS Standard 4.0.

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

Meridian presented eight supplemental databases in its Roadmap for consideration. Seven supplemental data sources were standard and one, MHP Internal, was considered to be non-standard.

The auditor reviewed the standard supplemental data sources during the on-site audit and found no concerns. The standard data sources included lab results, standard electronic medical records, and historical claims from the State of Illinois. All standard supplemental data sources were approved for use in HEDIS 2018 reporting.

The auditor selected a random sample from the non-standard MHP Internal database during the on-site audit. Meridian provided proof-of-service documentation for all random selections in the non-standard supplemental data source. All 50 records passed without any issues. The non-standard supplemental database was approved for use in HEDIS 2018 reporting.

The standard supplemental databases were as follows:

- Advocate EMR system
- Athena-HL7 Format-EMR
- Centegra-EMR
- Lab Results
- Oak Street-EMR
- OSF-EMR
- State of Illinois Historical Claims

All standard and non-standard supplemental data were approved to use for HEDIS 2018 reporting.

Meridian was fully compliant with IS Standard 5.0 following approval of the MHP Internal database.

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

Meridian's HEDIS repository structure contained all relevant fields for reporting. The HEDIS repository pulled data directly from MCS, maintaining all of the same data. There was no manual manipulation of the data. Meridian continued to use internally developed source code to produce the required measures.

The source code used to produce the measures validated numerators, denominators, and continuous enrollment appropriately. HSAG confirmed that Meridian had some source code changes that eliminated duplicate steps for acquiring continuous enrollment and updated dates of service for the current measurement year.

Meridian successfully passed source code review in March 2018. In addition to the source code review process, HSAG conducted primary source verification during the on-site audit along with additional queries to verify the source code and systems met expectations for capturing HEDIS relevant data.

HSAG conducted primary source verification on the *IET* and *MMA* measures. HSAG selected five members from each measure. Meridian passed all primary source verification with no issues.

Meridian was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Molina

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Molina Healthcare of Illinois, Inc.'s (Molina's) FHP/ACA and ICP populations. The audit indicated that Molina was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. All selected HEDIS measures received an *R* designation.

Table B-11—Molina 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation. *
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an NA for the 13–17 years of age stratification; however, the 18+ stratification received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

Final review indicated that the health plan was fully compliant with the IS standard 1.0 requirements.

Molina captured all HEDIS required codes, including Healthcare Common Procedure Coding System (HCPCS), ICD-9, ICD-10, and CPT Category II, to the required specificity. For the QNXT transaction system utilized for processing claims and encounters, Molina only accepted industry standard codes. The auditor did not identify any issues with the identification of primary or secondary codes. Global bills were accepted by the health plan for maternity services. The date of service used for maternity services was the date of delivery.

The health plan maintained separate processes for encounters and claims, but encounters passed the same set of thorough edits as claims. Claims and encounters were received either as paper or electronically through its clearinghouse Change Healthcare and direct submission. EDI edits were used upon receipt of claims followed by a comprehensive set of core system edits prior to loading data into the transaction system. Only industry standard codes and forms were accepted, except for a small number of out-of-network provider submissions. The majority of claims were received electronically.

Molina's electronic file formats conformed to ASC X12 HIPAA 837 compliant industry standards (version 5010A). Electronic transmissions were properly controlled by up-front validity edits, code validations, de-duplications, and error reporting. Molina's transaction system maintained edits to ensure member and provider data were valid, and that coding, field sizes, and date ranges were appropriate. Molina maintained documented policies and procedures that required complete and timely submission of claims or encounter data from all practitioners and facilities.

Molina used Hughes Way Claims, which used OCR technology to scan paper claims and encounters to submit to Change Healthcare for conversion to ASC X12 HIPAA 837 compliant electronic data, which were then loaded back into either QNXT for claims or the Operational Data Store for encounters.

Molina demonstrated appropriate oversight of vendors.

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

Final review indicated that the health plan was fully compliant with the IS standard 2.0 requirements.

Molina followed standardized policies and procedures for processing electronic transmissions of Medicaid member and eligibility data. The QNXT transaction system was compliant with ASC X12 HIPAA 834 5010A data format and processing standards. EDI submissions were processed in batches and subjected to preprocessing edits and balancing routines. Errors were kicked out and researched by Molina's Enrollment Department.

QNXT monitored the timeliness and accuracy of Medicaid enrollment data processing through system edits, internal audits, and reconciliations against State eligibility files. Discrepancies were manually corrected. Molina's enrollment system tracked changes in member identification and insurance product, and the health plan maintained historical information regarding previous enrollment periods. The enrollment system maintained unlimited lines of enrollment changes.

The health plan assigned a unique member ID number to all members for each of its product lines, which was also used as the primary key for HEDIS reporting. The health plan also utilized the State-assigned Medicaid ID to identify Medicaid members across internal and vendor data systems. The members were accurately segregated by ICP and FHP/ACA member status according to the rate codes provided in the enrollment files from the State.

During 2017, Molina covered Medicare-Medicaid dual eligible members, of which Molina managed the majority of members for both product lines. Molina excluded Medicaid members from HEDIS reporting who had Medicare or commercial primary insurance coverage with an external insurer.

Molina did not use a vendor to process enrollment data.

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

Final review indicated that the health plan was fully compliant with the IS standard 3.0 requirements.

Molina maintained standardized and documented provider credentialing and contracting policies and procedures. Molina's crosswalk of transaction system provider specialties to HEDIS provider types, including nephrologists, obstetrics/gynecologists, and PCPs demonstrated minor mapping errors. On May 16, 2018, the auditor selected a random sample of 10 providers and facilities for primary source verification to ensure that the majority of providers in each selection of the random sample consisted of a majority of PCP types. On May 27, 2018, the health plan provided the provider rosters for the random sample of providers and facilities. Primary source verification of the roster confirmed that the majority (63 percent) of providers at FQHCs and Community Health Clinics were PCP types. In addition, the credentials of the randomly selected providers, including non-PCP types, were verified.

Molina utilized Cactus for provider credentialing and maintained provider contracting data in the QNXT transaction system. Molina's workflow for provider credentialing and contracting required data entry into a credentialing system and the QNXT transaction system. There were comprehensive oversight and reconciliation protocols in place to ensure completeness and accuracy of provider data in both data environments. The provider directory was generated two times per year from QNXT.

Molina used the provider National Provider Identifier (NPI), as well as the QNXT system-generated provider ID, which was permanent, but not unique, as providers had different QNXT provider identifications, depending on product and practice location. The health plan used both identifications to link providers' claims and encounter histories across internal and external data systems. Although the providers were assigned only one unique NPI, Molina utilized the QNXT provider ID for HEDIS reporting because the various IDs facilitate accurate configuration of the hybrid measure chase logic. No further issues were identified.

The health plan conducted ongoing monitoring of vendors with responsibility for provider credentialing, which included annual on-site audits of policies and procedures and provider files. Vendors were required to submit monthly and quarterly updates regarding delegated providers and to comply with industry-standard credentialing standards. No significant compliance issues at delegated entities were identified in 2017.

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

Final review indicated that the health plan was fully compliant with the IS standard 4.0 requirements.

The health plan utilized internal staff members to conduct MRRs and quality assurance. Molina used Inovalon's medical record abstraction tool, QSHR, to complete the MRRs. HSAG reviewed Inovalon's QSHR tools and training manual and participated in a live demonstration of the MRR

application to determine compliance with HEDIS audit standards. Following completion of reviews, HSAG approved the Inovalon QSHR medical record abstraction tool and training materials.

Staff members were sufficiently qualified and trained in HEDIS Technical Specifications, as well as use of the QSHR abstraction tools, to accurately conduct HEDIS MRRs. Molina maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusion, and a random sample of numerator negatives. Reviewers were required to maintain an accuracy rate of 95 percent throughout the project.

The QSHR medical record abstraction tools contained several edit checks and help screens to promote accurate data entry. Abstractors collected data and received compliance updates in the abstraction tools, while the final HEDIS reports were determined by the measure-specific source code in the primary software application, QSI, which contained measures that were certified by NCQA.

Overall project management was the responsibility of the Quality Specialist, who oversaw the MRR project timeline and ensured the integrity and security of medical record data. The health plan conducted nearly all abstractions at the provider locations and had few difficulties in achieving data completeness of medical record data.

The health plan passed the medical record review validation in 2017 and did not make any significant changes to its staff, systems, or processes used for MRR in 2018. In addition, it did not report any new hybrid measures; therefore, the auditor determined that a convenience sample was not required for Molina for HEDIS 2018. Although a convenience sample was not required, Molina requested that convenience sample validation be conducted. Molina successfully passed convenience sample validation for the *ABA*, *W15—5 Visits*, *W15—6+ Visits*, *CCS*, and *IMA—Combo 2* measures.

Molina passed the final MRRV on May 19, 2018. Appendix B summarizes the results of the MRRV.

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

Final review indicated that the health plan was fully compliant with the IS standard 5.0 requirements.

The health plan appropriately integrated standard supplemental encounter data from extracts of historical encounter data submitted HFS, which was named care coordination claims data (CCCD), and CMS (i.e., CMS Historical). Data were downloaded using standardized and secure procedures from SFTP sites. The auditor reviewed data file layouts and ETL processes used to convert and upload data. Further evaluation of the mapping of immunizations and well child visits was conducted during the on-site. No issues were identified, and the database was approved on March 16, 2018.

Molina also appropriately integrated standard medical and laboratory encounter data from extracts of electronic health record (EHR) data submitted by the Molina Medical Group Clinics. Data were downloaded using standardized and secure procedures from secure FTP sites. The auditor reviewed data file layouts and ETL processes used to convert and upload data. No issues were identified, and the database was approved on March 16, 2018.

The health plan also appropriately integrated standard medical and laboratory encounter data from extracts of EHR clinical and laboratory data submitted by several providers, including Heartland Health Center Cook County, Near North Health Service, and OSF Health Group. Data were downloaded using standardized and secure procedures from SFTP sites or secure email servers. The auditor reviewed data file layouts and ETL processes used to convert and upload data. No issues were identified, and the database was approved on March 16, 2018.

Molina also maintained a separate standard supplemental database compiled from extracts of laboratory results data from several laboratory data submitters, including LabCorp and Quest. Data were downloaded using standardized and secure procedures from a SFTP site. The auditor reviewed data file layouts and ETL processes used to convert and upload data. No issues were identified, and the database was approved on March 16, 2018.

Molina utilized clinical data obtained through medical record abstractions from Quality Improvement (QI) intervention and provider submissions of records, as well as initial and annual health assessments to populate a non-standard supplemental database for various measures, including *CCS*, *BCS*, *IMA*, *W15*, and *W34*. The health plan employed trained medical record reviewers to abstract clinical data using a proprietary MRR application. The health plan conducted over reads of abstractions into the database and corrected any errors identified during review. The auditor reviewed the sample data as well as the database policies and procedures, and quality assurance (QA) results. Further evaluation of the mapping of services to industry standard codes was conducted during the on-site. No issues were identified, and primary source verification was completed on March 30, 2018.

The health plan utilized clinical data obtained through medical record abstractions to populate a non-standard supplemental database for several measures, including *CCS*, *IMA*, *W15*, and *W34*, called Prospective Medical Record Review. The health plan employed qualified and trained medical record reviewers to abstract clinical data using the Inovalon QSI QSHR medical record review application. The health plan conducted over reads of abstractions into the database and corrected any errors identified during review. The auditor reviewed the sample data as well as the database policies and procedures, and QA results. Further evaluation of the mapping of services to industry standard codes was conducted during the on-site. No issues were identified, and primary source verification was completed on March 28, 2018.

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

Final review indicated that the health plan was fully compliant with the IS standard 7.0 requirements.

The health plan appropriately identified and mapped all non-standard codes to industry-standard codes. The auditor review and approval of all mapping of non-standard codes to industry-standard codes was completed on March 16, 2018.

Review of ETL processes for data integration from transaction systems, both internal and vendor, to Molina's data warehouse, as well as review of sample data and data structures of the data warehouse did not identify any issues. All data integration procedures were standardized and appropriately documented, and the health plan conducted appropriate validations of data integrations, including record counts.

Molina maintained its contract with Inovalon in 2017 and 2018 to calculate HEDIS measure results in the QSI software application. The supporting database of the application was proprietary and specifically compliant with the data management and formatting requirements of the HEDIS reporting software application. Review of ETL processes for data integration from the data warehouse and supplemental databases to the HEDIS reporting application did not identify any issues. The auditor's review of sample data, data mapping documents, and data quality reports covering record counts and referential integrity did not identify any issues.

The QSI software application was installed on the health plan's servers and the health plan maintains a contract with Inovalon that stipulates that the vendor take appropriate measures to protect the confidentiality, integrity, and accessibility of any data shared by the health plan. The contract also includes language on requirements for maintenance of NCQA measure certification, including re-certification by releasing software patches when any software issues impacting compliance of the software with NCQA's IS standards, HEDIS Determination standards, or Technical Specifications are identified. Vendor contract language includes a project timeline and requirements that the vendor meets project deadlines to ensure timely reporting of HEDIS measure rates to NCQA and the State.

The health plan employed internal staff members from multiple departments who were responsible for the various tasks required for HEDIS report production, including data integration, data warehouse maintenance, and project management. The health plan conducted integration of data into the QSI required specifications format using SQL programming source code. Health plan staff members also validated data reports generated by the QSI reporting application against industry benchmarks and historical trends.

NCQA HEDIS Compliance Audit Results for NextLevel

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for NextLevel Health Partners, LLC's (NextLevel's) FHP/ACA and ICP populations. The audit indicated that NextLevel was fully compliant with the HEDIS IS standards for membership, provider, medical services, and supplemental data. NextLevel was partially compliant with the HEDIS IS standards for medical records data and data integration; however, HSAG determined only a minimal impact on reporting. All selected HEDIS measures received an *R* designation except for *BCS* and *MMA*.***BCS* received an NA designation and *MMA* received an NA for all identified population groups; however, *MMA* had an *R* designation for the total medication compliance of both 50 percent and 75 percent.

Table B-12—NextLevel 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	**Medical Services Data**	**Provider Data**	**Data Integration**	**Medical Record Data**	**Supplemental Data**	All selected HEDIS measures received an *R* designation* except for *BCS* and *MMA*.** *BCS* received an *NA* designation.
Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Partially Compliant	Fully Compliant	

* The *IET* measure was assigned an NA for the 13–17 age stratification; however, the 18+ stratification received an *R*.
** The *MMA* measure was assigned an NA for all identified population groups; however, the total rates received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

NextLevel contracted with DST Systems, Inc. (DST) for all medical claims processing. DST used the Exeter system for claims processing. The auditor confirmed that all necessary fields were captured in the system. There was no use of nonstandard coding. DST had adequate policies in place to validate electronic claim transmissions and paper claim OCR and data entry.

During 2017, claims were held for significant periods of time because the State did not have a budget until November. NextLevel indicated that once the budget was in place, the claims were paid and as of March 2018, less than 1 percent of claims were in pended status.

The issues that occurred in 2016 related to provider configuration errors in Exeter were minimal in 2017. NextLevel reported that additional time was spent validating provider configuration prior to the start of 2017 to ensure there would be no significant issues.

NextLevel reported there were no issues receiving the claims data files from its ancillary vendors during 2017.

NextLevel was fully compliant with IS Standard 1.0.

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

NextLevel contracted with DST for enrollment data processing. DST used the Membership and Billing (MAB) and Exeter systems for processing enrollment data. The auditor confirmed that all necessary fields were captured in Exeter.

There were no issues with timeliness for processing the enrollment files and time to process standards were met.

NextLevel reported an issue processing the State enrollment files during 2017 due to not receiving the line of business information needed to differentiate Medicaid FHP and ACA members. NextLevel was able to obtain the information by working with the State directly and by obtaining the information in a subsequent file.

NextLevel also reported an issue processing member termination dates. Most member terminations were identified in the State daily file; however, there were instances where members were identified as terminated by absence from the State monthly file but were not identified as terminated in the daily file. In these instances, the member should have been terminated in the Exeter system. NextLevel caught this issue during its internal auditing process and set up a process to send DST a weekly file of terminations to ensure correct information in Exeter. By the end of 2017, the issue was alleviated.

NextLevel was fully compliant with IS Standard 2.0.

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

NextLevel used the MCS system to maintain practitioner credentialing data. The auditor confirmed that all necessary fields were required and captured in MCS and Exeter.

Credentialing applications were audited prior to approval. Audits were also conducted on a monthly and ongoing basis in accordance with State, federal, and regulatory accreditation standards. No deficiencies were identified.

There were no reconciliations between the credentialing system and the claims system.

NextLevel delegated credentialing to Caidan Management Services and Evolve. Oversight was performed and no deficiencies were noted.

The auditor reviewed the provider specialty mapping document and submitted questions to NextLevel for clarification. NextLevel provided an updated mapping document, which was reviewed and approved by the auditor.

NextLevel was fully compliant with IS Standard 3.0.

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

HSAG reviewed NextLevel's IS 4 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS Standard 4.0 requirements.

NextLevel sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures.

For HEDIS 2018, NextLevel used internal staff members and temporary staff to abstract data into DST's CareAnalyzer® medical record abstraction tool. HSAG participated in a live vendor demonstration of DST's tool and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2018, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved DST's hybrid tool and instructions.

HSAG reviewed NextLevel's abstraction training manual and found no concerns. Reviewer qualifications, training, and oversight by NextLevel of its review staff were appropriate.

HSAG required a convenience sample for the following measures because the health plan has not previously reported these measures for the State of Illinois:

1. *CCS*
2. *IMA—Combo 2*
3. *W34*
4. *ABA*

The convenience sample was approved with no errors identified.

NextLevel passed the MRRV with no errors identified.

NextLevel submitted Roadmap Attachment 4.8 in May indicating 17 percent medical record review completion for FHP/ACA and 23 percent completion for ICP. The enrollment data load issue described in IS 7.0 required samples to be re-run and contributed to the delayed start for the MRR project.

The low completion rates significantly impacted final rates for the hybrid measures, which were all below the 5th percentile. The measures impacted were *ABA*, *CCS*, *IMA*, *W15*, and *W34*. Although MRRV was completed, the auditor determined the rates based on the hybrid methodology to be biased and instructed NextLevel to report the measures using the administrative only methodology.

NextLevel was partially compliant with IS Standard 4.0

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

NextLevel received historical claims data from the State of Illinois. The auditor considered these data to be standard supplemental data. Standard coding was used and no changes were made to the data when reformatting for upload to CareAnalyzer. File transmissions were monitored by NextLevel. The auditor did not identify any issues with the State's data and approved the database for use in HEDIS 2018 reporting.

NextLevel was fully compliant with IS Standard 5.0.

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

NextLevel included all necessary data sources in the data load to CareAnalyzer. The software was maintained and loaded by DST, who also processed the claims and enrollment. CareAnalyzer was loaded monthly throughout the year.

CareAnalyzer data load reports were produced and provided for the January load. The auditor reviewed the reports on-site. There were several warnings that applied to a significant number of claim lines; however, further research identified the warnings to be inconsequential. For Query Group #2—Data Loading Checks, NextLevel provided reports for the March load. No issues were identified.

The auditor completed Query Group #3—Drill-Down primary source validation during the on-site for three measures and found no errors. Query Group #6—Mapping Results Check was completed for the *FUH—7 Day Follow-Up* and *W34* measures with no errors.

Query Group #1—Overall Demographics was completed on-site and an issue with the membership load for the FHP/ACA population was identified. For Query Group #1—Overall Demographics, the auditor compared the data warehouse enrollment report to the Enrollment by Product Line (ENP) measure in CareAnalyzer. The ICP enrollment report was within 1 percent of the ENP measure total; however, FHP/ACA had a difference of 13 percent. Further analysis identified that the Enrollment by State (EBS) measure indicated 38,961 members for FHP/ACA, and the enrollment report indicated 47,514 members for the month of December.

NextLevel researched the discrepancy and reported that benefit changes were in the midst of being processed in the source system at the time the enrollment extracts were pulled for CareAnalyzer on January 23, 2018, causing incomplete enrollment spans to be included. NextLevel extracted new enrollment files in March 2018 reflecting complete spans for members as of February 2018. The auditor confirmed the fix was successful by comparing the corrected ENP measure counts to internal enrollment data. The difference was within 1 percent.

The issue processing the enrollment files significantly impacted the progress of the medical record reviews and the final rates for the hybrid measures, as described in IS 4.0.

NextLevel was partially compliant with IS Standard 7.0.

Plan-Specific Findings for Health Plans that Exited Illinois Medicaid Market

NCQA HEDIS Compliance Audit Results for Aetna

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Aetna Better Health's (Aetna's) FHP/ACA and ICP populations. The audit indicated that Aetna was fully compliant with the HEDIS IS standards for membership, medical services, provider, and medical record data. Aetna was partially compliant with the HEDIS IS standards for data integration and supplemental data; however, HSAG determined only a minimal impact on reporting. All selected HEDIS measures received an *R* designation.

Table B-13—Aetna 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	**Medical Services Data**	**Provider Data**	**Data Integration**	**Medical Record Data**	**Supplemental Data**	All selected HEDIS measures received an *R* designation.*
Fully Compliant	Fully Compliant	Fully Compliant	Partially Compliant	Fully Compliant	Partially Compliant	

* The *IET* measure was assigned an NA for the 13–17 years of age stratification; however, the 18+ stratification received an *R*.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

Aetna received the vast majority (95 percent) of claims through electronic submissions and only accepted these data in the standard 837 format. Paper claims were imaged and converted to 837 files by Change Healthcare which has performed this function for Aetna for over 10 years and have consistently met performance standards. Validations of member, provider, diagnosis codes, and procedure codes are conducted. Approximately 88 percent of claims were mass adjudicated and required no manual processing. Monthly oversight audits and weekly meetings were conducted with Change Healthcare. The Service Excellence Team conducted daily audits of manually processed claims on a 2 percent sample for each claims processor as well as on all high dollar claims (over $70,000). During 2017, all timeliness and accuracy standards were met.

Pharmacy data from CVS Caremark were monitored by the Aetna Encounter Team through weekly meetings with the CVS Encounter Team and reports. The Quarterly Pharmacy Metrics Report was a primary report that was reviewed. Data were loaded into the Plan Audit Data Tables and reviewed for accuracy and completeness through a standard set of reports that included volume and accuracy testing. Quarterly Rebate Reports were reviewed to reconcile payments with encounters received.

Aetna was fully compliant with IS Standard 1.0.

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

Enrollment data were maintained in the QNXT system. The data structure included fields for all data elements necessary to support HEDIS reporting. The system walk-through during the on-site demonstrated that all relevant data fields were populated, and that sufficient enrollment history was maintained.

Monthly and daily 834 files were received from the State and processed. Records that were identified with discrepancies, such as changes in name, date of birth, or address, were included in the exceptions reports and manually corrected. The typical exception rate was between 1 and 5 percent. Monthly files were used for full reconciliations. In addition, capitation payment was reconciled against enrollment files quarterly and showed an average concordance of 99 percent.

FHP/ACA and ICP membership remained steady through 2017.

Aetna was fully compliant with IS Standard 2.0.

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

Practitioner data were managed through the PCR process and the PDS Department. Provider additions, modifications, and terminations were made through this process. All PCR work requisitions were audited by the initiator when completed and performance was reported and monitored through weekly team meetings. A sample PDS Summary by Plan Department report was provided as an example of how the health plan monitored the accuracy of the PCR processing. The accuracy rate reported was 99.97 percent for PCRs submitted from January 1, 2017 through October 31, 2017. The average turn-around time for completion was approximately three days.

Provider groups delegated for credentialing were added and changed in the QNXT system through the PCR process. Delegates provided monthly addition and termination files and a quarterly reconciliation was conducted.

For both the ICP and FHP products, the health plan reported counts of PCPs from 2016 to 2017 were very consistent. The health plan indicated during the on-site interviews that the termination of the large provider group mentioned in the Roadmap did not impact the PCP counts because additional providers were added to the network to ensure compliance with accessibility requirements.

Aetna was fully compliant with IS Standard 3.0.

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

Aetna sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid

measures. The medical record project configuration and data were reviewed during the site visit. This review included sample parameters, chase logic, and the resulting medical record project data.

Aetna utilized internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of Inovalon's QSHR abstraction tool to accurately conduct medical record reviews. HSAG reviewed Aetna's training manual and had no concerns.

Aetna maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.

Due to revisions to several measure specifications for 2018 and all new measures for Aetna, a convenience sample was required for the following measures:

1. *ABA*
2. *W15—6+ Visits*
3. *W34*
4. *CCS*
5. *IMA—Combo 2*

Aetna passed the convenience sample review for all selected measures.

Aetna passed the MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics (BMI, BP) and Maternity—*ABA*
- Group B: Anticipatory Guidance and Counseling—*W15—6+ Visits*
- Group C: Laboratory—*CCS*
- Group D: Immunizations and Other Screenings—*IMA—Combo 2*
- Group F: All MR Exclusions

No critical errors were identified, and Aetna passed for all measures.

Aetna was fully compliant with IS Standard 4.0.

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

During the on-site visit, Aetna provided a walk-through of how each supplemental database was received, warehoused, and prepared for use in the HEDIS repository. CStone and ICare immunization registry files were received through weekly feeds from the State and loaded into the Plan Audit Database. The State supplied files included the State Medicaid identification number. The immunization descriptions were mapped to standard procedure codes during the extraction process. Visual inspection confirmed that all data elements required for HEDIS reporting were

included in the database. These two standard supplemental databases were approved for use in HEDIS 2018 reporting.

For Quest Lab, weekly files were received based on eligibility files provided by the health plan. Data were loaded into the Plan Data Audit tables. Files were received with member key and no transformations were required. Review of the database showed all relevant fields were included (member, LOINC, CPT). This standard supplemental database was approved for use in HEDIS 2018 reporting.

Year-round MRR and Care Unify databases both collected medical record evidence of HEDIS-related services and shared a common set of tables in the Plan Audit Database. The Care Unify collection process was a system through which providers submitted documentation of services requested by Aetna and were required to upload medical records to support entered data. The Year-round MRR process was a system through which Aetna staff collected documentation of services and were required to upload medical records to support entered data. Primary source verification was conducted on these two non-standard databases and no issues were identified. Both non-standard databases were approved for use in HEDIS 2018 reporting.

During review of the final impact report, the inclusion of a supplemental data source that was not previously disclosed or approved was identified. The source included EHR data (Athena) and provided a very small impact on the administrative rates for the *IMA* (Tdap = 0.36 percent, HPV = 0.32 percent and Meningococcal = 0.19 percent) and *W34* (0.02 percent) measures. Given the late identification and small impact, NCQA granted a one-time approval to allow the rate calculated with the unapproved data to be submitted.

Aetna was partially compliant with IS Standard 5.0.

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

Aetna integrated several supplemental data sources with transaction data sources, including external encounter data, immunization registry data, and lab results data. All data were extracted from the enterprise data warehouse and loaded into the Inovalon tool. Data integration was well documented through the Completeness, Accuracy, and Timeliness Report (CAT) reporting system which provided balancing comparisons between data records in the warehouse and those loaded into the tool.

For HEDIS 2018, Aetna used QSI Excel software. Aetna had a sound process for validating data loads into the QSI repository and tracking record counts for each data source through a simple spreadsheet referred to as the CAT. During the load process, the standard reports produced by QSI were reviewed. During the on-site, a demonstration of the process was performed and the QSI load validation reports were reviewed. Monthly data refreshes and rate calculations were performed and reviewed for reasonability and accuracy based on prior month reports.

During the on-site visit and a subsequent conference call, on-site queries that included record tracing for members for the (*FUH*, *ABA*, *BCS*, and *W34* measures were conducted. For each member, enrollment data and administrative data in the QSI repository were reviewed to confirm compliance with measure specifications and then the data elements used to meet the specifications were viewed in the source systems to confirm concordance.

In addition to the on-site query review, data for three additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers and loads into the QSI repository. Membership and enrollment data were assessed through the Query Group #1—Overall Demographics query for which Aetna provided monthly membership counts for 2017 by product and stratified by gender. Small and consistent monthly increases were observed in the FHP/ACA membership during the first half of the year. The ICP monthly membership was consistent for the full year. The member counts for both products were consistent with documentation provided in the Roadmap and during the on-site visit.

Aetna balancing reports comparing counts of extracted records to counts of records loaded into the QSI repository for all data sources was reviewed for the Query Group #2—Data Loading Checks query. The balancing report indicated 34 claims and 102 enrollment rows failed to load. The impact was minimal.

Review of native provider specialty to HEDIS provider type was assessed through the Query Group #6—Mapping Results Check. Aetna provided a list of providers associated with administrative numerator events for members in the *W15* measure. The list included each providers' native specialty code. The list of providers was reviewed to determine the percentage of native specialty codes that met the HEDIS definition of primary care provider. Of the 498 providers, 6 did not have a compliant specialty for the provider identification number assigned to the claim containing the qualifying procedure code. Further review of these six practitioner records found four of the six practitioners had additional specialty codes that were acceptable. The other two providers were affiliated with multispecialty clinics. Although these two providers did not meet the criteria, the impact on the measure results was not material.

Aetna was partially compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for FHN

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Family Health Network's (FHN's) FHP/ACA population. The audit indicated that FHN was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B-14—FHN 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation.
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were 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 continued to use VidaClaim and VidaCounter during the 2017 measurement year. During the previous year's review, FHN utilized external MSOs to process claims through May 2016. There were no MSOs involved with the processing of claims in 2017.

Both the VidaCounter and VidaClaim systems captured standard CPT and ICD-10 codes and neither system allowed non-standard coding. FHN's systems did not accept non-standard claim forms.

Encounter coding and coding specificity were reviewed as part of Query Group #3, primary source verification, during the on-site audit. FHN demonstrated VidaClaim and VidaCounter's ability to distinguish between primary and secondary codes. Additionally, FHN demonstrated VidaClaim and VidaCounter's ability to capture modifier codes.

FHN continued to have sufficient processes in place through the end of 2017. FHN audited the claims and encounter systems through annual audits of both financial and quality metrics. All medical claims were submitted on a fee-for-service basis in 2017 as no MSOs were involved with the claims process.

FHN's VidaClaim system only allowed for standard claim submissions and standard coding schemes. Claims not meeting HIPAA edits were rejected back to the provider for resubmission.

FHN was able to demonstrate VidaClaim's ability to capture multiple diagnosis and procedure codes during the primary source verification process on-site. The audit team had no concerns with FHN's ability to process claims in 2017.

FHN was fully compliant with IS Standard 1.0.

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

FHN continued to use its internal enrollment system, VidaBility, during 2017. FHN received a daily and monthly enrollment file from the State. The daily and monthly files were transmitted in standard 834 format and electronically uploaded to VidaBility. There were a few circumstances where FHN manually manipulated the enrollment files; however, this occurred in less than 1 percent of the overall enrollment capture. There were no changes to this process in 2017.

FHN's VidaBility system captured all relevant fields outlined in the HEDIS Roadmap. FHN had sufficient processes in place to ensure all data files were captured and processed timely. VidaBility and the general audit process ensured that members were only assigned one unique identifier. FHN continued to validate and audit daily change files to ensure duplicate member identifiers were not created.

FHN advised HSAG that it was ceasing operations in 2017 and that a significant amount of its membership was reassigned to other health plans in May of 2017. Through on-site queries, HSAG was able to verify that FHN's membership dropped significantly in the middle of 2017. The termination of thousands of members had a significant impact on eligible populations and hybrid and administrative rates for all measures under review.

Although the rates were impacted by the loss of membership, FHN's processes were fully compliant with HEDIS specifications.

HSAG required FHN to run enrollment queries during the on-site audit to show enrollment by month. HSAG had no concerns with the membership query review.

FHN was fully compliant with IS Standard 2.0.

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

During the on-site audit, FHN indicated that there were no changes to its provider data process since the previous year's review. FHN ceased operations in the Medicaid line of business at the end of 2017; however, its providers remained static over that time. FHN still operates in the Medicare market and since all providers contract with FHN for all lines of business, HSAG had no concerns for Medicaid members' access to care. FHN did not terminate any provider contracts as the Medicaid line of business was winding down.

HSAG reviewed the provider data system, VidaPro, and determined that it captured all relevant fields required for HEDIS reporting. VidaPro was able to uniquely identify a specific servicing

provider and its specialty without issue. The provider mapping document was reviewed and approved. A sample of mental health and primary care specialties was reviewed on-site and found to be compliant with respect to the credentialing process.

FHN used Gemini Diversified Services, a Credentials Verification Organization (CVO) for credentialing. The CVO provided FHN with the credentialing information. FHN and the CVO set up a FTP site to send credentialing information daily. The daily files were reviewed and audited regularly. FHN's internal credentialing team reviewed all files from the CVO and checked to ensure all credentialing data were present and matched the provider's education. FHN ensured that provider data were only entered into VidaPro after the credentialing process was completed.

FHN was fully compliant with IS Standard 3.0.

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

HSAG reviewed FHN's IS 4 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements.

FHN sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures.

FHN used internal staff members to abstract data into Verscend's medical record abstraction tool. HSAG participated in a live demonstration of Verscend's tool and instructions. All fields, edits, and drop- down boxes were reviewed for accuracy against NCQA's *HEDIS 2018, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved Verscend's hybrid tool and instructions.

HSAG reviewed FHN's abstraction training manual and found no concerns. Reviewer qualifications, training, and oversight by FHN of its review staff were appropriate.

HSAG required a convenience sample for the *W34* measure due to errors noted during the prior year's MRRV. HSAG also required a convenience sample for *IMA—Combination 1*. Both measures successfully passed the validation.

FHN completed MRRV without issue. FHN completed all chases of medical records but did not find many positive hits for its members. FHN successfully passed the MRRV process and no concerns were found. FHN's final year in operation was in 2017.

FHN was fully compliant with IS Standard 4.0.

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

FHN presented eight standard supplemental databases in its HEDIS Roadmap submission. There were no non-standard supplemental databases submitted for HEDIS reporting. The majority of the

data sources were for laboratory services, with the exception of one historical claims database provided by the State. All supplemental data sources met HEDIS requirements for standard supplemental data. All file layouts met the specification guidelines and no mapping of data was required.

Standard supplemental data sources included:

- American Scientific Laboratory
- BioReference Labs
- CCCD Historical Data
- CMSO Quest Laboratory Results
- Lab Corp
- MedStar Laboratories
- Quest Laboratory Results
- Sinai Laboratories

All standard supplemental data sources were approved to use for HEDIS 2018 reporting.

FHN was fully compliant with IS Standard 5.0.

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

There were no changes to the data integration process from the previous year's review. All claims were processed through the VidaClaim system. Extracts to the data warehouse were pulled directly from VidaClaim and the supplemental data tables. Pharmacy data were also extracted from the internal pharmacy tables in the EDW. Extracts of all source data were provided to the certified measures software vendor in the vendor's required file layout. FHN provided four years of claims data along with enrollment and eligibility files to complete the file loads with Verscend.

The audit team reviewed several SQL Server tables and reviewed record counts for several sources during the on-site audit. The audit team also conducted primary source verification to determine if the data extracts matched the source system for numerator positive members. All primary source records met the numerator compliance upon review.

The audit team reviewed Roadmap tables 1.7, 2.2, 3A.2, and 3B.3 to ensure all required data elements were captured in the EDW and transferred to Verscend. No issues were found during this review.

FHN did not use non-standard coding for any measures. FHN did not use global billing codes for any of the measures under review.

Report production for FHN was handled by the certified measure vendor, Verscend, and the repository structure appeared to be satisfactory.

Final rate review was completed without issue. FHN's rates were within NCQA benchmarks and eligible populations were not a significant issue even though populations dropped by the end of 2017. This was FHN's final audit for the Illinois Medicaid market as it is no longer operating in Illinois.

FHN was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Humana

HSAG conducted a 2018 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Humana Health Plan, Inc.'s (Humana's) ICP population. The audit indicated that Humana was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B-15—Humana 2018 NCQA HEDIS Compliance Audit Results

Main Information Systems						Selected MY 2017 HEDIS Measure Results
Membership Data	Medical Services Data	Provider Data	Data Integration	Medical Record Data	Supplemental Data	All selected HEDIS measures received an *R* designation. *
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	

* The *IET* measure was assigned an NA for the 13–17 years of age stratification; however, the 18+ stratification received an *R*.

The rationale for full and partial compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving MCO processes were also identified.

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

Humana provided services to the ICP population under a managed care contract with the HFS.

Humana used its centralized teams for the processing of claims and encounter data for the Illinois ICP population from its Louisville, Kentucky offices. The ICP used a fee-for-service delivery system during 2017 with no capitated service agreements. The fee-for-service delivery systems supported data completeness since a claim was required by Humana to process payment.

Humana used its Claims Administration System (CAS) as its claims transactional system during 2017 and there were no substantive changes in the processing of claims data between 2016 and 2017. Humana had complete process flows and descriptions for the handling of electronic and paper claims submissions.

Humana only accepted the submission of industry-standard claims forms. In addition, the ICP did not accept or use any non-standard coding schemes; therefore, there was no mapping of non-standard codes to standard codes.

CAS captured primary and secondary codes and other required claims fields. During the on-site audit, Humana demonstrated the field capture of CPT II code modifiers, if submitted, within the CAS system. Humana had robust and mature processes for claims edits including the use of Claims

Xten, McKesson, iHealth, and Verisk software which addressed different stages of coding review. Humana used some APR-DRGs for inpatient claims and some MS-DRGs for certain contracted providers; however, all claims diagnosis and procedures codes were retained for HEDIS reporting. The individual claims lines for diagnosis, procedure, and revenue codes were all appropriately brought in for HEDIS reporting.

Humana used Conduent, formerly Xerox, as its paper claims scanning vendor. Conduent had adequate processes in place to assign a document control number to paper claims received and has a clean desk policy. Conduent primarily used OCR to obtain information on the claim and transfer it into a EDI format. Manual keying was done only to correct unreadable images by the OCR. There was adequate oversight and monitoring of Conduent. Humana identified no concerns with Conduent during 2017.

Humana monitored claims timeliness and workflow through its MACESS system. The system allowed the directing of certain claims types by claims processor skill-set. Humana identified an issue with some claims processed during 2017 that were rejected based on taxonomy codes in error, which resulted in a delay in processing these claims. The auditor requested information related to the timing of the issue, the volume, and the resolution time frame. Humana provided information post-on-site to demonstrate the volume of pended claims, which was insignificant to HEDIS reporting. No further issues were identified.

Humana contracted with Beacon to provide behavioral health services and process claims. Beacon used a fee-for-service delivery system for the Illinois ICP population. Humana did not identify any issues with claims processing accuracy or timeliness during 2017. Humana did identify some issues with Beacon outside of the scope of the audit and not relevant to measure reporting. There were no identified issues with claims backlog.

Humana contracted with EyeMed to provide vision services and to process claims. EyeMed used a fee-for-service delivery system for the Illinois ICP population. There were no concerns with claims processing and encounter data submission. There was adequate delegation oversight of the vendor.

No measures under the scope of the audit used pharmacy data; therefore, this area was not assessed during 2017.

All vendor encounter data were received in a Humana required format and processed within CAS and all system edits were applied to the encounter data except for adjudication edits.

During the on-site audit, claims data were reviewed for a portion of Query Group #3—Onsite Drill-Down. Humana demonstrated the CAS system for five members selected for review by the auditor from Humana's universe of administrative numerator compliant members for the *FUH* measure for the 30-day follow-up indicator and the *IET* measure for the initiation indicator. There were no concerns identified.

Humana was fully compliant with IS Standard 1.0.

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

Humana processed enrollment files received from HFS for its ICP population on a daily basis. Each 834 file was received and processed by a centralized enrollment team through an automated process. In addition, the ICP received and processed a monthly audit file from HFS. The monthly audit file was used for reconciliation against the State eligibility information.

Humana captured enrollment information within the customer interface (CI) system, which included the capture of current and historical enrollment spans, the State client identification number (CIN), as well as a Humana member identification number that was automatically generated by the ICP. There was an interface between CI and CAS for the purposes of claims payment.

A portion of Query Group #3—Onsite Drill-Down was conducted during the on-site audit with a live demonstration of the CI system. Five members from the *FUH* and *IET* measures were reviewed to confirm eligibility for denominator criteria. There were no concerns identified.

Humana was fully compliant with IS Standard 2.0.

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

During 2017, Humana loaded provider data into its Apex tool, which feeds certain data elements to PIMS and to CAS for claims payment. Each system created a unique identifier for each provider. Humana loaded provider data information from each of the systems to a repository and created a unique provider link across the different sources of provider data. For HEDIS 2018, Humana used the provider CMS taxonomy codes and mapped those codes to the Verscend HEDIS provider-type mapping. The auditor reviewed and approved the provider mapping for the mental health practitioner provider-type and no issues were identified.

During the on-site audit, Query Group #6—Provider Mapping Result Checks, was conducted on a sample of five numerator compliant cases from the *FUH* measure. These cases confirmed the use of a mental health practitioner for the post-hospitalization follow-up visit. No issues were identified.

Humana was fully compliant with IS Standard 3.0.

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

Humana performed internal medical record retrieval and all medical record abstraction using Verscend's Quality Reporter abstraction tool for all record abstraction. HSAG participated in a live vendor demonstration of Verscend's tool and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against the current year's technical specifications. HSAG reviewed and approved Verscend's hybrid tool and Humana's training manual prior to the on-site review and no issues were identified. Humana staff members and its temporary staff were qualified and trained to perform medical record abstraction for the HEDIS project.

Humana had an adequate oversight plan of its abstractors through appropriate interrater reliability (IRR) testing after training and ongoing audits throughout the project. Humana's process was to conduct over-reads on 10 percent of its abstractions. At the time of the on-site audit, Humana estimated that approximately 75 percent of its medical record project was complete. The auditor requested IRR results by reviewer as well as the percentage of internal abstracted cases reviewed. This information was provided post-on-site and no concerns were identified.

Hybrid sample sizes were reviewed, and no concerns were identified.

There were no changes to the MRR process; however, there were two new hybrid measures selected for Illinois ICP reporting; therefore, Humana was required to submit a convenience sample for the *ABA* and *CCS* measures. The convenience sample was reviewed with no issues detected prior to the on-site audit.

The auditor requested a chase completion report, once the hybrid project was completed and this report was provided with no issues identified.

Humana made appropriate adjustments to its overall project plan to account for the compressed MRR time frame for HEDIS 2018. There were no concerns identified.

Humana elected to report the *CCS* measure via the administrative method; therefore, only the *ABA* measure was reported via the hybrid methodology. Humana passed medical record review validation for this measure.

Humana was fully compliant with IS Standard 4.0.

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

For HEDIS 2018, Humana submitted two supplemental data sources. The first data source was the State of Illinois Medicaid/Medicare Standard Supplemental Data Feed, which included standard file layouts from Illinois providers' electronic health record systems. This data source was determined to be a standard data source and the data mapping was reviewed and approved. In addition, Humana used its Online STARS Quality Report (OSQR) data source, which included health care data from providers, which was supported by proof-of-service documentation. The data source was determined to be non-standard and therefore, PSV was performed on a sample of records. Humana passed PSV. Both data sources were reviewed and approved for HEDIS 2018 reporting.

A third data source, COA, was initially submitted but was later withdrawn since there was no data used from this data source for the measures under the scope of the audit.

Humana was fully compliant with IS Standard 5.0.

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

Humana contracted with Verscend as its software vendor for the production of 2018 HEDIS rates. During the on-site, Humana discussed the process flow of enrollment, provider, claims, vendor, medical record, and supplemental data for integration for measure production.

Humana conducted a monthly prospective data run during 2017. Claims, encounter, provider, and enrollment data were loaded from CAS with the exception of pharmacy data, which were loaded from the EDW. Humana did a full HEDIS production run in January. During the on-site audit, the auditor reviewed the data loading report provided by Verscend. There were no unexplained issues identified. Humana staff members conducted a variety of data reasonability and quality checks on the monthly prospective data runs; therefore, the full HEDIS production run was within Humana's expectations.

Humana confirmed that no members were excluded from HEDIS reporting outside of hospice exclusions and measure-specific exclusions. Query Group #1—Enrollment by Product Line was reviewed on-site and no issues were identified.

During the on-site audit, preliminary rate review was conducted with Humana presenting administrative rate data with comparisons to the prior year data. Rates were produced after measure certification for each of the five measures under the scope of the audit. There were minimal changes between years and no concerns.

Humana was fully compliant with IS Standard 7.0.

Validation of State Performance Measures for Primary Care Case Management (PCCM)/Children's Health Insurance Program Reauthorization Act (CHIPRA)

Introduction

HFS contracts with HSAG to conduct a review of the PCCM and CHIPRA programs for a selected set of performance measures.

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the CMS publication, *EQR Protocol 2, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review,* Version 2.0, September 2012. HSAG also uses the NCQA manual, *HEDIS 2018, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.

Conducting the Review

The primary objectives of the performance measure validation (PMV) process are to:

- Evaluate the processes used to collect the performance measure data by HFS.
- Determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.

HFS identifies the performance measurement period for validation for each program for the reporting year. HFS selected NCQA HEDIS measures as well as CMS Adult Core Set and Child Core Set performance measures for the PCCM and CHIPRA programs. Most measures used the HEDIS 2017 Technical Specifications. For measures that were both HEDIS and Core Set measures, HSAG reviewed source code according to both the HEDIS 2017 Technical Specifications, the June 2016 Adult Core Set, and the June 2016 Child Core Set. This was acceptable since the specifications for most, if not all, of the HEDIS measures were the same as the Core Set, except for the age breakouts. There were also measures which utilized the Maternal and Infant Health Initiative (MIHI) Contraceptive Care Measures technical specifications and the Data Definitions technical specifications produced by HFS. For a list of the validated measures and their corresponding rates, see Appendix F of this report.

Pre-Audit Activities

HSAG requests that HFS submit a list of measures under the scope of the audit, a completed Information Systems Capabilities Assessment Tool (ISCAT), source code for each performance measure, and any additional supporting documentation necessary to complete the audit. A conference call is conducted to answer questions and prepare for the audit.

Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of these data:

- ISCAT: HFS was responsible for completing and submitting the ISCAT document to HSAG. Upon receipt, HSAG conducted a cursory review of the ISCAT to ensure that HFS completed all sections and included all needed attachments. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used the information in the ISCAT to complete the review tools, as applicable.
- Source code (programming language) for performance measures: HSAG requested source code from HFS for all performance measures. HSAG source code reviewers completed a line-by-line code review and evaluation of program logic flow to ensure compliance with the specifications required by HFS. The source code reviewers identified areas of deviation and shared them with HFS for adjustment. The source code reviewers also informed the audit team of any deviations from the measure specifications so the team could evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Supporting documentation: HSAG requested documentation and data queries that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for follow-up.

Performance Measure Validation Findings

To validate the performance measures, data from various sources, including provider data, claims/encounter systems, and enrollment data, must be audited. The auditor scrutinizes these processes and makes a determination as to the validity of the data collected. HSAG uses a variety of audit methods, including analysis of computer programs, PSV, and staff member interviews to determine a result for each measure.

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the designations identified in the CMS PMV Protocol listed below in Table B-16.

Table B-16—Performance Measure Audit Results and Definitions

Result	Definition
R	*Reportable.* Measure was compliant with the State's specifications and the rate can be reported.
NR	*Not Reported.* This designation is assigned to measures for which (1) the rate was materially biased, or (2) the rate was not required to be reported.
NB	*No Benefit.* Measure was not reported because the benefit required by the measure was not offered.

HSAG determined that all data supported the elements necessary for reporting and measures were calculated appropriately according to the required measure specifications. Further, all performance measures under the scope of the audit received an *R* designation.

Appendix C. 2017–2018 Performance Measure Results

Background

The performance measure results tables in Appendix C display the rates for the Family Health Plan/Affordable Care Act (FHP/ACA) and Integrated Care Program (ICP) health plans for the Healthcare Effectiveness Data and Information Set (HEDIS) and state-defined measures using data collected in calendar year (CY) 2017. The CY 2017 (HEDIS 2018) measure rates were compared to the National Committee for Quality Assurance's (NCQA's) Quality Compass national Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS 2017, where applicable. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure indicator was compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2017, since this indicator not published in Quality Compass. Table C-1 displays the health plans' performance utilizing star ratings.

Table C-1—Star Ranking and Corresponding Percentile Performance Levels

Stars	Quality Compass Percentiles
★★★★★ Excellent	Met or exceeded the national Medicaid 90th percentile
★★★★ Very Good	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★ Good	At or above the national Medicaid 50th percentile but below the 75th percentile
★★ Fair	At or above the national Medicaid 25th percentile but below the 50th percentile
★ Poor	Below the national Medicaid 25th percentile

Pay-for-Performance Summary

HFS identifies pay-for-performance (P4P) measures with specific, performance-driven target objectives. P4P measures create an incentive for health plans to spend money on care that produces valued outcomes. For this reporting year, there were eight FHP/ACA P4P bundled measures and five ICP P4P bundled measures. To determine if the health plans met the P4P performance target for state fiscal year (SFY) 2018, the results for the P4P measures were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018. A summary of the health plans' performance is provided below.

MEASURES AND METHODOLOGY

FHP/ACA & ICP Measures

a. *Breast Cancer Screening*
b. *Cervical Cancer Screening*
c. *Comprehensive Diabetes Care—HbA1c Testing*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*
d. *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*
e. *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total—Total* and *Engagement of AOD Treatment—Total—Total*

FHP/ACA Measures

f. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
g. *Well-Child Visits—W15—Six or More Well-Child Visits* and *W34*
h. *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

HFS applies withholds (a percentage of total capitation rates each month) of:

- 1% in the first measurement year
- 1.5% in the second measurement year
- 2% in the third and subsequent measurement years

The Contractor may earn a percentage of the withhold based on:

- Quality metrics
- Operational metrics
- Achievement of implementation goals

2018 PAYOUT

FHP/ACA

Measure	a	b	c	d	e	f	g	h
Met	0	4	1	0	1	2	1	4

ICP

Measure	a	b	c	d	e
Met	0	0	3	0	0

# of plans that met performance goal

FHP/ACA: 9 plans reported
ICP: 10 plans reported

FHP/ACA Performance Measures

This section presents the performance measure rates and P4P measures for the FHP/ACA health plans. The Illinois Department of Healthcare and Family Services (HFS) required the FHP/ACA health plans to report rates for 20 HEDIS measures for CY 2017. Eight of these measures were required for the P4P incentive bonus program. These measure rates had specific target goals (e.g., to meet the national Medicaid 50th percentile) set by HFS, in which the health plans were rewarded for meeting target goals by earning a percentage of their capitation payment in incentives. The tables in the FHP/ACA Plan-Specific Findings section present the plan-specific findings for the performance measures and P4P measures.

FHP/ACA Health Plan Reporting

Table C-2 displays the reporting status for 2017–2018 for each FHP/ACA health plan. The data reported for SFY 2018 represent the third year of reporting for the FHP/ACA health plans, providing data for comparison of performance across years.

Table C-2—FHP/ACA Health Plan Reporting Status

FHP/ACA Health Plan	Reporting Status for 2017–2018
Aetna Better Health (Aetna)	Third Year of Reporting
Blue Cross Blue Shield of Illinois (BCBSIL)	Third Year of Reporting
CountyCare Health Plan (CountyCare)	Third Year of Reporting
Family Health Network (FHN)	Third Year of Reporting
Harmony Health Plan of Illinois, Inc. (Harmony)	Third Year of Reporting
IlliniCare Health Plan, Inc. (IlliniCare)	Third Year of Reporting
Meridian Health Plan, Inc. (Meridian)	Third Year of Reporting
Molina Healthcare of Illinois, Inc. (Molina)	Third Year of Reporting
NextLevel Health Partners, LLC (NextLevel)	Second Year of Reporting

FHP/ACA Plan-Specific Findings for HealthChoice Illinois Plans

BCBSIL

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for BCBSIL are displayed in the tables below.

Table C-3—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—BCBSIL

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	70.50%	★	75.47%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	457.13	NC	410.86	NC
ED Visits—Total	51.11	NC	51.74	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	68.06%	★	75.18%	★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	71.30%	★★	75.18%	★★★
Combination 3	66.67%	★★	68.13%	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	80.78%	★★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	33.82%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	59.49%	★★	63.99%	★★
Counseling for Nutrition—Total	50.69%	★	58.15%	★
Counseling for Physical Activity—Total	41.44%	★	51.34%	★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	53.94%	★★	61.56%	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.12%	★	77.62%	★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	57.69%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	60.19%	★★★	64.48%	★★★
Chlamydia Screening in Women				
Total	58.63%	★★★	58.56%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.19%	★★★	85.89%	★★★
Postpartum Care	67.04%	★★★	70.07%	★★★★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	86.85%	★★	87.83%	★★★
Diuretics	83.49%	★	86.22%	★★
Total[1]	—	NC	87.19%	NC
Comprehensive Diabetes Care				
HbA1c Testing	86.95%	★★★	86.13%	★★
Eye Exam (Retinal) Performed	29.20%	★	42.82%	★
Medical Attention for Nephropathy	90.49%	★★	89.54%	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	33.41%	★	41.85%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	54.05%	★★	53.54%	★★
Medication Compliance 75%—Total	28.91%	★★	28.57%	★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	65.28%	★★★★	65.73%	★★★★
Statin Adherence 80%	56.15%	★★	49.18%	★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	20.34%	NC
30-Day Follow-Up	—	NC	34.30%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	45.66%	NC
Engagement of AOD Treatment—Total—Total	—	NC	15.04%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	34.86%	★★★	38.58%	★★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-4—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—BCBSIL

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	59.49%	75th Percentile	63.99%	NOT MET
Counseling for Nutrition—Total	50.69%	75th Percentile	58.15%	
Counseling for Physical Activity—Total	41.44%	75th Percentile	51.34%	
Well-Child Visits				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	53.94%	90th Percentile	61.56%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.12%	90th Percentile	77.62%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	57.69%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	60.19%	75th Percentile	64.48%	**MET**

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.19%	50th Percentile	85.89%	**MET**
Postpartum Care	67.04%	75th Percentile	70.07%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	86.95%	75th Percentile	86.13%	NOT MET
Eye Exam (Retinal) Performed	29.20%	75th Percentile	42.82%	
Medical Attention for Nephropathy	90.49%	75th Percentile	89.54%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	34.30%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	45.66%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	15.04%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

CountyCare

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for CountyCare are displayed in the tables below.

Table C-5—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—CountyCare

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	74.47%	★	77.06%	★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	359.44	NC	NR	NC
ED Visits—Total	63.05	NC	NR	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	85.89%	★★★	89.78%	★★★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	73.48%	★★	NR	NC
Combination 3	69.34%	★★	NR	NC
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	86.62%	★★★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	39.42%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	73.24%	★★★	86.62%	★★★★
Counseling for Nutrition—Total	63.75%	★★★	80.54%	★★★★
Counseling for Physical Activity—Total	55.72%	★★★	75.18%	★★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	44.04%	★	67.15%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.67%	★★★	79.56%	★★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	63.54%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	50.36%	★★	62.77%	★★★
Chlamydia Screening in Women				
Total	62.64%	★★★★	NR	NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	67.88%	★	NR	NC
Postpartum Care	54.74%	★	NR	NC
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	84.62%	★	85.52%	★
Diuretics	82.99%	★	84.36%	★
Total[1]	—	NC	85.00%	NC
Comprehensive Diabetes Care				
HbA1c Testing	87.83%	★★★	89.05%	★★★
Eye Exam (Retinal) Performed	34.79%	★	53.04%	★★
Medical Attention for Nephropathy	88.81%	★★	91.48%	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	50.61%	★★	51.34%	★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	59.75%	★★★	44.28%	★
Medication Compliance 75%—Total	31.96%	★★★	19.22%	★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	65.70%	★★★★	58.94%	★★
Statin Adherence 80%	58.14%	★★	60.37%	★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	25.37%	NC
30-Day Follow-Up	—	NC	41.05%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	41.48%	NC
Engagement of AOD Treatment—Total—Total	—	NC	10.92%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	31.82%	★★★	NR	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

NR indicates the rate was not reported.

Table C-6—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—CountyCare

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	73.24%	75th Percentile	86.62%	**MET**
Counseling for Nutrition—Total	63.75%	75th Percentile	80.54%	
Counseling for Physical Activity—Total	55.72%	75th Percentile	75.18%	
Well-Child Visits				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	44.04%	90th Percentile	67.15%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.67%	90th Percentile	79.56%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	63.54%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	50.36%	75th Percentile	62.77%	**MET**

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	67.88%	50th Percentile	NR	NOT MET
Postpartum Care	54.74%	75th Percentile	NR	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	87.83%	75th Percentile	89.05%	NOT MET
Eye Exam (Retinal) Performed	34.79%	75th Percentile	53.04%	
Medical Attention for Nephropathy	88.81%	75th Percentile	91.48%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	41.05%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	41.48%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	10.92%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.
NR indicates the rate was not reported.

Harmony

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Harmony are displayed in the tables below.

Table C-7—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—Harmony

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	70.65%	★	68.67%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	232.14	NC	239.94	NC
ED Visits—Total	61.17	NC	63.80	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	87.20%	★★★	91.84%	★★★★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	69.34%	★★	66.67%	★
Combination 3	63.75%	★	61.80%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	82.73%	★★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	28.47%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	78.64%	★★★★	81.05%	★★★★
Counseling for Nutrition—Total	72.11%	★★★★	78.16%	★★★★
Counseling for Physical Activity—Total	64.82%	★★★★	72.11%	★★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	55.47%	★★	57.74%	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.00%	★★★	74.76%	★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	50.96%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	64.05%	★★★★	66.05%	★★★★
Chlamydia Screening in Women				
Total	57.76%	★★★	53.22%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	80.65%	★★	84.79%	★★★
Postpartum Care	58.81%	★★	65.59%	★★★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	73.44%	★	78.13%	★
Diuretics	71.79%	★	76.52%	★
Total[1]	—	NC	77.44%	NC
Comprehensive Diabetes Care				
HbA1c Testing	83.45%	★★	85.40%	★★
Eye Exam (Retinal) Performed	39.66%	★	38.93%	★
Medical Attention for Nephropathy	88.32%	★★	90.51%	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	45.50%	★	42.82%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	43.06%	★	46.36%	★
Medication Compliance 75%—Total	18.55%	★	22.22%	★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	54.61%	★	60.46%	★★
Statin Adherence 80%	45.63%	★	43.84%	★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	28.22%	NC
30-Day Follow-Up	—	NC	46.41%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	47.45%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Engagement of AOD Treatment—Total—Total	—	NC	14.87%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	27.48%	★★	28.33%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-8—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—Harmony

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	78.64%	75th Percentile	81.05%	**MET**
Counseling for Nutrition—Total	72.11%	75th Percentile	78.16%	
Counseling for Physical Activity—Total	64.82%	75th Percentile	72.11%	
Well-Child Visits in the First 15 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	55.47%	90th Percentile	57.74%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.00%	90th Percentile	74.76%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	50.96%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	64.05%	75th Percentile	66.05%	**MET**

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	80.65%	50th Percentile	84.79%	**MET**
Postpartum Care	58.81%	75th Percentile	65.59%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	83.45%	75th Percentile	85.40%	NOT MET
Eye Exam (Retinal) Performed	39.66%	75th Percentile	38.93%	
Medical Attention for Nephropathy	88.32%	75th Percentile	90.51%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	46.41%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	47.45%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	14.87%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

IlliniCare

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for IlliniCare are displayed in the tables below.

Table C-9—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—IlliniCare

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	75.26%	★	71.30%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	270.21	NC	236.93	NC
ED Visits—Total	60.05	NC	60.14	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	78.10%	★★	73.96%	★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	45.67%	★	55.96%	★
Combination 3	39.66%	★	51.09%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	75.43%	★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	28.22%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	57.14%	★★	66.42%	★★
Counseling for Nutrition—Total	56.65%	★★	63.75%	★★
Counseling for Physical Activity—Total	49.01%	★★	58.15%	★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	41.48%	★	51.34%	★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.68%	★★★	72.75%	★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	51.68%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	50.48%	★★	57.91%	★★
Chlamydia Screening in Women				
Total	56.88%	★★★	60.32%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.03%	★★★	83.45%	★★
Postpartum Care	69.32%	★★★★	61.31%	★★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	85.97%	★★	86.81%	★★
Diuretics	84.79%	★	85.51%	★
Total[1]	—	NC	86.29%	NC
Comprehensive Diabetes Care				
HbA1c Testing	84.03%	★★	86.13%	★★
Eye Exam (Retinal) Performed	57.41%	★★★	53.40%	★★
Medical Attention for Nephropathy	89.35%	★★	87.59%	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	33.87%	★	39.90%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	51.20%	★★	51.91%	★★
Medication Compliance 75%—Total	26.08%	★★	26.98%	★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	61.88%	★★★	63.53%	★★★
Statin Adherence 80%	52.63%	★★	51.30%	★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	33.14%	NC
30-Day Follow-Up	—	NC	52.55%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	47.90%	NC
Engagement of AOD Treatment—Total—Total	—	NC	18.15%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	35.74%	★★★★	27.09%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-10—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—IlliniCare

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	57.14%	75th Percentile	66.42%	NOT MET
Counseling for Nutrition—Total	56.65%	75th Percentile	63.75%	
Counseling for Physical Activity—Total	49.01%	75th Percentile	58.15%	
Well-Child Visits				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	41.48%	90th Percentile	51.34%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.68%	90th Percentile	72.75%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	51.68%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	50.48%	75th Percentile	57.91%	NOT MET

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.03%	50th Percentile	83.45%	NOT MET
Postpartum Care	69.32%	75th Percentile	61.31%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	84.03%	75th Percentile	86.13%	NOT MET
Eye Exam (Retinal) Performed	57.41%	75th Percentile	53.40%	
Medical Attention for Nephropathy	89.35%	75th Percentile	87.59%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	52.55%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	47.90%	**MET**
Engagement of AOD Treatment—Total—Total	—	75th Percentile	18.15%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Meridian

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Meridian are displayed in the tables below.

Table C-11—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—Meridian

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	79.21%	★★	78.54%	★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	326.99	NC	310.50	NC
ED Visits—Total	56.32	NC	54.60	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	88.66%	★★★	88.08%	★★★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	80.09%	★★★★	76.89%	★★★
Combination 3	74.07%	★★★	72.51%	★★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	91.00%	★★★★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	37.47%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	70.53%	★★★	75.18%	★★★
Counseling for Nutrition—Total	64.50%	★★★	69.83%	★★★
Counseling for Physical Activity—Total	55.92%	★★★	67.64%	★★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	79.17%	★★★★★	78.83%	★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.64%	★★★★	81.51%	★★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	59.23%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	69.34%	★★★★	66.42%	★★★★
Chlamydia Screening in Women				
Total	60.22%	★★★	56.25%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	91.44%	★★★★★	87.59%	★★★
Postpartum Care	75.69%	★★★★★	74.21%	★★★★★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	86.33%	★★	84.36%	★
Diuretics	84.97%	★	84.15%	★
Total[1]	—	NC	84.27%	NC
Comprehensive Diabetes Care				
HbA1c Testing	88.11%	★★★	88.69%	★★★
Eye Exam (Retinal) Performed	53.96%	★★★	57.48%	★★★
Medical Attention for Nephropathy	89.33%	★★	89.96%	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	67.22%	★★★★	60.83%	★★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	65.23%	★★★★	73.95%	★★★★★
Medication Compliance 75%—Total	46.34%	★★★★	52.10%	★★★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	60.86%	★★★	62.58%	★★★
Statin Adherence 80%	70.28%	★★★★★	67.49%	★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	40.97%	NC
30-Day Follow-Up	—	NC	63.64%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	39.92%	NC
Engagement of AOD Treatment—Total—Total	—	NC	14.66%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	29.51%	★★	34.38%	★★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-12—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—Meridian

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	70.53%	75th Percentile	75.18%	NOT MET
Counseling for Nutrition—Total	64.50%	75th Percentile	69.83%	
Counseling for Physical Activity—Total	55.92%	75th Percentile	67.64%	
Well-Child Visits				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	79.17%	90th Percentile	78.83%	**MET**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.64%	90th Percentile	81.51%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	59.23%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	69.34%	75th Percentile	66.42%	**MET**

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	91.44%	50th Percentile	87.59%	**MET**
Postpartum Care	75.69%	75th Percentile	74.21%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	88.11%	75th Percentile	88.69%	NOT MET
Eye Exam (Retinal) Performed	53.96%	75th Percentile	57.48%	
Medical Attention for Nephropathy	89.33%	75th Percentile	89.96%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	63.64%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	39.92%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	14.66%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Molina

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Molina are displayed in the tables below.

Table C-13—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—Molina

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	68.33%	★	65.64%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	227.52	NC	244.36	NC
ED Visits—Total	68.22	NC	65.89	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	81.11%	★★	64.23%	★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	71.30%	★★	73.97%	★★
Combination 3	64.02%	★	68.61%	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	83.70%	★★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	30.90%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	69.09%	★★★	70.80%	★★
Counseling for Nutrition—Total	63.36%	★★★	65.45%	★★
Counseling for Physical Activity—Total	57.17%	★★★	60.58%	★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	64.46%	★★★	72.51%	★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.92%	★★★★	74.94%	★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	52.74%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	55.53%	★★	57.42%	★★
Chlamydia Screening in Women				
Total	61.44%	★★★	62.20%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.33%	★★	77.86%	★★
Postpartum Care	64.22%	★★★	60.83%	★★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	84.18%	★	86.26%	★★
Diuretics	83.67%	★	85.82%	★★
Total[1]	—	NC	86.07%	NC
Comprehensive Diabetes Care				
HbA1c Testing	80.44%	★	82.24%	★
Eye Exam (Retinal) Performed	45.56%	★★	54.99%	★★
Medical Attention for Nephropathy	88.44%	★★	88.08%	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	35.67%	★	45.99%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	53.99%	★★	50.25%	★
Medication Compliance 75%—Total	28.74%	★★	24.96%	★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	59.49%	★★★	60.22%	★★
Statin Adherence 80%	54.09%	★★	47.93%	★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	29.32%	NC
30-Day Follow-Up	—	NC	53.63%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	40.54%	NC
Engagement of AOD Treatment—Total—Total	—	NC	10.34%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	33.88%	★★★	29.20%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-14—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—Molina

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	69.09%	75th Percentile	70.80%	NOT MET
Counseling for Nutrition—Total	63.36%	75th Percentile	65.45%	
Counseling for Physical Activity—Total	57.17%	75th Percentile	60.58%	
Well-Child Visits in the First 15 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	64.46%	90th Percentile	72.51%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.92%	90th Percentile	74.94%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	52.74%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	55.53%	75th Percentile	57.42%	NOT MET

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.33%	50th Percentile	77.86%	NOT MET
Postpartum Care	64.22%	75th Percentile	60.83%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	80.44%	75th Percentile	82.24%	NOT MET
Eye Exam (Retinal) Performed	45.56%	75th Percentile	54.99%	
Medical Attention for Nephropathy	88.44%	75th Percentile	88.08%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	53.63%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	40.54%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	10.34%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

NextLevel

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for NextLevel are displayed in the tables below.

Table C-15—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—NextLevel

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	34.02%	★	35.95%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	NR	NC	105.26	NC
ED Visits—Total	NR	NC	62.08	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	NA	NC	23.59%	★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	NA	NC	0.73%	★
Combination 3	NA	NC	0.00%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	26.36%	★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	4.55%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	NA	NC	19.72%	★
Counseling for Nutrition—Total	NA	NC	12.76%	★
Counseling for Physical Activity—Total	NA	NC	8.19%	★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	NA	NC	20.62%	★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	NC	38.24%	★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	NA	NC
Cervical Cancer Screening				
Cervical Cancer Screening	8.46%	★	21.22%	★
Chlamydia Screening in Women				
Total	61.84%	★★★★	66.90%	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	47.89%	★	52.71%	★
Postpartum Care	42.25%	★	37.68%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	78.24%	★	79.36%	★
Diuretics	75.96%	★	80.86%	★
Total[1]	—	NC	80.00%	NC
Comprehensive Diabetes Care				
HbA1c Testing	71.25%	★	68.78%	★
Eye Exam (Retinal) Performed	15.31%	★	19.31%	★
Medical Attention for Nephropathy	88.60%	★★	83.07%	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	BR	NC	BR	NC
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	NA	NC	68.42%	★★★★
Medication Compliance 75%—Total	NA	NC	52.63%	★★★★★
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	NA	NC	48.70%	★
Statin Adherence 80%	NA	NC	64.89%	★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	9.60%	NC
30-Day Follow-Up	—	NC	18.36%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	46.80%	NC
Engagement of AOD Treatment—Total—Total	—	NC	12.08%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	NA	NC	NA	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

NR indicates the rate was not reported.

BR indicates the rate was withheld because it was determined to be materially biased.

Table C-16—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—NextLevel

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	NA	75th Percentile	19.72%	NOT MET
Counseling for Nutrition—Total	NA	75th Percentile	12.76%	
Counseling for Physical Activity—Total	NA	75th Percentile	8.19%	
Well-Child Visits in the First 15 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	NA	90th Percentile	20.62%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	90th Percentile	38.24%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	NA	Not Applicable
Cervical Cancer Screening				
Cervical Cancer Screening	8.46%	75th Percentile	21.22%	NOT MET

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	47.89%	50th Percentile	52.71%	NOT MET
Postpartum Care	42.25%	75th Percentile	37.68%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	71.25%	75th Percentile	68.78%	NOT MET
Eye Exam (Retinal) Performed	15.31%	75th Percentile	19.31%	
Medical Attention for Nephropathy	88.60%	75th Percentile	83.07%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	18.36%	NOT MET
Initiation and Engagement of AOD Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	46.80%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	12.08%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.
NA indicates the rate was withheld because the denominator was less than 30.

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Aetna

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Aetna are displayed in the tables below.

Table C-17—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—Aetna

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	76.85%	★	76.52%	★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	297.34	NC	285.99	NC
ED Visits—Total	57.21	NC	57.30	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	72.39%	★	62.29%	★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	52.78%	★	41.12%	★
Combination 3	50.46%	★	38.69%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	62.53%	★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	24.09%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	62.27%	★★	55.96%	★
Counseling for Nutrition—Total	58.33%	★★	55.23%	★
Counseling for Physical Activity—Total	52.31%	★★	45.74%	★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	52.08%	★	67.15%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.61%	★★★	75.43%	★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	53.84%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	52.69%	★★	54.01%	★★
Chlamydia Screening in Women				
Total	54.92%	★★	56.12%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.74%	★★★	83.70%	★★★
Postpartum Care	68.60%	★★★★	65.45%	★★★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	84.66%	★	86.35%	★★
Diuretics	82.93%	★	85.69%	★★
Total[1]	—	NC	86.09%	NC
Comprehensive Diabetes Care				
HbA1c Testing	87.96%	★★★	89.78%	★★★
Eye Exam (Retinal) Performed	47.69%	★★	61.31%	★★★
Medical Attention for Nephropathy	88.43%	★★	91.73%	★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	46.58%	★	37.71%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	BR	NC	56.69%	★★
Medication Compliance 75%—Total	BR	NC	32.05%	★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	60.06%	★★★	63.52%	★★★
Statin Adherence 80%	BR	NC	54.26%	★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	32.99%	NC
30-Day Follow-Up	—	NC	50.28%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	42.89%	NC
Engagement of AOD Treatment—Total—Total	—	NC	14.96%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	34.30%	★★★	31.41%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

BR indicates the rate was withheld because it was determined to be materially biased.

Table C-18—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—Aetna

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	62.27%	75th Percentile	55.96%	NOT MET
Counseling for Nutrition—Total	58.33%	75th Percentile	55.23%	
Counseling for Physical Activity—Total	52.31%	75th Percentile	45.74%	
Well-Child Visits				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	52.08%	90th Percentile	67.15%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.61%	90th Percentile	75.43%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	53.84%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	52.69%	75th Percentile	54.01%	NOT MET

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.74%	50th Percentile	83.70%	**MET**
Postpartum Care	68.60%	75th Percentile	65.45%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	87.96%	75th Percentile	89.78%	**MET**
Eye Exam (Retinal) Performed	47.69%	75th Percentile	61.31%	
Medical Attention for Nephropathy	88.43%	75th Percentile	91.73%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	50.28%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	42.89%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	14.96%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

FHN

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for FHN are displayed in the tables below.

Table C-19—FHP/ACA HEDIS 2017 and HEDIS 2018 Performance Measure Results—FHN

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	77.34%	★★	67.98%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	277.44	NC	239.04	NC
ED Visits—Total	58.49	NC	46.69	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	56.45%	★	28.47%	★
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	75.67%	★★★	65.21%	★
Combination 3	71.78%	★★★	62.53%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	NC	79.08%	★★★
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	NC	34.79%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	58.15%	★★	15.57%	★
Counseling for Nutrition—Total	56.20%	★★	19.46%	★
Counseling for Physical Activity—Total	49.15%	★★	6.08%	★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	70.32%	★★★★	44.28%	★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	84.43%	★★★★★	73.97%	★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	54.44%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	64.96%	★★★★	58.64%	★★★
Chlamydia Screening in Women				
Total	63.13%	★★★★	49.00%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.94%	★★★	69.34%	★
Postpartum Care	64.72%	★★★	57.91%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	83.35%	★	87.76%	★★
Diuretics	81.29%	★	86.56%	★★
Total[1]	—	NC	87.28%	NC
Comprehensive Diabetes Care				
HbA1c Testing	84.12%	★★	82.48%	★
Eye Exam (Retinal) Performed	51.64%	★★	66.61%	★★★★
Medical Attention for Nephropathy	90.69%	★★★	87.04%	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	26.76%	★	1.70%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	47.00%	★	45.43%	★
Medication Compliance 75%—Total	23.97%	★	18.03%	★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	62.14%	★★★	64.11%	★★★
Statin Adherence 80%	54.47%	★★	62.32%	★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	26.32%	NC
30-Day Follow-Up	—	NC	47.29%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	42.09%	NC
Engagement of AOD Treatment—Total—Total	—	NC	12.03%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	28.72%	★★	43.18%	★★★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-20—FHP/ACA Pay-for-Performance Results for 2018 Contracted Goals and Results—FHN

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Child & Adolescent Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	58.15%	75th Percentile	15.57%	NOT MET
Counseling for Nutrition—Total	56.20%	75th Percentile	19.46%	
Counseling for Physical Activity—Total	49.15%	75th Percentile	6.08%	
Well-Child Visits in the First 15 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	70.32%	90th Percentile	44.28%	NOT MET
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	84.43%	90th Percentile	73.97%	
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	54.44%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	64.96%	75th Percentile	58.64%	NOT MET

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.94%	50th Percentile	69.34%	NOT MET
Postpartum Care	64.72%	75th Percentile	57.91%	
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	84.12%	75th Percentile	82.48%	NOT MET
Eye Exam (Retinal) Performed	51.64%	75th Percentile	66.61%	
Medical Attention for Nephropathy	90.69%	75th Percentile	87.04%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	47.29%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	75th Percentile	42.09%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	12.03%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

ICP Performance Measures

This section presents the performance measure rates and P4P measure results for the ICP health plans. HFS required the ICP health plans to report rates for 14 HEDIS measures for CY 2017. Five of these measures were required for the P4P incentive bonus program. These measure rates had specific target goals (e.g., to meet the national Medicaid 50th percentile) set by HFS, in which the health plans were rewarded for meeting target goals by earning a percentage of their capitation payment in incentives. The tables in the ICP Plan-Specific Findings section present the plan-specific findings for the performance measures and P4P measures.

ICP Health Plan Reporting

Table C-21 displays the reporting status for 2017–2018 for each ICP health plan. The data reported for SFY 2018 represent various years of reporting for the ICP health plans, providing data for comparison of performance across years.

Table C-21—ICP Health Plan Reporting Status

ICP Health Plan	Reporting Status for 2017–2018
Aetna	Sixth Year of Reporting
BCBSIL	Third Year of Reporting
Cigna-HealthSpring of Illinois (Cigna)	Third Year of Reporting
Community Care Alliance of Illinois (CCAI)	Fourth Year of Reporting
CountyCare	Third Year of Reporting
Humana Health Plan, Inc. (Humana)	Third Year of Reporting
IlliniCare	Sixth Year of Reporting
Meridian	Fourth Year of Reporting
Molina	Fourth Year of Reporting
NextLevel	Second Year of Reporting

ICP Plan-Specific Findings for HealthChoice Illinois Plans

BCBSIL

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for BCBSIL are displayed in the tables below.

Table C-22—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—BCBSIL

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	84.29%	★★★	85.48%	★★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	872.64	NC	759.60	NC
ED Visits—Total	91.73	NC	93.80	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	69.61%	★	69.83%	★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	49.21%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	40.93%	★	47.93%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.91%	★	61.36%	★
Postpartum Care	50.00%	★	50.00%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.32%	★★★★	90.98%	★★★★
Diuretics	90.84%	★★★★	90.59%	★★★★
Total[1]	—	NC	90.82%	NC
Comprehensive Diabetes Care				
HbA1c Testing	88.94%	★★★	92.46%	★★★★
Eye Exam (Retinal) Performed	45.58%	★★	47.20%	★
Medical Attention for Nephropathy	91.15%	★★★	94.89%	★★★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Controlling High Blood Pressure				
Controlling High Blood Pressure	26.07%	★	42.58%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	67.42%	★★★★	64.40%	★★★
Medication Compliance 75%—Total	43.94%	★★★★	37.70%	★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	64.03%	★★★★	71.38%	★★★★★
Statin Adherence 80%	53.03%	★★	54.26%	★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	11.08%	NC
30-Day Follow-Up	—	NC	26.37%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	50.21%	NC
Engagement of AOD Treatment—Total—Total	—	NC	12.43%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-23—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—BCBSIL

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	49.21%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	40.93%	75th Percentile	47.93%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	88.94%	75th Percentile	92.46%	NOT MET
Eye Exam (Retinal) Performed	45.58%	75th Percentile	47.20%	
Medical Attention for Nephropathy	91.15%	75th Percentile	94.89%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	26.37%	NOT MET
Initiation and Engagement of AOD Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	50.21%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	12.43%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

CountyCare

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for CountyCare are displayed in the tables below.

Table C-24—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—CountyCare

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	86.01%	★★★★	NR	NC
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	629.21	NC	686.01	NC
ED Visits—Total	99.36	NC	76.08	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	89.54%	★★★★	86.37%	★★★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	56.72%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	46.96%	★	55.72%	★★
Chlamydia Screening in Women				
Total	67.14%	★★★★	47.92%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA	NC	NA	NC
Postpartum Care	NA	NC	NA	NC
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	88.82%	★★★	NR	NC
Diuretics	90.49%	★★★★	NR	NC
Total[1]	—	NC	NR	NC
Comprehensive Diabetes Care				
HbA1c Testing	89.29%	★★★	NR	NC
Eye Exam (Retinal) Performed	36.50%	★	NR	NC
Medical Attention for Nephropathy	91.97%	★★★★	NR	NC
Controlling High Blood Pressure				
Controlling High Blood Pressure	51.09%	★★	NR	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	71.95%	★★★★★	52.22%	★★
Medication Compliance 75%—Total	42.68%	★★★★	27.78%	★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	68.49%	★★★★★	NR	NC
Statin Adherence 80%	55.50%	★★	NR	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	20.72%	NC
30-Day Follow-Up	—	NC	33.47%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	46.65%	NC
Engagement of AOD Treatment—Total—Total	—	NC	9.68%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

NR indicates the rate was not reported.

Table C-25—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—CountyCare

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	56.72%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	46.96%	75th Percentile	55.72%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	89.29%	75th Percentile	NR	NOT MET
Eye Exam (Retinal) Performed	36.50%	75th Percentile	NR	
Medical Attention for Nephropathy	91.97%	75th Percentile	NR	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	33.47%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	46.65%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	9.68%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.
NR indicates the rate was not reported.

IlliniCare

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for IlliniCare are displayed in the tables below.

Table C-26—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—IlliniCare

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	86.60%	★★★★	85.38%	★★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	617.77	NC	584.34	NC
ED Visits—Total	93.74	NC	96.63	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	74.19%	★	84.11%	★★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	56.98%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	39.89%	★	46.23%	★
Chlamydia Screening in Women				
Total	56.16%	★★★	53.50%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	67.42%	★	65.63%	★
Postpartum Care	49.44%	★	39.06%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	92.41%	★★★★★	92.61%	★★★★
Diuretics	92.12%	★★★★	92.68%	★★★★★
Total[1]	—	NC	92.64%	NC
Comprehensive Diabetes Care				
HbA1c Testing	89.63%	★★★★	90.02%	★★★
Eye Exam (Retinal) Performed	66.67%	★★★★	66.91%	★★★★
Medical Attention for Nephropathy	93.30%	★★★★	95.38%	★★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	40.91%	★	44.04%	★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	68.72%	★★★★	71.60%	★★★★
Medication Compliance 75%—Total	48.55%	★★★★★	48.07%	★★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	69.22%	★★★★★	71.45%	★★★★★
Statin Adherence 80%	66.27%	★★★★	63.41%	★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	27.61%	NC
30-Day Follow-Up	—	NC	44.26%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	48.95%	NC
Engagement of AOD Treatment—Total—Total	—	NC	11.19%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-27—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—IlliniCare

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	56.98%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	39.89%	75th Percentile	46.23%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	89.63%	75th Percentile	90.02%	**MET**
Eye Exam (Retinal) Performed	66.67%	75th Percentile	66.91%	
Medical Attention for Nephropathy	93.30%	75th Percentile	95.38%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	44.26%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	48.95%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	11.19%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Meridian

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Meridian are displayed in the tables below.

Table C-28—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—Meridian

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	83.14%	★★★	84.71%	★★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	561.84	NC	556.04	NC
ED Visits—Total	117.82	NC	111.84	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	87.70%	★★★	91.73%	★★★★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	59.95%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	53.40%	★★	55.96%	★★
Chlamydia Screening in Women				
Total	65.12%	★★★★	50.38%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	69.84%	★	73.68%	★
Postpartum Care	44.44%	★	57.89%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.27%	★★★★	86.12%	★★
Diuretics	90.12%	★★★★	87.17%	★★
Total[1]	—	NC	86.56%	NC
Comprehensive Diabetes Care				
HbA1c Testing	86.26%	★★★	87.04%	★★
Eye Exam (Retinal) Performed	57.91%	★★★	63.14%	★★★
Medical Attention for Nephropathy	92.82%	★★★★	92.88%	★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	61.81%	★★★	66.91%	★★★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	75.25%	★★★★★	80.50%	★★★★★
Medication Compliance 75%—Total	53.54%	★★★★★	66.00%	★★★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	64.81%	★★★★	68.64%	★★★★★
Statin Adherence 80%	72.52%	★★★★★	72.24%	★★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	35.46%	NC
30-Day Follow-Up	—	NC	52.26%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	39.77%	NC
Engagement of AOD Treatment—Total—Total	—	NC	7.35%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

Table C-29—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—Meridian

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	59.95%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	53.40%	75th Percentile	55.96%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	86.26%	75th Percentile	87.04%	NOT MET
Eye Exam (Retinal) Performed	57.91%	75th Percentile	63.14%	
Medical Attention for Nephropathy	92.82%	75th Percentile	92.88%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	52.26%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	39.77%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	7.35%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Molina

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Molina are displayed in the tables below.

Table C-30—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—Molina

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	79.38%	★★	79.39%	★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	427.50	NC	457.18	NC
ED Visits—Total	130.49	NC	122.31	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	83.66%	★★	87.10%	★★★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	47.36%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	47.29%	★	44.77%	★
Chlamydia Screening in Women				
Total	55.42%	★★★	50.00%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA	NC	NA	NC
Postpartum Care	NA	NC	NA	NC
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	88.54%	★★★	89.91%	★★★
Diuretics	87.55%	★★★	90.83%	★★★★
Total[1]	—	NC	90.32%	NC
Comprehensive Diabetes Care				
HbA1c Testing	83.19%	★★	89.78%	★★★
Eye Exam (Retinal) Performed	53.10%	★★	62.29%	★★★
Medical Attention for Nephropathy	91.15%	★★★	92.70%	★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	40.47%	★	50.12%	★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	81.01%	★★★★★	77.94%	★★★★★
Medication Compliance 75%—Total	53.16%	★★★★★	45.59%	★★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	63.66%	★★★	63.37%	★★★
Statin Adherence 80%	67.32%	★★★★	54.13%	★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	27.83%	NC
30-Day Follow-Up	—	NC	51.89%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	37.01%	NC
Engagement of AOD Treatment—Total—Total	—	NC	5.20%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

Table C-31—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—Molina

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	47.36%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	47.29%	75th Percentile	44.77%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	83.19%	75th Percentile	89.78%	**MET**
Eye Exam (Retinal) Performed	53.10%	75th Percentile	62.29%	
Medical Attention for Nephropathy	91.15%	75th Percentile	92.70%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	51.89%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	37.01%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	5.20%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

NextLevel

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for NextLevel are displayed in the tables below.

Table C-32—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—NextLevel

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	55.94%	★	56.46%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	NR	NC	280.96	NC
ED Visits—Total	NR	NC	94.25	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	NA	NC	27.45%	★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	NA	NC
Cervical Cancer Screening				
Cervical Cancer Screening	7.97%	★	20.43%	★
Chlamydia Screening in Women				
Total	NA	NC	NA	NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA	NC	NA	NC
Postpartum Care	NA	NC	NA	NC
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	88.31%	★★★	85.80%	★
Diuretics	85.66%	★★	82.80%	★
Total[1]	—	NC	84.43%	NC
Comprehensive Diabetes Care				
HbA1c Testing	72.44%	★	70.55%	★
Eye Exam (Retinal) Performed	24.15%	★	27.33%	★
Medical Attention for Nephropathy	87.02%	★	85.59%	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	BR	NC	BR	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total	NA	NC	NA	NC
Medication Compliance 75%—Total	NA	NC	NA	NC
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	NA	NC	63.25%	★★★
Statin Adherence 80%	NA	NC	68.72%	★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	10.97%	NC
30-Day Follow-Up	—	NC	20.25%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	52.31%	NC
Engagement of AOD Treatment—Total—Total	—	NC	7.14%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

NR indicates the rate was not reported.

BR indicates the rate was withheld because it was determined to be materially biased.

Table C-33—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—NextLevel

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	NA	Not Applicable
Cervical Cancer Screening				
Cervical Cancer Screening	7.97%	75th Percentile	20.43%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	72.44%	75th Percentile	70.55%	NOT MET
Eye Exam (Retinal) Performed	24.15%	75th Percentile	27.33%	
Medical Attention for Nephropathy	87.02%	75th Percentile	85.59%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	20.25%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	52.31%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	7.14%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.
NA indicates the rate was withheld because the denominator was less than 30.

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Aetna

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Aetna are displayed in the tables below.

Table C-34—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—Aetna

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	86.16%	★★★★	86.36%	★★★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	605.27	NC	569.47	NC
ED Visits—Total	90.91	NC	91.03	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	79.17%	★★	63.50%	★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	53.98%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	41.57%	★	46.23%	★
Chlamydia Screening in Women				
Total	44.55%	★	45.09%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.00%	★★	58.82%	★
Postpartum Care	52.50%	★	42.65%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.91%	★★★★	92.03%	★★★★
Diuretics	90.86%	★★★★	92.39%	★★★★
Total[1]	—	NC	92.18%	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	91.20%	★★★★	90.51%	★★★★
Eye Exam (Retinal) Performed	65.28%	★★★★	68.13%	★★★★
Medical Attention for Nephropathy	92.13%	★★★★	91.24%	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	52.23%	★★	42.58%	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	BR	NC	67.97%	★★★★
Medication Compliance 75%—Total	BR	NC	46.00%	★★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	67.83%	★★★★★	69.95%	★★★★★
Statin Adherence 80%	BR	NC	64.55%	★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	33.57%	NC
30-Day Follow-Up	—	NC	48.63%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	46.54%	NC
Engagement of AOD Treatment—Total—Total	—	NC	10.32%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

BR indicates the rate was withheld because it was determined to be materially biased.

Table C-35—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—Aetna

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	53.98%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	41.57%	75th Percentile	46.23%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	91.20%	75th Percentile	90.51%	**MET**
Eye Exam (Retinal) Performed	65.28%	75th Percentile	68.13%	
Medical Attention for Nephropathy	92.13%	75th Percentile	91.24%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	48.63%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	46.54%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	10.32%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Cigna

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Cigna are displayed in the tables below.

Table C-36—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—Cigna

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	66.48%	★	NA	NC
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	374.81	NC	435.79	NC
ED Visits—Total	82.81	NC	79.96	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	75.67%	★	NA	NC
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	NA	NC
Cervical Cancer Screening				
Cervical Cancer Screening	29.20%	★	NA	NC
Chlamydia Screening in Women				
Total	46.94%	★	NA	NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA	NC	NA	NC
Postpartum Care	NA	NC	NA	NC
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.37%	★★★★	NA	NC
Diuretics	91.44%	★★★★	NA	NC
Total[1]	—	NC	NA	NC
Comprehensive Diabetes Care				
HbA1c Testing	84.18%	★★	NA	NC
Eye Exam (Retinal) Performed	43.31%	★	NA	NC
Medical Attention for Nephropathy	89.60%	★★	NA	NC
Controlling High Blood Pressure				
Controlling High Blood Pressure	41.61%	★	NA	NC

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	70.13%	★★★★	NA	NC
Medication Compliance 75%—Total	44.16%	★★★★	NA	NC
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	64.10%	★★★★	NA	NC
Statin Adherence 80%	59.75%	★★★	NA	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	38.35%	NC
30-Day Follow-Up	—	NC	48.87%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	47.77%	NC
Engagement of AOD Treatment—Total—Total	—	NC	7.96%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

Table C-37—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—Cigna

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	NA	Not Applicable
Cervical Cancer Screening				
Cervical Cancer Screening	29.20%	75th Percentile	NA	Not Applicable
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	84.18%	75th Percentile	NA	Not Applicable
Eye Exam (Retinal) Performed	43.31%	75th Percentile	NA	
Medical Attention for Nephropathy	89.60%	75th Percentile	NA	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	48.87%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	47.77%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	7.96%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.
NA indicates the rate was withheld because the denominator was less than 30.

CCAI

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for CCAI are displayed in the tables below.

Table C-38—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—CCAI

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	79.44%	★★	83.55%	★★★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	430.20	NC	439.52	NC
ED Visits—Total	97.35	NC	99.71	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	61.56%	★	26.28%	★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	54.80%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	45.50%	★	53.77%	★★
Chlamydia Screening in Women				
Total	68.18%	★★★★	NA	NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	55.17%	★	53.66%	★
Postpartum Care	37.93%	★	43.90%	★
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.24%	★★★★	92.09%	★★★★
Diuretics	89.93%	★★★	93.92%	★★★★★
Total[1]	—	NC	92.86%	NC
Comprehensive Diabetes Care				
HbA1c Testing	85.89%	★★	87.09%	★★
Eye Exam (Retinal) Performed	45.99%	★★	56.62%	★★★
Medical Attention for Nephropathy	91.24%	★★★	91.39%	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	29.93%	★	1.98%	★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	59.61%	★★★	NA	NC
Medication Compliance 75%—Total	36.45%	★★★	NA	NC
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	67.89%	★★★★★	66.67%	★★★★
Statin Adherence 80%	57.47%	★★	69.83%	★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	25.29%	NC
30-Day Follow-Up	—	NC	38.08%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	43.24%	NC
Engagement of AOD Treatment—Total—Total	—	NC	8.97%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

Table C-39—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—CCAI

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	54.80%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	45.50%	75th Percentile	53.77%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	85.89%	75th Percentile	87.09%	NOT MET
Eye Exam (Retinal) Performed	45.99%	75th Percentile	56.62%	
Medical Attention for Nephropathy	91.24%	75th Percentile	91.39%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	38.08%	NOT MET
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	43.24%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	8.97%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Humana

The SFY 2017 and SFY 2018 performance measure results and SFY 2018 P4P results for Humana are displayed in the tables below.

Table C-40—ICP HEDIS 2017 and HEDIS 2018 Performance Measure Results—Humana

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Access/Utilization of Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	66.55%	★	66.55%	★
Ambulatory Care (per 1,000 Member Months)				
Outpatient Visits—Total	261.62	NC	246.33	NC
ED Visits—Total	71.50	NC	71.09	NC
Preventive Care				
Adult BMI Assessment				
Adult BMI Assessment	88.56%	★★★	87.50%	★★★
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	NC	34.12%	NC
Cervical Cancer Screening				
Cervical Cancer Screening	36.98%	★	33.66%	★
Chlamydia Screening in Women				
Total	56.72%	★★★	67.16%	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	NA	NC	NA	NC
Postpartum Care	NA	NC	NA	NC
Appropriate Care				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	89.90%	★★★	90.79%	★★★★
Diuretics	87.47%	★★	90.00%	★★★
Total[1]	—	NC	90.47%	NC
Comprehensive Diabetes Care				
HbA1c Testing	85.16%	★★	85.16%	★★
Eye Exam (Retinal) Performed	45.99%	★★	51.09%	★★
Medical Attention for Nephropathy	92.70%	★★★★	89.29%	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	56.34%	★★★	53.53%	★★

Measure	HEDIS 2017 Rate	2017 Performance Level	HEDIS 2018 Rate	2018 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total[2]	NA	NC	74.19%	★★★★★
Medication Compliance 75%—Total	NA	NC	48.39%	★★★★
Statin Therapy for Patients With Diabetes[3]				
Received Statin Therapy	60.95%	★★★	65.33%	★★★★
Statin Adherence 80%	79.61%	★★★★★	79.59%	★★★★★
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up	—	NC	23.87%	NC
30-Day Follow-Up	—	NC	36.94%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation of AOD Treatment—Total—Total	—	NC	49.26%	NC
Engagement of AOD Treatment—Total—Total	—	NC	6.65%	NC

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performance for this measure.*

[2] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

[3] *Quality Compass benchmarks were not previously available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes for the HEDIS 2017 rates.*

— indicates that the measure was not presented in the previous year's report; therefore, that year's HEDIS measure rate and percentile ranking are not presented in this year's report. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a percentile ranking was not determined because the HEDIS 2018 measure rate was not reported, or the measure did not have an applicable benchmark.

NA indicates the rate was withheld because the denominator was less than 30.

Table C-41—ICP Pay-for-Performance Results for 2018 Contracted Goals and Results—Humana

Measure	2017 Rate	2018 Target Goal	2018 Rate	Overall Result
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	75th Percentile	34.12%	NOT MET
Cervical Cancer Screening				
Cervical Cancer Screening	36.98%	75th Percentile	33.66%	NOT MET
Appropriate Care				
Comprehensive Diabetes Care				
HbA1c Testing	85.16%	75th Percentile	85.16%	NOT MET
Eye Exam (Retinal) Performed	45.99%	75th Percentile	51.09%	
Medical Attention for Nephropathy	92.70%	75th Percentile	89.29%	
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	75th Percentile	36.94%	NOT MET
Initiation and Engagement of AOD Dependence Treatment				
Initiation of AOD Treatment—Total—Total	—	90th Percentile	49.26%	NOT MET
Engagement of AOD Treatment—Total—Total	—	75th Percentile	6.65%	

— indicates that NCQA recommended a break in trending for this measure; therefore, the HEDIS 2017 rate is not displayed.

Encounter Data Completeness

The tables below display the estimate of the administrative data completeness for the CY 2017 (HEDIS 2018) measure rate calculated using the hybrid methodology for each FHP/ACA and ICP health plan. Health plans were not required to report using the hybrid method; therefore, the measures in the tables may differ between health plans. Encounter data completeness tables for NextLevel and Cigna are not shown due to the health plans not supplementing their administrative encounter data with medical record data. These measures use administrative encounter data and supplement the results with medical record data. The information provided in the tables below present the percentage of each HEDIS measure rate that was determined using administrative encounter data only.

Table C-42—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—Aetna

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	32.03%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	52.07%
Combination 3	52.20%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	91.05%
Combination 2 (Meningococcal, Tdap, HPV)	87.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	24.35%
Counseling for Nutrition—Total	14.10%
Counseling for Physical Activity—Total	11.17%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	80.07%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	95.48%

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	90.54%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	99.13%
Postpartum Care	94.80%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	96.75%
Eye Exam (Retinal) Performed	92.06%
Medical Attention for Nephropathy	97.88%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-43—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—BCBSIL

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	41.10%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	41.10%
Combination 3	38.93%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	75.30%
Combination 2 (Meningococcal, Tdap, HPV)	64.75%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	42.21%
Counseling for Nutrition—Total	31.80%
Counseling for Physical Activity—Total	18.48%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	93.28%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	98.75%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	92.83%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	94.33%
Postpartum Care	95.14%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.87%
Eye Exam (Retinal) Performed	91.48%
Medical Attention for Nephropathy	99.18%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-44—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—CountyCare

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	40.11%
Child & Adolescent Care	
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	61.52%
Combination 2 (Meningococcal, Tdap, HPV)	55.56%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	25.28%
Counseling for Nutrition—Total	21.15%
Counseling for Physical Activity—Total	14.24%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	82.97%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	93.88%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	86.82%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	93.99%
Eye Exam (Retinal) Performed	70.64%
Medical Attention for Nephropathy	97.87%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-45—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—FHN

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	99.15%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	100.00%
Combination 3	100.00%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	99.38%
Combination 2 (Meningococcal, Tdap, HPV)	99.30%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	100.00%
Counseling for Nutrition—Total	100.00%
Counseling for Physical Activity—Total	100.00%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	98.35%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	99.34%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	100.00%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	96.14%
Postpartum Care	99.58%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	100.00%
Eye Exam (Retinal) Performed	100.00%
Medical Attention for Nephropathy	100.00%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-46—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—Harmony

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	63.89%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	97.45%
Combination 3	96.85%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	96.76%
Combination 2 (Meningococcal, Tdap, HPV)	97.44%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	60.39%
Counseling for Nutrition—Total	46.13%
Counseling for Physical Activity—Total	39.05%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	76.60%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	94.87%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	87.65%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	90.00%
Postpartum Care	94.68%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	90.88%
Eye Exam (Retinal) Performed	80.63%
Medical Attention for Nephropathy	96.51%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-47—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—IlliniCare

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	44.60%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	43.91%
Combination 3	43.33%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	85.16%
Combination 2 (Meningococcal, Tdap, HPV)	68.97%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	45.05%
Counseling for Nutrition—Total	30.15%
Counseling for Physical Activity—Total	15.90%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	80.09%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	96.32%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	90.76%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	95.92%
Postpartum Care	90.08%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.87%
Medical Attention for Nephropathy	99.72%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-48—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—Meridian

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	59.12%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	97.15%
Combination 3	97.32%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	99.47%
Combination 2 (Meningococcal, Tdap, HPV)	98.70%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	43.37%
Counseling for Nutrition—Total	28.92%
Counseling for Physical Activity—Total	17.99%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	95.06%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	96.42%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	93.77%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	98.61%
Postpartum Care	94.43%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.97%
Eye Exam (Retinal) Performed	97.46%
Medical Attention for Nephropathy	99.59%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-49—FHP/ACA Estimated Encounter Data Completeness for Hybrid Measures—Molina

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	45.08%
Child & Adolescent Care	
Childhood Immunization Status	
Combination 2	97.37%
Combination 3	98.23%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	97.67%
Combination 2 (Meningococcal, Tdap, HPV)	98.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	39.86%
Counseling for Nutrition—Total	35.32%
Counseling for Physical Activity—Total	25.70%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	94.97%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	99.03%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	96.19%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.50%
Postpartum Care	96.00%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.52%
Eye Exam (Retinal) Performed	93.36%
Medical Attention for Nephropathy	99.17%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-50—ICP Estimated Encounter Data Completeness for Hybrid Measures—Aetna

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	41.76%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	95.79%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	100.00%
Postpartum Care	89.66%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	95.97%
Eye Exam (Retinal) Performed	91.43%
Medical Attention for Nephropathy	97.33%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-51—ICP Estimated Encounter Data Completeness for Hybrid Measures—BCBSIL

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	46.34%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	85.79%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	88.89%
Postpartum Care	81.82%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.42%
Eye Exam (Retinal) Performed	95.36%
Medical Attention for Nephropathy	99.23%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-52—ICP Estimated Encounter Data Completeness for Hybrid Measures—CCAI

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	96.30%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	100.00%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	100.00%
Postpartum Care	100.00%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	100.00%
Eye Exam (Retinal) Performed	100.00%
Medical Attention for Nephropathy	100.00%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-53—ICP Estimated Encounter Data Completeness for Hybrid Measures—CountyCare

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	38.31%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	88.65%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	NA
Postpartum Care	NA

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

NA indicates the measure was reported using the hybrid methodology, but the rate and encounter data completeness were withheld because the denominator was less than 30.

Table C-54—ICP Estimated Encounter Data Completeness for Hybrid Measures—Humana

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	62.73%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	94.86%
Eye Exam (Retinal) Performed	96.67%
Medical Attention for Nephropathy	97.28%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-55—ICP Estimated Encounter Data Completeness for Hybrid Measures—IlliniCare

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	62.59%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	95.79%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.65%
Eye Exam (Retinal) Performed	96.00%
Medical Attention for Nephropathy	99.74%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-56—ICP Estimated Encounter Data Completeness for Hybrid Measures—Meridian

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	77.72%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	96.52%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.62%
Postpartum Care	93.94%
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	99.16%
Eye Exam (Retinal) Performed	96.24%
Medical Attention for Nephropathy	99.61%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

Table C-57—ICP Estimated Encounter Data Completeness for Hybrid Measures—Molina

2018 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Preventive Care	
Adult BMI Assessment	
Adult BMI Assessment	51.40%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	94.02%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	NA
Postpartum Care	NA
Appropriate Care	
Comprehensive Diabetes Care	
HbA1c Testing	98.10%
Eye Exam (Retinal) Performed	95.31%
Medical Attention for Nephropathy	99.21%

Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

NA indicates the measure was reported using the hybrid methodology, but the rate and encounter data completeness were withheld because the denominator was less than 30.

Appendix D. PCCM/CHIPRA Performance Measure Validation Results

Overview

Health Services Advisory Group, Inc. (HSAG), conducted a review of the Primary Care Case Management (PCCM) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) programs for a select set of performance measures, following the Performance Measure Validation (PMV) protocol outlined by the Centers for Medicare & Medicaid Services (CMS). Using the most recent data available at the time, HSAG evaluated the processes the Illinois Department of Healthcare and Family Services (HFS) used to collect the performance measure data and determined the extent to which the performance measures followed the established specifications. See Appendix B and Appendix C for more details regarding the performance measure validation process.

CY 2016 Performance Measures

The calendar year (CY) 2016 performance measures selected by HFS included a combination of the Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS measures. The non-HEDIS measures consisted of Adult Core Set and Child Core Set measures, Maternal and Infant Health Initiative Contraceptive Care measures, as well as measures that were defined by HFS. All HEDIS measures were reviewed for compliance with the HEDIS 2017 technical specifications. The non-HEDIS measures were reviewed for compliance with either the June 2016 Adult Core Set, the June 2016 Child Core Set, the October 2016 Maternal and Infant Health Initiative Contraceptive Care measures, or specifications that were provided by HFS. For measures that were both HEDIS and Core Set measures, HSAG reviewed the age stratifications required by both the HEDIS and Core Set specifications.

Although the PCCM and CHIPRA measure sets contained different measures, some measures applied to both populations.

CY 2016 Results

Multiple data sources were validated by the auditor to make a determination as to the validity of the data collected by HFS. HSAG determined that the data supported the elements necessary for reporting, and measures were calculated appropriately according to the required measure specifications. As a result, all performance measures audited received an audit designation of *Reportable* (*R*). Table D-1 displays the CY 2016 rates for the PCCM and CHIPRA performance measures validated by HSAG.

Table D-1—CY 2016 PCCM/CHIPRA Performance Measures

Performance Measure	PCCM Rate	CHIPRA Rate
PCCM and CHIPRA Measures		
Adult Body Mass Index Assessment		
Ages 18 to 64	16.10%	17.62%
Ages 65 to 74	17.34%	17.95%
Total	16.11%	17.35%
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits	331.23	272.99
*Emergency Department Visits**	69.72	61.41
Antidepressant Medication Management		
Effective Acute Phase Treatment	36.05%	42.24%
Effective Continuation Phase Treatment	20.24%	23.57%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	49.70%	48.35%
Breast Cancer Screening		
Ages 50 to 64	50.69%	53.56%
Ages 65 to 74	42.86%	48.97%
Total	50.38%	53.18%
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	97.35%	94.04%
Ages 25 Months to 6 Years	92.24%	86.99%
Ages 7 to 11 Years	92.86%	88.84%
Ages 12 to 19 Years	96.22%	89.97%
Total	94.08%	—
Cervical Cancer Screening		
Cervical Cancer Screening	55.11%	51.67%
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	85.82%	81.36%
Eye Exam (Retinal) Performed	42.02%	39.26%
Medical Attention for Nephropathy	86.20%	87.53%

Performance Measure	PCCM Rate	CHIPRA Rate
Chlamydia Screening in Women		
Ages 16 to 20	34.86%	45.59%
Ages 21 to 24	51.33%	56.72%
Total	42.81%	—
Childhood Immunization Status		
Combination 2	64.07%	62.59%
Combination 3	60.68%	58.50%
Combination 4	51.04%	54.20%
Combination 5	49.15%	48.81%
Combination 6	23.38%	27.19%
Combination 7	42.96%	45.87%
Combination 8	20.98%	26.18%
Combination 9	18.60%	23.10%
Combination 10	18.60%	23.10%
Frequency of Ongoing Prenatal Care		
<21 Percent	1.19%	3.68%
21 Percent to 40 Percent	1.32%	3.46%
41 Percent to 60 Percent	1.75%	4.23%
61 Percent to 80 Percent	3.20%	6.27%
>80 Percent	92.54%	82.36%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Ages 6 to 20	—	45.74%
7-Day Follow-Up—Ages 21 to 64	—	27.17%
7-Day Follow-Up—Ages 65 and Older	—	21.32%
7-Day Follow-Up—Total	40.58%	—
30-Day Follow-Up—Ages 6 to 20	—	67.99%
30-Day Follow-Up—Ages 21 to 64	—	43.48%
30-Day Follow-Up—Ages 65 and Older	—	33.82%
30-Day Follow-Up—Total	63.17%	—

Performance Measure	PCCM Rate	CHIPRA Rate
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—Ages 13 to 17	—	46.45%
Initiation of AOD Treatment—Ages 18 and Older	—	35.41%
Initiation of AOD Treatment—Total	38.52%	—
Engagement of AOD Treatment—Ages 13 to 17	—	10.39%
Engagement of AOD Treatment—Ages 18 and Older	—	9.38%
Engagement of AOD Treatment—Total	14.76%	—
Medication Management for People with Asthma		
Medication Compliance 50%—Ages 5 to 11 Years	61.37%	48.22%
Medication Compliance 50%—Ages 12 to 18 Years	52.02%	44.31%
Medication Compliance 50%—Ages 19 to 50 Years	54.11%	53.34%
Medication Compliance 50%—Ages 51 to 64 Years	65.99%	68.81%
Medication Compliance 50%—Total	56.91%	—
Medication Compliance 75%—Ages 5 to 11 Years	32.93%	22.00%
Medication Compliance 75%—Ages 12 to 18 Years	28.14%	21.15%
Medication Compliance 75%—Ages 19 to 50 Years	27.78%	27.53%
Medication Compliance 75%—Ages 51 to 64 Years	36.55%	41.99%
Medication Compliance 75%—Total	30.30%	—
Annual Monitoring for Patients on Persistent Medications		
Total—Ages 18 to 64	—	79.14%
Total—Ages 65 and Older	—	83.65%
Total	82.14%	—
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	71.78%	57.25%
Postpartum Care	64.74%	56.18%
Well-Child Visits in the First 15 Months of Life		
*Zero Visits**	0.50%	3.40%
One Visit	1.10%	3.20%
Two Visits	1.60%	4.30%
Three Visits	2.30%	6.60%
Four Visits	4.10%	9.70%

Performance Measure	PCCM Rate	CHIPRA Rate
Five Visits	7.80%	14.00%
Six or More Visits	82.6%	58.70%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Total	72.78%	71.63%
Weight Assessment and Counseling for Nutrition and Physical Activity		
BMI Percentile—Ages 3 to 11	4.95%	13.61 %
BMI Percentile—Ages 12 to 17	6.16%	14.41 %
BMI Percentile—Total	5.39%	14.01 %
Counseling for Nutrition—Ages 3 to 11	2.37%	8.65 %
Counseling for Nutrition—Ages 12 to 17	2.47%	8.78 %
Counseling for Nutrition—Total	2.40%	8.72 %
Counseling for Physical Activity—Ages 3 to 11	1.62%	1.73 %
Counseling for Physical Activity—Ages 12 to 17	12.26%	8.02 %
Counseling for Physical Activity—Total	5.52%	—
CHIPRA Measures (Only)		
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication		
Initiation Phase	—	31.34%
Continuation and Maintenance Phase	—	40.18%
Contraceptive Care Postpartum Women Ages 15–44		
Were provided most effective or moderately effective FDA-approved methods of contraception within 3 days of delivery	—	7.2%
Were provided most effective or moderately effective FDA-approved methods of contraception within 60 days of delivery	—	26.3%
Were provided a long-acting reversible method of contraception within 3 days of delivery	—	.4%
Were provided a long-acting reversible method of contraception within 60 days of delivery	—	9.5%
Contraceptive Care All Women Ages 15–44		
Were provided a most effective or moderately effective FDA-approved method of contraception (ages 15-20)	—	19.5%
Were provided a most effective or moderately effective FDA-approved method of contraception (ages 21-44)	—	19.9%
Were provided a long-acting reversible method of contraception (ages 15-20)	—	2.0%
Were provided a long-acting reversible method of contraception (ages 21-44)	—	3.8%

Performance Measure	PCCM Rate	CHIPRA Rate
Developmental Screening in the First Three Years of Life		
Age 1	—	60.9%
Age 2	—	57.7%
Age 3	—	44.4%
Total	—	54.6%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications		
Glucose Test	—	89.7%
HbA1c Test	—	29.5%
Diabetes Screening	—	90.1%
Immunizations for Adolescents		
Meningococcal	—	77.95%
Tdap/Td	—	87.69%
All Immunized—Total	—	19.64%
Live Births Weighing Less Than 2,500 Grams		
Live Births Weighing Less Than 2,500 Grams	—	9.17%
Cesarean Section for Nulliparous Singleton Vertex		
Cesarean Section for Nulliparous Singleton Vertex	—	20.14%
Percentage of Eligibles Who Received Preventive Dental Services		
Total	—	41.66%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)		
Ages 18 to 64	—	13.13
Ages 65 and Older	—	9.98
Total	—	13.07
Chronic Obstructive Pulmonary Disease Admission Rate (per 100,000 Member Months)		
Ages 40 to 64	—	67.21
Ages 65 and Older	—	105.58
Total	—	69.01
Heart Failure Admission Rate (per 100,000 Member Months)		
Ages 18 to 64	—	20.07
Ages 65 and Older	—	124.03
Total	—	22.64

Performance Measure	PCCM Rate	CHIPRA Rate
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)		
Total	—	5.85
Adherence to Antipsychotics for Individuals with Schizophrenia		
Adherence to Antipsychotics for Individuals with Schizophrenia	—	55.07%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	17.12%
PCCM Measures (Only*)*		
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44	82.19%	—
Ages 45 to 64	86.23%	—
Ages 65 and Older	87.15%	—
Total	83.57%	—
Objective Vision Screening in the Fourth, Fifth, and Sixth Years of Life		
Age 4	33.69%	—
Age 5	62.47%	—
Age 6	38.27%	—
Total	39.15%	—
Perinatal Depression Screening		
Prenatal Depression Screening	47.12%	—
Postpartum Depression Screening	37.38%	—
Both Screenings—Total	22.29%	—
Lead Screening in Children		
One or More Tests	74.79%	—
State-Modified Developmental Screening in the First Three Years of Life		
Age 1	79.8%	—
Age 2	63.6%	—
Age 3	44.8%	—
Total	57.4%	—
State-Modified Lead Screening in Children		
Two Tests	13.91%	—

** For this measure, a lower rate may indicate better performance.*

CY 2017 Performance Measures

The CY 2017 performance measures selected by HFS included a combination of HEDIS measures as well as CMS Adult Core Set and Child Core Set performance measures. All HEDIS measures were reviewed for compliance with the HEDIS 2018 technical specifications. For measures that were both HEDIS and Core Set measures, the source code was reviewed according to both the HEDIS 2018 technical specifications, the February 2018 Adult Core Set, and the February 2018 Child Core Set. This was acceptable since the specifications for most, if not all, HEDIS measures were the same as the Core Set, except for age breakouts. There were also measures which utilize the Maternal and Infant Health Initiative (MIHI) Contraceptive Care Measures technical specifications and the Data Definitions technical specifications produced by HFS.

Although the PCCM and CHIPRA measure sets contained different measures, some measures applied to both populations.

CY 2017 Results

Multiple data sources were validated by the auditor to make a determination as to the validity of the data collected by HFS. HSAG determined that the data supported the elements necessary for reporting, and measures were calculated appropriately according to the required measure specifications. As a result, all performance measures audited received an audit designation of *R*. Table D-2 displays the CY 2017 rates for the PCCM and CHIPRA performance measures validated by HSAG.

Table D-2—CY 2017 PCCM/CHIPRA Performance Measures

Performance Measure	PCCM Rate	CHIPRA Rate
PCCM and CHIPRA Measures		
Adult Body Mass Index Assessment		
Ages 18 to 64	18.84%	20.86%
Ages 65 to 74	21.84%	22.85%
Total	18.86%	20.90%
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits	346.17	276.31
*Emergency Department Visits**	73.17	61.16
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	48.92%	48.75%

Performance Measure	PCCM Rate	CHIPRA Rate
Annual Monitoring of Patients on Persistent Medications		
Ages 16-64	—	81.50%
Ages 65+	—	86.30%
Total	81.82%	—
Antidepressant Medication Management		
Percent on Medications: 12 Weeks	38.73%	19.21%
Percent on Medications: 6 Months	41.82%	23.12%
Breast Cancer Screening		
Ages 50 to 64	50.30%	52.42%
Ages 65 to 74	44.56%	48.91%
Total	50.09%	52.12%
Cervical Cancer Screening		
Cervical Cancer Screening	53.99%	52.32%
Chlamydia Screening in Women		
Ages 16-20 Years	36.19%	52.03%
Ages 21-24 Years	46.79%	57.62%
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12-24 Months	97.70%	93.93%
Ages 25 Months-6 Years	92.41%	87.09%
Ages 7-11 Years	93.28%	89.10%
Ages 12-19 Years	96.35%	90.42%
Developmental Screening in the First 3 Years of Life		
1 Year	80.0%	63.4%
2 Years	63.1%	61.8%
3 Years	47.5%	51.2%
Total	57.8%	58.9%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Ages 6 to 20	—	48.39%
7-Day Follow-Up—Ages 21 to 64	—	26.39%
7-Day Follow-Up—Ages 65 and Older	—	13.77%
7-Day Follow-Up—Total	38.25%	—

Performance Measure	PCCM Rate	CHIPRA Rate
30-Day Follow-Up—Ages 6 to 20	—	68.04%
30-Day Follow-Up—Ages 21 to 64	—	42.47%
30-Day Follow-Up—Ages 65 and Older	—	20.24%
30-Day Follow-Up—Total	59.76%	—
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment		
Initiation of AOD: Alcohol Abuse or Dependence—Ages 13 to 17	42.86%	32.38%
Initiation of AOD: Alcohol Abuse or Dependence—Ages 18+	35.66%	30.48%
Initiation of AOD: Alcohol Abuse or Dependence—Total	35.83%	32.36%
Engagement of AOD: Alcohol Abuse or Dependence—Ages 13 to 17	9.18%	8.89%
Engagement of AOD: Alcohol Abuse or Dependence—Ages 18+	12.03%	3.74%
Engagement of AOD: Alcohol Abuse or Dependence—Total	11.97%	8.84$
Initiation of AOD: Opioid Abuse or Dependence—Ages 13 to 17	75.00%	41.37%
Initiation of AOD: Opioid Abuse or Dependence—Ages 18+	44.22%	42.59%
Initiation of AOD: Opioid Abuse or Dependence—Total	44.29%	41.39%
Engagement of AOD: Opioid Abuse or Dependence—Ages 13 to 17	50.00%	18.13%
Engagement of AOD: Opioid Abuse or Dependence—Ages 18+	23.44%	15.21%
Engagement of AOD: Opioid Abuse or Dependence—Total	23.50%	18.09%
Initiation of AOD: Other Drug Abuse or Dependence—Ages 13 to 17	55.08%	36.06%
Initiation of AOD: Other Drug Abuse or Dependence—Ages 18+	35.00%	30.30%
Initiation of AOD: Other Drug Abuse or Dependence—Total	36.74%	36.03%
Engagement of AOD: Other Drug Abuse or Dependence—Ages 13 to 17	17.58%	11.18%
Engagement of AOD: Other Drug Abuse or Dependence—Ages 18+	13.91%	4.04%
Engagement of AOD: Other Drug Abuse or Dependence—Total	14.23%	11.14%
Medication Management for People with Asthma		
Medication Compliance 50%—Ages 5 to 11	58.58%	50.73%
Medication Compliance 50%—Ages 12 to 18	53.22%	47.15%
Medication Compliance 50%—Ages 19 to 50	58.22%	
Medication Compliance 50%—Ages 19-20	—	48.69%
Medication Compliance 50%—Ages 51 to 64	69.95%	—
Medication Compliance 50%—Total	57.69%	49.26%

Performance Measure	PCCM Rate	CHIPRA Rate
Medication Compliance 75%—Ages 5 to 11 Years	32.26%	22.00%
Medication Compliance 75%—Ages 12 to 18 Years	30.01%	21.15%
Medication Compliance 75%—Ages 19 to 50 Years	33.51%	27.53%
Medication Compliance 75%—Ages 19-20	—	25.19%
Medication Compliance 75%—Ages 51 to 64 Years	45.90%	—
Medication Compliance 75%—Total	32.87%	23.65%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	69.97%	64.68%
Postpartum Care	54.28%	56.37%
Well-Child Visits in the First 15 Months of Life		
*Zero Visits**	.8%	3.6%
One Visit	1.2%	3.3%
Two Visits	1.3%	4.6%
Three Visits	2.1%	6.7%
Four Visits	4.0%	9.7%
Five Visits	7.8%	13.6%
Six or More Visits	82.9%	58.6%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Total	71.77%	71.11%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	—	83.60%
Combination 2 (Meningococcal, Tdap, HPV)	—	30.40%
Meningococcal	—	89.80%
Tdap/Td	—	86.00%
HPV	—	33.60%
CHIPRA Measures (Only*)		
Adherence to Antipsychotics for Individuals with Schizophrenia		
Total	—	54.75%
Asthma in Younger Adults Admission Rate(Per 100,000 Member Months)		
Total	—	6.16

Performance Measure	PCCM Rate	CHIPRA Rate
Cesarean Section for Nulliparous Singleton Vertex		
Cesarean Section for Nulliparous Singleton Vertex	—	23.76%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)		
Ages 18-64	—	61.34
Ages 65+	—	110.86
Total (All Ages)	—	63.80
Contraceptive Care-Postpartum Women Ages 15-44		
Were provided most effective or moderately effective FDA-approved methods of contraception within 3 days of delivery (Ages 15-20)	—	1.0%
Were provided most effective or moderately effective FDA-approved methods of contraception within 60 days of delivery (Ages 15-20)	—	24.8%
Were provided most effective or moderately effective FDA-approved methods of contraception within 3 days of delivery (Ages 21-44)	—	7.7%
Were provided most effective or moderately effective FDA-approved methods of contraception within 60 days of delivery (Ages 21-44)	—	26.5%
Were provided a long-acting reversible method of contraception within 3 days of delivery (Ages 15-20)	—	.8%
Were provided a long-acting reversible method of contraception within 60 days of delivery (Ages 15-20)	—	12.1%%
Were provided a long-acting reversible method of contraception within 3 days of delivery (Ages 21-44)	—	.7%
Were provided a long-acting reversible method of contraception within 60 days of delivery (Ages 21-44)	—	11.2.%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Total	—	12.78%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications		
Total	—	94.9%
Diabetes Short-Term Complications Admission Rate (Per 1000,000 Member Months)		
Ages 18-64	—	13.27
Ages 65+	—	10.97
Total (All Ages)	—	13.23

Performance Measure	PCCM Rate	CHIPRA Rate
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation	—	30.72%
Continuance and Maintenance	—	40.05%
Heart Failure Admission Rate(Per 100,000 Member Months)		
Ages 18-64	—	21.46
Ages 65+	—	123.57
Total (All Ages)	—	23.00
Live Births Weighing Less Than 2,500 Grams		
Live Births Weighing Less Than 2,500 Grams	—	9.84%
Weight Assessment and Counseling for Nutrition and Physical Activity		
BMI Percentile (Ages 3-11 Years)	—	18.82%
BMI Percentile (Ages 12-17 Years))	—	19.73%
Counseling for Nutrition (Ages 3-11 Years)	—	12.78%
Counseling for Nutrition (Ages 12-17 Years))	—	12.59%
Counseling for Physical Activity (Ages 3-11 Years)	—	4.36%
Counseling for Physical Activity (Ages 12-17 Years))	—	10.52%
PCCM Measures (Only*)*		
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44	80.85%	—
Ages 45 to 64	85.41%	—
Ages 65 and Older	86.00%	—
Total	82.42%	—
Lead Screening in Children		
One or more tests	72.57%	—
Two Tests	11.99%	—
Objective Vision Screening in the Fourth, Fifth, and Sixth Years of Life		
3 Years of Age	23.91%	—
4 Years of Age	37.06%	—
5 Years of Age	63.27%	—
6 Years of Age	44.26%	—
Total (All Age Groups)	42.36%	—

Performance Measure	PCCM Rate	CHIPRA Rate
Perinatal Depression Screening		
Prenatal	48.70%	—
Postpartum	40.68%	—
Prenatal and Postpartum	29.92%	—

** For this measure, a lower rate may indicate better performance.*

Appendix E. MLTSS Performance Measure Validation Methodology

Introduction

The Illinois Department of Healthcare and Family Services (HFS) contracted with Health Services Advisory Group, Inc. (HSAG), the External Quality Review Organization (EQRO) for Illinois, to conduct validation of selected measures for data collected by the health plans during calendar year (CY) 2017. HFS selected two measures for validation:

- Managed Long Term Services and Supports (MLTSS) program Measure 2.2: Moderate- and high-risk members with a comprehensive assessment completed within required time frames.
- MLTSS Measure 3.2: Enrollees with documented discussions of person-centered care goals.

To ensure full submission of data and complete all validation activities, HFS scheduled the MLTSS Quality Withhold Performance Measure Validation (PMV) for completion during state fiscal year (SFY) 2019.

Methodology

HSAG will validate the data collection and reporting processes used by the health plans to report the quality withhold performance measure data for CY 2017 in accordance with the Centers for Medicare & Medicaid Services (CMS) publication *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[E-1] HFS provided the specifications and supplemental guidance that the health plans were required to use for reporting the performance measures.

The CMS EQR protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG conducted the analysis of these data:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—Health plans will be required to submit a shortened completed ISCAT (see Appendix A). An ISCAT is a systems assessment tool that allows the organization to provide step-by-step details on its information systems, processes used for collecting and processing data, and processes used for performance measure reporting. The ISCAT will be modified to include questions related to MLTSS 2.2 and MLTSS 3.2 processes only.
- **Supporting Documentation**—Health plans will submit documentation to HSAG that provides additional information to complete the validation process, including file layouts, system flow diagrams, data collection process descriptions, policies/procedures and plans, and MLTSS 2.2 and 3.2 enrollee-specific data files.

[E-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 4, 2019.

The PMV review of the health plans' reported data will consist of remote validation and post-validation activities focusing on the Health Risk Assessment (HRA) processes, care plan processes, and performance measure production. HSAG will utilize the National Committee for Quality Assurance (NCQA) methodology[E-2] for the file reviews for both MLTSS Measures 2.2 and 3.2, referred to as the "8 and 30" file sampling procedure.

[E-2] National Committee for Quality Assurance (NCQA). *An Explanation of the "8 and 30" File Sampling Procedure Used by NCQA During Accreditation Survey Visits May 1, 2001.* Available at: https://www.ncqa.org/wp-content/uploads/2018/07/20180110_830_Procedure.pdf. Accessed on: Feb 4, 2019.

Appendix F. HCBS Record Reviews Methodology and Detailed Results

Sampling Methodology

Health Services Advisory Group, Inc. (HSAG), developed a sampling methodology based on the waiver requirements approved by the Illinois Department of Healthcare and Family Services (HFS). HSAG conducted a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selected a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group were determined based on the number of eligible members in each waiver program. Once the required sample sizes were identified, a proportional random sample was selected based on the distribution of the health plans' population within each designated waiver program. Each sample was selected to ensure a 95 percent confidence level and 5 percent margin of error at the waiver program level, with a maximum sample population of 5,000 cases across the Family Health Plan/Affordable Care Act (FHP/ACA), Integrated Care Program (ICP), and Medicare-Medicaid Alignment Initiative (MMAI) waiver enrollees. Additionally, a 10 percent oversample based on the proportional distribution of enrollees across health plans was selected to replace ineligible cases. The samples were selected in July 2017 and included waiver members enrolled as of May 1, 2017. Limitations to the sampling methodology included known variables, such as beneficiary disenrollment from waiver services or the health plan, beneficiary death, beneficiary waiver type change, health plan exit from the market, or beneficiary program participation change (e.g., previously enrolled in ICP and transferred to MMAI). As a result, the following records were reviewed in state fiscal year (SFY) 2018:

Table F-1—Total Records Reviewed

Program	Sample Size	Total Records Completed	Waiver Program				
			BI	ELD	HIV	PD	SLF
FHP/ACA	636	559	55	262	25	217	0
ICP	1,369	1,341	260	365	182	356	178
MMAI	1,223	1,204	141	359	95	296	313
Total	**3,228**	**3,104**	**456**	**986**	**302**	**869**	**491**

Persons with Brain Injury (BI)
Persons who are Elderly (ELD)
Persons with HIV/AIDS (HIV)
Persons with Physical Disabilities (PD)
Persons in a Supportive Living Facility (SLF)

Scoring Methodology

During the on-site review, the HSAG review team reviewed documentation for the selected cases for each review period, consisting of a six-month look back period from the date of the review. The review team determined evidence of case compliance with each of the HFS-selected scored elements. A score of Yes, No, or Not Applicable (N/A) was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as Yes or No. These scores indicated the health plan's compliance with the requirements. HSAG also used a designation of N/A if the requirement was not applicable to a record; N/A findings were not included in the two-point scoring methodology.

HSAG calculated the score by adding the score from each eligible case and dividing the summed scores by the total number of eligible cases. HSAG aggregated the results across all records by health plan, by waiver population, and by performance measure.

Web-Based Abstraction Tool and Reporting Database

HSAG uses an electronic web-based abstraction tool and reporting database to collect and store the data gathered during on-site record reviews. The automated tool includes all waiver performance measures gathered from the review of records, as well as ICP, FHP/ACA, and MMAI contract requirements. It was modeled after the current tool used by the State to monitor the fee-for-service population to ensure waiver enrollees are monitored in a similar manner. The tool was used to assess compliance with case management activities, including comprehensive assessments, care planning, waiver service planning, beneficiary interaction, and specialized waiver evaluations.

For SFY 2018, changes to the Centers for Medicare & Medicaid Services (CMS) waiver performance measures and review tool included:

- Collection of additional performance measures related to survey responses for ELD waiver participants.
- Collection of an additional performance measure related to completion of overdue service plans.
- Collection of an additional performance measure to validate waiver service provision.
- Revision of evaluation criteria to ensure accurate collection of CMS performance measures.
- Alignment of performance measure numbering to ensure consistency of CMS performance measure reporting.
- Reduction in review look back period from 12 months to six months.

Interrater Reliability (IRR)

The IRR reviews were conducted by HSAG's senior project manager for 10 percent of all records completed by each individual reviewer. An accuracy rate of 95 percent was required, with retraining completed if required. Reviews were completed across all review quarters, waivers, program types, and health plans to ensure continued compliance to the 95 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent during SFY 2018.

Remediation Tracking

HSAG's report of findings was submitted to the State within 30 days of each review. Findings were reported for each health plan reviewed and as a summary by waiver. Once approved by the State, the report of findings was forwarded to each health plan for remediation. HSAG uses a remediation tracking database which details findings related to waiver performance measures, as well as ICP, FHP/ACA, and MMAI contract requirements. The remediation tracking database tracks the date the health plan was notified of findings, the date the remediation action was completed (as reported by the health plan), and the number of days from notification of the finding until the remediation action was completed. Health plans have access to their respective reports and the remediation tracking database via the HSAG Web portal, all of which can be accessed by HFS.

Remediation Validation

Remediation validation for the health plans was conducted on-site during the Quarter (Q) 2 and Q4 SFY 2018 waiver performance measure reviews. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed.

All health plans received their remediation sample 10 days prior to on-site remediation validation review, and they were responsible for ensuring all necessary remediation documentation was available during the on-site review. Remediation validation included a review of each record in the sample and supporting documentation, to ensure the action taken and completion date documented in the remediation tracking database were consistent with the information in the health plan's care management record and/or staff training records.

Multiple causative factors for noncompliance were identified, including incorrect data entry into the HSAG database and lack of documentation to validate completion of care coordinator training. HSAG provided technical assistance and database training to each health plan to mitigate future noncompliance. Remediation validation reviews will continue in SFY 2019.

Waiver Programs Included in SFY 2018 Reviews

The following home- and community-based services (HCBS) waiver programs were included in the CMS performance measures record reviews:

- Persons with Physical Disabilities (PD): Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility, and can be safely maintained in the home or community-based setting with the services provided in the plan of care. Individuals 60 years or older, who began services before age 60, may choose to remain in this waiver.
- Persons with HIV/AIDS (HIV): Persons of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and are at risk of placement in a nursing facility.
- Persons with Brain Injury (BI): Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- Persons who are Elderly (ELD): Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are aged 65 and older, and those who are physically disabled, ages 60 through 64.
- Persons in a Supportive Living Facility (SLF): Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 years of age and older).

CMS Performance Measures Description

Table F-2 provides a description of each CMS performance measure, including the identification of waiver-specific measures.

Table F-2—CMS Waiver Performance Measure Descriptions

Measure #	Measure Description
4A	Overdue Service Plan was completed within 30 days of expected renewal.
31D	The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.
32D	The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.
33D	The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.
34D	The enrollee reported he/she received the services he/she needed when he/she needed them. ELD Waiver only
35D	The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.
36D	PD Waiver—The case manager made annual contact with the enrollee or there is valid justification in record.
	HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record. (prior to March 2014)
	BI Waiver—The case manager made valid contact with the enrollee at least 1 time a month, or valid justification is documented in the enrollee's record.
37D	PD, HIV, SLF, and ELD Waivers—The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
	BI Waiver—The most recent care/service plan is in the record and completed in a timely manner. (Completed within 6 months from review date)
38D	The care/service plan was updated when the enrollee's needs changed.
39D	Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.
40D	The enrollee reported he/she received all services listed in the plan of care. ELD Waiver only
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
44G	The enrollee reported he/she was being treated well by direct support staff. ELD Waiver only
49G	Most recent Service Plan includes a backup plan that includes the name of the backup. BI, HIV, PD Waivers

ICP Detailed Findings

SFY 2018 represented the fifth year of review for the ICP population, and successes continued to be realized.

- Eleven of the 15 CMS performance measures averaged 90 percent or greater compliance in SFY 2018.
- Four of the 10 health plans averaged 90 percent or greater compliance in SFY 2018.

Opportunities for Improvement

Overall, eight of the 10 health plans demonstrated a statistically significant decrease in overall performance in SFY 2018, when compared to SFY 2017. The addition of new measures in SFY 2018 contributed to the decrease in performance; two of these measures, 4A and 39D, were identified as the greatest opportunities for improvement during SFY 2018. Caution should also be taken when comparing performance in SFY 2018 against SFY 2017 due to the increase in the number of performance measures reported (15 in SFY 2018 compared to 12 in SFY 2017).

Review of SFY 2018 performance identified the following opportunities for improvement:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 37 percent compliance in SFY 2018. Caution should be taken when reviewing or comparing the data, as this measure is only applicable to records in which there was an overdue service plan. Seven of the nine health plans (Cigna-HealthSpring of Illinois did not have any applicable records for this measure) performed at a rate of 50 percent or less in SFY 2018.
- Measure 37D, *timely completion of service plan*, demonstrated a statistically significant decrease in performance in SFY 2018 when compared to SFY 2017 (-15 percentage points, p=<0.0001). Performance on 37D correlates directly with performance on 4A (records found non-compliant for 37D constitute the denominator for 4A).
- For Measure 37D, six of the 10 health plans demonstrated statistically significant decreases in performance from SFY 2017 to SFY 2018.
- Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 51 percent and 44 percent compliance for the BI and HIV waivers, respectively, in SFY 2018.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, averaged 51 percent compliance in SFY 2018. Seven of the 10 health plans performed at a rate of less than 50 percent in SFY 2018.

FHP/ACA Detailed Findings

SFY 2018 represented the third year of review for the FHP/ACA population, and several successes were identified.

- Twelve of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018.
- Six of the nine health plans averaged 90 percent or greater compliance in SFY 2018.
- Compared to SFY 2017, measure 31D realized a statistically significant increase in overall performance in SFY 2018 (+3 percentage points, p=0.0262). Compared to SFY 2017, Blue Cross Blue Shield of Illinois (BCBSIL) realized a statistically significant increase in performance in measure 31D in SFY 2018 (+8 percentage points, p=0.0029).
- Compared to SFY 2017, measure 32D realized a statistically significant increase in overall performance in SFY 2018 (+2 percentage points, p=0.0414). Compared to SFY 2017, BCBSIL realized a statistically significant increase in performance in measure 32D in SFY 2018 (+4 percentage points, p=0.0367).

Opportunities for Improvement

Overall, seven of the nine health plans demonstrated a statistically significant decrease in overall performance in SFY 2018, when compared to SFY 2017. The addition of new measures in SFY 2018 contributed to the decrease in performance; two of these measures, 4A and 39D, were identified as the greatest opportunities for improvement during SFY 2018. Caution should also be taken when comparing performance in SFY 2018 against SFY 2017 due to the increase in the number of performance measures reported (15 in SFY 2018 compared to 12 in SFY 2017).

Review of SFY 2018 performance identified the following opportunities for improvement:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 38 percent compliance in SFY 2018. Caution should be taken when reviewing or comparing the data due to small numbers analysis, as this measure is only applicable to records in which there was an overdue service plan (total of 71 in SFY 2018). Six of the nine health plans performed at a rate of 50 percent or less in SFY 2018.
- Measure 37D, *timely completion of service plan*, demonstrated a statistically significant decrease in performance in SFY 2018 when compared to SFY 2017 (-7 percentage points, p=<0.0001). Performance on 37D correlates directly with performance on 4A (records found non-compliant for 37D constitute the denominator for 4A).
- Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 56 percent and 40 percent compliance for the BI and HIV waivers, respectively, in SFY 2018.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, averaged 43 percent

compliance in SFY 2018. Seven of the nine health plans performed at a rate of less than 50 percent in SFY 2018.

- CountyCare Health Plan performed at a statistically significant lower rate than four other health plans for measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan,* with performance of 30 percent during SFY 2018.

MMAI Detailed Findings

SFY 2018 represented the fourth year of review for the MMAI population, and several successes were identified.

- Ten of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2018.
- Five of the seven health plans averaged 90 percent or greater compliance in SFY 2018.
- Compared to SFY 2017, measure 32D realized a statistically significant increase in overall performance in SFY 2018 (+1 percentage point, p=0.0267).

Opportunities for Improvement

Overall, all seven health plans demonstrated a statistically significant decrease in overall performance in SFY 2018, when compared to SFY 2017. The addition of new measures in SFY 2018 contributed to the decrease in performance; two of these measures, 4A and 39D, were identified as the greatest opportunities for improvement during SFY 2018. Caution should also be taken when comparing performance in SFY 2018 against SFY 2017 due to the increase in the number of performance measures reported (15 in SFY 2018 compared to 12 in SFY 2017).

Review of SFY 2018 performance identified the following opportunities for improvement:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 36 percent compliance in SFY 2018. All seven health plans performed at a rate of 50 percent or less in SFY 2018.
- Measure 37D, *timely completion of service plan*, demonstrated a statistically significant decrease in performance in SFY 2018 when compared to SFY 2017 (-14 percentage points, p=<0.0001). Performance on 37D correlates directly with performance on 4A (records found non-compliant for 37D constitute the denominator for 4A).
- Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 58 percent and 45 percent compliance for the BI and HIV waivers, respectively, in SFY 2018.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, averaged 55 percent compliance in SFY 2018. All seven health plans performed at a rate of 60 percent or less in SFY 2018.

Remediation Validation

HSAG and HFS also monitor health plans' compliance with completion of all remediation actions, via on-site reviews to ensure that remediation actions were completed according to the health plan's documentation in the remediation tracking database. Validation of remediation was completed in Q2 and Q4. The following trends were identified related to noncompliant documentation of remediation actions:

- The remediation date entered into HSAG's database did not match the date on documentation in the enrollee's electronic and/or paper record (care plan/service, assessments, etc.) related to the remediated finding.
- The remediation date documented in HSAG's database was the date the health plan entered the information into the database rather than the date the remediation action was completed.
- Remediation training documentation did not contain the signature or other evidence of care manager attendance for training related to the remediated finding.
- Remediation training documentation did not contain education regarding the performance measure requirement related to the remediated finding.
- Remediation training documentation did not contain the facilitator name, credentials, or date/time/length of training.

HCBS Program Recommendations for Improvement

Based on an analysis of performance, as well as observations during on-site reviews, HSAG identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Plan-specific recommendations were included in quarterly and annual reports. HSAG recommended the following actions to address performance-measure specific opportunities for improvement:

- Health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A and 37D, efforts might include the following steps:

- Ensure internal audit processes focus on review of these measures, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans.
- Educate care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

For measure 36D, efforts might include the following steps:

- Conduct root cause analysis to determine opportunities to effect change.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.

- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

For measure 39D, efforts might include the following steps:

- Establish a process to complete ongoing claims validation of the waiver service plan.
- Conduct root cause analysis to determine service providers who may benefit from outreach and education regarding claims submission.
- Ensure completion of education with beneficiaries related to approved hours for personal assistants.
- Conduct staff training to ensure timely follow up with beneficiaries who have a change in service provider. Training should include a component for review of claims to validate service provision and steps to ensure there are no gaps in waiver services.
- Ensure all appropriate staff are provided access and trained on navigation of waiver agency portals to review beneficiary information.

Appendix G. Beneficiary Satisfaction With Care Methodology and Results

Beneficiary Satisfaction Surveys

Objectives

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. Blue Cross Blue Shield of Illinois (BCBSIL), CountyCare Health Plan (CountyCare), Harmony Health Plan of Illinois, Inc. (Harmony), IlliniCare Health Plan, Inc. (IlliniCare), Meridian Health Plan, Inc. (Meridian), Molina Healthcare of Illinois, Inc. (Molina), and NextLevel Health Partners, LLC (NextLevel) were responsible for contracting with a CAHPS vendor to administer the CAHPS surveys on their behalf. Results for all seven plans were forwarded to Health Services Advisory Group, Inc. (HSAG) for analysis. For the statewide Illinois Medicaid (i.e., children covered under Title XIX) and All Kids (i.e., children covered under Title XXI/Children's Health Insurance Program [CHIP]) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of the Illinois Department of Healthcare and Family Services (HFS).

The CAHPS results are presented by program type and population. Under the Family Health Plan/Affordable Care Act (FHP/ACA), the adult Medicaid and child Medicaid populations were surveyed for BCBSIL, CountyCare, Harmony, IlliniCare, Meridian, Molina, and NextLevel.[G-1] Under the Integrated Care Program (ICP), the adult Medicaid population was surveyed for BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel.[G-2,G-3] Under the Statewide Survey, a statewide sample of child members enrolled in the All Kids and Illinois Medicaid programs were surveyed.[G-4]

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their healthcare experiences.

Overview

In July 2014, Illinois transitioned from the voluntary managed care (VMC) program in select counties to the FHP/ACA within mandatory managed care regions that cover most of the State. The FHP/ACA was

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G-1 SPH Analytics administered the CAHPS surveys on behalf of CountyCare, Harmony, and Molina. Morpace administered the CAHPS surveys on behalf of BCBSIL, IlliniCare, Meridian, and NextLevel.

G-2 Morpace administered the CAHPS surveys on behalf of BCBSIL, IlliniCare, Meridian, and NextLevel. SPH Analytics administered the CAHPS surveys on behalf of CountyCare and Molina.

G-3 HSAG combined the results for the Family Health Plan/Affordable Care Act (FHP/ACA) and Integrated Care Program (ICP) adult Medicaid populations presented in this report.

G-4 The Illinois statewide program aggregate results presented in this report represent the results of the All Kids and Illinois Medicaid programs combined.

a mandatory program for children and their families as well as newly eligible ACA adults. Under FHP/ACA, the State contracted with health plans to manage the provision of healthcare for FHP/ACA clients through care coordination. VMC continued to be an option for clients to choose for their care coordination services within many nonmandatory counties.

In May 2011, HFS implemented the ICP as Illinois' first integrated healthcare program for Seniors and Persons with Disabilities (SPDs) who were eligible for Medicaid but not eligible for Medicare. ICP served SPD individuals in five mandatory regions in Illinois that consisted of 30 counties throughout the State. When it was originally implemented, the program only covered standard Medicaid acute, primary, and behavioral health services to beneficiaries. In 2013, the State integrated a range of long-term care services and home- and community-based services that were formerly available through various state waivers into its package of ICP-coordinated services.

Starting January 1, 2018, the Medicaid Managed Care Program began expanding to include all counties in Illinois. The expanded program, called HealthChoice Illinois, is member-focused and brought together the current FHP/ACA Managed Care Program, ICP, and Long Term Services and Supports (LTSS) Program under one program. With HealthChoice Illinois, only seven health plans (i.e., BCBSIL, CountyCare, Harmony, IlliniCare, Meridian, Molina, and NextLevel) have continued to serve Illinois Medicaid beneficiaries.

Technical Methods of Data Collection and Analysis

FHP/ACA and ICP Health Plans

The technical method of data collection was through the administration of the CAHPS 5.0H Adult Medicaid Survey to the adult populations and the CAHPS 5.0H Child Medicaid Survey to the child populations. All health plans used a mixed-mode methodology for data collection, which included both mail and telephone surveys for data collection, with the option to complete the surveys in English and Spanish.[G-5]

All Kids and Illinois Medicaid Statewide Survey

The technical method of data collection was through the administration of the CAHPS 5.0 Child Medicaid Survey with the Children with Chronic Conditions (CCC) measurement set to a statewide sample of the child population enrolled in each program. For All Kids and Illinois Medicaid, a sample representing the general child population and a CCC supplemental sample (i.e., a sample of child members who were identified as more likely to have a chronic condition) were selected from each program. All Kids and

[G-5] BCBSIL and IlliniCare used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.0H Adult Medicaid Survey and CAHPS 5.0H Child Medicaid Survey. This protocol allowed sampled members the option to complete the survey via the Internet.

Illinois Medicaid used a standard mixed-mode methodology for data collection, which included both mail and telephone surveys for data collection, with the option to complete the survey in English and Spanish.

Survey Measures for CAHPS

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite measures. The global ratings reflected members' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

The National Committee for Quality Assurance (NCQA) requires a minimum of 100 responses on each item to report the measure as a valid CAHPS Survey result; however, for this report, if available, plans'/populations' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

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). In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (i.e., 1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the composite measures, 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) "No" and "Yes." For four of the composites (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), a positive, or top-box response, was defined as a response of "Usually" or "Always." For one composite (*Shared Decision Making*), a positive, or top-box, response was defined as a response of "Yes." Composite measure scores were calculated by averaging the percentage of positive responses for each item. The percentage of top-box responses was referred to as a global proportion for the composite measures.

In addition to the global proportions, a three-point mean was calculated for four of the composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*). Scoring was based on a three-point scale. Responses of "Always" were given a score of 3, responses of "Usually" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.

For each of the CAHPS global ratings and four of the composite measures, the resulting 2017 three-point mean scores were compared to NCQA's 2017 Healthcare Effectiveness and Data Information Set (HEDIS) Benchmarks and Thresholds for Accreditation, and the resulting 2018 three-point mean scores

were compared to NCQA's 2018 HEDIS Benchmarks and Thresholds for Accreditation.[G-6,G-7] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for the four global ratings and four composite measures, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, three-point mean scores are not presented and star ratings could not be derived for this measure. These are denoted with a dash (—) in the plan-specific findings below.

For All Kids and Illinois Medicaid, in addition to the four global ratings and five composite measures, the CAHPS survey also included the CCC measurement set of survey questions, which are categorized into five measures of satisfaction. These measures included three CCC composite measures and two CCC individual item measures. The CCC composites and items are sets of questions and individual questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

G-6 National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA. May 4, 2017.

G-7 National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018*. Washington, DC: NCQA. August 20, 2018.

Adult CAHPS Medicaid Survey

Adult Plan-Specific Findings and Comparisons

The 2017 and 2018 adult Medicaid CAHPS three-point mean scores, overall member satisfaction ratings (i.e., star ratings), and top-box percentages are presented in the tables below for each adult health plan (i.e., FHP/ACA and ICP combined) and the statewide aggregate (i.e., all health plans combined).[G-8]

Composite Measures

Table G-1—2017 and 2018 Adult Plan-Specific National Comparisons Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2017	★★ 2.28	★ 2.30	★★★★★ 2.65	★★ 2.52	—
	2018	★ 2.29	★ 2.32	★★★★★ 2.71	★★ 2.52	—
CountyCare	2017	★★ 2.28	★★ 2.39	★★★★★ 2.64	★★★ 2.57	—
	2018	★ 2.31	★★ 2.40	★★★★★ 2.68	★★★★★ 2.63	—
Harmony	2017	★ 2.24	★★ 2.34	★★★★★ 2.66	★★★★ 2.59	—
	2018	★ 2.10	★ 2.27	★★★★★ 2.68	★★ 2.49	—
IlliniCare	2017	★★ 2.29	★ 2.30	★★★★ 2.63	★ 2.46	—
	2018	★ 2.16	★ 2.29	★★★★ 2.59	★ 2.37	—
Meridian	2017	★★ 2.33	★★ 2.38	★★★★★ 2.67	★★★★★ 2.63	—
	2018	★★ 2.34	★★ 2.39	★★★★★ 2.66	★★★ 2.57	—
Molina	2017	★★ 2.28	★★ 2.34	★★★★★ 2.66	★★ 2.48	—
	2018	★ 2.30	★ 2.34	★★★★★ 2.68	★★★★★ 2.62	—

[G-8] The 2017 and 2018 CAHPS results for Harmony represent the FHP/ACA adult Medicaid population only. Harmony did not serve members under ICP in 2017 or 2018. Please exercise caution when comparing Harmony's results to the other plans' results, which reflect a combined FHP/ACA and ICP adult Medicaid population.

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
NextLevel	2017	★ 2.14	★ 2.18	★★ 2.51	★ 2.46+	—
	2018	★ 2.13	★ 2.25	★★★★★ 2.69	★ 2.24+	—
Statewide Aggregate	2017	★★ 2.28	★★ 2.33	★★★★★ 2.64	★★★ 2.54	—
	2018	★ 2.26	★ 2.34	★★★★★ 2.67	★★ 2.53	—

+ indicates that results for this measure did not meet the minimum number of 100 responses.

— indicates that NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Table G-2—2017 and 2018 Adult Plan-Specific Top-Box Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2017	78.9%	76.9%	92.7%	85.6%	75.7%
	2018	76.5%	76.5%	94.5%	87.6%	83.0%
CountyCare	2017	76.0%	79.8%	89.9%	88.3%	79.2%
	2018	78.7%	80.5%	92.1%	91.2%	75.1%
Harmony	2017	77.1%	79.2%	90.8%	88.5%	81.6%
	2018	67.8%	75.6%	91.0%	86.9%	74.9%+
IlliniCare	2017	78.0%	77.8%	89.9%	83.4%	78.3%
	2018	72.6%	75.7%	88.4%	82.3%	77.4%
Meridian	2017	79.0%	81.5%	91.2%	90.4%	77.7%
	2018	80.1%	79.5%	92.3%	88.9%	73.7%
Molina	2017	75.9%	79.5%	91.4%	84.9%	80.1%
	2018	77.8%	77.7%	91.4%	89.5%	73.7%
NextLevel	2017	66.6%	70.8%	81.6%	83.5%+	61.1%+
	2018	61.3%	68.9%	90.0%	67.3%+	73.6%+
Statewide Aggregate	2017	77.2%	78.7%	90.7%	86.7%	77.5%
	2018	75.8%	77.5%	91.8%	87.0%	76.7%

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Global Ratings

Table G-3—2017 and 2018 Adult Plan-Specific National Comparisons Results

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
BCBSIL	2017	★★★ 2.38	★★ 2.45	★ 2.45	★★★ 2.46
	2018	★★★ 2.41	★★★★ 2.55	★★★★★ 2.63	★★★ 2.49
CountyCare	2017	★★★★ 2.44	★★★★ 2.54	★★★★★ 2.59	★★★ 2.44
	2018	★ 2.34	★★★★ 2.56	★★★ 2.53	★★★★ 2.52
Harmony	2017	★★ 2.35	★★ 2.45	★★★ 2.53	★ 2.28
	2018	★ 2.29	★★ 2.48	★ 2.39+	★ 2.29
IlliniCare	2017	★ 2.31	★★★ 2.52	★★★ 2.55	★ 2.33
	2018	★ 2.29	★ 2.39	★ 2.41	★ 2.24
Meridian	2017	★ 2.29	★★★★ 2.54	★★★★★ 2.59	★★ 2.38
	2018	★★ 2.38	★★★ 2.50	★★★★ 2.57	★★ 2.45
Molina	2017	★★ 2.33	★★★★★ 2.58	★★ 2.49	★ 2.29
	2018	★ 2.33	★★ 2.49	★★★★ 2.57	★ 2.36
NextLevel	2017	★ 2.13	★ 2.20	★ 2.18+	★ 2.03
	2018	★ 2.33	★★ 2.44	★ 2.37+	★ 2.14
Statewide Aggregate	2017	★★ 2.34	★★★ 2.50	★★★ 2.52	★★ 2.36
	2018	★★ 2.35	★★★ 2.50	★★★ 2.53	★★ 2.41

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Table G-4—2017 and 2018 Adult Plan-Specific Top-Box Results

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
BCBSIL	2017	52.4%	58.8%	59.6%	58.0%
	2018	54.2%	66.2%	69.3%	61.1%
CountyCare	2017	59.2%	65.8%	68.7%	58.1%
	2018	50.3%	67.5%	63.1%	64.8%
Harmony	2017	51.4%	59.0%	63.4%	49.1%
	2018	48.4%	61.7%	56.8%+	50.0%
IlliniCare	2017	49.6%	64.4%	68.8%	51.9%
	2018	49.7%	57.5%	58.7%	47.6%
Meridian	2017	48.3%	66.5%	68.5%	54.6%
	2018	53.5%	64.4%	70.2%	59.5%
Molina	2017	52.0%	66.7%	64.5%	50.4%
	2018	51.6%	63.3%	68.8%	53.0%
NextLevel	2017	36.4%	44.0%	50.3%+	36.3%
	2018	54.1%	63.3%	59.0%+	39.1%
Statewide Aggregate	2017	51.3%	62.8%	64.9%	53.6%
	2018	51.9%	64.1%	65.1%	56.9%

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Child CAHPS Medicaid Survey

FHP/ACA Child Plan-Specific Findings and Comparisons

The 2017 and 2018 child Medicaid CAHPS three-point mean scores, overall member satisfaction ratings (i.e., star ratings), and top-box percentages are presented in the tables below for each FHP/ACA health plan and the statewide aggregate (i.e., all FHP/ACA health plans combined).

Composite Measures

Table G-5—2017 and 2018 FHP/ACA Child Plan-Specific National Comparisons Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2017	★ 2.32	★★ 2.54	★★★★ 2.73	★ 2.48	—
	2018	★ 2.28	★ 2.50	★★★ 2.71	★★★ 2.54	—
CountyCare	2017	★ 2.33	★ 2.44	★★★ 2.70	★ 2.45	—
	2018	★★ 2.39	★ 2.48	★★★★ 2.73	★★★ 2.53	—
Harmony	2017	★★ 2.38	★ 2.48	★ 2.62	★ 2.44	—
	2018	★ 2.29	★ 2.48	★★ 2.65	★★★ 2.53	—
IlliniCare	2017	★★ 2.41	★ 2.48	★★★★ 2.72	★★★ 2.55+	—
	2018	★ 2.23+	★ 2.45	★★ 2.67	★ 2.38	—
Meridian	2017	★★ 2.39	★★ 2.55	★★★★ 2.74	★★★★ 2.59	—
	2018	★ 2.32	★★ 2.56	★★★★ 2.73	★★★ 2.54	—
Molina	2017	★★ 2.38	★★ 2.54	★★ 2.67	★★★ 2.57	—
	2018	★★ 2.38	★ 2.51	★★★ 2.70	★ 2.45	—
NextLevel	2017	★ 2.08+	★ 2.24+	★ 2.57+	★ 2.41+	—
	2018	★ 2.14+	★ 2.32+	★★ 2.66+	★ 2.45+	—

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Statewide Aggregate	2017	★ 2.36	★ 2.51	★★★ 2.69	★★ 2.52	—
	2018	★ 2.32	★ 2.50	★★★ 2.70	★★ 2.50	—

+ indicates that results for this measure did not meet the minimum number of 100 responses.

— indicates that NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Table G-6—2017 and 2018 FHP/ACA Child Plan-Specific Top-Box Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2017	76.8%	83.6%	94.0%	85.5%	75.8%
	2018	75.6%	82.2%	93.8%	86.4%	71.7%
CountyCare	2017	80.0%	82.4%	93.3%	83.5%	72.9%+
	2018	81.1%	83.2%	93.8%	89.4%	84.8%+
Harmony	2017	82.6%	82.6%	90.5%	82.9%	76.4%+
	2018	77.4%	84.1%	90.0%	87.2%	78.6%+
IlliniCare	2017	83.9%	83.3%	93.9%	85.7%+	79.7%+
	2018	75.2%+	82.1%	92.1%	79.8%	76.6%+
Meridian	2017	81.8%	86.4%	93.8%	87.0%	82.5%
	2018	78.1%	86.2%	94.6%	88.6%	83.5%
Molina	2017	81.5%	85.7%	92.5%	88.6%	76.1%
	2018	80.4%	83.9%	92.0%	82.8%	74.3%
NextLevel	2017	62.1%+	71.5%+	87.2%+	80.0%+	79.2%+
	2018	70.0%+	76.1%+	85.6%+	80.6%+	83.3%+
Statewide Aggregate	2017	80.7%	84.5%	93.3%	86.0%	78.4%
	2018	77.7%	83.9%	93.2%	86.4%	78.6%

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Global Ratings

Table G-7—2017 and 2018 FHP/ACA Child Plan-Specific National Comparisons Results

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
BCBSIL	2017	★★★★★ 2.66	★★★★★ 2.70	★★★★★ 2.70+	★★★★★ 2.69
	2018	★★★★★ 2.68	★★★★★ 2.73	★★★★★ 2.70+	★★★★★ 2.71
CountyCare	2017	★★★ 2.53	★★★★★ 2.69	★★ 2.56+	★★ 2.56
	2018	★★★★★ 2.68	★★★★★ 2.81	★★★★★ 2.71+	★★★★★ 2.68
Harmony	2017	★★ 2.49	★★★★ 2.68	★★★★★ 2.73+	★ 2.50
	2018	★★★★★ 2.59	★★★★★ 2.72	★★★★★ 2.76+	★★★★ 2.64
IlliniCare	2017	★★★★★ 2.59	★★★★★ 2.69	★★★★★ 2.70+	★ 2.49
	2018	★ 2.46	★★★ 2.64	★★★★★ 2.70+	★ 2.50
Meridian	2017	★★★★ 2.58	★★★★★ 2.76	★★★★★ 2.78	★★★★ 2.64
	2018	★★★★★ 2.66	★★★★★ 2.75	★★★★★ 2.66	★★★★ 2.66
Molina	2017	★★★ 2.56	★★★★★ 2.69	★★★★★ 2.71	★ 2.47
	2018	★★★★★ 2.64	★★★★★ 2.70	★★★★ 2.65	★★ 2.56
NextLevel	2017	★ 2.41+	★ 2.48+	★★ 2.55+	★ 2.17
	2018	★ 2.43+	★ 2.49+	★★ 2.54+	★ 2.22+
Statewide Aggregate	2017	★★★★ 2.57	★★★★★ 2.70	★★★★★ 2.70	★★ 2.55
	2018	★★★★★ 2.63	★★★★★ 2.72	★★★★★ 2.68	★★★★ 2.62

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Table G-8—2017 and 2018 FHP/ACA Child Plan-Specific Top-Box Results

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
BCBSIL	2017	72.4%	75.3%	77.0%+	74.6%
	2018	74.2%	77.9%	76.7%+	75.2%
CountyCare	2017	64.7%	74.0%	68.0%+	65.6%
	2018	73.1%	84.6%	75.0%+	74.1%
Harmony	2017	58.8%	73.5%	78.4%+	62.7%
	2018	65.9%	76.3%	79.6%+	70.3%
IlliniCare	2017	70.1%	76.3%	78.4%+	64.1%
	2018	54.8%	71.7%	74.1%+	61.5%
Meridian	2017	66.2%	78.9%	84.5%	71.4%
	2018	72.3%	79.9%	74.0%	72.1%
Molina	2017	64.5%	74.8%	77.2%	61.6%
	2018	69.0%	75.6%	74.2%	66.1%
NextLevel	2017	56.8%+	61.4%+	63.6%+	45.9%
	2018	59.3%+	60.7%+	61.5%+	47.1%+
Statewide Aggregate	2017	66.9%	76.2%	78.9%	68.4%
	2018	69.9%	78.2%	75.3%	71.0%

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Statewide Survey Findings and Comparisons

The 2017 and 2018 general child population's CAHPS three-point mean scores and overall member satisfaction ratings (i.e., star ratings), as well as the 2017 and 2018 general child and CCC populations' top-box percentages are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.

The global ratings and composite measures were calculated using the methodology described above for the general child population and CCC populations. For each of the CCC composites and items for the CCC population, 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) "No" and "Yes." For three of the CCC composite measures/items (*Access to Specialized Services*, *Access to Prescription Medicines*, and *Family-Centered Car* (*FCC): Getting Needed Information*), a positive, or top-box, response was defined as a response of "Usually" or "Always." For two CCC composite measures/items (*FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions*), a positive, or top-box, response was defined as a response of "Yes." CCC composite and item scores were calculated by averaging the percentage of positive responses for each item.

General Child Population

Table G-9—2017 and 2018 Statewide Survey General Child National Comparisons Results[G-9]

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2017	★★ 2.44	★★ 2.41	★★★ 2.50
	2018	★★ 2.40	★★ 2.39	★★ 2.41
Getting Care Quickly	2017	★★ 2.58	★★ 2.56	★★★ 2.63
	2018	★ 2.51	★ 2.48	★★ 2.56
How Well Doctors Communicate	2017	★★★ 2.69	★★★ 2.69	★★★ 2.69
	2018	★★★ 2.71	★★★★ 2.73	★★ 2.67

[G-9] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

Satisfaction With Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Customer Service	2017	★ 2.40	★ 2.33	★ 2.48
	2018	★ 2.40	★ 2.38	★ 2.44
Shared Decision Making	2017	—	—	—
	2018	—	—	—
Global Ratings				
Rating of All Health Care	2017	★★★★★ 2.60	★★★★★ 2.60	★★★★★ 2.61
	2018	★★★★★ 2.60	★★★★★ 2.62	★★★★ 2.57
Rating of Personal Doctor	2017	★★★★ 2.65	★★★ 2.63	★★★★ 2.68
	2018	★★★★★ 2.70	★★★★★ 2.71	★★★★★ 2.70
Rating of Specialist Seen Most Often	2017	★★★★★ 2.67	★★★★★ 2.68	★★★★ 2.64+
	2018	★★★★★ 2.69	★★★★★ 2.68	★★★★★ 2.71+
Rating of Health Plan	2017	★ 2.47	★ 2.44	★★ 2.53
	2018	★ 2.50	★★ 2.51	★ 2.49

+ indicates that results for this measure did not meet the minimum number of 100 responses.

— indicates that NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Table G-10—2017 and 2018 Statewide Survey General Child Top-Box Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2017	87.0%	84.1%	87.3%
	2018	82.7%	82.5%	82.7%
Getting Care Quickly	2017	90.0%	87.9%	90.2%
	2018	85.9%	83.7%	86.1%
How Well Doctors Communicate	2017	92.7%	93.4%	92.7%
	2018	92.1%	95.1%	91.8%
Customer Service	2017	85.5%	79.8%	86.0%
	2018	85.1%	81.8%	85.4%
Shared Decision Making	2017	80.9%	82.3%	80.7%
	2018	78.2%	80.4%	78.0%+
Global Ratings				
Rating of All Health Care	2017	67.4%	65.0%	67.7%
	2018	63.2%	66.7%	62.8%
Rating of Personal Doctor	2017	74.6%	69.6%	75.1%
	2018	74.6%	74.4%	74.7%
Rating of Specialist Seen Most Often	2017	68.5%	73.3%	68.0%+
	2018	76.6%	71.6%	77.1%+
Rating of Health Plan	2017	62.9%	57.0%	63.5%
	2018	61.3%	61.3%	61.3%

+ indicates that results for this measure did not meet the minimum number of 100 responses.

CCC Child Population[G-10]

Table G-11—2017 and 2018 Statewide Survey CCC Top-Box Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2017	86.4%	87.6%	84.8%
	2018	84.8%	86.0%	83.1%
Getting Care Quickly	2017	90.4%	89.7%	91.4%
	2018	88.8%	89.9%	87.3%
How Well Doctors Communicate	2017	94.6%	95.0%	94.1%
	2018	94.3%	94.8%	93.6%
Customer Service	2017	84.9%	83.2%	87.0%
	2018	81.7%	81.7%	81.8%
Shared Decision Making	2017	84.7%	85.7%	83.4%
	2018	83.2%	81.5%	85.4%
Global Ratings				
Rating of All Health Care	2017	60.9%	61.3%	60.4%
	2018	61.7%	65.6%	56.5%
Rating of Personal Doctor	2017	71.2%	71.4%	71.1%
	2018	71.4%	72.8%	69.6%
Rating of Specialist Seen Most Often	2017	72.3%	72.3%	72.3%
	2018	72.8%	74.6%	70.5%
Rating of Health Plan	2017	55.4%	56.2%	54.5%
	2018	53.4%	52.4%	54.6%
CCC Composites and Items				
Access to Specialized Services	2017	69.7%	69.8%+	69.8%+
	2018	72.8%	68.5%+	76.9%+
Family-Centered Care: Personal Doctor Who Knows Child	2017	90.0%	91.0%	88.7%
	2018	90.1%	91.0%	89.1%

G-10 NCQA does not publish benchmarks and thresholds for the CCC population; therefore, star ratings could not be calculated for the CCC population.

Satisfaction With Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Coordination of Care for Children with Chronic Conditions	2017	80.7%	80.4%	81.2%+
	2018	79.4%	78.8%	80.1%+
Access to Prescription Medicines	2017	89.0%	87.7%	90.6%
	2018	87.8%	88.5%	86.8%
Family-Centered Care: Getting Needed Information	2017	91.2%	91.7%	90.5%
	2018	90.5%	93.0%	87.1%

+ indicates that results for this measure did not meet the minimum number of 100 responses.

Appendix H. Performance Improvement Projects Methodology and Results

Objective

To evaluate and validate the health plans' performance improvement projects (PIPs), Health Services Advisory Group, Inc. (HSAG), used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[H-1] The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in the code of federal regulations (CFR) at 42 §438.330.

Conducting the Review

For PIPs to achieve real improvement in care and member satisfaction, as well as confidence in the reported results, PIPs must be designed, conducted, and reported using a sound methodology. At a minimum, each PIP must include a baseline and two annual remeasurements. The remeasurement study indicator outcomes were compared to the baseline to determine if real and sustained improvement was achieved.

HSAG evaluates the following components of the quality improvement process:

1. The technical structure of the PIPs to ensure the health plan designed, conducted, and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs. HSAG's review determined whether a PIP could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring real and sustained improvement.

2. The outcomes of the PIPs. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. Evaluation of each PIP's outcomes determined whether the health plan improved its rates through the implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results) and, through these processes, achieved statistically significant improvement over the baseline rate.

[H-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 29, 2019.

Technical Methods of Data Collection and Analysis

Using the CMS protocol, HSAG, in collaboration with the Illinois Department of Healthcare and Family Services (HFS), developed the PIP Summary Form, which each health plan completed and submitted to HSAG for validation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that the projects addressed CMS requirements. HSAG, with input and approval from HFS, 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. Select the Study Topic
- Activity II. Define the Study Question(s)
- Activity III. Select the Study Indicator(s)
- Activity IV. Use a Representative and Generalizable Study Population
- Activity V. Use Sound Sampling Techniques (if Sampling Was Used)
- Activity VI. Reliably Collect Data
- Activity VII. Analyze and Interpret Study Results
- Activity VIII. Implement Intervention and Improvement Strategies
- Activity IX. Assess for Real Improvement
- Activity X. Assess for Sustained Improvement

HSAG calculated the percentage score of evaluation elements met for each health plan 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. If one critical evaluation element receives a *Partially Met* score, the overall PIP validation status will be *Partially Met*. Similarly, if one critical evaluation element receives a *Not Met* score, the overall PIP validation status will be *Not Met*. HSAG's PIP Validation Tool also provides, for informational purposes, the percentage of critical elements met, which is calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*.

Findings

Community Based Care Coordination PIP (Care Coordination PIP)

SFY 2018 Validation

For state fiscal year (SFY) 2018, one health plan (IlliniCare Heath Plan, Inc. [IlliniCare]) reported Remeasurement 5 data for its Integrated Care Program (ICP) population and Remeasurement 2 data for the Family Health Plan (FHP) population. NextLevel Health Partners, LLC (NextLevel) was assessed through Activity IX (Real Improvement) with the reporting of Remeasurement 1 data, and the remaining health plans were assessed through Activity X (Sustained Improvement) with Remeasurement 2 data reported. Table H-1 displays the overall validation results for each activity and stage of the Care Coordination PIP across all health plans.

Table H-1—SFY 2018 Performance Improvement Project Validation Results Across All Managed Care Organizations (MCOs) for the *Community Based Care Coordination* PIP (N = 7 PIPs)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	Review the Selected Study Topic	100% 14/14	0% 0/14	0% 0/14
	Review the Study Question	100% 7/7	0% 0/7	0% 0/7
	Review the Selected Study Indicators	100% 21/21	0% 0/21	0% 0/21
	Review the Identified Study Populations	100% 7/7	0% 0/7	0% 0/7
	Review Sampling Methods (if sampling was used)	100% 30/30	0% 0/30	0% 0/30
	Review the Data Collection Procedures	100% 38/38	0% 0/38	0% 0/38
Design Total		**100% 117/117**	**0% 0/117**	**0% 0/117**
Implementation	Review the Data Analysis and Interpretation of Results	93% 57/61	5% 3/61	2% 1/61
	Assess the Improvement Strategies	100% 28/28	0% 0/28	0% 0/28
Implementation Total		**96% 85/89**	**3% 3/89**	**1% 1/89**

Stage	Activity	Percentage of Applicable Elements*		
		Met	***Partially Met***	***Not Met***
Outcomes	Assess for Real Improvement Achieved	25% 7/28	75% 21/28	0% 0/28
	Assess for Sustained Improvement	0% 0/6	100% 6/6	0% 0/6
Outcomes Total		**21% 7/34**	**79% 27/34**	**0% 0/34**
Percentage Score of Applicable Evaluation Elements *Met*		**87% 209/240**	**13% 30/240**	**0% 1/240**

* Percentage totals may not equal 100 due to rounding.

Outcomes

The Care Coordination PIP had three study indicators that are outlined in Table H-2.

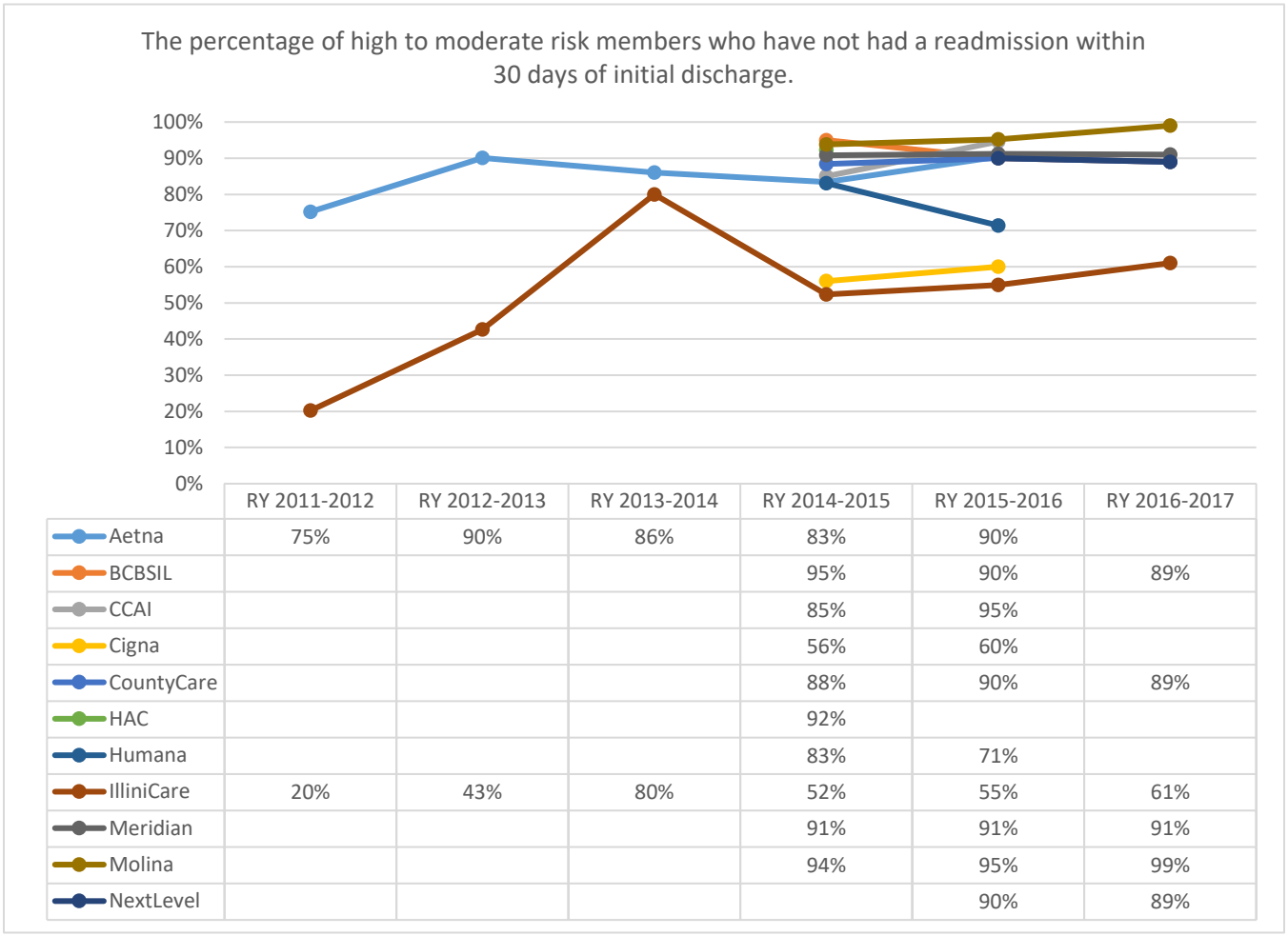
Table H-2—*Care Coordination* PIP Study Indicators

Indicator	Description of Indicator
1	The percentage of high-to-moderate risk members who have not had a readmission within 30 days of an initial discharge.
2	The percentage of high-to-moderate risk members who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge.
3	The percentage of high-to-moderate risk members accessing community resources within 14 days of discharge.

ICP

SFY 2018 was the sixth year of participation for Aetna Better Health (Aetna) and IlliniCare and the third year of participation for the other ICP health plans. ICP results for SFY 2018 are presented in Section 4 of this report. Figure H-1, Figure H-2, and Figure H-3 display trended outcomes for the Care Coordination PIP study indicators for all participating ICP health plans for SFY 2018.

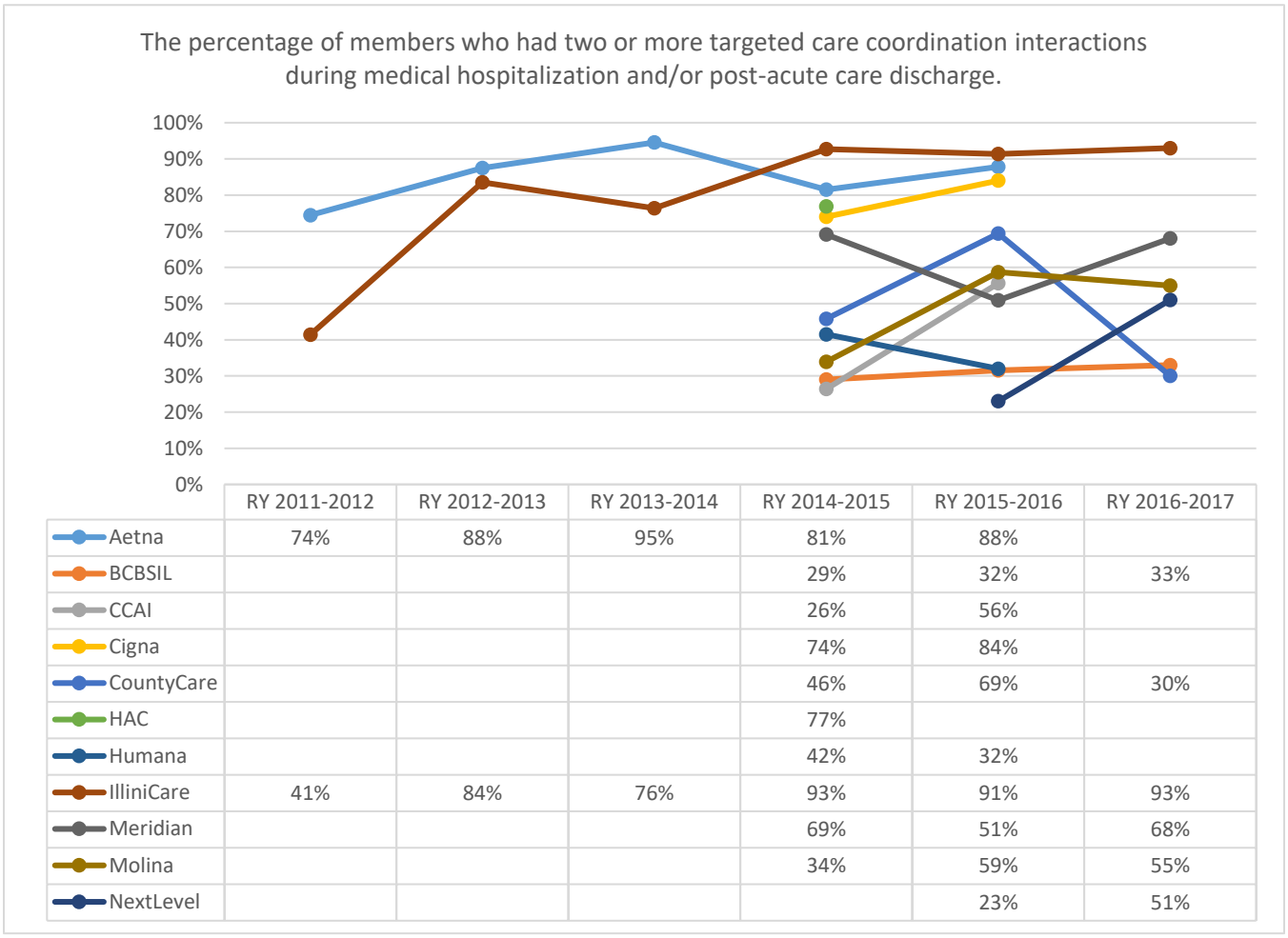
Figure H-1—Trended Study Indicator 1 Results for ICP—SFY 2018



	RY 2011-2012	RY 2012-2013	RY 2013-2014	RY 2014-2015	RY 2015-2016	RY 2016-2017
Aetna	75%	90%	86%	83%	90%	
BCBSIL				95%	90%	89%
CCAI				85%	95%	
Cigna				56%	60%	
CountyCare				88%	90%	89%
HAC				92%		
Humana				83%	71%	
IlliniCare	20%	43%	80%	52%	55%	61%
Meridian				91%	91%	91%
Molina				94%	95%	99%
NextLevel					90%	89%

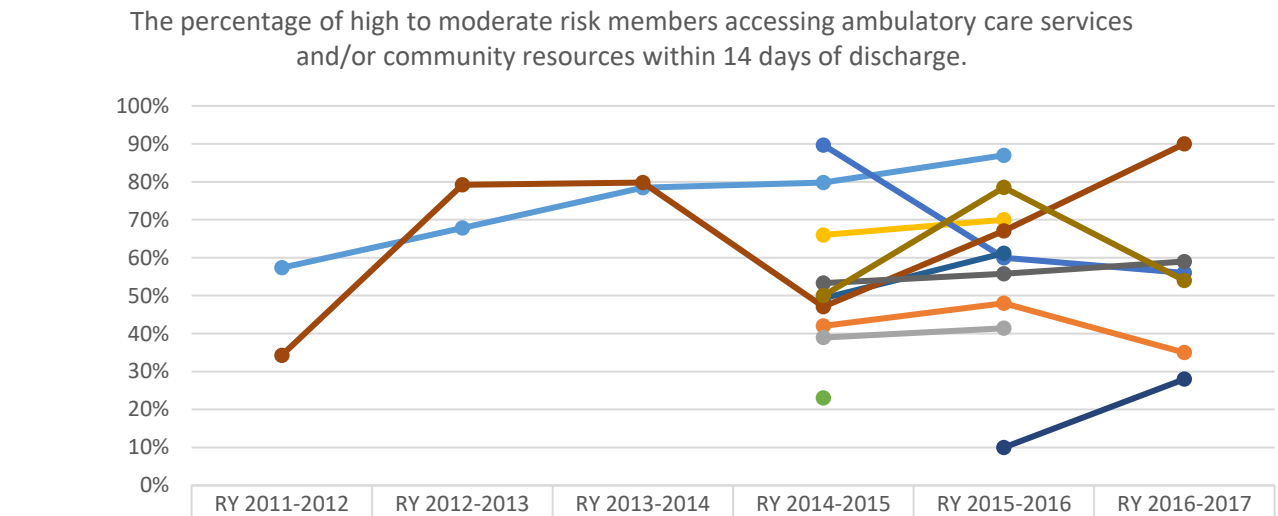
Remeasurement year (RY)
Community Care Alliance of Illinois (CCAI)
Cigna-HealthSpring of Illinois (Cigna)
Health Alliance Connect, Inc. (HAC or Health Alliance)
Humana Health Plan, Inc. (Humana)

Figure H-2—Trended Study Indicator 2 Results for ICP—SFY 2018



	RY 2011-2012	RY 2012-2013	RY 2013-2014	RY 2014-2015	RY 2015-2016	RY 2016-2017
Aetna	74%	88%	95%	81%	88%	
BCBSIL				29%	32%	33%
CCAI				26%	56%	
Cigna				74%	84%	
CountyCare				46%	69%	30%
HAC				77%		
Humana				42%	32%	
IlliniCare	41%	84%	76%	93%	91%	93%
Meridian				69%	51%	68%
Molina				34%	59%	55%
NextLevel					23%	51%

Figure H-3—Trended Study Indicator 3 Results for ICP—SFY 2018

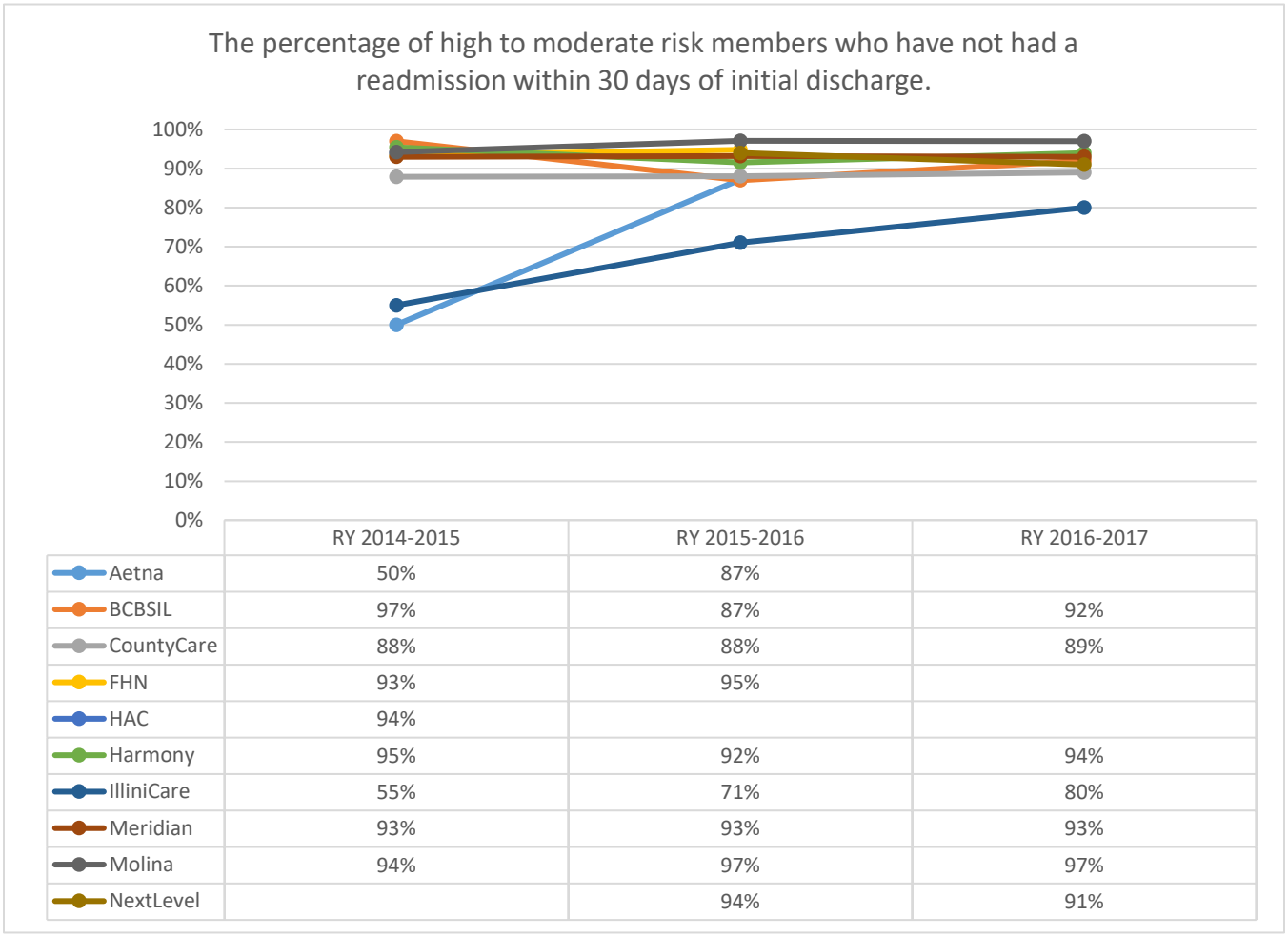


	RY 2011-2012	RY 2012-2013	RY 2013-2014	RY 2014-2015	RY 2015-2016	RY 2016-2017
Aetna	57%	68%	78%	80%	87%	
BCBSIL				42%	48%	35%
CCAI				39%	41%	
Cigna				66%	70%	
CountyCare				90%	60%	56%
HAC				23%		
Humana				49%	61%	
IlliniCare	34%	79%	80%	47%	67%	90%
Meridian				53%	56%	59%
Molina				50%	79%	54%
NextLevel					10%	28%

FHP/ACA

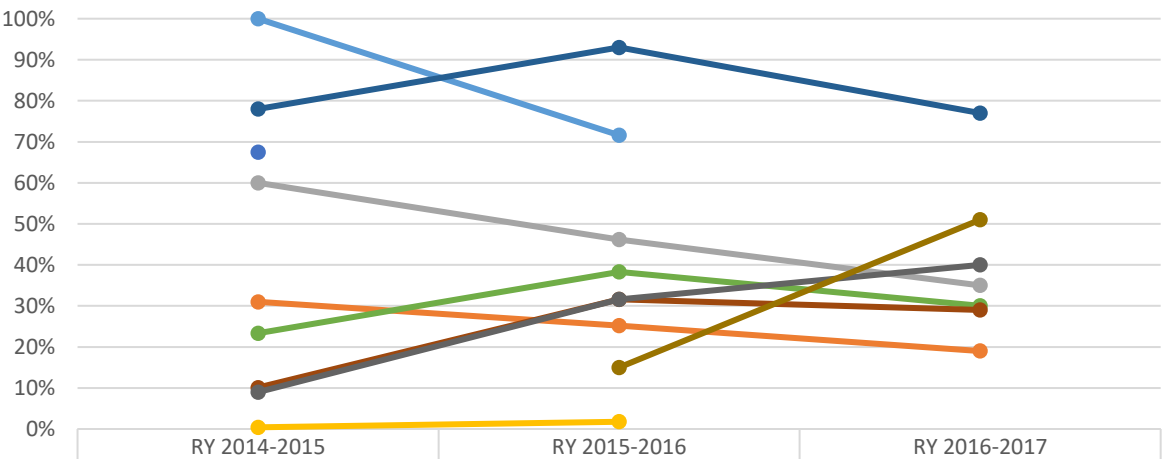
SFY 2018 was the third year of participation for the FHP/ACA health plans. FHP/ACA results for SFY 2018 are presented in Section 4 of this report. Figure H-4, Figure H-5, and Figure H-6 display trended outcomes for the Care Coordination PIP study indicators for all participating ICP health plans for SFY 2018.

Figure H-4—Trended Study Indicator 1 Results for FHP/ACA—SFY 2018



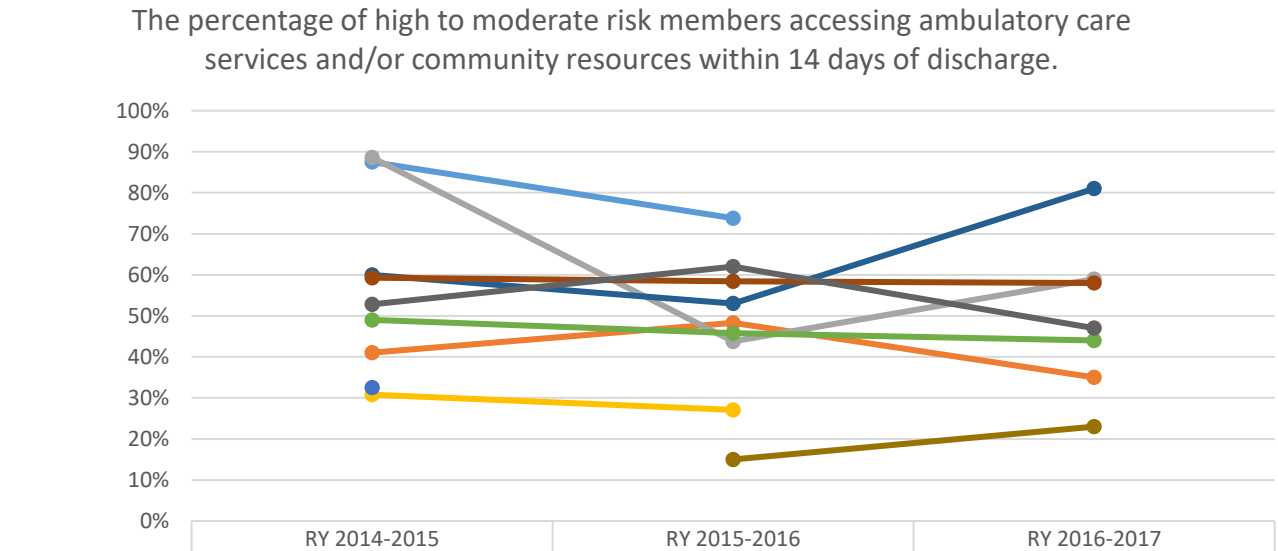
	RY 2014-2015	RY 2015-2016	RY 2016-2017
Aetna	50%	87%	
BCBSIL	97%	87%	92%
CountyCare	88%	88%	89%
FHN	93%	95%	
HAC	94%		
Harmony	95%	92%	94%
IlliniCare	55%	71%	80%
Meridian	93%	93%	93%
Molina	94%	97%	97%
NextLevel		94%	91%

Figure H-5—Trended Study Indicator 2 Results for FHP/ACA—SFY 2018



	RY 2014-2015	RY 2015-2016	RY 2016-2017
Aetna	100%	72%	
BCBSIL	31%	25%	19%
CountyCare	60%	46%	35%
FHN	0%	2%	
HAC	68%		
Harmony	23%	38%	30%
IlliniCare	78%	93%	77%
Meridian	10%	32%	29%
Molina	9%	32%	40%
NextLevel		15%	51%

Figure H-6—Trended Study Indicator 3 Results for FHP/ACA—SFY 2018



	RY 2014-2015	RY 2015-2016	RY 2016-2017
Aetna	88%	74%	
BCBSIL	41%	48%	35%
CountyCare	89%	44%	59%
FHN	31%	27%	
HAC	33%		
Harmony	49%	46%	44%
IlliniCare	60%	53%	81%
Meridian	59%	58%	58%
Molina	53%	62%	47%
NextLevel		15%	23%

Improvement Outcomes

Table H-3—Improvement Outcomes for the Care Coordination PIP—ICP SFY 2018

Comparison to Study Indicator Results From Prior Measurement Period			
Health Plan	**Number of Study Indicators**	**Statistically Significant Improvement ($p<.05$)**	**Sustained Improvement**
Blue Cross Blue Shield of Illinois	6	1	1
CountyCare Health Plan	6	1	2
Harmony Health Plan of Illinois, Inc.	3	1	1
IlliniCare Health Plan, Inc.	6	3	5
Meridian Health Plan, Inc.	6	2	2
Molina Healthcare of Illinois, Inc.	6	2	4
NextLevel Health Partners, LLC	6	4	Not Assessed
Overall Totals	**39**	**14**	**15**

Not Assessed: An additional measurement period is required to assess for sustained improvement.

Of the 39 study indicators that were assessed for statistically significant improvement, 14 (35.9 percent) demonstrated statistically significant improvement when compared to the previous measurement period. All the health plans were able to achieve statistically significant improvement for at least one study indicator. Fifteen study indicators (38.5 percent) achieved sustained improvement. NextLevel reported Remeasurement 1 data for its study indicators; therefore, it could not be assessed for sustained improvement. One health plan, IlliniCare, reported data for its ICP population. For the ICP population, one study indicator achieved statistically significant improvement, and all three study indicators demonstrated sustained improvement.

Health Plan-Specific Barriers/Interventions

Blue Cross Blue Shield of Illinois (BCBSIL)

Barriers:

- Lack of collaboration between the hospital, health plan, and provider.
- Life circumstances and lack of social support for members.
- Unable to reach members.
- Lack of provider appointment availability.
- Lack of care coordinator staff/"hiring freeze."
- Difficulty tracking community resources.

Interventions:

- Implemented a new care management system that addresses population health.
- Implemented a new Care Gap web-system.
- Implemented a new utilization management process.
- Implemented the Community Care Center Pilot.
- Continued the Feet on the Street Program.
- Hired additional care coordinator staff.
- Provided field staff with iPads.

CountyCare Health Plan (CountyCare)

Barriers:

- The member has low literacy and understanding of symptom management.
- The member has difficulty managing medication(s).
- Members' social determinants.
- The care coordinator is unaware of the member's hospital admission.
- Care coordination staff challenges with caseload.

Interventions:

- After a member is hospitalized, care managers are prompted by a worklist within care management software to reach out to the member within seven days and conduct a reassessment with the member.
- Implemented a delegate care management model that enables specialized care coordination with complex needs within a variety of settings.
- Care coordination staff are made aware, in-real time, of the member's admission into the hospital and emergency department, and can assist with discharge planning, medication management upon discharge, and scheduling follow-up care.
- The health plan analyzes the care management system to ensure caseloads do not exceed required thresholds.

Harmony Health Plan of Illinois, Inc. (Harmony)

Barriers:

- Lack of resources at the health plan to fully address community-based care coordination activities.
- Members lack awareness/education of their medical condition and of the importance of follow-up care, and they also have barriers to care (i.e., transportation).
- Staff turnover and lack of resources/training for case managers.
- Providers lack resources to provide care coordination activities and discharge planning.
- PCP is unaware of hospital admissions; lack of continuity of care and communication between providers.
- Difficulty locating members who could benefit from care coordination.
- Members often refuse care coordination services.

Interventions:

- Hired new care coordination staff and one supervisor to further develop and conduct additional member outreach.
- Improved and expanded staff training opportunities to promote understanding of care coordination activities, empower staff, and provide valuable resources.
- Increased member outreach/care coordination activities including:
  - Increased outreach by new care coordination team to screen members and connect to case managers.
  - Attending physician appointments as needed.
  - Providing linkage to community resources and follow-through to ensure these linkages are successful, and providing member education to promote self-management.
- Enhanced the Transition Care Management team.
- Recruited an external agency, Best Foot Forward, to help locate and engage high-risk members.
- Incentivized members to enroll in the care management program.

IlliniCare Health Plan, Inc. (IlliniCare)

Barriers:

- Lack of timely notification of the member's admission by the admitting facility.
- Inconsistent notification of the member's discharge by the admitting facility.
- Lack of the member's adherence to the treatment plan.
- Members not being connected to the appropriate community services/resources.
- Lack of training for staff at admitting facilities.
- Lack of standardized discharge process.

Interventions:

- Implemented an education initiative for utilization management and care coordinators at admitting facilities.
- Established the IL Discharge/Readmission Initiative.
- Corporate-sponsored initiative to call all members within three and 10 days of discharge.
- Developed and implemented a dedicated discharge planning team within the utilization management department.
- Integrated care nurses at three high-volume facilities.
- Collaboration on discharge plan process.

Meridian Health Plan, Inc. (Meridian)

Barriers:

- Inadequate training on topics related to transition of care, readmissions, and discharge planning for care coordinators.
- Further development of community resources needed for members.
- Lack of follow-up with members post-discharge.

Interventions:

- Weekly care coordination training meetings to provide care coordinators with necessary information related to members and training.
- Monthly trainings for all care coordination teams.
- Created two new contact codes in the Managed Care System that will track when a member has been referred to a community resource and when a community resource need has been identified by a care coordinator.
- Community stakeholder meetings to discuss available resources and form community partnerships to better serve the members. Revised Meridian's Transition of Care (TOC) program. Care coordination staff will meet weekly to create the process for Medicaid members.
- Focus on improving average caseload of care coordinators.

Molina Healthcare of Illinois, Inc. (Molina)

Barriers:

- The member does not follow the discharge plan, or social determinants overwhelm the member's ability to execute the discharge plan.
- The member does not receive or does not understand the discharge plan.
- Lack of communication between hospital staff and health plan staff regarding the discharge plan.
- Caseloads prevent quality time spent with assisting members in executing their discharge plan.

Interventions:

- Utilize the Community Connector Program in instances where Transition of Care staff or case management staff are unable to locate or contact the member to facilitate engagement.
- Partnered with hospitals to have Molina staff conduct and participate on-site or telephonically as part of the discharge planning process in collaboration with the facility team.
- Developed and implemented a curriculum for transition of care and care management staff trainings.

NextLevel Health Partners, LLC (NextLevel)

Barriers:

- Limited staff capacity to contact members who required individualized attention.
- The member did not have an initial HRA screening due to incorrect phone number and address.
- Lack of resources.
- Care management staff not meeting the standards for complex care and disease management of members.
- Staff knowledge of care management resources.
- Member health literacy.

Interventions:

- Developed a more robust care coordination program that enhances patient needs, prioritization, and scheduling of services.
- Case management rounds.
- Defined health promotion communication plan.
- Managers audit documentation and process.

Follow-up After Hospitalization for Mental Illness Behavioral Health Collaborative PIP (Behavioral Health PIP)

SFY 2018 Validation

For SFY 2018 validation, NextLevel was assessed through Activity IX (Real Improvement) with the reporting of Remeasurement 1 data, and the remaining health plans were assessed through Activity X (Sustained Improvement) with the reporting of Remeasurement 2 data. Table H-4 displays the overall validation results for each activity and stage of the Behavioral Health PIP across all health plans.

Table H-4—SFY 2018 Performance Improvement Project Validation Results Across All MCOs for the *Follow-up After Hospitalization for Mental Illness* PIP (N = 7 PIPs)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Review the Selected Study Topic	100% 14/14	0% 0/14	0% 0/14
	Review the Study Question	100% 7/7	0% 0/7	0% 0/7
	Review the Selected Study Indicators	93% 14/15	7% 1/15	0% 0/15
	Review the Identified Study Populations	100% 7/7	0% 0/7	0% 0/7
	Review Sampling Methods (if sampling was used)	*Not Applicable*		
	Review the Data Collection Procedures	100% 28/28	0% 0/28	0% 0/28
Design Total		**99% 70/71**	**1% 1/71**	**0% 0/71**
Implementation	Review the Data Analysis and Interpretation of Results	96% 54/56	4% 2/56	0% 0/56
	Assess the Improvement Strategies	100% 27/27	0% 0/27	0% 0/27
Implementation Total		**98% 81/83**	**2% 2/83**	**0% 0/83**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	Assess for Real Improvement Achieved	46% 13/28	18% 5/28	36% 10/28
	Assess for Sustained Improvement	0% 0/6	33% 2/6	67% 4/6
Outcomes Total		**38% 13/34**	**21% 7/34**	**41% 14/34**
Percentage Score of Applicable Evaluation Elements *Met*		**87% 164/188**	**5% 10/188**	**7% 14/188**

*Percentage totals may not equal 100 due to rounding.

Outcomes

The Behavioral Health PIP had two study indicators that are outlined in Table H-5.

Table H-5—Behavioral Health PIP Study Indicators

Indicator	Description of Indicator
1	The percentage of members who received follow-up within 7 days of discharge.
2	The percentage of members who received follow-up within 30 days of discharge.

FHP/ACA

SFY 2018 was the third year of participation for the FHP/ACA health plans. FHP/ACA results for SFY 2018 are presented in Section 4 of this report. Figure H-7 and Figure H-8 display trended outcomes for the Behavioral Health PIP study indicators for all participating FHP/ACA health plans for SFY 2018.

Figure H-7—Trended Study Indicator 1 Results for FHP/ACA

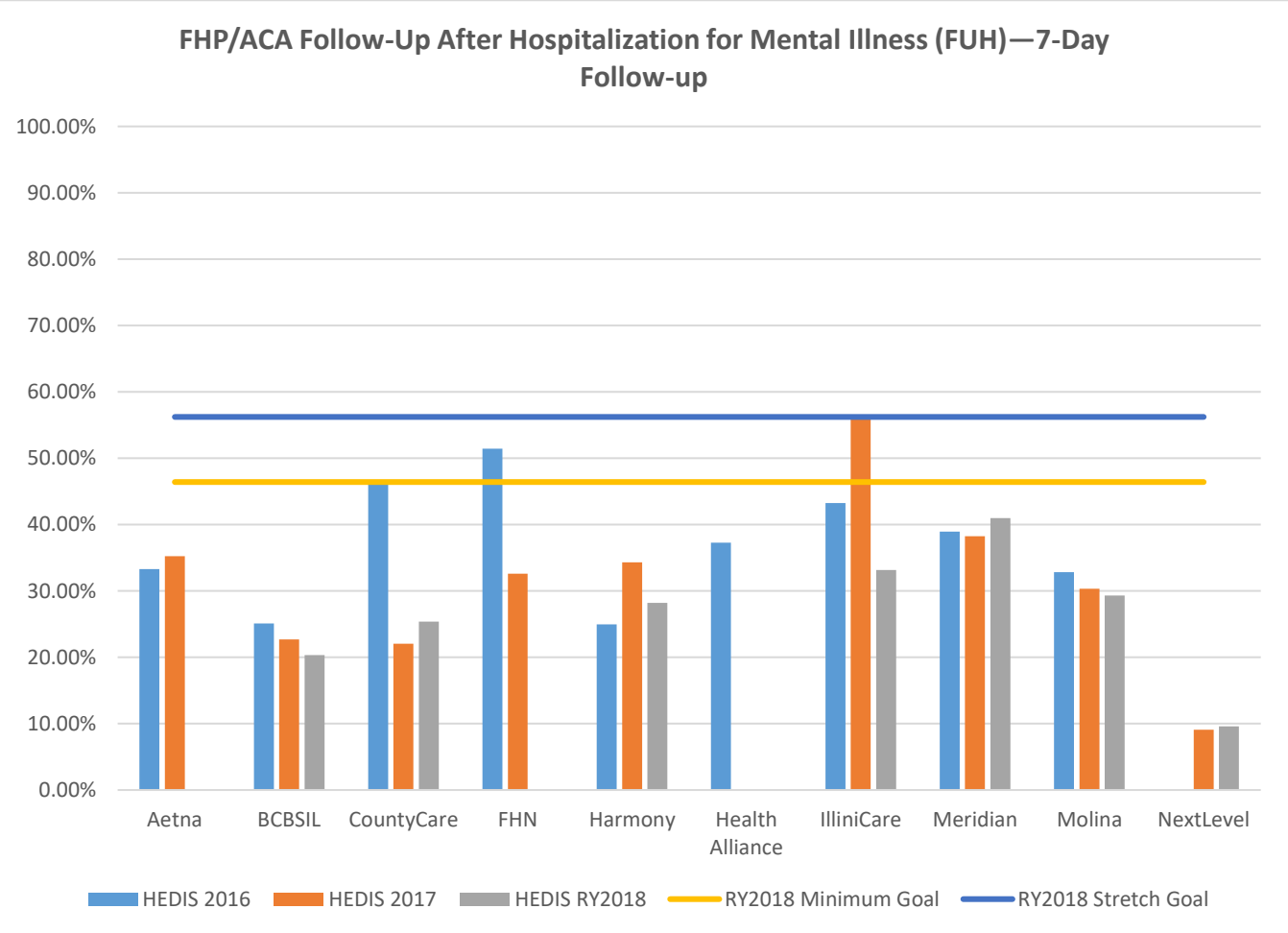
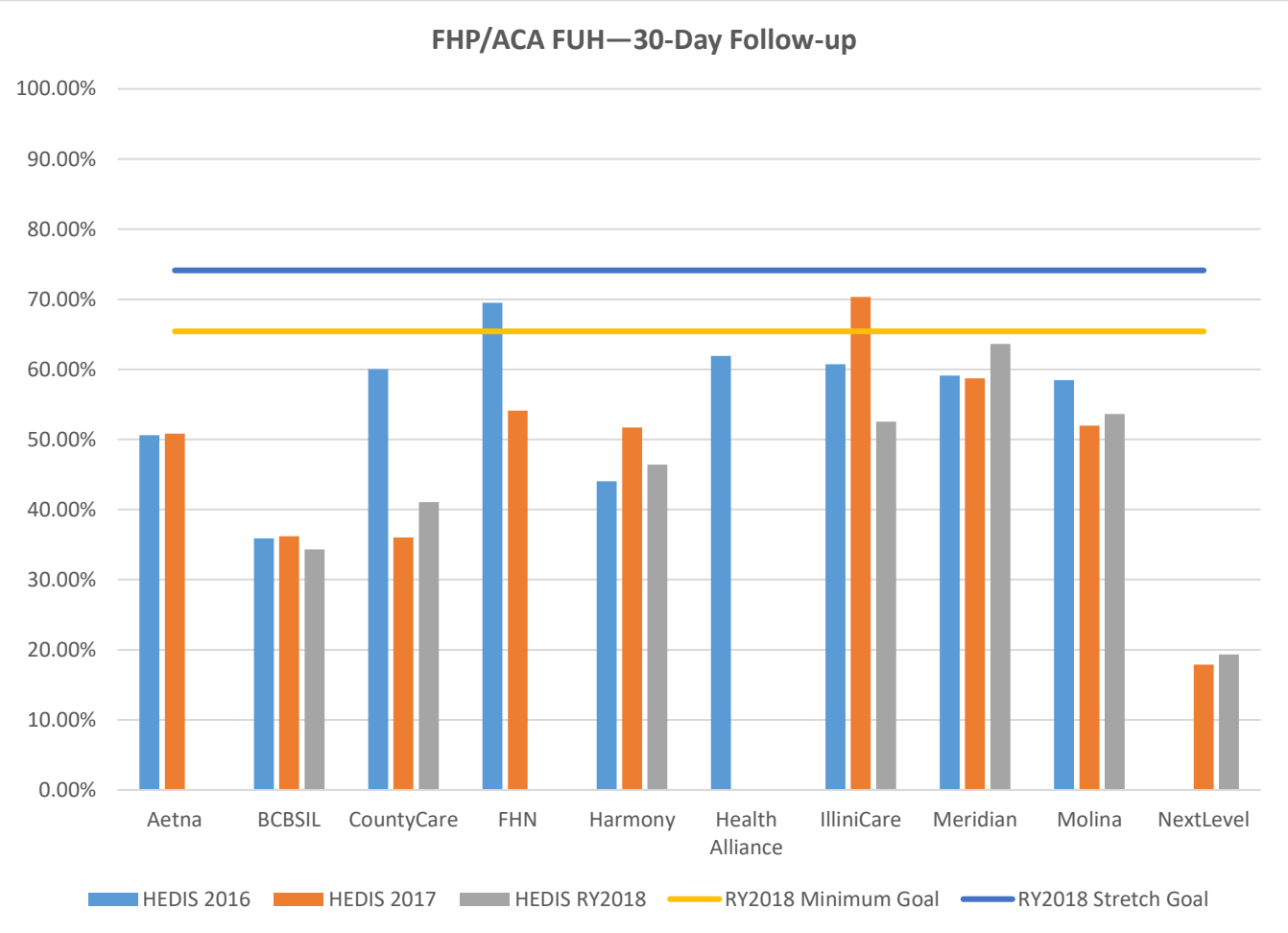


Figure H-8—Trended Study Indicator 2 Results for FHP/ACA



ICP

SFY 2018 was the third year of participation for the ICP health plans. ICP results for SFY 2018 are presented in Section 4 of this report. Figure H-9 and Figure H-10 display trended outcomes for the Behavioral Health PIP study indicators for all participating ICP health plans for SFY 2018.

Figure H-9—Trended Study Indicator 1 Results for ICP

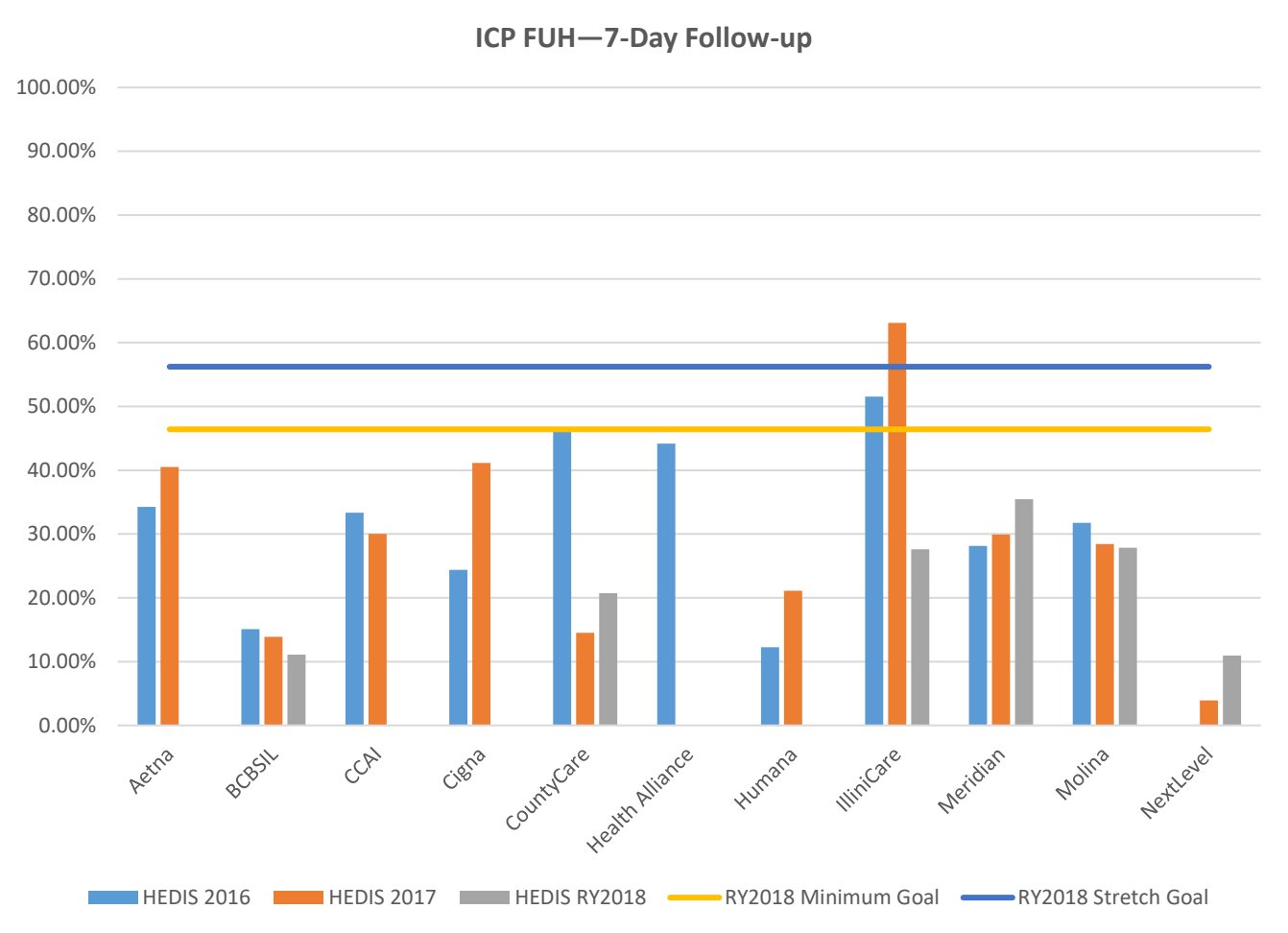
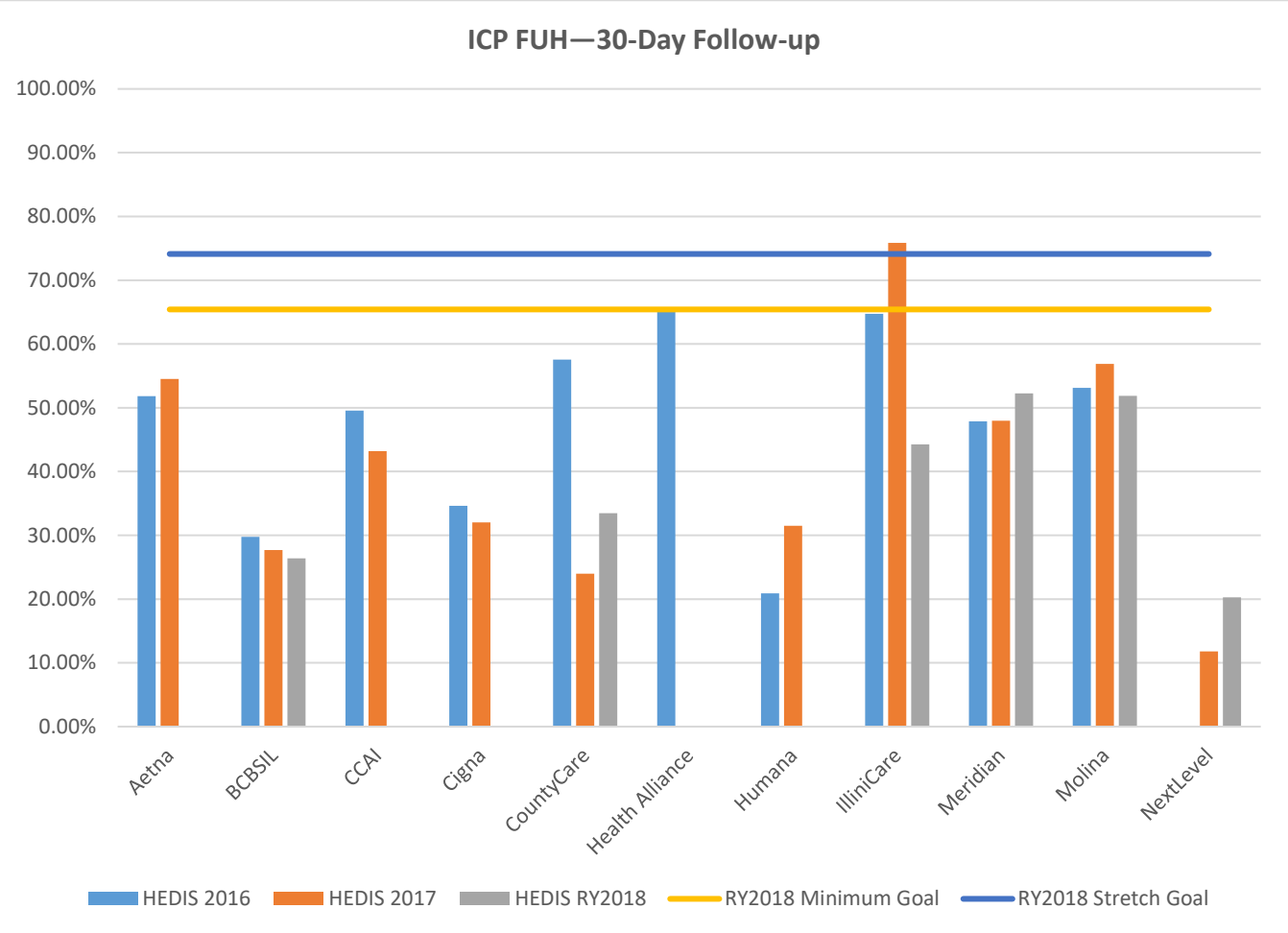


Figure H-10—Trended Study Indicator 2 Results for ICP



Improvement Outcomes

Table H-6 displays SFY 2018 improvement outcomes for each health plan for the Behavioral Health PIP.

Table H-6—SFY 2018 Improvement Outcomes for Behavioral Health PIP Study Indicators

Comparison to Study Indicator Results from Prior Measurement Period			
Health Plan	**Number of Study Indicators**	**Statistically Significant Improvement ($p<.05$)**	**Sustained Improvement**
BCBSIL	4	0	0
CountyCare	4	4	0
Harmony	2	0	*
IlliniCare	4	0	0
Meridian	4	4	2
Molina	4	1	0
Next Level	4	4	Not Assessed
Overall Totals	**26**	**13**	**2**

* The health plan received a *Partially Met* score for Activity X in the PIP Validation Tool for sustained improvement. The Remeasurement 2 rates for both study indicators were above the baseline; however, demonstrated a statistically significant decline from the Remeasurement 1 rates.

Not Assessed: An additional measurement period is required to assess for sustained improvement.

For the Behavioral Health PIP, the study indicator outcome results were mixed. Half of the study indicators achieved statistically significant improvement over the prior year's results. NextLevel reported Remeasurement 1 data for its study indicators; therefore, it could not be assessed for sustained improvement in study outcomes. Three health plans (CountyCare, Meridian, and NextLevel) achieved statistically significant improvement from the previous measurement period across all study indicators. Molina achieved statistically significant improvement for one study indicator. BCBSIL, Harmony, and IlliniCare were unsuccessful in achieving real improvement at Remeasurement 2. Meridian was the only health plan to demonstrate sustained improvement in two of four study indicators.

Health Plan-Specific Barriers/Interventions

BCBSIL

Barriers:

- Inadequate discharge planning. Discharge planning does not occur early in members' inpatient stay.
- Members' lack of awareness for keeping a follow-up appointment or other barriers such as lack of transportation.
- Limited member support system. Members with comorbid/co-occurring mental health and substance use disorders may be more treatment-ambivalent due to the comorbidity of their substance use disorder or issues and their current stage of change.
- Lack of provider availability within seven and 30 days following discharge.
- Select high-volume facilities continue to underperform with Healthcare Effectiveness Data and Information Set (HEDIS) *Follow-Up After Emergency Department Visit for Mental Illness* (*FUM)* rates when compared to other facilities.

Interventions:

- Care Coordination Early Intervention (CCEI) Program staff connect with members discharging from facilities and assist with aftercare follow-up needs and education (i.e., transportation).
- Financial Incentive Program: Select high-volume mental health facilities offered to take part in a performance tier-based monetary incentive program.
- TOC program: The TOC care coordinator (CC) coordinates with the facility to schedule a visit with the member within 48 hours of notification of admission.
- Behavioral health network provider, facility, and staff training on *FUM* measure requirements.

CountyCare

Barriers:

- Network providers and facility staff are unaware of the *FUM* performance measure and its requirements.
- Medical homes are unaware when members are hospitalized and discharged.
- Lack of information about members and timeliness to obtain records due to not having proper authorization on file to share records between the hospital and the medical home or behavioral health agency.
- Network inadequacy for access and availability to behavioral health providers and appointments for members.
- Members lack rapport with the medical home, behavioral health agencies, and/or medical home.
- TOC services must be improved to allow continuity of care by engaging with members while they are inpatient and scheduling outpatient appointments.

Interventions:

- Coordination of discharge planning. With the notification of admission, utilization management staff begin immediately to inquire about discharge plans.
- Distribution of the Provider Education packet developed by the IL MCO Collaboration. Provider and facility staff training sessions on other topics, such as overview of managed care and medical necessity criteria. The same process and contact persons can be utilized for education to the top 10 inpatient providers of mental healthcare on the importance of follow-up post-hospitalization for mental illness.
- Inpatient behavioral health admissions are referred to health plan case management staff. If the member is not contacted while still inpatient, case management conducts outreach to the member after discharge to remind the member of the upcoming appointment, reviews resolutions to any barriers (such as transportation) and uses motivational interviewing to address ambivalence about adherence to the follow-up appointment.
- In November 2017, CountyCare launched a Member Incentive Program for completing a follow-up appointment within seven or 30 days of a behavioral health hospitalization.

Harmony

Barriers:

- Lack of transition planning prior to the member's discharge.
- The behavioral health network may not be adequate to meet the timeliness requirements of seven- and 30-day follow-up.
- Providers lack knowledge of the HEDIS *FUM* measure requirements.
- The member's lack of understanding on the importance of follow-up visits.
- Members' social determinants.

Interventions:

- Continued provider and facility staff trainings to promote the understanding of needed seven- and 30-day follow-up visits.
- Expanded the network to include additional behavioral health providers, community mental health agencies, and federally qualified health centers.
- Ongoing quarterly Member Engagement Committees in Cook and Collar counties and Southern Illinois to engage and educate members.
- A collaboration workgroup provided outreach to nontraditional groups and associations to increase overall network capacity.
- Expand member outreach activities upon discharge to promote healthy behaviors and improve members' self-management of their behavioral health illness.
- Contracted with 7 Hills Healthcare to provide follow up services.

- Initiated a pilot focused on meeting members while still in the hospital and providing follow-up care in the community.

IlliniCare

Barriers:

- The behavioral health network may not be adequate to meet the timeliness requirements of seven- and 30-day follow-up.
- Providers lack knowledge of the HEDIS *FUM* measure requirements.
- Workflow processes need to be assessed and redirected to ensure adequate clinical resources are available to ensure timely follow-up after discharge.
- Lack of provider engagement.

Interventions:

- Participation in Illinois MCO Behavioral Health Collaboration Project.
- Developed and implemented provider and facility staff trainings to promote understanding of the importance of seven- and 30-day follow-up care in the effective treatment of mental illness.
- Used Geographical Access tools to close one of the two behavioral health network gaps.
- Added 552 behavioral health practitioners to provider network.

Meridian

Barriers:

- Lack of member knowledge about importance of follow-up.
- Ineffective transitions of care.
- TOC inefficiencies or lack of follow-up on the part of the members.
- Providers lack knowledge of the HEDIS *FUM* measure requirements.
- Lack of follow-up with members post-discharge.
- Lack of members' compliance with medication and follow-up care visits.
- PCP unaware of members' inpatient stay.
- Lack of social support and unstable living conditions of members.

Interventions:

- Coordinated discharge planning between the facility and health plan case manager upon inpatient mental health admission or upon concurrent notification of the admission.
- Provider outreach for TOC.

- Meridian follow-up with members post-discharge.
- Developed and implemented provider and facility staff trainings to promote understanding of the importance of seven- and 30-day aftercare follow-up in the effective treatment of mental illness.
- Developed and implemented member outreach activities to promote healthy behaviors and improve members' self-management of their behavioral health illness.
- Meridian's behavioral health community care coordinator (CCC) team visit members face-to-face while they are admitted to an inpatient facility to discuss their condition and barriers to care and to schedule follow-up appointments.
- Behavioral health CCC team tracked *FUM* appointment attendance to determine if members attended their appointment in real time; if they are still within the 30-day time frame, behavioral health CCC team could reschedule another appointment for the members.

Molina

Barriers:

- Members' lack motivation or are unwilling to seek recovery for mental illness.
- Members are not established with a mental health provider or a PCP.
- Members are unable to follow the discharge plan due to social determinants.
- Poor communication between the inpatient facility and the health plan to coordinate the discharge plan.
- Providers lack knowledge of the HEDIS *FUM* measure requirements.
- Staff turnover and heavy caseloads make it difficult to handle the volume of members and to dedicate sufficient time engaging members.
- Disjointed processes and communication.

Interventions:

- Developed and implemented member outreach activities to promote healthy behaviors and improve members' self-management of their behavioral health illness.
- Coordinated discharge planning between the facility and plan case manager upon inpatient mental health admission or upon concurrent notification of the admission. Directed additional resources to foster partnerships with high-volume facilities.
- Developed and implemented a consistent curriculum and performance metrics for provider and facility staff education to promote understanding of the importance of seven- and 30-day aftercare follow-up in the effective treatment of mental illness.
- Revamped TOC Program, staff training materials, and processes.

NextLevel

Barriers:

- Discharge planning does not occur early in the member's inpatient stay.
- The behavioral health network may not be adequate to meet the timeliness requirements of seven- and 30-day follow-up.
- Providers/facilities lack knowledge of the HEDIS *FUM* measure requirements.
- Workflow processes need to be assessed and redirected so that adequate clinical resources are available to ensure timely follow-up after discharge.
- Members' lack of knowledge of the importance of keeping a follow-up appointment or other member barriers like lack of transportation, medication side effects, etc., may prevent them from seeking a follow-up appointment.

Interventions:

- Coordinated discharge planning between the facility and health plan case manager upon inpatient mental health admission or upon concurrent notification of the admission.
- Developed and implemented provider and facility staff trainings to promote understanding of the importance of seven- and 30-day follow-up care in the effective treatment of mental illness.
- Developed and implemented member outreach activities to promote healthy behaviors and improve members' self-management of their behavioral health illness.

Appendix I. Structure and Operations Methodology and Additional Information

Overview

This section presents the methodology and detailed descriptions of the activities Health Services Advisory Group, Inc. (HSAG), conducted to assess and monitor the health plan's structure and operations as required by federal regulations and by request of the Illinois Department of Healthcare and Family Services (HFS).

Section Contents

Compliance and Readiness Reviews

Introduction

As set forth in 42 Code of Federal Regulations (CFR) §438.358(3), states are required to conduct an administrative compliance review of each health plan, within the previous three-year period, to determine health plan compliance with federal regulatory provisions, state standards, and contract requirements. HFS has an annual monitoring process in place to ensure the CFR and Balanced Budget Act (BBA) requirements are met over a three-year period. HSAG reviews health plan compliance with the state standards, and in accordance with 42 CFR §438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR §438.206–42 CFR §438.242, which address requirements related to access, structure and operations, and measurement and improvement standards. Compliance is also determined through review of individual files to evaluate implementation of standards.

Compliance Review Process

Background

The BBA of 1997 requires that states contract with an external quality review organization (EQRO) to conduct an evaluation of their health plans to determine compliance with standards related to access, measurement and improvement, structure and operations, and program integrity. The U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), regulates procedures for external quality review (EQR). Oversight activities of the EQRO focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries.

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards for quality healthcare is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The CMS protocols for external quality review of Medicaid managed care organizations and prepaid inpatient health plans describe the second step.[I-1]

Objectives

The primary objective of HSAG's compliance review was to provide meaningful information to HFS and the health plans regarding compliance with federal managed care regulations and contract requirements. The compliance review areas selected included standards listed below under the four areas of Access, Structure and Operations, Measurement and Improvement, and Practice Guidelines. The remaining Administrative Review standards are scheduled for review in 2017.

To complete the compliance 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 the report of its findings.

[I-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocols. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Mar 14, 2018.

Standards

The compliance review tool included requirements that addressed the following operational areas. The information and findings from HSAG's reviews were used by HFS and each health plan to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve the quality, accessibility, and timeliness of services.

Access Standards

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care (Including Transition of Care)

Structure and Operations Standards

- Standard VII—Subcontracts and Delegation

Measurement and Improvement Standards

- Standard XIII—Health Information Systems
- Standard XIV—Required Minimum Standards of Care/Practice Guidelines
- Standard XV—Critical Incidents

Practice Guidelines

- Standard XIV—Practice Guidelines and Required Minimum Standards of Care

Review Activities and Technical Methods of Data Collection

The compliance review process was divided into the following seven phases.

- Phase 1: Preparation
- Phase 2: Health plan desk review
- Phase 3: HSAG desk review
- Phase 4: HSAG on-site review
- Phase 5: Health plan reporting and remediation review
- Phase 6: HSAG remediation review
- Phase 7: Final report

Throughout preparation for the compliance review and performance of the activities during the on-site review, HSAG worked closely with HFS and the health plan to ensure a coordinated and supportive approach to completing the required activities. HSAG also followed the guidelines in the CMS' *EQR*

Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.[I-2]

Web-Based Administrative Tool

The *Administrative Review Web-Based Tool* (review tool) was developed for HFS by HSAG. The review tool is a web-based application that contains the standards, elements, and scoring for each standard. The web-based tool is used to record the desk review findings, on-site review findings, remediation actions (if needed), and evaluation of remediation actions. Health plans use the web-based tool to submit documentation to support compliance with each standard/element during the desk review, view the report of findings following the on-site review, and respond to noncompliant elements through documentation of the remediation plan and submission of documents to support the remediation plan.

Pre-On-Site Activities

Prior to the on-site administrative compliance review, the health plan participated in weekly conference calls with HFS and HSAG to review the preparation for implementation of the program. A list of mandatory documents required for approval before the "go live" date was provided to the health plan. The mandatory document list was determined based on HFS contractual requirements. HSAG reviewers used the documentation to gain insight into each health plan's structure and operations, access to care for its members, and quality assessment and performance improvement program. HSAG also used the documentation to begin compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers documented findings from the review of the materials submitted as evidence of compliance with the requirements, identified areas and issues requiring further clarification during the on-site interviews, and identified additional documentation for request during the on-site visit.

HFS, with assistance from HSAG, reviewed and approved all mandatory documentation prior to implementation of the program. Throughout this desk review process, the health plan was required to revise any documents not meeting the federal, State, and contract requirements and resubmit them for approval.

On-Site Activities

During the on-site portion of the review, health plan staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. During the on-site review, HSAG used interviews to obtain a complete picture of compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the health plan's performance. HSAG also reviewed information, documentation, and systems demonstrations. Throughout the on-site review process, reviewers used the

[I-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Mar 14, 2018.

review tool to identify relevant information sources and to document findings regarding compliance with the standards.

HSAG received and reviewed files designated for the file reviews. HSAG generated unique record review samples based on data files supplied by the health plans and HFS. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the health plans' policies and procedures. As a final step for the on-site review, HSAG reviewers met with staff members from the health plan and HFS to provide a high-level summary of the preliminary findings.

Provider Network Analysis for Compliance Reviews

As set forth in 42 Code of Federal Regulations (CFR) §438.358(3), states are required to conduct a compliance review of each health plan, within the previous three-year period, to determine health plan compliance with federal regulatory provisions, State standards, and contract requirements. HSAG develops tools and documents using specific criteria from applicable CFRs, as well as state statutes and contracts. HSAG uses the tool to assess reviews of health plans' compliance with applicable standards.

The administrative reviews include assessment of availability of services and assurance of adequate capacity and service. HSAG's provider network analyses help HSAG determine health plans' compliance with network adequacy standards. HSAG reviews health plan activities for oversight of their networks and validates those activities as part of the administrative review process including review of health plan internal oversight and monitoring procedures and review of network capacity reporting. HSAG conducts several specific file reviews to determine compliance with access and availability standards as described below.

- **Provider Directory Review**—A more in-depth analysis of the accuracy of the health plans' searchable online provider network. Health plans are required to monitor the accuracy of the online provider directory and hardcopy provider directory. For this review, health plans were required to provide the most recent "open/closed panel report," which is a listing of all notifications the plan has received from its providers regarding providers' availability to accept new patients. HSAG selected a random sample of network providers to evaluate 13 data elements for each sampled provider. HSAG analyzed the provider directory information to determine the degree to which each health plan's provider directory complied with contract requirements.
- **Access-Related Grievance File Review**—HSAG developed a review tool to determine compliance with contract standards regarding the intake and processing of grievances. Health plans were required to submit all access-related grievances for the calendar year. HSAG sorted this file by type of access-related grievance to determine the number of grievances by category as identified, and randomly selected 10 files among the grievance categories.
- **Review of Provider Contracts**—HSAG performed a review of contracts for the following provider types: ancillary, facility, federally qualified health center (FQHC), hospital, physician hospital organization (PHO), and provider. For each provider type, HSAG reviewed a template contract against 15 elements to determine compliance with requirements.

- **Review of Access and Availability Reports**—HSAG reviewed health plan provider access and appointment availability audit results to assess health plans' monitoring of provider compliance with appointment availability and after-hours access standards. The review includes comparing health plan monitoring procedures against access and availability standards including procedures to follow up with providers found noncompliant.

Scoring

Based on the results from the comprehensive compliance review tool and conclusions from the review activities, HSAG assigned each element within the standards in the compliance monitoring tool a score of *Met*, *Not Met*, or *Not Applicable* (*NA*). HSAG used scores of *Met* and *Not Met* to indicate the degree of compliance with the requirements by the health plan. HSAG used a designation of *NA* when a requirement was not applicable to an organization during the period covered by the review. This scoring methodology was consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Health Plan Descriptions

Harmony Health Plan of Illinois, Inc. (Harmony)

WellCare Health Plans, Inc., Harmony's parent company, provides managed care services targeted to government-sponsored healthcare programs, focusing on Medicaid and Medicare. Headquartered in Tampa, Fla., WellCare offers a variety of health plans for families; children; and the aged, blind, and disabled (ABD) population. It also provides prescription drug plans. As a subsidiary, Harmony works with doctors, hospitals, governments, and communities to provide quality, cost-effective healthcare solutions.

Cigna-HealthSpring of Illinois (Cigna)

Cigna has various locations, but most of the operational areas such as customer service, network operations and contracting, compliance, service coordination, and utilization management (UM) are in Chicago. Cigna's claims are processed and managed in Baltimore, MD. Cigna's person-centered care management program includes medical, behavioral, and social services, with the key initiatives focusing on individual needs and keeping the member in the least restrictive environment. Cigna's registered nurses (RNs), those with master of social work (MSW) degrees, and licensed clinical professional counsellors (LCPCs) work remotely, reside in the same ZIP code as members, and utilize specialty vendors to enhance the service provided to members focusing on unable-to-locate members. The tables below present a summary of Cigna's initial compliance review results for the Integrated Care Program (ICP) and Medicare-Medicaid Alignment Initiative (MMAI).

Blue Cross Blue Shield of Illinois (BCBSIL)

BCBSIL is an Illinois-based division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, established and licensed in 1936. The organization was founded when a group of local civic leaders, hospital officials, and physicians came together during the Great Depression to find a solution to the problem of affordable healthcare. In 1936, they pooled resources and incorporated as Hospital Services Corporation to offer prepaid benefits, under the statutes of the State of Illinois. BCBSIL is the largest operating health plan within HCSC, with 8.19 million members out of a total of 14.90 million. HCSC employs 19,000 people, of which 9,500 are in Illinois in 17 locations throughout the State. Today, BCBSIL is Illinois' largest insurer and continues to partner with providers and communities to implement innovative new models of care that improve value and quality of health for all Illinois residents.

Family Health Network (FHN)

FHN, is a not-for-profit MCO founded in 1994 as a Managed Care Community Network (MCCN) sponsored by several Chicago-based safety net hospitals. Over the past 22 years, those hospitals have become Norwegian American Hospital, Sinai Health System, Saint Anthony Hospital, Saint Bernard Hospital, and Presence Health. On June 29, 2015, FHN became an Illinois-licensed health maintenance organization (HMO). As of April 2017, FHN acquired its National Committee for Quality Assurance (NCQA) accreditation. There are two Medicaid populations currently served by FHN, the Family Health Plan (FHP) population, formerly known as the Temporary Assistance for Needy Families (TANF) population (consisting of primarily women and children) and the Affordable Care Act (ACA) population. In response to a new Illinois Medicaid Innovations initiative in 2013, FHN created a wholly owned subsidiary, Community Care Alliance of Illinois (CCAI). This MCCN provides managed healthcare to the Integrated Care Program participants, formerly known as the ABD population. The two companies, FHN and CCAI, established and maintain many shared departments to provide consistent and documented processes within both organizations.

Community Care Alliance of Illinois (CCAI)

CCAI is a wholly owned subsidiary of Family Health Network. CCAI is an MCCN organized under Illinois statute in 2013 as part of the Department of Healthcare and Family Services (HFS) Integrated Care Program. CCAI provides managed health services to seniors and adults with disabilities under the Illinois Medicaid program. In April 2017, CCAI acquired its NCQA accreditation. CCAI offers a Medicaid product through the ICP, which consists of older adults and adults with disabilities who are enrolled in Medicaid, but not Medicare.

Aetna Better Health (Aetna)

Aetna has provided service to HFS' ICP membership since May 2011. The plan added FHP/ACA membership in the winter of 2014 and added the MMAI demonstration project (membership in Cook, DuPage, Kane, Kankakee and Will counties) in the early spring of 2015.

Meridian Health Plan, Inc. (Meridian)

Family owned and operated, Meridian has been a Medicaid HMO since 2000. Meridian was founded by Dr. David Cotton in 1997 as a Medicaid health plan in Michigan. Over the years, Meridian has expanded into other states including Illinois, Indiana, Kentucky, Michigan, and Ohio. Meridian expanded into Illinois in 2008 and currently serves the IL Medicaid FHP/ACA, ICP, and MMAI populations in all mandatory managed care regions in counties across Illinois.

Molina Healthcare of Illinois, Inc. (Molina)

Molina was founded more than 35 years ago by Dr. C. David Molina, an emergency room (ER) physician. Dr. Molina opened the first medical clinic to serve the patients he frequently treated in the ER simply because they did not have their own primary care doctor. From that clinic, Molina Healthcare continued to grow for the next three decades to become what it is now—a national healthcare company that provides care through government-sponsored programs across the country. Today, Molina Healthcare serves the diverse needs of members across the United States through programs such as Medicaid, Medicare, and Health Insurance Marketplace. Molina also offers health information management and business process outsourcing solutions for state Medicaid programs through its subsidiary, Molina Medicaid Solutions. Additionally, Molina continues to expand its primary care clinics across the country through Molina Medical.

IlliniCare Health Plan, Inc. (IlliniCare)

IlliniCare, a managed care organization founded in 2011, is contracted with the State of Illinois to provide healthcare services to the Medicaid and Medicare populations. In 2014, IlliniCare launched a variety of commercial health insurance plans, which are available for purchase on the Health Insurance Marketplace. IlliniCare aims to improve healthcare outcomes and quality of care, partner with providers, and control costs.

Humana Health Plan, Inc. (Humana)

Founded in 1961 and headquartered in Louisville, KY, Humana's 43,000 associates focus on helping approximately 12 million members achieve lifelong well-being. Humana's commitment to Illinois is best exemplified by its 30 years of experience participating in the Medicare Advantage and M+C programs. Humana has developed longstanding shared responsibility relationships with some of the largest and most respected provider groups and hospital systems in Illinois. Humana leveraged many of

these relationships and developed new partnerships for the launch of both the MMAI and ICP programs in March 2014 with new partners, Independent Living Systems (ILS) and Beacon Health Options.

CountyCare Health Plan (CountyCare)

In fall 2012, the Cook County Health & Hospitals System (CCHHS) launched CountyCare as a demonstration project through a CMS 1115 Waiver granted to the State of Illinois Medicaid agency to early-enroll eligible low-income Cook County adults (ACA adults) into a Medicaid managed care program. In July 2014, CountyCare transitioned from the federal waiver authority and subsequently became a Medicaid managed care plan under the State's County MCCN rules. This transition allowed CountyCare to expand beyond the newly eligible ACA adult population to include traditional Medicaid populations in FHP and Seniors and Persons with Disabilities (SPD) coverage. The CountyCare provider network includes all CCHHS facilities, every FQHC in Cook County, and more than 30 hospitals. CountyCare also covers approved HCBS and allows members to fill prescriptions at local pharmacies or use CCHHS' mail order system.

NextLevel Health Partners, LLC (NextLevel)

NextLevel became operational by July 2014. Over the next year, NextLevel grew quickly in membership, expanding its membership to serve not only SPD members, but also to serve newly eligible ACA adults. Additionally, NextLevel's service area grew to include all of Cook County, with its provider network growing to almost 500 primary care providers (PCPs), and strong partnerships with hospitals, FQHCs, community mental health centers (CMHCs), and other needed ancillary providers.

Care Coordination/Care Management (CC/CM)

Annual Care Coordination Staffing Reviews

Methodology

Staffing

HSAG reviewed the staffing specifications described in the HealthChoice Illinois and MMAI contracts to define the scope of the staffing analysis for state fiscal year (SFY) 2018. HSAG developed an Excel workbook tool that each health plan was required to complete for analysis. HSAG used the tool to assess contract compliance in each of the following domains:

- Waiver member caseloads per contract type
- Weighted caseloads total per contract type
- Staff qualifications
- Staff-related experience

HSAG also used the tool to assess non-contractually-required data related to management and staff positions.

The tool HSAG provided included several spreadsheets requiring health plans to identify their care coordination/care management (CC/CM) staffing as described below.

Internal CC/CM Management Positions

Health plans were required to identify their internal CC/CM management staff. The CC/CM management staffing worksheet identified the names, positions, residency, date of hire, full time equivalency (FTE), and credentials of each CC/CM managerial position. CC/CM managerial staffing levels are not directed by contract; however, data was collected to provide information regarding oversight of the CC/CM program.

Delegated CC/CM Management Positions

The health plans were also required to identify delegated CC/CM management staff. For those health plans that delegated CC/CM services, HSAG performed an evaluation of the delegated entity's management against the same standards as the health plan's internal CC/CM management staff.

Internal CC/CM Staff

Health plans were required to provide case management base type (telephonic or field), positions, qualifications and related experience of internal CC/CM staff. Additionally, health plans were required to list each CC/CM's member caseload assignments by waiver, non-waiver, and risk stratification level for all applicable contracts, as well as the FTE assigned per CC/CM per contract.

Delegated CC/CM Staff

Those health plans that delegated CC/CM services were required to identify all delegated CC/CM staff. HSAG performed an evaluation of the delegated entity's CC/CM staff against the same standards as the health plan's internal CC/CM staff.

Training

HSAG reviewed the training specifications described in the HealthChoice Illinois and MMAI contracts to define the scope of the training analysis for calendar year (CY) 2018. HSAG developed tools to assess the following domains of health plan case management training:

- Training curriculum completeness
- Training curriculum content
- Training hours
- Waiver training topic completeness
- Waiver training hours

Methodology for Analysis

Staffing

HSAG analyzed each health plan's compliance with contract requirements in the areas described below:

- CC/CM staff qualifications for staff managing waiver caseloads
- CC/CM-related experience for staff managing human immunodeficiency virus (HIV) waiver caseloads
- CC/CM staff caseload assignment for staff managing HIV and/or brain injury (BI) waiver caseloads
- CC/CM staff weighted caseload by contract
- CC/CM staff total caseload by contract

HSAG also analyzed the following non-contractually-required data:

- CC/CM management positions

  - Total dedicated FTE
  - Ratio of total dedicated managerial staff to total CC/CM staff
  - Residency of management staff
  - Qualifications of management staff
- CC/CM staff
  - Total dedicated FTE
  - Qualifications of CC/CM staff
  - Type of care management provided (telephonic- or field-based)

Training

HSAG analyzed each health plan's compliance with contract requirements in the areas described below:

- Training curriculum completeness by contract
- Training curriculum content
- Training hours overall
- Waiver training topic completeness for staff managing waiver caseloads
- Waiver training hours for staff managing waiver caseloads

Requirements

The CC/CM staffing, qualifications, and training review included the following state-selected requirements.

Table I-1—CMS HCBS Waiver Qualification Requirements

Staffing Qualifications by Waiver Type*			
Elderly	**Disabilities**	**Brain Injury**	**HIV/AIDS♦**
1. Registered Nurse licensed in Illinois 2. Bachelor's degree in nursing, social sciences, social work, or related field 3. Licensed practical nurse (LPN) with one year's experience in conducting comprehensive assessments and provision of formal service for the elderly 4. One year of satisfactory program experience may replace one year of college education; at least four years' experience may replace baccalaureate degree	1. Registered Nurse licensed in Illinois 2. Licensed Clinical Social Worker 3. Licensed Marriage and Family Therapist 4. Licensed Clinical Professional Counselor 5. Licensed Professional Counselor 6. PhD 7. Doctorate in Psychology 8. Bachelor's or master's degree prepared in human services-related field 9. LPN	1. Registered Nurse licensed in Illinois 2. Certified or Licensed Social Worker 3. Unlicensed Social Worker: minimum of bachelor's degree or at least three years' experience working with people with disabilities 4. Vocational Specialist: certified rehabilitation counselor or at least three years' experience working with people with disabilities 5. Licensed Clinical Professional Counselor 6. Licensed Professional Counselor 7. Certified Case Manager	1. Registered Nurse licensed in Illinois and bachelor's degree in nursing, social work, social sciences, or counseling or four years' case management experience 2. Social Worker with bachelor's degree in social work, social sciences, or counseling (bachelor's or master's in social work from a school accredited by nationally recognized organization for accreditation of social work schools preferred) 3. Individual with bachelor's degree in human services field; minimum five years' case management experience
			Additionally—Care Coordinator for HIV/AIDS Waiver enrollees must have experience working with: • Addictive and dysfunctional family systems • Racial and ethnic minorities • Homosexuals and bisexuals • Persons with AIDS, and • Substance abusers

* Contract reference: HealthChoice Illinois: Attachment XVI, MMAI: Appendix K.

♦ Human immunodeficiency virus/Acquired immunodeficiency syndrome (HIV/AIDS)

Table I-2—Care Coordination Caseload Requirements

Caseload Requirements*
Care coordinators responsible for enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. A care coordinator's caseload shall have **a maximum weighted caseload of 600 with low risk weighted as one, moderate risk weighted as four, and high risk weighted as eight.** Caseloads of care coordinators shall not exceed the following standards on average during the calendar year: • High Risk Enrollees: 75 • Moderate Risk Enrollees: 150 • Low Risk Enrollees: 600 • BI and HIV/AIDS: 30

* Contract references: HealthChoice Illinois 5.17.1–5.17.2.1, MMAI 2.5.2.7–2.5.2.7.1.4

Table I-3—Care Coordination General Training Requirements

General Training Requirements	
Topic	**Contract Reference**
Cultural Competency and Linguistic Training	HealthChoice Illinois 2.7.3 MMAI 2.5.2.2
Diversity Training	HealthChoice Illinois 5.21.4
Potential Quality of Care/Critical Incidents and Reporting	HealthChoice Illinois 5.23.1 MMAI 2.9.7.1
Fraud, Waste, and Abuse	HealthChoice Illinois 5.35.1, 5.35.1.9 MMAI 2.9.7.1
Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Confidentiality Training	HealthChoice Illinois 5.32 MMAI 5.2.1
Delivering Patient-Centered Care Training	HealthChoice Illinois 5.14 MMAI 2.5.2.2
Motivational Interviewing Training	HealthChoice Illinois 5.13.4
Provision of Medical Needs for the Seniors and Persons with Disabilities Population	HealthChoice Illinois 5.14.1, 5.14.2
Provision of Behavioral Healthcare Needs for the Seniors and Persons with Disabilities Population	HealthChoice Illinois 5.14.1, 5.14.2
The Ombudsman Program	MMAI 2.5.2.2
Americans with Disabilities Act	MMAI 2.5.2.2
Independent Living and Recovery	MMAI 2.5.2.2
Provision of Medical Needs for the MMAI Population	MMAI 2.5.2.4.1
Provision of Behavioral Health Needs for the MMAI Population	MMAI 2.5.2.4.1

Table I-4—HCBS Waiver Training Requirements

Waiver Training Requirements	
Topic	**Contract Reference**
Persons who are Elderly (ELD) Waiver: Aging-related subjects	HealthChoice Illinois Attachment XVI, 1.3.1.1.1 MMAI Appendix K, A
BI Waiver: Provision of services to persons with brain injuries	HealthChoice Illinois Attachment XVI, 1.3.1.2.1 MMAI Appendix K, A
HIV/AIDS Waiver: Provision of services to persons with AIDS	HealthChoice Illinois Attachment XVI, 1.3.1.3.1 MMAI Appendix K, A
Persons in a Supported Living Facility (SLF) Waiver: Resident rights	HealthChoice Illinois Attachment XVI, 1.3.1.4.1 MMAI Appendix K, A
SLF Waiver: Prevention and notification of abuse, neglect, and exploitation	HealthChoice Illinois Attachment XVI, 1.3.1.4.1 MMAI Appendix K, A
SLF Waiver: Behavioral interventions	HealthChoice Illinois Attachment XVI, 1.3.1.4.1 MMAI Appendix K, A
SLF Waiver: Techniques for working with the elderly and persons with disabilities	HealthChoice Illinois Attachment XVI, 1.3.1.4.1 MMAI Appendix K, A
SLF Waiver: Disability sensitivity	HealthChoice Illinois Attachment XVI, 1.3.1.4.1 MMAI Appendix K, A