Division of Medical Programs

COMPREHENSIVE MEDICAL PROGRAMS QUALITY STRATEGY

2016-2018

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Section 1. Quality Framework

HealthChoice Illinois Quality Strategy

The Choice for Quality

Purpose

The Illinois Department of Healthcare and Family Services (HFS) developed *Partnering for Performance: Making the Choice for Quality* as its Medicaid Comprehensive Medical Programs Quality Strategy (Quality Strategy). The Quality Strategy provides a framework to accomplish HFS' mission.

Mission

HFS is committed to ensuring quality health care coverage at sustainable costs, empowering people to make sound decisions about their wellbeing, and maintaining the highest standards of program integrity on behalf of Illinoisans.

Objectives

Our 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.

Goals

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 (EQR) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

HealthChoice Illinois Quality Strategy

The Choice for Quality

ROADMAP FOR QUALITY FRAMEWORK

Focus Populations

Transformation Levers

Desired Health Improvements

Behavioral Health

Chronic Disease

Maternal and Child Health

Healthy Adults

Long-Term Services and Support

- Low- and high-intensity assessment and care planning
- Community-based care
- Evidenced-based care
- Robust and sustainable behavioral health services
- Investment in support services
- Enhanced identification and screening
- Modernized service delivery
- Consumer education, information, and choice
- Payment reform
- Data-driven decisions
- Increased workforce and system capacity
- Integrated health information technology systems

- Integration of behavioral and physical health care service delivery
- Timely treatment, follow-up, and monitoring

- Management of diabetes, asthma, blood pressure, and use of persistent medications

- Preventive care and screenings
- Immunizations
- Prenatal and Postpartum Care
- Pre-term birth rates

- Preventive care and screenings

- Institution to community care

Section 2. Introduction

Purpose

The Illinois Department of Healthcare and Family Services (HFS or the Department) developed *Partnering for Performance: Making the Choice for Quality* as its Medicaid Comprehensive Medical Programs Quality Strategy (Quality Strategy) in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.340 et seq.

The Quality Strategy provides a framework to accomplish HFS' mission. The Quality Strategy is designed to foster the delivery of the highest-quality, most cost-effective services possible by establishing a framework for ongoing assessment and the identification of potential opportunities for healthcare coordination and improvement.

The Quality Strategy's goals and objectives, scope, assessment of performance, improvement interventions, plan for periodic evaluation, and accomplishments are detailed in this Quality Strategy. See a list of acronyms used in this report in Appendix N.

Our Journey Here

Reboot

HFS administers the medical assistance programs most commonly known as Medicaid, Children's Health Insurance Program (CHIP), and All Kids. These programs are jointly financed by State and federal government funds and provide critical healthcare coverage to Illinois' most vulnerable populations.

HealthChoice Illinois—the State's rebooted Medicaid managed care program—launched on January 1, 2018, to serve almost 2.7 million residents. The reboot was designed to enhance care while managing costs to keep the program sustainable in coming years. The new program streamlines administration, includes tools to measure and promote success, and incorporates a coordinated care system that addresses the total health history and needs of each member. It includes built-in enhancements for care coordination, quality measures, and whole-person care.

Under the managed care program reboot, seven Medicaid managed care health plans (health plans) committed to providing care for 80 percent of all Medicaid beneficiaries statewide. The former managed care program was designed to operate in only 30 counties and failed to reach people in the most rural areas of Illinois.

Managed Care Timeline

Figure 2-1—Managed Care Timeline

1976

VMC

Managed care introduced to Illinois through Voluntary Managed Care (VMC)

2011

ICP

Mandatory managed care introduced through Integrated Care Program (ICP)

2014

Expansion

- Medicare-Medicaid Alignment Initiative (MMAI) launched for dual-eligibles
- Expansion of ICP
- Family Health Plan/Affordable Care Act (FHP/ACA)
- 1.4M fee-for-service members transitioned to managed care

2015-2016

Transition

- State managed care law takes effect
- Transition from CCEs/ACEs to risk-based MCOs/ MCCNs
- Managed Long Term Services and Supports (MLTSS)

Illinois Health and Human Services (HHS) Transformation

2017

RFP

New managed care request for proposal (RFP) for Medicaid managed care statewide expansion

- Integration of programs and populations

2018

Statewide Managed Care

- Implementation of HealthChoice Illinois Managed Care Program
- Statewide HealthChoice Illinois Managed Care Program Expansion

Focus of Efforts:

- **Establish the foundation for mandatory managed care**
- **Extend managed care to new populations and geographies**
- **Enhance quality, outcomes, and accountability with streamlined offerings**

Managed Care Coverage: Limited; 4.5% (136K); 65% (2M); >80% (2.7M)

Sources: HFS Annual Reports: 2015, 2016, and 2017. HFS Press Release: December 28, 2017.

Managed Care Expansion

This map graphically displays the Medicaid Reform Care Coordination Expansion in Illinois. As noted, statewide expansion for long-term services and supports (LTSS) and waiver services was delayed till October 1, 2018.

Figure 2-2—HealthChoice Illinois Managed Care Program Map

All Statewide HealthChoice Illinois Plans serve Cook County.
Two Cook County HealthChoice Illinois Plans serve only Cook County.

Statewide HealthChoice Illinois Plans

Blue Cross Community Health Plans
Harmony Health Plan
IlliniCare Health
Meridian Health Plan
Molina Healthcare

Cook County HealthChoice Illinois Plans

CountyCare Health Plan
NextLevel Health Partners

Medicare-Medicaid Alignment Initiative (MMAI) Plans

Aetna Better Health Premier Plan
Cook, DuPage, Kane, Kankakee, Will

Blue Cross Community MMAI
Cook, DuPage, Kane, Kankakee, Lake, Will

Humana Health Plan
Cook, DuPage, Kane, Kankakee, Lake, Will

IlliniCare Health
Cook, DuPage, Kane, Kankakee, Lake, Will

Meridian Complete
Cook, DuPage, Kane, Will

Molina Healthcare
Voluntary Enrollment only: Champaign, DeWitt, Ford, Knox, McLean, Peoria, Stark, Tazewell, Vermilion

HealthChoice Illinois Implementation Delayed for:

Long Term Services and Supports (LTSS)

Enrollment of potential enrollees receiving LTSS has been **delayed** in all expansion counties. Enrollment of LTSS continues in: Cook, DuPage, Kane, Kankakee, Lake, Will.

Waiver Services

Enrollment of potential enrollees receiving waiver services (including Elderly, Supportive Living program and Division of Rehabilitation waivers services) has been **delayed** in all expansion counties. Enrollment of waiver services continues in: Boone, Champaign, Clinton, Cook, DeWitt, DuPage, Ford, Henry, Kane, Kankakee, Knox, Lake, Madison, McHenry, McLean, Mercer, Peoria, Rock Island, St. Clair, Stark, Tazewell, Vermilion, Will, Winnebago.

Managed Care Programs

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

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

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

With managed care statewide expansion, most Medicaid beneficiaries in Illinois are served through HealthChoice Illinois. HealthChoice Illinois health plans provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. Populations covered include:

- Families and children eligible for Medicaid through Title XIX or Title XXI (Children's Health Insurance Program).
- Affordable Care Act expansion Medicaid-eligible adults.
- Medicaid-eligible adults with disabilities who are not eligible for Medicare.
- Medicaid-eligible older adults who are not eligible for Medicare.
- Dual-eligible adults who are receiving LTSS in an institutional care setting or through a Home and Community-based Services (HCBS) waiver, excluding those receiving partial benefits who are enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI), or are subject to other exclusions.
- Special needs children, defined as enrollees under the age of 21 who are eligible for Medicaid through Supplemental Security Income (SSI), Division of Specialized Care for Children (DSCC), or a disability category of eligibility.
- Children in the care of the Department of Children and Family Services (DCFS Youth), including those formerly under this care who have been adopted or who entered a guardianship.

Managed Long Term Services and Supports (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 implementation in October 1, 2018.

However, the MMAI program continues to operate under a separate three-way contract between HFS, the federal Centers for Medicare & Medicaid Services (CMS), and health plans and will not be expanded to additional counties in 2018.

Managed Care Enrollment

HealthChoice Illinois, the State's rebooted Medicaid managed care program, launched on January 1, 2018, and statewide expansion began on April 1, 2018, providing comprehensive healthcare coverage to more than 2.3 million Illinoisans. Enrollment figures as of May 31, 2018, are displayed in Table 2-1 below. More detailed enrollment, including enrollment by health plan, by gender and age, and by ethnicity can be found in Appendix A.

Table 2-1—Illinois Medicaid Enrollment

Program Type	May 2018 Enrollment
HealthChoice Illinois	2,211,755
MLTSS	36,427
MMAI	54,143
Total Beneficiaries	**2,302,325**

Quality Management Structure

The **Bureau of Managed Care** (BMC) administers and monitors HFS' managed care/care coordination programs. The **Bureau of Quality Management** (BQM) is purposed to improve healthcare quality for HFS beneficiaries in Illinois. Together, these bureaus work to administer initiatives and programs to help beneficiaries improve their health status by ensuring the highest-quality, most cost-effective services possible to meet their needs, including disease management, hospital quality and utilization management, interfaces between primary care and behavioral health, as well as ongoing assessment and analysis of potential opportunities for healthcare coordination and improvement.

The bureaus are responsible for developing an overarching agency quality improvement strategy, coordinating agency-wide quality initiatives and overseeing the development of outcome measurements, and implementing quality improvement projects (QIPs) for current providers and managed care/care coordination programs. They evaluate the quality and effectiveness of Medicaid-funded programs by systematically monitoring and evaluating the quality of care and services; overseeing the design, implementation, monitoring, and evaluation of the quality management activities statewide; and developing and implementing a quality management workplan that identifies specific activities, measures, and indicators that are the focus of the Quality Management program.

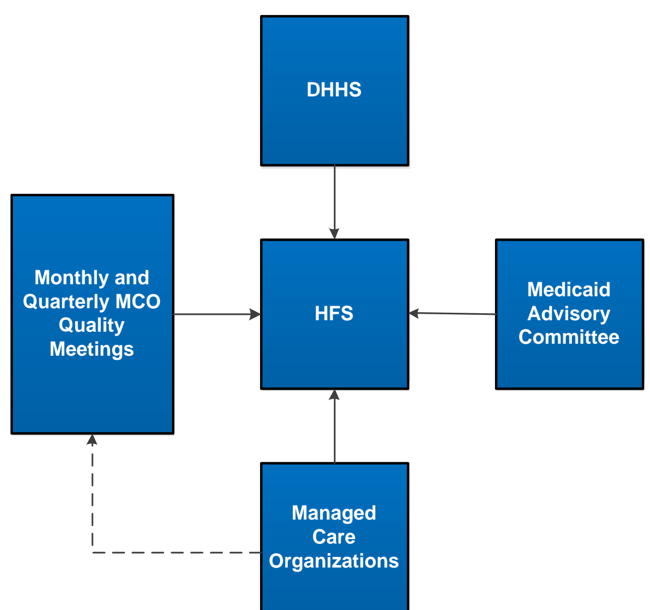
The bureaus are also responsible for oversight, monitoring, and evaluation of quality assurance to ensure health plans are in compliance with State standards, federal regulations, and contract requirements. HFS monitors each health plan's compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via its internal quality management program and on-site reviews of compliance with various quality assessment/improvement standards.

HFS' external quality review organization (EQRO), Health Services Advisory Group, Inc., conducts compliance reviews at least once every three years. The purpose of the reviews is to determine a health plan's understanding and application of federal regulations and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during an on-site evaluation. The reviews include an assessment of each plan's quality improvement structure. This structure is necessary in facilitating quality improvement of performance measures and performance improvement projects (PIPs), which measure each health plan's performance in achieving quality goals and objectives identified in the Quality Strategy. The report enables the health plans to implement improvement interventions to correct any areas of deficiency. The report also helps HFS determine each health plan's compliance with the contract and identify contractual areas that need to be modified or strengthened to ensure that a health plan complies with the standards and can achieve the goals and objectives identified in the Quality Strategy.

HFS also holds monthly conference calls and quarterly face-to-face meetings with health plans to provide a forum for discussion of quality of care and outcomes for Illinois Medicaid beneficiaries. During these meetings, HFS and health plan staff review and discuss performance measure results, PIP results, and whether the quality improvement outcomes align with the Quality Strategy goals and objectives. Further, the health plans are required to present information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome obstacles that impede performance. In addition, HFS conducts monthly quality meetings with each health plan to review its operations, quality initiatives, quality outcomes, and barriers and strategies for improving the quality of care and services provided to Medicaid beneficiaries.

HFS meets with the health plans independently for monthly operations meetings and quarterly business reviews (QBRs) to monitor plan performance. Each plan is asked to provide HFS with a presentation on its recent activities and developments. These meetings serve as an interactive environment for open communication between health plans and HFS. This time also provides the opportunity for the health plans to ask any operational questions or receive assistance from HFS. HFS is interested in seeing what works well for the plans, what needs improvement, any planned future developments, and what HFS can do to help. On-site visits enhance HFS' ability to oversee the health plans and build relationships with plan leadership. As the quarterly operations meetings progress, HFS is anticipating an overall presentation of each health plan's latest data, achievements, and issues/concerns. In addition, the Medicaid Advisory Committee (MAC) advises HFS with respect to policy and planning related to the health and medical services provided under HFS' medical programs pursuant to federal Medicaid requirements established at 42 CFR §431.12. The MAC consists of up to 15 members, at least five of whom must be consumers or advocates. The MAC meets six times a year and currently has five subcommittees: Quality Care, Public Education, Pharmacy, Health Equity, and Telemedicine. The subcommittees are supported by workgroups.

Figure 2-3—Illinois HFS Quality Strategy Organizational Structure



Contracting for Managed Care

Right Care, Right Time, Right Place

Effective managed care expansion has been central to the Department's planning and essential to the transformation of the Illinois Medicaid program. HFS believes managed care enhances HFS' ability to offer the right care, at the right time, in the right place. Managed care offers a way to deliver better Medicaid services with the promise of reduced and predictable costs. The graphic below outlines HFS' primary strategies for implementing statewide managed care.

Technology

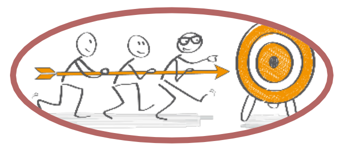
Tools and strategies such as enhanced reporting systems internally and externally, with strong and helpful visuals to make information digestible and more useful.

Care Coordination

Streamline procedures to better serve the needs of patients and providers and establish vital guidelines for better whole-person care coordination.

Consumer-centric Preventive Care

To facilitate consumer choice, HFS developed a quality rating system that displays health plan performance in service categories that resonate with consumer concerns. Consumers can use the rating results to make health plan selections. The Department and health plans will also partner on awareness initiatives that encourage smart healthcare choices. Pooling resources, they will speak with a common voice to foster medical provider participation, coordinated care, prevention, early treatment of chronic conditions, and other strategies that help people lead healthier lives.



Payment Reform

Evidence-based practices in service delivery to move from fee-for-service (FFS) to value-based payment. HFS is focusing on helping with treatment of high-volume, costly, high-risk, and preventable conditions. Risk and performance must be tied to reimbursement to continue to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes.

Goals and Objectives

Consistent with its mission, HFS has identified the following goals for its Quality Strategy. Listed below each goal are supporting activities and initiatives that HFS will use to achieve the goals and objectives of the Quality Strategy.

Better Care

Goal 1: Improve population health

1.1	Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] performance measures
1.2	Behavioral health and physical health integration
1.3	Implementation of integrated health homes
1.4	Risk stratification—Identify high-risk/high-cost beneficiaries
1.5	Care management/care coordination (CM/CC) programs
1.6	Care transition programs

Goal 2: Improve access to care (including community-based long-term services and supports)

2.1	Monitoring and validation of provider network capacity—time/distance analysis, appointment availability, provider online directory
2.2	Monitoring and validation of HCBS and MLTSS network capacity
2.3	Monitoring and validation of HCBS CMS performance measures
2.4	Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2-2]
2.5	Access-related grievances

Goal 3: Increase effective coordination of care

3.1	CM/CC programs
3.2	Care transition programs
3.3	PIPs and QIPs designed to measure the effectiveness of care coordination
3.4	HEDIS performance measures

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

[2-2] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Healthy People/Healthy Communities

Goal 4: Improve participation in preventive care and screenings

4.1 HEDIS performance measures
4.2 Provider and member incentive programs
4.3 Care gap reporting
4.4 Focused quality forums on preventive care that include community stakeholders, HFS, and health plans

Goal 5: Promote integration of behavioral and physical healthcare

5.1 1115 demonstration “transformation” waiver
5.2 Implementation of integrated health homes
5.3 Behavioral health care transition programs
5.4 HEDIS measures

Goal 6: Create consumer-centric healthcare delivery system

6.1 Quality Rating System—Illinois HealthChoice Plan Report Card
6.2 Member grievances and appeals
6.3 Health, safety, and welfare (HSW) monitoring, including critical incidents and abuse, neglect, and exploitation
6.3 CAHPS consumer satisfaction survey—adult, child, and children with chronic conditions
6.4 Member call center metrics

Affordable Care

Goal 7: Transition to value- and outcome-based payment

7.1 Pay-for-performance (P4P) program
7.2 Integrated health homes (aligning financial incentives to evidence-based practices and tiered bonus levels based on performance outcomes)

Goal 8: Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration

8.1 Developing a state-of-the art technology platform including Provider Enrollment System (enabling uniform credentialing), Integrated Eligibility System, Pharmacy Benefit Management System, Data Analytics Platform (MedInsight) Implementation, Long-Term Care Billing, and Medicaid Management Information System (MMIS)/Illinois Medicaid Program Advanced Cloud Technology (IMPACT).
8.2 Monitoring of encounter data for completeness, accuracy, and timeliness
8.3 Health plan scorecard
8.4 Pharmacy utilization reporting

Performance Goals

To ensure consistent focus on the accomplishment of Quality Strategy goals, HFS identified priority measures that correlate to each goal of the Quality Strategy. Table 2-2 and Table 2-3 list the measures for the HealthChoice Illinois and MMAI programs for the HEDIS data collection year 2019 (reported in 2018), and their alignment to the Quality Strategy goals. The health plans will begin reporting on P4P measures with specific, performance-driven targets in reporting year 2020. For the Summary of Performance Measure Results from prior years, see Appendix B. For a list of all HealthChoice performance measures, see Appendix C.

Table 2-2—Priority Measures for HealthChoice Illinois

Measure Focus	Key Measure Name/Description	Goal Alignment
Healthy Adults	*Adults' Access to Preventive/Ambulatory Health Services*	1, 4
	Adult BMI Assessment	4
	Breast Cancer Screening	4
	Cervical Cancer Screening	4
	Chlamydia Screening in Women	4
	Ambulatory Care	
	1) *Outpatient Visits*	1
	2) *ED Visits*	
Maternal and Child Health Care	*Childhood Immunization Status*	1
	Immunizations for Adolescents	1
	Annual Dental Visit	1
	Prenatal and Postpartum Care	
	1) *Timeliness of Prenatal Care*	1
	2) *Postpartum Care*	
	Well-Child Visits	
	1) *Well-Child Visits in the First 15 Months of Life (W15)*	1, 4
	2) *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	
	1) *BMI Percentile Documentation*	1, 4
	2) *Counseling for Nutrition*	
	3) *Counseling for Physical Activity*	

Table 2-2—Priority Measures for HealthChoice Illinois

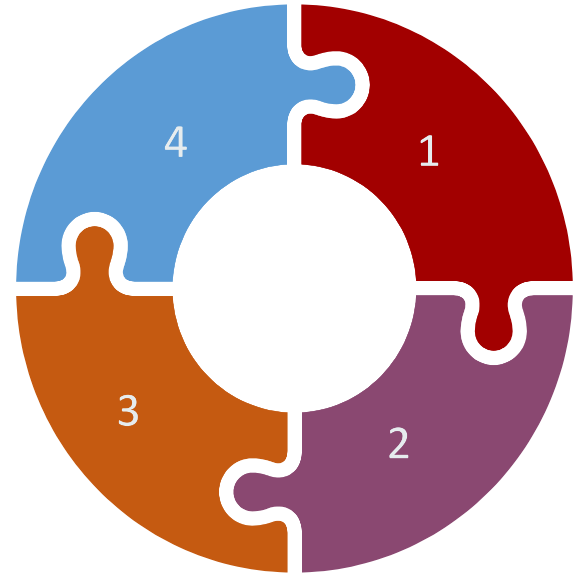
Measure Focus	Key Measure Name/Description	Goal Alignment
Chronic Disease	*Controlling High Blood Pressure*	1
	Comprehensive Diabetes Care	
	1) Hemoglobin A1c (HbA1c) Testing	1,4
	2) Eye Exam (Retinal) Performed	
	3) Medical Attention for Nephropathy	
	Statin Therapy for Patients with Diabetes	
	1) Received Statin Therapy	1
	2) Statin Adherence 80%	
	Medication Management for People with Asthma	
	1) ≥50% of the Treatment Period	1
	2) ≥75% of the Treatment Period	
	Annual Monitoring for Patients on Persistent Medications	
	1) Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)	1
	2) Digoxin	
	3) Diuretics	
	4) *Total Rate*	
Behavioral Health	*Metabolic Monitoring for Children and Adolescents on Antipsychotics*	1, 4, 5
	Follow-up after Hospitalization for Mental Illness	
	1) 7 Days	1, 3, 5
	2) 30 Days	
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
	Initiation of AOD Treatment	1, 3, 5
	Engagement of AOD Treatment	

Table 2-3—Measures for MMAI

Measure Focus	Key Measure Name/Description	Goal Alignment
Long-Term Services and Supports	Percentage of Adults 66 Years and Older Who Had:	
	1) Advance Care Planning	1, 2
	2) Medication Review	
	3) Functional Status Assessment	
	4) Pain Assessment	
	Percentage of Members 66 Years and Older Who Received:	
	1) At Least One High-Risk Medication	1
	2) At Least Two Different High-Risk Medications	

Development and Review of the Quality Strategy

HFS meets the requirements for development, evaluation, revision, and availability of the Quality Strategy as described in §438.340(c)and(d).



Developing a Quality Strategy

HFS obtains input from beneficiaries and stakeholders as well as the MAC to draft and revise the Quality Strategy.

Review

HFS reviews and updates the Quality Strategy as needed, but no less than every three years. Reviews include evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. Results of reviews are made available on HFS' website.

Public Comment

The Quality Strategy is posted on the HFS website for public comment. HFS takes public recommendations into consideration for updating the quality strategy.

Updates

Updates are made as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the Medicaid program. HFS considers statewide expansion or the addition of new programs/delivery systems as significant changes that necessitate updates to the Quality Strategy. HFS submits the Quality Strategy to CMS as required and makes the strategy available on its website required by §438.10(c)(3).

Additional Information

For more information about HealthChoice Illinois, visit: https://enrollhfs.illinois.gov/news/healthchoice-illinois.

For additional information about Medicaid programs, eligibility, enrollment, and HFS, visit: https://www.illinois.gov/hfs/MedicalClients/Pages/default.aspx.

Section 3. Assessment

Assessing and Improving the Quality of Health Care and Services

As required in CFR §438.340, this section describes HFS' strategies for assessing and improving the quality of health care and services furnished by its Medicaid managed care health plans. Table 3-1 summarizes HFS' assessment strategies for each federal regulation designated as requirements of HFS' Quality Strategy, and any changes to HFS' strategies necessitated by CMS' Medicaid and CHIP Managed Care Final Rule (Final Rule).[3-1]

Table 3-1—HFS Strategies to Assess and Improve the Quality of Health Care and Services

42 CFR	Summary of Requirement	HFS Strategy	Strategies HFS Implemented Due to Changes in the CMS Final Rule
§438.334	Adopt a Medicaid managed care quality rating system in accordance with CMS requirements.	HFS developed a **quality rating system (QRS)** to help beneficiaries pick the health plan that is best for them by showing each plan's performance in providing care and services to its members for specific measures in key performance areas.	To meet this new requirement, HFS implemented the Illinois HealthChoice Plan Report Card. HFS plans to develop an online interactive version of the QRS that displays results by specific performance measure within each composite domain.
§438.340(b)(1)	State-defined network adequacy and availability of services standards. Validation of health plan network adequacy during the preceding 12 months to comply with requirements set forth in §438.68.	**Quarterly Provider Network Capacity Reviews** conducted by the EQRO include the 11 types of providers specified in §438.68 as well as LTSS providers. **Network Capacity Readiness Reviews** to monitor the capacity of each health plan's provider network in the expansion counties, including LTSS providers. **Secret shopper telephone surveys** of provider offices to evaluate compliance with appointment and after-hours call standards.	HFS implemented a time and distance analysis to evaluate the degree to which health plans are complying with the time and distance network standards as outlined in the model Medicaid contract. HFS added additional provider types, including LTSS providers, to the quarterly provider network capacity reviews.

[3-1] Medicaid.gov. Medicaid and CHIP Managed Care Final Rule. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Accessed on: June 22, 2018.

Table 3-1—HFS Strategies to Assess and Improve the Quality of Health Care and Services

42 CFR	Summary of Requirement	HFS Strategy	Strategies HFS Implemented Due to Changes in the CMS Final Rule
§438.340(b)(1)	Examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	HFS requires health plans to incorporate **practice guidelines** that meet nationally recognized standards and that: • Are based on valid, reliable clinical evidence. • Consider the needs of enrollees. • Are adopted in consultation with network providers. • Are reviewed and updated periodically as appropriate.	No changes necessitated by the new rule.
§438.340(b)(3)(i)	Description of the quality metrics and performance targets to measure the performance and improvement of each health plan.	The priority measures identified by HFS are shown in tables 2-2 and 2-3 above.	The Final Rule added a requirement for states to include a description of quality metrics in the Quality Strategy; however, HFS had previously and will continue to include this description in its Quality Strategy.
§438.340(b)(3)(i)(i)	PIPs to be implemented.	HFS requires HealthChoice Illinois health plans to **conduct PIPs** and MMAI health plans to conduct QIPs. All health plans are required to participate in two mandatory PIPs: The *Community-Based Care Coordination PIP* (CC PIP) and the *Follow-up After Hospitalization for Mental Illness (FUH)* (BH PIP). The CC PIP focuses on medically high-risk beneficiaries with a recent hospital discharge and the relationship between care coordination and community resources, timely ambulatory care services, and hospital readmission rates less than 30 days post discharge. The BH PIP aims to reduce the rate of avoidable behavioral health-related rehospitalization. The HEDIS *FUH* measure is the study indicator for this PIP since it is an industry standard for measurement of transitions in care	To meet the requirements of §438.330(d), HFS will implement the Institute for Healthcare Improvement's (IHI's) rapid-cycle performance improvement approach for PIPs in 2019, which places a greater emphasis on improving outcomes using quality improvement science. In addition, HFS plans to change the focus of the CC PIP to a transition of care (TOC) PIP to focus on improving the effectiveness of transitions of care.

Table 3-1—HFS Strategies to Assess and Improve the Quality of Health Care and Services

42 CFR	Summary of Requirement	HFS Strategy	Strategies HFS Implemented Due to Changes in the CMS Final Rule
		between inpatient and behavioral health outpatient levels of care.	
§438.340(b)(4)	Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered by the health plans.	See the "External Quality Review" (EQR) section below.	The Final Rule set forth new mandatory, required activities for Medicaid EQROs. HFS contracted with its EQRO to perform the newly required activities, as described in the EQR section below.
§438.340(b)(5)	A description of the State's TOC policy.	HFS requires health plans to **manage TOC** and continuity of care for new enrollees and for enrollees moving from an institutional setting to a community living arrangement. Health plans are required to submit a TOC Plan to HFS initially and when there are updates to the plan. HFS requires health plans to implement a quality improvement plan to address the EQR recommendations to improve the effectiveness of care transitions.	To meet the new requirements at §438.62, HFS account managers will oversee the implementation of health plans' quality improvement plan for improving TOCs and monitor progress through weekly and quarterly meetings with the health plans. HFS will require all health plans to participate in a PIP using the rapid-cycle approach that will be focused on improving and measuring the effectiveness of TOCs.
§438.340(b)(6)	State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status.	HFS identifies the **race, sex, age, ethnicity, disability status, primary language spoken**, and **waiver type** for each Medicaid beneficiary and provides this information to the health plans at the time of enrollment. The Illinois Client Enrollment Broker (CEB) transmits an enrollment file containing race/ethnicity and primary language of each enrollee to the health plans monthly. Health plans are required to develop and implement a **cultural competency plan**, offer appropriate foreign language versions of all	The Final Rule set forth the additional categories of age, sex, and disability status, which HFS included in its enrollment information to health plans. HFS' Quality Care Subcommittee has assigned a workgroup to assess racial or ethnic disparity in LTSS programs and recommend strategies for equality and quality of services for LTSS enrollees throughout Illinois.

Table 3-1—HFS Strategies to Assess and Improve the Quality of Health Care and Services

42 CFR	Summary of Requirement	HFS Strategy	Strategies HFS Implemented Due to Changes in the CMS Final Rule
		beneficiary materials, and develop member materials which can be easily understood at a sixth-grade reading level. Health plans are required to monitor network provider compliance with **Americans with Disabilities Act (ADA) requirements**. The health plans also make ADA access information available in the online and hard copy provider directory. Health plans are required to have a cultural competency plan. The plan is submitted to HFS for approval. Plans are required to offer trainings to health plan staff and network providers. Health plans are required to proactively attempt to hire staff who reflect the diversity of enrollee demographics. Plan staff are required to complete linguistic and cultural competence training upon hire and no less frequently than annually. Health plans are required to have a process to verify subcontractors' and provider network's compliance with the plans' Cultural Competency Plan. Health plans are required to collaborate with community-based organizations to address social determinants of health, assess beneficiary needs, formulate collaborative responses, and evaluate outcomes for community health improvement and eliminating health disparities.	HFS uses CMS' Parity Compliance Toolkit (Toolkit) to assess compliance with the final Medicaid/CHIP parity rule. HFS uses the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) to evaluate the health plan cultural competency program plans.

Table 3-1—HFS Strategies to Assess and Improve the Quality of Health Care and Services

42 CFR	Summary of Requirement	HFS Strategy	Strategies HFS Implemented Due to Changes in the CMS Final Rule
§438.340(b)(7)	Appropriate use of intermediate sanctions for health plans.	HFS sets forth the right to impose civil money penalties, late fees, and performance penalties (collectively, "monetary sanctions"), and other sanctions, on health plans for failure to substantially comply with the terms of the contract with HFS. Sanctionable events are included on pages 92–97 of the model contract.	No changes necessitated by the new rule.
§438.340(b)(9)	State's mechanisms to identify persons who need LTSS or persons with special healthcare needs and specify those mechanisms in the Quality Strategy.	HFS **defines special healthcare needs** children as children under the age of 21 who are eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 *et seq*.) or Medicaid-eligible and eligible to receive benefits pursuant to Title XVI of the Social Security Act. Children with special healthcare needs (CSHN) also include Medicaid-eligible children under the age of 21 who receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 *et seq*.) via the Division of Specialized Care for Children (DSCC) or other such entity that the Department may designate for providing such services and CSHN as specified in Section 1932 (a)(2)(A) of the Social Security Act. HFS requires health plans to have specific mechanisms in place to identify individuals who need LTSS services or have special healthcare needs. HFS requires health plans to have a **special healthcare needs plan** to conduct timely identification and screening, comprehensive assessments, and appropriate case management services. Compliance is reviewed by HFS' EQRO.	HFS has had a mechanism in place since 2012 to identify persons who need LTSS services and children with special healthcare needs using a program code on the enrollment file. To assess satisfaction of members with special needs, HFS added supplemental questions to the health plan CAHPS surveys that include the HCBS population as well as adults with mental health conditions. Questions covering children with special healthcare needs were added to the HFS statewide CAHPS survey.

Table 3-1—HFS Strategies to Assess and Improve the Quality of Health Care and Services

42 CFR	Summary of Requirement	HFS Strategy	Strategies HFS Implemented Due to Changes in the CMS Final Rule
		HFS monitors quality and appropriateness of services for beneficiaries with LTSS and special healthcare needs through compliance monitoring activities and regular review of health plan reporting. HFS requires health plans to conduct comprehensive assessments for individuals in need of LTSS as well as special healthcare needs by qualified service coordinators. Health plans are required to have a consumer advisory board. Health plans are required to identify a liaison who will be a consumer advocate for high-needs children. The individual is responsible for internal advocacy for these enrollees' interests, including input in policy development, planning, decision-making, and oversight. Health plans are required to have a full-time LTSS program manager, who oversees the LTSS program and acts as a liaison between LTSS statewide agency liaisons.	
§438.340(b)(10)	Nonduplication of mandatory activities with Medicare or accreditation review.	HFS requires all health plans to obtain **NCQA accreditation**. Six of the seven plans had obtained NCQA accreditation in 2016 and 2018. The remaining plan is scheduled to complete the NCQA accreditation survey in 2019.	A nonduplication review of mandatory activities will be conducted in 2019 when all health plans have achieved NCQA accreditation.

State Monitoring

Monitoring System

As required in CFR §438.66, this section describes HFS' monitoring system which addresses all aspects of the managed care program, including the performance of each health plan in the areas designated in the CFR, as summarized in Table 3-2. The table also indicates areas that are included as key indicators in health plan scorecards. Scorecards are a key component of HFS' monitoring system, developed to depict health plan performance on key metrics and performance indicators. The scorecards are reviewed quarterly. See the scorecard example in Appendix D.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(1)	Administration and management.	HFS has established key required position requirements for the administration and management of key operational areas/positions for the health plans.	Key required positions are reviewed during readiness and administrative reviews.
§438.66(b)(2)	Appeal and grievance systems. Key Scorecard Indicator	Health plans are required to maintain a health information system that collects, analyzes, integrates, and reports appeal/grievance data. See the grievance system requirements in Appendix E. Quarterly grievance and appeal report including summary count and outcomes. Quarterly **summary of grievances/appeals** and resolutions and external independent reviews and resolutions report. Reports are monitored and trended. Health plans are required to identify outliers and action plans for improvement. HFS hosts a **provider complaint portal** for providers to submit complaints to HFS about issues they are experiencing with health plans in an electronic,	Grievance and appeal file reviews are conducted during the administrative compliance reviews to determine compliance with contract standards regarding the intake and timeliness of processing grievances and appeals. Health plan grievance and appeals systems are evaluated during readiness and administrative reviews. The provider complaint resolution process is reviewed during readiness and administrative reviews.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		secure format. Providers' complaints are reviewed and resolved promptly to ensure fair resolution of disputes between health plans and providers. HFS tracks and reports the volume of complaints received and resolved. Health plans are required to have a **provider complaint resolution process** and submit procedures to HFS as well as submit a quarterly summary of provider complaints and resolutions.	
§438.66(b)(3)	Claims management. Key Scorecard Indicator	Health plans are required to submit the following claims and encounter management reports: • Monthly encounter data report. • Monthly adjudicated claims inventory summary. • Monthly pharmacy claims monitoring report.	An enrollment and claims system review was conducted during 2017 as part of the HealthChoice program readiness reviews.
§438.66(b)(4)	Enrollee materials and customer services, including the activities of the beneficiary support system. Key Scorecard Indicator	All enrollee materials must be approved by HFS initially and as revised. Enrollee service call center reporting metrics are monitored through the scorecard. HFS offers a variety of avenues for an individual to receive education and enrollment assistance under its beneficiary support system, including an enrollment call center that provides education and enrollment assistance, a secure online enrollment portal, and the availability of education and enrollment materials in other formats or languages (auxiliary aids) when requested.	The readiness and administrative reviews include a review of enrollment materials and review of service level agreement (SLA) reporting for the member services for each health plan.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(5)	Finance, including medical loss ratio (MLR) reporting.	Quarterly unaudited financial reports and annual audited financial reports. Annual submission of benefit expense claims for each MLR reporting year, including an attestation to the accuracy of all data and of the MLR calculation. Health plans are also required to collect all underlying data associated with MLR reporting from any third-party vendors and to calculate and validate the accuracy of MLR reporting. Each health plan must submit an annual cost report that provides a reconciliation of its audited financial statement to the annual cost report. The reconciliation must be reviewed and certified by an independent auditor or by an executive officer of the health plan.	The EQRO does not monitor this requirement.
§438.66(b)(6)	Information systems, including encounter data reporting.	Health plans submit a monthly encounter data report, and HFS conducts two levels of review. The review includes a check for completeness and accuracy of the data, and health plans are required to correct and resubmit the data if errors are identified.	An enrollment and claims system review is conducted for the HealthChoice program readiness reviews.
§438.66(b)(7)	Marketing.	All marketing materials, plans, and procedures must be approved initially and as revised.	The EQRO does not monitor this requirement.
§438.66(b)(8)	Medical management, including utilization management and case management. Key Scorecard Indicator	**Care Management** Care management and disease management program descriptions are submitted initially and as revised. Health plans are required to submit the following monthly and quarterly reports:	The readiness and administrative reviews include utilization management and care management. The EQRO also conducts a CM/CC staffing, qualifications, and training review to review the educational qualifications, related experience, annual training hours, full-time equivalency (FTE)

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		• Monthly care coordination effectiveness summary report. • Annual care gap plan. • Quarterly outreach summary report. • Transition of care plan, initially and as revised. • Care management metrics are also monitored through the scorecard. **Utilization Management** **Health plans are required to submit the following monthly UM reports:** • Monthly prior authorization report. • Monthly utilization management report, pharmacy utilization monitoring report, psychotropic review report, and drug utilization report. • Utilization metrics are also monitored through the scorecard.	allocation, and caseloads of CM/CC staff serving the Medicaid managed care population against state-selected requirements.
§438.66(b)(9)	Program integrity.	Health plans are required to submit the following program integrity reports: • Quarterly fraud and abuse report. • Annual certification to confirm compliance of each contractor and its subcontractors. • Recipient verification procedure, initially, annually, and as revised. • Fraud, Waste, and Abuse (FWA) compliance plan.	Review of the FWA compliance plan, reporting, training, and mechanisms in place to detect FWA is conducted during readiness and administrative reviews.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(10)	Provider network management, including provider directory standards. Key Scorecard Indicator	Monthly provider directory attestation reports. Quarterly review of health plan network capacity status. Monthly review of network capacity and health plan contracting efforts prior to statewide Medicaid expansion. Provider metrics are also monitored through the scorecard.	Review of provider contracts for the following provider types: ancillary, facility, federally qualified health center (FQHC), hospital, physician hospital organization (PHO), and provider. The EQRO reviews a template contract against 15 elements to determine compliance with requirements. A review of the health plan provider complaint resolution process is conducted during the readiness review. Compliance with provider directory standards is reviewed during the readiness and administrative reviews.
§438.66(b)(11)	Availability and accessibility of services, including network adequacy standards. Key Scorecard Indicator	Health plans are required to submit the following weekly and monthly provider network reports: • Weekly primary care provider, hospital, and affiliated specialist file (CEB Provider File). • Monthly provider network file (complete). • Provider site closures/terminations notification (as each occurs). • Network access metrics are also monitored through the scorecard.	Quarterly network provider capacity reviews. Network capacity reviews as part of administrative and readiness reviews. Ad hoc network capacity analysis. Review of 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. Analysis of time/distance standards for specific network providers including PCPs, obstetricians/gynecologists (OB/GYNs), behavioral health, specialists, hospitals, pharmacy, and adult and pediatric dental.

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(12)	Quality improvement. Key Scorecard Indicator	Health plans are required to submit the following quarterly and annual reports: • A Quality Assessment and Performance Improvement (QAPI) program description annually and evaluate the effectiveness of the QAPI program as indicated in the annual Quality Assurance, Utilization Review, and Peer Review (QA/UR/PR) Report/Program Evaluation. • Adult and child CAHPS results are reported in the health plan's annual QAPI evaluation report. • Quarterly HEDIS measure rates report. • Submission of QA/UR/PR committee meeting minutes at the request of HFS.	Review of the QAPI program description, annual QAPI evaluation report, and annual external quality review. Administrative, readiness, and focused reviews. PIPs. The EQR report includes the results of the CAHPS surveys, quality measures, and all EQR mandatory and optional activities conducted during the preceding 12 months.
§438.66(b)(13)	Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program. Key Scorecard Indicator	Health plans are required to submit the following critical incident reports: • Health plans are required to submit policies and procedures for processing critical incidents, initially and as revised. • Monthly critical incident detail report and quarterly critical incidents summary report. Critical incident metrics are monitored through the scorecard. • The EQRO also submits the following reports as a result of monitoring of critical incidents and HSWs. • EQR HSW reports identified during quarterly record reviews. • Quarterly summary of HSW reports.	Quarterly review of plan compliance with the HCBS CMS performance measures. Review of HSW concerns during quarterly record reviews and review of health plan remediation actions. Annual review of qualifications, training, and caseload requirements. Review of compliance with critical incident reporting during administrative reviews.
§438.66(b)(14)	All other provisions of the contract, as appropriate.	See the section on health plan reporting below.	See the EQR section below.

Health Plan Reporting

HFS has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure compliance with contract requirements and evaluate performance.

HFS requires health plans to submit regular reports to assist HFS in monitoring performance. HFS staff analyze data in the health plan reports, examine trends over time, and compare the performance of health plans to each other, when applicable. HFS has implemented a reporting system that collects data from the health plans and permits reliable comparisons on various topics and specified outcome measures. HFS ensures a regular flow of information by inserting a list of required reports (or deliverables), along with frequency requirements, into the health plan contracts.

Health plans submit most of their regular reports and deliverables to HFS using Microsoft SharePoint technology. The HFS SharePoint site was designed as a report repository to facilitate document collaboration and incorporates document management best practices specific to report review. When reports are uploaded to the SharePoint site, they are automatically date and time stamped and reside in each health plan's respective library for assignment and review by HFS staff.

Reporting is required monthly, quarterly, and annually as demonstrated in the reporting tables found in Attachment XIII (Required Deliverables, Submissions, and Reporting) of the health plan contract as included in Appendix F.

The MMAI program has specific federal reporting requirements that can be reviewed at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Illinois.html.

Using Monitoring Data to Improve Performance

As required in CFR §438.66(c), HFS uses data collected from its monitoring activities to improve the performance of its managed care program, including:

- Enrollment and disenrollment trends in each health plan.
- Member grievance and appeal logs.
- Provider complaint and appeal logs.
- Findings from the EQR process.
- Results from any enrollee or provider satisfaction survey conducted by HFS or the health plan.
- Performance on required quality measures.
- Medical management committee reports and minutes.
- Annual quality improvement plan for each health plan.
- Audited financial and encounter data submitted by each health plan.
- Medical loss ratio summary reports required by CFR §438.8.
- Customer service performance data submitted by each health plan and performance data submitted by the beneficiary support system.
- Any other data related to the provision of LTSS not otherwise included in this section as applicable to the managed care program.

Monitoring Through Readiness Reviews

As required in CFR §438.66(d), HFS assesses the readiness of each contracted health plan as follows:

- Prior to the State implementing a managed care program, whether the program is voluntary or mandatory.
- When the specific health plan entity has not previously contracted with the State.
- When any health plan currently contracting with the State will provide or arrange for the provision of covered benefits to new eligibility groups.

HFS ensures that readiness reviews are:

- Initiated at least three months prior to the effective date of the events described above.
- Completed in sufficient time to ensure smooth implementation of an event described above.
- Submitted to CMS for CMS to make a determination that the contract or contract amendment is approved.

HFS also ensures that readiness reviews include both a desk review of documents and on-site reviews as required by federal regulations and assess the ability and capacity of the health plan to perform satisfactorily in all the applicable areas outlined in CFR §438.66(d)(4).

HFS' Monitoring of Quality Assessment and Performance Improvement (QAPI) Programs

According to 42 CFR §438.330, HFS requires health plans to have an ongoing QAPI program that assesses the quality of care and adjusts processes and operations to improve the quality of care provided to beneficiaries. The QAPI programs consist of a committee that must meet regularly, with a frequency sufficient to demonstrate that the committee is following up on all findings and required actions. To ensure continuous quality improvement, HFS requires health plans to conduct regular examination (annually at a minimum) of the scope and content of the quality improvement plan (QAP) to ensure that it covers all types of services, including behavioral health services, in all settings. Health plans are required to submit a written report on the QAP as a component of the quality assurance/utilization review/peer review (QA/UR/PR) Annual Report. The report includes an executive summary that provides a high-level discussion/analysis of each area of the annual report of findings, accomplishments, barriers, and continued need for quality improvement and provides detailed analysis of each of the following:

- QA/UR/PR plan with overview of goal areas
- Major initiatives to comply with the State Quality Strategy
- Quality improvement and workplan monitoring
- Contractor network access and availability and service improvements, including access and utilization of dental services
- Cultural competency
- FWA monitoring

- Population profile
- Improvements in CM/CC and clinical services/programs
- Effectiveness of care coordination model of care
- Effectiveness of quality program structure
- Summary of monitoring conducted including issues or barriers addressed or pending remediation
- Comprehensive quality improvement workplans
- Chronic conditions
- Behavioral health (includes mental health and substance abuse services)
- Dental care
- Discussion of the health education program
- Member satisfaction
- Enrollee safety
- FWA and privacy and security
- Delegation

The EQR technical report also addresses the effectiveness of a health plan's QAPI program.

External Quality Review

HFS contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, the EQRO conducts the mandatory and optional EQR activities as set forth in 42 CFR §438.358. The EQRO performs services in accordance with 42 CFR and the Balanced Budget Act of 1997. To see the 2017–2018 EQR workplan, see Appendix G.

Mandatory EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the health plan contract, HFS' EQRO conducts the mandatory EQR activities listed below.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(i)	**Validates PIPs** in accordance with §438.330(b)(1) to determine if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and beneficiary satisfaction.
§438.358(b)(1)(ii)	**Validates performance measures**. Conducts NCQA HEDIS Compliance Audits™[3-2] and performance measure validation (PMV) audits in accordance with §438.330(b)(2).

§438.358(b)(1)(iii)	**Conducts a review**, at least every three years, **to determine health plan compliance** with federal standards (subpart D) and the QAPI requirements described in §438.330. HFS' EQRO conducts a variety of types of compliance reviews including:
	• Administrative Reviews and Remediation
	  o To determine health plan compliance with various quality assessment/improvement standards in 16 areas of compliance (as listed in Appendix H).
	• Readiness Reviews and Remediation
	  o To evaluate, prior to client enrollment, whether a health plan's internal organizational structure, health information systems, staffing, and oversight are sufficient to enroll beneficiaries.
	• HCBS Record Reviews and Remediation
	  o In accordance with CMS requirements, quarterly on-site record reviews of a statistically valid sample, weighted by waiver type, are conducted by the EQRO. All record review findings and remediation of findings are tracked in the record review database. Annual reviews of HCBS staffing, experience, qualifications, FTEs, and caseload assignments are conducted on all health plans that provide services to HCBS waiver beneficiaries. See a list of CMS HCBS waiver performance measures in Appendix I.
	• HSW Reviews and Remediation
	  o To audit health plan processes for identifying and resolving HSW concerns by conducting case file reviews.
	• Focused Studies
	  o Rely on review of medical records to conduct a study focused on specific types of services for quality improvement, administrative, legislative, or other purposes.

[3-2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(iv)	**Validates managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) network adequacy** to comply with requirements set forth in §438.68. The EQRO conducts a quarterly review of the provider network as well as a time/distance analysis of selected providers to evaluate compliance with time/distance standards requirements. HFS' EQRO also conducts an analysis of the health plans' provider networks as a key component of pre- and post-implementation readiness reviews to evaluate the progress of each health plan in contracting with a sufficient number of providers to establish network capacity in the expansion areas.
§438.364	**Produces an annual EQR technical report** and submits to the State in accordance with the CFR requirements. The EQRO works with HFS to follow up on EQR recommendations by building and monitoring EQR recommendations, quality improvement plans, and corresponding implementation plans with each health plan. See appendices J and K.

Optional EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the health plan contract, HFS' EQRO conducts the optional EQR activities listed below.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(c)(1)	**Validates encounter data** reported by health plans. Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates; however, these data must be valid, complete, and accurate.
§438.358(c)(2)	**Validates and administers consumer surveys of quality of care**. Each year, the health plans are required to independently administer a consumer satisfaction survey for both adults and children as applicable to the programs they cover. The EQRO administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. The EQRO summarizes the health plan and statewide data and includes the results of the CAHPS surveys in the annual EQR technical report.
§438.358(c)(3)	**Validates performance measures for the Primary Care Case Management (PCCM) Program and CHIP** using the CMS protocol. The primary objectives are to evaluate the processes used to collect the performance measure data by HFS and determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.
§438.358(c)(5)	**Conducts studies on quality** that focus on an aspect of clinical or nonclinical services at a point in time. The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of health plan beneficiaries.
§438.358(c)(6)	**Assists** with the development and production of the **quality rating of health plans** report card consistent with §438.334.
§438.358(d)	**Provides technical guidance (TA)** to HFS and the health plans. The EQRO 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, CM/CC programs, CAHPS sampling and development of CAHPS supplemental questions, pay-for-performance (P4P) program measures, health

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
	plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS waiver program requirements, and more.
§438.340(c)(2)(ii)	**Evaluation of Quality Strategy**. States are required to review the Quality Strategy including an evaluation of its effectiveness. This can be done by means of the annual EQR technical report by ensuring the report includes a section that addresses the effectiveness of the State's Quality Strategy and determines whether any updates to the strategy are necessary based on EQR results.

Section 4. State Standards

HFS' contracts with HealthChoice Illinois health plans include the standards for access, structure and operations, and quality measurement and performance improvement as specified in 42 CFR Part 438 Subpart D.

Access Standards

Standards for HealthChoice Illinois related to access can be found in Article 5 of the model contract, including Section 5.7 (Provider Network) and Section 5.8 (Access to Care Standards). A detailed crosswalk between the CFR requirements for access standards and HFS' contract references can be found in Appendix H.

Structure and Operations Standards

Standards for HealthChoice Illinois related to structure and operations can be found in Article 5 of the model contract. A detailed crosswalk between the CFR requirements for structure and operations standards and HFS' contract references can be found in Appendix H.

Measurement and Improvement Standards

Standards for HealthChoice Illinois related to measurement and improvement can be found in Article 5 of the model contract. A detailed crosswalk between the CFR requirements for measurement and improvement standards and HFS' contract references can be found in Appendix H.

Section 5. Improvement and Interventions

Continuous Quality Improvement

HFS recognizes that having standards is a first step in promoting safe and effective healthcare. Monitoring so that standards are followed is the next step. However, HFS is committed to ongoing assessment and identification of opportunities for improvement to ensure delivery of the highest-quality, most cost-effective services. Based on the results of the assessment and monitoring activities outlined in sections 3 and 4 of this report, Illinois has worked to develop comprehensive approaches for continuous quality improvement with the goal of improving healthcare outcomes to all beneficiaries enrolled in a Medicaid program. HFS' major, overarching strategies for improvement are described below.

Scorecards

Scorecards are developed to depict health plan performance on key metrics and performance indicators. See the example in Appendix D. Health plans develop action plans for improvement.

Account Managers

HFS restructured management to add a new layer of Medicaid oversight. Each health plan is assigned an HFS account manager. Weekly meetings and monthly operations meetings are conducted to follow up on action plans.

Quarterly Business Reviews

QBRs are conducted with all health plans to review scorecards, discuss trends in performance, identify barriers, share best practices, and promote continuous improvement.

Corrective Action Plans (CAPs)

HFS account managers track the progress of health plan implementation of CAPs developed in response to administrative and readiness reviews, network monitoring, and HCBS record reviews.

EQR Recommendations

HFS has developed a phased process for the State and health plans to follow up on recommendations from the annual EQR process. See an example of EQR recommendations, quality improvement plan, and implementation plan in appendices J and K.

Health, Safety, and Welfare (HSW)

HFS developed a policy and procedure for identifying, reporting, and following up on critical incidents and HSW concerns. HFS has implemented tracking and reporting of critical incidents/HSWs through a SharePoint site. Quarterly reporting documents the types and numbers of incidents by health plan, which is monitored by the account managers.

Quality Improvement Interventions

As part of HealthChoice Illinois, HFS and health plans will partner on awareness initiatives that encourage informed healthcare choices. Pooling resources, they will speak with a common voice to foster medical provider participation, coordinated care, prevention, early treatment of chronic conditions, and other strategies that help people lead healthier lives. HFS has directed the health plans' efforts on the focus populations and initiatives described in this section.

Focus Population	Initiatives
Healthy Adults	In April 2018, HFS held the **Innovation in Practice: Quality Forum for Breast Cancer Screening and Treatment**. This brought community organizations, State leadership, and health plan administrators together to design initiatives to improve breast cancer screening and treatment. Based on recommendations from the most recent EQR technical report, HFS is considering the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure for the P4P program, as the rates have been low and contribute to the wellbeing of beneficiaries across multiple domains of care.
Behavioral Health	Illinois is undertaking a significant **transformation effort to integrate behavioral and physical health services** and shift the system to be more community-based through its **1115 Demonstration Waiver** and integrated health home model. In May 2018, HFS received federal government approval to implement the waiver to build a continuum of services for mental health and substance use disorder treatment. Waiver pilots will begin launching on July 1. Some pilots will be statewide while others will be limited in geographic scope and numbers of participants. They include residential and inpatient treatment for individuals with substance use disorder, crisis intervention services for individuals experiencing a psychiatric crisis, and intensive in-home services to stabilize behaviors that may lead to crisis. HFS worked toward the development of a mental health assessment and service plan of care tool called the **Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS) tool,** which will be used by Medicaid providers. This tool will be designed to improve behavioral health outcomes by providing standardization, continuity, and consistency in identifying and treating beneficiaries with behavioral health needs. As the State's Medicaid infrastructure began to evolve through the introduction of care coordination and managed care service delivery systems, the State's approach to crisis response has also evolved. Many of the children and youth who are experiencing a mental health crisis and whose care requires public funding are now being served by **Mobile Crisis Response**

Focus Population	Initiatives
	(MCR) programs administered and funded by the health plans. MCR features centralized intake via the **Crisis and Referral Entry System (CARES)** and access to face-to-face crisis intervention services. HFS actively works with health plans to ensure coordination and continuity across the crisis response systems. The **Specialized Family Support Program (SFSP)** launched in April 2017 pursuant to the Custody Relinquishment Prevention Act 20 ILCS 540. It is a collaborative effort between HFS, DCFS, Department of Human Services (DHS), Department of Juvenile Justice (DJJ), Department of Public Health (DPH), and the Illinois State Board of Education (ISBE). The SFSP is designed to identify the behavioral health needs of youth at risk of custody relinquishment and to link them to appropriate services. HFS plans to develop **measures** that will gauge the success of **BH/medical integration** to help direct adjustments and needed resources. HFS is **enhancing the validation of the BH provider network** through the addition of a time/distance analysis of the BH network. State activities are currently being planned to focus on telemedicine.
Chronic Disease	The Illinois DPH published the 2013–2018 **Illinois Diabetes State Plan**, which outlines efforts to identify and improve services for persons with diabetes and their families. The State plan addresses a comprehensive set of policy and program recommendations intended to provide State and local agencies, healthcare providers, organizations, funding agencies, policy and decision makers, and consumers direction and support for creating a system of prevention that proactively promotes a comprehensive, integrated approach to reducing the morbidity and mortality of diabetes. In the most recent EQR technical report, HFS' EQRO recommended that HFS form a **collaborative partnership to align health plan initiatives and improvement strategies with those of the State plan.**
Maternal and Child Health	HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), has developed a **Statewide Bright Smiles from Birth Program** that uses web-based training to educate physicians, nurse practitioners, and FQHCs on how to perform oral health screenings, assessments, and fluoride and varnish applications in both the FFS and managed care delivery system. The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care, and studies confirm that fluoride varnish applications are effective in reducing early childhood caries in young children. See http://illinoisaap.org/projects/bright-smiles/ for more information. **HFS is partnering** with the Illinois DPH on the Collaborative Improvement and Innovation Network (CoIIN) **to reduce infant mortality**. **DCFS youth** are now served by HealthChoice Illinois.

Focus Population	Initiatives
Long-Term Services and Supports	**Supplemental CAHPS questions** are added to the health plan adult surveys to obtain input on the satisfaction with HCBS services, including satisfaction with direct support staff and receipt of waiver services. HFS' **Quality Care Subcommittee** has assigned a workgroup to **assess** racial or ethnic **disparity in LTSS programs** and recommend strategies for equality and quality of services for LTSS enrollees throughout Illinois. Health plans are required to have a member advisory committee with a reasonable representation of LTSS enrollees.
All Populations	HFS plans to begin implementing **integrated health homes** through a separate State plan amendment in October 2018. The integrated health homes will focus on coordination of care spanning physical healthcare, behavioral healthcare, and social needs. HFS believes the care coordination system to be very individualized and dependent on each member's different needs. Health home members will be divided into tiers, with Tier A for members with h physical and behavioral health needs, Tier B for high behavioral with low-to-moderate physical health needs, and Tier C for high physical with low-to-moderate behavioral health needs. Most Medicaid members are within Tier D, members with low physical and behavioral health needs. However, Tier A providers will have to accept members from all tiers in order to serve the entire family unit, allowing a family to be served by the same health home with the overall goal of truly integrated health homes. **Performance Management Initiative: Transition of Care Programs** (including CM/CC) • Increase HFS' performance management oversight of the MCOs. • MCOs identification of top hospitals with which they are working relative to transitions of care. • MCOs will submit weekly rosters to HFS account managers identifying behavioral health inpatient admissions. • HFS account managers will have weekly discussions with the MCOs to review the roster and to understand how the MCO is actively managing members' transition(s) of care. **Performance Management Initiative: Emergency Department Utilization** **Performance Management Initiative: Executive Scorecard Performance.** MedInsight metrics and MCO self-reported metrics. **Telemedicine task force** is charged with expanding the use of telemedicine within the Medicaid program.

Focus Population	Initiatives
	P4P Program. Health plans may earn payments based on performance with respect to select quality metrics that support the Quality Strategy goals. Collection of data and calculation of health plan performance against the P4P measures are in accordance with national HEDIS timelines and specifications. Health plans must obtain an independent validation of their HEDIS and HEDIS-like results by an NCQA certified auditor, and HFS compares health plan performance against the P4P measures and encounter data. HFS is working to **engage enrollees in an advisory capacity** and participation in the MAC. **Health Plan Accreditation.** Pursuant to 305 ILCS 5/5-30 (a) and (h), HFS requires that any health plan serving at least 5,000 seniors, or people with disabilities, or 15,000 beneficiaries in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one year are considered eligible for accreditation and will be accredited by the NCQA within two years after the date the health plan was eligible for accreditation. The health plans must achieve and/or maintain a status of "Excellent," "Commendable," or "Accredited." **Electronic Health Records (EHR) Payment Incentive Program.** Section 4210 of the Health Information Technology for Economic and Clinical Health (HITECH) Act established an EHR provider incentive payment program, which allows Medicaid to pay an incentive to eligible professionals who attested to adopt, implement, upgrade, or meaningfully use certified EHR technology. In September 2011, HFS launched Illinois' Medicaid EHR Incentive Payment Program, allowing attestations via a State Web application (now called the EHR Medicaid Incentive Payment Program [eMIPP]) from providers who had initiated the registration process on a CMS website. Since the program's inception through March 8, 2018, HFS has awarded over $604.5 million in incentive payments to 9,166 eligible Medicaid providers (EPs) and 174 eligible Medicaid hospitals (EHs) to encourage them to adopt, implement, or upgrade their local EHR system, with a later goal of engaging in the "meaningful use" of said technology. The State estimates that the 100 percent federally funded payments to eligible providers will exceed $800 million over the life of the program, which continues through 2021.

Health Plan Sanctions

In accordance with Section 7.16 of the health plan contract, HFS may impose civil money penalties, late fees, performance penalties (collectively, "monetary sanctions"), and other sanctions on health plans for failure to substantially comply with the terms of the contract. Monetary sanctions may be imposed, as detailed in the contracts, with determination of the amount at the sole discretion of HFS, within the ranges set forth in the contracts. Self-reporting by a health plan is taken into consideration in determining the sanction amount. HFS may waive the imposition of sanctions for failures determined to be minor or insignificant. Upon determination of substantial noncompliance, HFS gives written notice to the health plan describing the noncompliance, the opportunity to cure the noncompliance where a cure is not otherwise disallowed under the contracts, and the sanction that HFS will impose. HFS may impose a performance penalty and/or suspend enrollment of potential beneficiaries. Areas subject to sanctions are included in the contract and include failure to submit required reports or performance results, misrepresentation of information, or failure to provide covered services.

Corrective/Remedial Actions

If HFS determines a health plan has not made significant progress in monitoring or carrying out its required QAP, implementing its QAP, or demonstrating improvement in deficient areas, HFS shall provide notice that the health plan is required to develop a CAP. The CAP must specify the types of problems requiring remedial/corrective action; the type of corrective action to be taken; the goals of the corrective action; the timetable and workplan for action; the identified changes in processes, structure, and internal and external education; the type of follow-up monitoring, evaluation, and improvement; and the identified improvements and enhancements of existing outreach and care management activities, if applicable. Health plans are required to monitor and evaluate corrective actions to assure that appropriate changes have been made and to follow up on identified issues to ensure that actions for improvement have been effective and provide documentation on this process.

Health Information Technology (HIT)

Technology initiatives are also an essential part of HFS' Medicaid transformation agenda. Systems changes support initial and ongoing operation and review of the Quality Strategy as well as ensure progress toward HFS' goals.

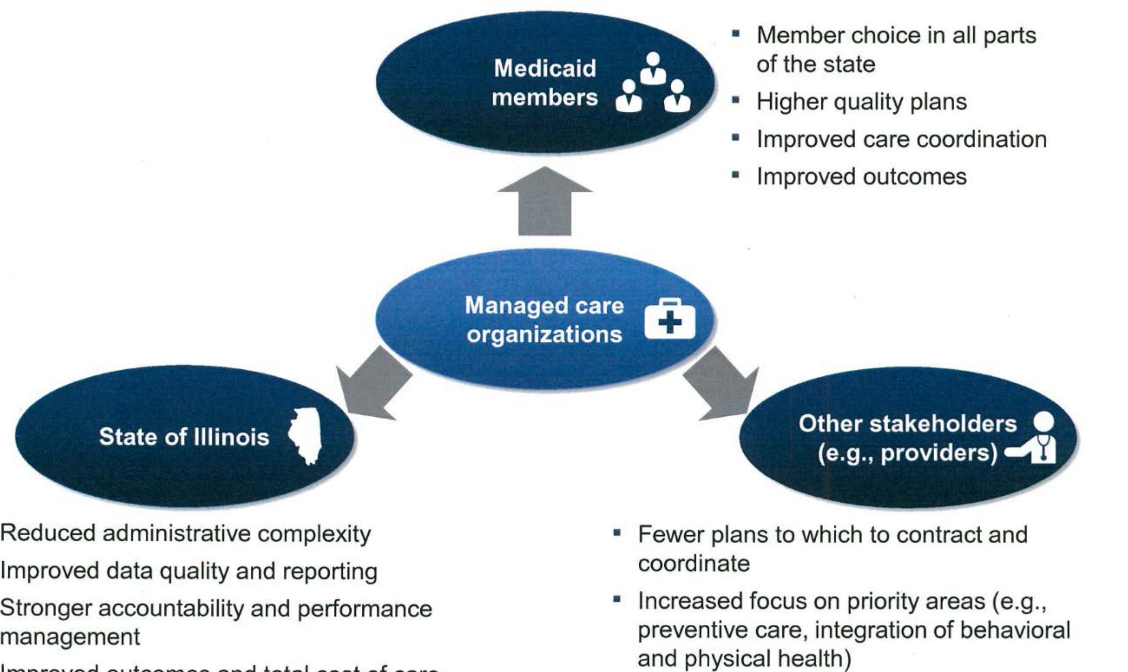
INTEGRATED ELIGIBILITY SYSTEM (IES)	• New eligibility system will determine eligibility for medical programs: Supplemental Nutrition Assistance Program (SNAP), formerly known as "food stamps"; and cash assistance, primarily for Temporary Assistance for Needy Families (TANF). • In collaboration with DHS and the Department of Innovation and Technology (DoIT) • Cost of development and installation largely defrayed by enhanced 90% match from federal government.
DATA ANALYTICS PLATFORM (MEDINSIGHT)	Implementation of a data warehousing and decision-support tool that enables performance reporting across claims, enrollment, and pharmaceutical records. This comprehensive reporting system will allow HFS to accurately generate performance metrics on demand.
ADVANCED CLOUD TECHNOLOGY (IMPACT)	The IMPACT initiative is a multi-agency effort that modernizes HFS' 30-year-old MMIS which was built to support a FFS Medicaid program. The MMIS supports claims processing for the HFS medical assistance programs.
IMPACT'S FOUR PHASES	• **Electronic Health Records Medicaid Incentive Payment Program (eMIPP)**: Provides incentive payments to EPs, EHs, and critical access hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. • **Web Provider Enrollment**: Beginning in July 2015, providers have been required to enroll and revalidate their enrollment through the new IMPACT Web portal. • **Pharmacy Benefits Management System (PBMS)**: Internet-based application capable of interacting with providers, manufacturers, and other stakeholders to conduct the business processes of managing the Pharmacy Services and Drug Rebate program. • **Full Implementation/CoreSystem**: This phase is the largest and most complex. It encompasses numerous subsystems including claims/encounters, prior approval, eligibility/enrollment, business administration, and financials. The Full Implementation/Core System is projected to be completed in 2020. Once completed, the Department will have a modern, single, cloud-enabled MMIS for all Medicaid claims processing.

Section 6. Conclusions

Successes

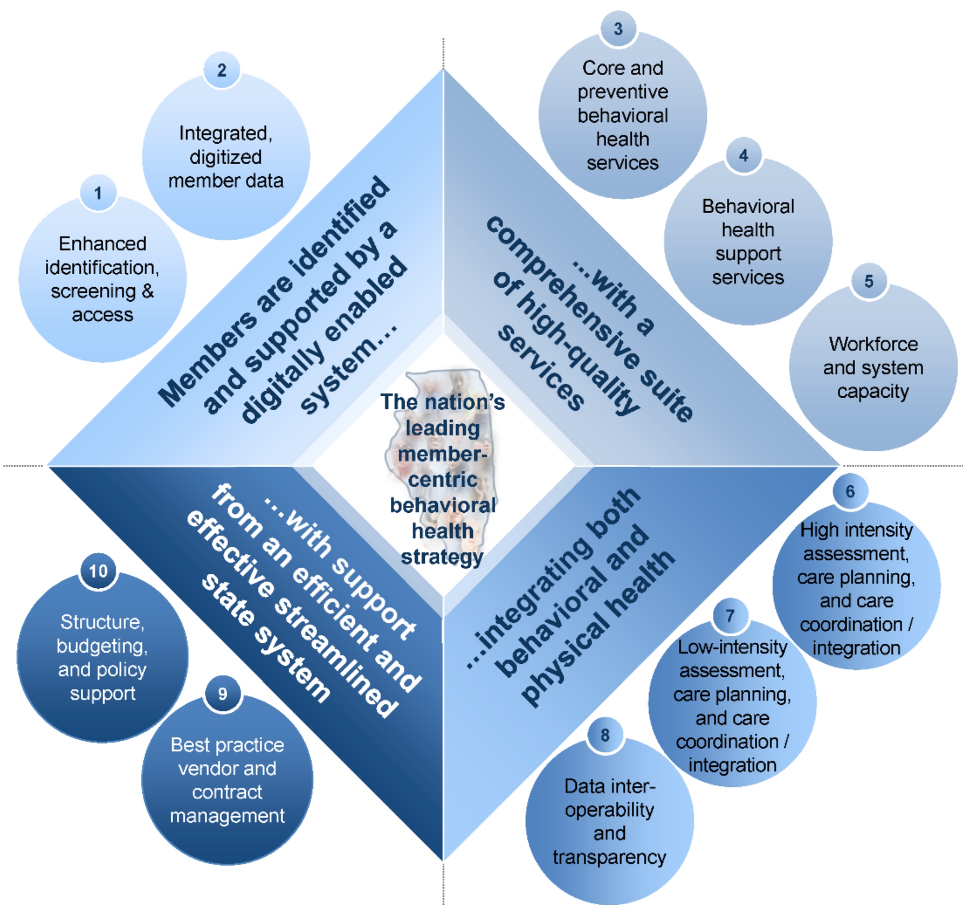
Managed Care Reboot

HFS rose to the challenge of Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148) by expanding managed care statewide. The recontracting process for HealthChoice Illinois has benefits for the entire Medicaid community as shown in the diagram below. As statewide expansion is implemented, HFS will measure its success in improving outcomes and continue to seek out innovative, efficient strategies to meet the demands of Medicaid reform.



Behavioral/Physical Health Integration

Illinois' behavioral health transformation strategy, developed to support the 1115 Medicaid demonstration waiver, puts customers at the center, integrates behavioral and physical health, and transforms a fragmented and unsustainable system with new payment and delivery models, increased managed care, enhanced workforce capacity, and greater accountability across the system. The four central approaches and their 10 supporting initiatives are illustrated below. Initial successes of the transformation include an increase of community-based health providers to serve Medicaid members.



Recredentialing Through IMPACT

The IMPACT system produces a pool of state-credentialed practitioners from which health plans can draw to build their Medicaid practitioner networks. The system streamlined the credentialing process and greatly reduced administrative burdens for both providers and health plans. The table in Appendix L demonstrates the many functions now managed by the State/IMPACT system for contracting with state-credentialed Medicaid practitioners. HFS is receiving positive feedback from providers and health plans regarding the significant efficiencies IMPACT has created.

Medicaid Plan Report Card

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. Illinois Public Act 099-0725 set forth requirements for the Medicaid quality rating system. As a result, HFS is designing an online, interactive version of the report card. A copy of the most recently published report card can be found in Appendix M and at: https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2017CY2016HealthChoiceIllinoisReportCardF1combined.pdf.

Improving Encounter Data

HFS' contractual requirements for encounter data submission include these four components: submission, testing, production, and evaluation. The testing component includes two levels of HFS review. The first level of review and edits performed by HFS checks the data file format. Once the format is correct, HFS performs the second level of review: standard claims processing edits. These edits include, but are not limited to, the following: correct provider numbers, valid beneficiary numbers, valid procedure and diagnosis codes, and crosschecks to assure provider and beneficiary numbers match the name on file. The acceptable error rate of claims processing edits of the encounter data provided by the contractor is determined by HFS. Once an acceptable error rate has been achieved, as determined by HFS, the contractor is informed that the testing phase is complete, and those data can be put into production. HFS has made significant strides in improving encounter data accuracy. HFS now formally evaluates health plan encounter claims submissions quarterly through a methodology developed by its consulting actuary, Milliman, Inc., called Encounter Utilization Monitoring (EUM). Thresholds are established each quarter which the health plans are expected to meet. When health plans fail to meet the thresholds, both financial and auto-assignment sanctions are issued. At the end of 2015, when EUM was introduced, less than 50 percent of paid claims were successfully submitted and accepted as encounters. In early 2018, the percentage had increased to over 90 percent.

NCQA Accreditation

Illinois amended its Public Aid Code to require Medicaid health plans to be accredited by NCQA. NCQA accreditation is a comprehensive evaluation based on results of clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures) and is a widely recognized symbol of quality. HFS believes requiring NCQA accreditation lays the framework for health plans serving Medicaid beneficiaries to improve care, enhance service, and reduce costs. As required by §438.10(c)(3), HFS makes the accreditation status of each health plan available on its website.

Challenges/Opportunities

Implementing Integrated Health Homes

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. Illinois' vision for integration is ambitious because the current provider delivery system is not structured to support it. Today, behavioral and physical

healthcare providers often operate in siloes and fail to exchange information, let alone collaborate as part of a seamlessly integrated care team. The development of IHHs and the payment model to sustainably support them will be a significant but challenging step. Illinois recognizes that these IHHs will not materialize without considerable planning and intends to use extensive stakeholder input, allow flexibility for multiple models to emerge across the State, and allow for continued provider innovation. HFS 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.

Medicaid Provider Capacity

HFS understands that statewide expansion of Medicaid managed care presents challenges in building and maintaining a provider network with sufficient capacity to serve Medicaid beneficiaries, particularly for specialty areas such as obstetrics and behavioral health. HFS will be actively working to monitor access to care for Medicaid beneficiaries and identify opportunities and initiatives to address potential access concerns. HFS is already exploring opportunities to promote the use of telemedicine and build the Medicaid healthcare workforce.

Conclusion

2016–2018 saw the advancement of the medical assistance programs' transformation through the reboot of the managed care program, continued work on the 1115 federal demonstration waiver, and progress on technology initiatives. Transformation is about maximizing outcomes given state resources. The State believes it can dramatically improve health outcomes for Illinoisans and, as a by-product, avoid unsustainable spending by pursuing three goals:

- Focus on prevention and public health.
- Build a healthcare delivery system based on the best data and evidence.
- Deliver care in the community to the greatest extent possible.

These transformations are essential for achieving HFS' mission of empowering Illinoisans to make sound decisions about their wellbeing, delivering quality healthcare coverage at sustainable costs, and maintaining the highest standards of program integrity on behalf of the citizens of Illinois.

HealthChoice Illinois Enrollment

As of May 31, 2018 there were seven health plans that participated: Blue Cross Blue Shield of Illinois (BCBSIL), CountyCare, Harmony Health Plan (Harmony), IlliniCare Health Plan (IlliniCare), Meridian Health (Meridian), Molina HealthCare of Illinois (Molina), and NextLevel Health (NextLevel).

Enrollment figures for HealthChoice Illinois are displayed in the tables below. Table 1-1 presents overall enrollment, Table 1-2 and Table 1-3 display the gender and age bands of Medicaid/non-CHIP and CHIP enrollment, respectively, as of May 31, 2018. Table 1-4 presents non-match figures (non-match refers to State funding with no federal matching dollars), and Table 1-5 presents the race/ethnicity composition of beneficiaries.

Table 1-1—HealthChoice Illinois Enrollment

HEALTH PLANS	MAY 2018 ENROLLMENT
BCBSIL	470,751
CountyCare	328,545
Harmony	259,811
IlliniCare	323,921
Meridian	553,040
Molina	214,529
NextLevel	61,158
Total HealthChoice Illinois Enrollment	**2,211,755**

Table 1-2— HealthChoice Illinois Non-CHIP Enrollment by Gender and Age

GENDER/AGE BAND	MAY 2018 ENROLLMENT
<1 year	52,807
1–2 years	126,503
3–14 years	727,224
Females 15–18	100,116
Males 15–18	292,825
Females 19–34	390,092
Males 19–34	99,536
Females 35+	170,271
Males 35+	293,711
Total non-CHIP	**2,253,085**

Table 1-3— HealthChoice Illinois CHIP Enrollment by Gender and Age

GENDER/AGE BAND	MAY 2018 ENROLLMENT
<1 year	844
1–2 years	6,968
3–14 years	180,742
Females 15–18	29,493
Males 15–18	55,071
Females 19–34	83,016
Males 19–34	29,895
Females 35+	21,160
Males 35+	17,862
Total CHIP	**425,051**

Table 1-4— HealthChoice Illinois Non-Match Enrollment by Gender and Age

GENDER/AGE BAND	MAY 2018 ENROLLMENT
<1 year non-match	657
1–2 years non-match	6,852
3–14 years non-match	69,763
Females 15–18 non-match	13,616
Males 15–18 non-match	71,955
Females 19–34 non-match	70,078
Males 19–34 non-match	14,057
Females 35+ non-match	55,430
Males 35+ non-match	75,058
Total Non-Match	**377,466**

Table 1-5— HealthChoice Illinois Enrollment Race/Ethnicity Composition

	COOK COUNTY			DOWNSTATE			
RACE	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	TOTAL
American Indian/Alaska Native	215	553	538	301	573	935	**3,115**
Asian	4,511	2,392	38,219	5,533	1,570	39,802	**92,027**
Black	27,664	6,348	345,269	24,764	4,894	258,203	**667,142**
Did Not Answer/ Unknown	384,925	73,930	17,755	477,145	68,120	19,040	**1,040,915**
Hawaiian Native/ Other Pacific Islander	188	390	568	275	391	776	**2,588**
Multi-Race	263	365	1,229	361	445	2,230	**4,893**
White	40,081	132,093	149,880	78,802	139,575	477,126	**1,017,557**
Total	**457,847**	**216,071**	**553,458**	**587,181**	**215,568**	**798,112**	**2,828,237**

Managed Long Term Care Services and Supports (MLTSS) Enrollment

HFS submitted to CMS a 1915(b) waiver application to implement the MLTSS waiver. Under the waiver, in specified geographies, dual eligible beneficiaries who receive institutional (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) will be required to enroll in managed care, unless they meet another exclusion. Current eligibility determination guidelines for institutional or hand community based (HCBS) services will not change under the waiver unless modified by the State. Under the waiver, beneficiaries will receive the Medicaid institutional and community-based long-term services and supports (LTSS), transportation, and behavioral health services through a Prepaid Health Insurance Plan (PIHP). Waiver beneficiaries will have a choice of at least two PIHPs in a geographic area (service area). The covered geography expands statewide when MLTSS and waiver services are incorporated into HealthChoice Illinois, scheduled for October 1, 2018. Table 1-1 presents MLTSS enrollment.

Table 1-7—Managed Long-Term Care Services and Supports Enrollment

HEALTH PLANS	MAY 2018 ENROLLMENT
BCBSIL	11,719
CountyCare	5,947
Harmony	1,332
IlliniCare	7,795
Meridian	8,101
Molina	1,116
NextLevel	417
Total	**36,427**

Medicare-Medicaid Alignment Initiative (MMAI) Enrollment

As of June 30, 2018, there were seven health plans that participated in select counties: Aetna Better Health Premier Plan (Aetna), Blue Cross Community MMAI (BSBSIL), Humana Gold Plan Integrated (Humana), IlliniCare Health (Illinicare), MeridianComplete (Meridian), and Molina Dual Options Medicaid-Medicaid Plan (Molina). Overall MMAI enrollment figures are displayed in Table 1-8.

Table 1-8—Medicare-Medicaid Alignment Initiative Enrollment

HEALTH PLANS	MAY 2018 ENROLLMENT
Aetna	7,378
BCBSIL	19,563
Humana	8,123
IlliniCare	7,535
Meridian	7,759
Molina	3,785
Total	**54,143**

P4P 2017	Measure Domain – Measure List	# Plans Reporting 2017	National Benchmark Plan Performance 2017				Statewide Avg. 2017 / Trended 16-17	Improved Trended Performance 2016-2017	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	5	2	-	-	< 25th ↓	1 of 6 plans[i]	A
Ambulatory Care (per 1,000 Member Months – A Utilization Measure)[ii]									
	Outpatient Visit - Total	6[iii]	2	2	1	1	25th-49th [ii]	n/a[ii]	n/a[ii]
	Emergency Department Visit - Total	6[iii]	1	2	3	-	25th-49th [ii]	n/a[ii]	n/a[ii]
Preventive Care									
Adult BMI Assessment									
	Adult BMI Assessment	6[iv]	2	1	3	-	25th-49th ↑	4 of 5 plans[v]	Q
Child & Adolescent Care									
Childhood Immunization Status									
	Combination 2	6[iv]	1	4	-	1	25th-49th ↑	3 of 6 plans	Q
	Combination 3	6[iv]	3	2	1	-	25th-49th ↑	3 of 6 plans	Q
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents									
P4P	BMI Percentile - Total	6[iv]	-	2	3	1	25th-49th ↑	4 of 6 plans	Q
P4P	Counseling for Nutrition - Total	6[iv]	1	1	3	1	25th-49th ↑	5 of 6 plans	Q
Well-Child Visits (WCV)									
P4P	≥6 WCV in the First 15 Months of Life	6[iv]	2	2	1	1	50th-74th ↑	2 of 5 plans[v]	Q
P4P	WCV in the 3rd, 4th, 5th, 6th Years of Life	6[iv]	1	-	3	2	50th-74th ↓	3 of 6 plans	Q
Women's Health									
Breast Cancer Screening									
P4P	Breast Cancer Screening	6[iv]	2	1	3	-	25th-49th ↑	2 of 5 plans[v]	Q
Cervical Cancer Screening									
P4P	Cervical Cancer Screening	7	1	3	1	2	50th-74th ↑	6 of 6 plans[i]	Q
Chlamydia Screening in Women[vi]									
	Total	7	-	-	6	1	50th-74th ↑	5 of 6 plans[i]	Q
Prenatal and Postpartum Care[vi]									
P4P	Timeliness of Prenatal Care	7	2	2	2	1	50th-74th ↓	2 of 6 plans[i]	Q, T, A
P4P	Postpartum Care	7	2	1	2	2	50th-74th ↓	2 of 6 plans[i]	Q, T, A

P4P 2017	Measure Domain – Measure List	# Plans Reporting 2017	National Benchmark Plan Performance 2017				Statewide Avg. 2017 / Trended 16-17	Improved Trended Performance 2016-2017	Quality (Q) Timeliness (T) Access (A)
			<25th	25th-49th	50th-74th	≥75th			
Appropriate Care									
Annual Monitoring for Patients on Persistent Medications [vii]									
	Angiotensin Converting Enzyme Inhibitors or Angiotensin Receptor Blockers	7	4	-	3	-	25th-49th	1 of 5 plans[viii]	Q
	Digoxin	5[ix]	-	2	1	2	50th-74th	0 of 3 plans[x]	Q
	Diuretics	7	4	2	1	-	25th-49th	0 of 5 plans[viii]	Q
	Total	7	4	2	1	-	25th-49th	1 of 5 plans[viii]	Q
Comprehensive Diabetes Care									
P4P	Hemoglobin A1c (HbA1c) Testing	7	2	1	4	-	50th-74th	2 of 5 plans[xi]	Q
P4P	Medical Attention for Nephropathyxii	7	1	4	2	-	25th-49th [xii]	n/a[xii]	Q
P4P	Eye Exam (Retinal) Performed	7	4	1	1	1	25th-49th	3 of 5 plans[xi]	Q
Controlling High Blood Pressure									
	Controlling High Blood Pressure	6[xiii]	4	1	-	1	< 25th [xiv]	n/a[xiv]	Q
Medication Management for People with Asthma [vi]									
	Medication Compliance 50% - Total[xv]	6[iv]	1	1	3	1	50th-74th	1 of 3 plans[xvi]	Q
	Medication Compliance 75% - Total	6[iv]	1	2	2	1	50th-74th	1 of 3 plans[xvi]	Q
Statin Therapy for People with Diabetes [xv]									
	Received Statin Therapy	6[iv]	1	-	2	3	≥ 75th [xiv]	n/a[xiv]	Q
	Statin Adherence 80%	6[iv]	1	3	1	1	50th-74th [xiv]	n/a[xiv]	Q
Behavioral Health									
Follow-Up after Hospitalization for Mental Illness									
	7-Day Follow-Up	7	4	2	-	1	< 25th	3 of 5 plans [xvii]	Q, T, A
P4P	30-Day Follow-Up	7	5	1	1	-	< 25th	3 of 5 plans[xvii]	Q, T, A
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment									
P4P	Initiation of AOD Treatment – Total	7	-	1	3	3	50th-74th	2 of 6 plans[i]	Q, T, A
P4P	Engagement of AOD Treatment - Total	7	1	1	3	2	50th-74th	5 of 6 plans[i]	Q, T, A
Metabolic Monitoring for Children and Adolescents on Antipsychotics									
	Total	6[iv]	-	2	3	1	50th-74th	n/a[xiv]	Q

Key	P4P	Pay-for-Performance Measure 2017	▼	Performance declined from 2016 to 2017	▲	Performance improved from 2016 to 2017

[i] For NextLevel, only the HEDIS 2017 rate is included because it was the first year the health plan reported data.
[ii] The Ambulatory Care (per 1,000 Member Months) is a utilization measure. Since the rates reported 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 for strictly informational purposes and no trending is available. Caution should be exercised when comparing measure rates between health plans.
[iii] NextLevel's rate was not reported. HEDIS 2017 was the first year NextLevel reported data.
[iv] NextLevel's HEDIS 2017 was withheld because the denominator was less than 30. HEDIS 2017 was the first year NextLevel reported data.
[v] NextLevel's HEDIS 2017 rate and CountyCare's HEDIS 2016 rate was withheld because the denominator was less than 30.
[vi] The HEDIS 2016 rates for this measure only contain data for the FHP/ACA population, as the ICP population was not required to report this rate.
[vii] The HEDIS 2016 rates only contain data for the ICP population, as the FHP/ACA population was not required to report this rate.
[viii] Harmony was not required to report this measure in HEDIS 2016, as the health plan served only the FHP/ACA population. For NextLevel, only the HEDIS 2017 rate is included because it was the first year the health plan reported data.
[ix] HEDIS 2017 rates for Harmony and NextLevel were withheld because the denominator was less than 30.
[x] HEDIS 2016 rates for BCBSIL and CountyCare, and HEDIS 2017 rates for Harmony and NextLevel were withheld because the denominator was less than 30.
[xi] BCBSIL rate for HEDIS 2016 was not reported and HEDIS 2017 was the first year NextLevel reported data.
[xii] Due to changes in NCQA's technical specifications for this measure indicator, comparisons to national percentiles are not available for HEDIS 2016. Therefore, exercise caution when comparing HEDIS 2017 rates to prior years' rates. HEDIS 2017 was the first year NextLevel reported data.
[xiii] NextLevel's HEDIS 2017 rate was withheld because the rate was materially biased.
[xiv] No trending is available because the health plans were not required to report a rate for HEDIS 2016.
[xv] Quality Compass Benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.
[xvi] HEDIS 2016 rates for BCBSIL, CountyCare, and Illinicare, and HEDIS 2017 rates for NextLevel were withheld because the denominator was less than 30.
[xvii] Molina was not required to report for this measure in HEDIS 2016. Only the HEDIS 2017 rate is included for NextLevel because it was their first year reporting data.

HealthChoice Illinois Managed Care Program
Healthcare and Quality of Life Performance Measures

Table 1 to Attachment XI: Healthcare and Quality of Life Performance Measures

Acronym	Performance measure	Further description	Reporting methodology	Source
AAP	Adults' Access to Preventive/Ambulatory Health Services	Percentage of member's 20 years and older who had an ambulatory or preventive care visit during the measure year. (Report 3 age ranges and total)	Admin	HEDIS
AMB	Ambulatory Care	This measure summarizes utilization of ambulatory care in the following categories: • Outpatient Visits • ED Visits. (Reported per 1,000 member months, on 9 age ranges and total)	Admin	HEDIS
PPC	Prenatal and Postpartum Care	Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • *Timeliness of Prenatal Care*. Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care*. Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Hybrid / Admin	HEDIS
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. Percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. Percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 34 days of the initiation visit.	Admin	HEDIS

HealthChoice Illinois Managed Care Program
Healthcare and Quality of Life Performance Measures

W15	Well-Child Visits in the First 15 Months of Life (W15)	Percentage of members who turned 15 months old during the measure year and who had the following number of well-child visits with a primary care Provider during the first 15 months of life: Zero, One, Two, Three, Four, Five and Six or more.	Hybrid / Admin	HEDIS
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	Percentage of members 3-6 years of age who had one or more well-child visits with a primary care Provider during the measure year.	Hybrid / Admin	HEDIS
ADV	Annual Dental Visit	Percentage of members 2-20 years of age who had at least one dental visit during the measurement year. (Report 6 age ranges and total)	Admin	HEDIS
ABA	Adult BMI Assessment	Percentage of members 18-74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	Hybrid / Admin	HEDIS
BCS	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Admin	HEDIS
CCS	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had a cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Hybrid / Admin	HEDIS
CHL	Chlamydia Screening in Women	Percentage of women age 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measure year.	Admin	HEDIS
CBP	Controlling High Blood Pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and who's BP was adequately controlled during the measurement year based on the following criteria: • Members 18-59 years of age whose BP was <140/90mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90mm Hg.	Hybrid	HEDIS

HealthChoice Illinois Managed Care Program
Healthcare and Quality of Life Performance Measures

CIS	Childhood Immunization Status	Percentage of children 2 years of age who had four DTaP; three IPV; one MMR; three HiB; three HepB; one VZV; four PCV; one HepA; two or three RV; and two Flu vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Hybrid / Admin	HEDIS
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity.	Hybrid / Admin	HEDIS
IMA	Immunizations for Adolescents	Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and all required doses of the Human Papillomavirus (HPV) vaccine by their 13th birthday. This measure calculates a rate for each vaccine and two combination rates.	Hybrid / Admin	HEDIS
CDC	Comprehensive Diabetes Care	Percentage of members18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing. • Eye exam (retinal) performed. • Medical attention for nephropathy.	Hybrid / Admin	HEDIS
SPD	Statin Therapy for Patients With Diabetes	Percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1) *Received Statin Therapy*. Members who were dispensed at least one statin medication of any intensity during measurement year. 2) *Statin Adherence 80%*. Members who remained on a statin medication of any intensity for at least 80% of the treatment period	Admin	HEDIS
MPM	Annual Monitoring for Patients on Persistent Medications	Percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one	Admin	HEDIS

HealthChoice Illinois Managed Care Program
Healthcare and Quality of Life Performance Measures

		therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate. • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). • Annual monitoring for members on digoxin. • Annual monitoring for members on diuretics. • Total Rate (the sum of the three numerators divided by the sum of the three denominators.		
MMA	Medication Management for People With Asthma	Percentage of member's 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1) Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2) Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period. (Report 5 age groups)	Admin	Yes
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Report three age stratifications and total)	Admin	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for member's 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1) Percentage of discharges for which the member received follow-up within 30 days of discharge. 2) Percentage of discharges for which the member received follow-up within 7 days of discharge.	Admin	HEDIS
IL 3.6	Movement of Members Within Service Populations	Difference (Movement) between members in the community and those in LTC. Measured on January 1st and December 31st of the calendar year.	Admin	MLTSS

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Healthcare and Quality of Life Performance Measures

CDF-HH	Screening for Clinical Depression and Follow-Up Plan	Percentage of Health Home enrollees age 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	Hybrid or e-measure	CMS
PQI92-HH	Chronic Condition Hospital Admission Composite—PQI	Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months for Health Home enrollees age 18 and older. This measure includes adult hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Admin	AHRQ
PCR-HH	Plan All Cause Readmissions	For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories: Count of Index Hospital Stays (IHS) (denominator); Count of 30-Day Readmissions (numerator); Readmission Rate.	Admin	HEDIS
n/a	IP admits per 1,000	Rate of acute inpatient care and services per 1,000 enrollee months among Health Home enrollees.	Admin	CMS
n/a	Behavioral Health Related Emergency Department Visits Per 1,000	Rate of Behavioral health related emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.	Admin	CMS
IU-HH	Inpatient utilization	Measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, medicine.	Admin	HEDIS
MPT	Mental Health Utilization	The number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or	Admin	HEDIS

HealthChoice Illinois Managed Care Program
Healthcare and Quality of Life Performance Measures

		partial hospitalization, outpatient or ED		

HealthChoice Illinois – Scorecard

Trending metrics monthly, quarterly and annually as appropriate.

Ref #	Source/ Report Name	Executive Scorecard Metric	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G
	Clinical								
1	New Enrollee Health Screenings and Health Assessments	% of new Enrollees with a health risk assessment or a health risk screening within 60 days of enrollment							
2	Enrollee Engagement: Care Assessment and Individualized Plan of Care (IPoC)	% high risk Enrollees with an IPoC completed within 90 days after being identified as high risk							
3	Enrollee Engagement: Care Assessment and Individualized Plan of Care (IPoC)	% of Enrollees deemed newly eligible for HCBS Waiver who had a Service Plan within 15 days after the MCO is notified of the Enrollees HCBS Waiver eligibility							
4	MedInsights Population Health & Condition Mgmt	% of Enrollees (Adult) with a PCP visit in the past 12 months							
5	MedInsights Population Health & Condition Mgmt	% of Enrollees (Child) with a PCP visit in the past 12 months							
6	MedInsights Population Health & Condition Mgmt	% of the Enrollees (Female) who delivered a newborn, who had at least 1 prenatal visit in each trimester and 1 post partum visit in the 4 - 6 week timeframe after the delivery date with an OB/GYN.							
7	MedInsights Utilization Mgmt. (UM)	Total Health Benefit Cost (PMPM) (risk adjusted, by population)							
8	MedInsights Utilization Mgmt. (UM)	Total Inpatient (IP) Admits (per 1,000 Enrollees)							
9	MedInsights Utilization Mgmt. (UM)	Total IP Average Length of Stay (ALOS) (days)							
10	MedInsights Utilization Mgmt. (UM)	Total IP Costs, Per Member Per Month (PMPM)							
11	MedInsights Utilization Mgmt. (UM)	Maternity Admits (per 1,000 Enrollees)							

HealthChoice Illinois – Scorecard

Trending metrics monthly, quarterly and annually as appropriate.

Ref #	Source/ Report Name	Executive Scorecard Metric	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G
12	MedInsights Utilization Mgmt. (UM)	Maternity ALOS (days)							
13	MedInsights Utilization Mgmt. (UM)	Maternity Costs (PMPM)							
14	MedInsights Utilization Mgmt. (UM)	Behavioral Health (BH) Admits (per 1,000 Enrollees)							
15	MedInsights Utilization Mgmt. (UM)	Behavioral Health ALOS (days)							
16	MedInsights Utilization Mgmt. (UM)	Behavioral Health Costs (PMPM)							
17	MedInsights Utilization Mgmt. (UM)	% Readmissions within 30 days of (non BH) inpatient discharge							
18	MedInsights Utilization Mgmt. (UM)	% Readmissions within 30 days of (BH) inpatient discharge							
19	MedInsights Emergency Dept. (ED) Utilization	Total ED Visits (per 1,000 Enrollees)							
20	MedInsights Emergency Dept. (ED) Utilization	Total ED Visit costs (PMPM)							
21	MedInsights Emergency Dept. (ED) Utilization	Total ED Visit costs with a Behavioral Health, mental health diagnosis (PMPM)							
22	MedInsights Emergency Dept. (ED) Utilization	Total ED Visits with a Behavioral Health, mental health diagnosis (per 1,000 Enrollees)							
23	MedInsights Emergency Dept. (ED) Utilization	Total ED Visit costs with a Behavioral Health, substance abuse diagnosis (PMPM)							
24	MedInsights Emergency Dept. (ED) Utilization	Total ED Visits with a Behavioral Health, substance abuse diagnosis (per 1,000 Enrollees)							
25	MedInsights Physician/ Prof services	Total Physician Services Visits (per 1,000 Enrollees)							

HealthChoice Illinois – Scorecard

Trending metrics monthly, quarterly and annually as appropriate.

Ref #	Source/ Report Name	Executive Scorecard Metric	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G
26	MedInsights Physician/ Prof services	Total Physician Services Costs (PMPM)							
27	MedInsights Dental/ Prof services	Dental Visits (per 1,000 Enrollees)							
28	MedInsights Dental/ Prof services	Dental Costs (PMPM)							
29	MedInsights Pharmacy	PMPM overall % change from prior month (& per Qtr)							
30	MedInsights Pharmacy	Brand to Generic ratio							
31	HEDIS	Metrics (To Be Determined - TBD)							
	Operational								
32	Provider and Enrollee Service Call Center Stats	Total call volume per 1,000 Enrollees (combined Provider calls and Enrollee calls)							
33	Provider and Enrollee Service Call Center Stats	Average speed to answer in seconds (combined Provider calls and Enrollee calls)							
34	Provider and Enrollee Service Call Center Stats	% of calls answered in 30 seconds or less (combined Provider calls and Enrollee calls)							
35	Provider and Enrollee Service Call Center Stats	% of calls abandoned (combined Provider calls and Enrollee calls)							
36	Claims Report (non BH)	% denied (non behavioral health)							
37	Claims Report (non BH)	% rejected (non behavioral health)							
38	Claims Report - BH (Mental Health)	% denied (behavioral health - mental health)							
39	Claims Report - BH (Mental Health)	% rejected (behavioral health - mental health)							

HealthChoice Illinois – Scorecard

Trending metrics monthly, quarterly and annually as appropriate.

Ref #	Source/ Report Name	Executive Scorecard Metric	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G
40	Claims Report - BH (Substance Abuse)	% denied (behavioral health - substance abuse)							
41	Claims Report - BH (Substance Abuse)	% rejected (behavioral health - substance abuse)							
42	New Provider Access and Payment	Number of New Providers accessible 0-30 days from HFS certification (accessible = Provider is able to receive payments)							
43	Provider Network Access	% of Enrollees with access to a PCP within established standards							
44	Provider Network Access	% of Enrollees with access to a Behavioral Health Provider within established standards							
45	Provider Network Access	% of Enrollees with access to a Dentist within established standards							
46	Prior Authorization	% of total denied							
47	Prior Authorization	Total volume per 1,000 Enrollees (# per month)							
48	Prior Authorization	% of RX requests with the decision communicated within 24 hours							
49	Prior Authorization	% of Ordinary/Routine requests with the decision communicated within 4 days							
50	Prior Authorization	% of Expedited requests with the decision communicated within 48 hours							
51	Provider Disputes Summary	# of disputes (per 1,000 Enrollees)							
52	Provider Disputes Summary	average number of days to resolve a standard complaint							

HealthChoice Illinois – Scorecard

Trending metrics monthly, quarterly and annually as appropriate.

Ref #	Source/ Report Name	Executive Scorecard Metric	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G
53	Enrollee Grievance & Appeals	Number of Grievances (per 1,000 Enrollees)							
54	Enrollee Grievance & Appeals	% Grievances resolved within 90 days							
55	Enrollee Grievance & Appeals	Number Appeals (per 1,000 Enrollees)							
56	Enrollee Grievance & Appeals	% Expedited Appeals determinations > 24 hours of receiving required information from the Enrollee							
57	Enrollee Grievance & Appeals	% Appeals determinations > 15 business days							
58	Critical Incidents	Number of Critical Incidents (per 1,000 Enrollees)							

Grievance System

Definitions

Grievance: An expression of dissatisfaction about any matter other than an action, as "action" is defined below.

Action:
1. the denial or limited authorization of a requested service, including the type of level of service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service.
4. the failure to provide services in a timely manner, as defined by the State;
5. the failure of a Managed Care Organization (MCO) to act within the timeframes provided below;
6. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under the Balanced Budget Act (BBA) (438.52(b)(2)(ii), to obtain service outside the network.

Appeal: A request for review of an action as "action" is defined above.

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
General Requirements	**Grievance System.** Contractor shall have a formally structured Grievance system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 CFR Parts 431 Subpart E and 438 Subpart F to handle all Grievances and Appeals subject to the provisions of such sections of the Act and regulations.		Article 5.30		
	MCO establishes and maintains a procedure for reviewing Grievances by an Enrollee or an Enrollee's authorized representative.	MCO establishes and maintains a procedure for reviewing Appeals by Enrollees or an Enrollee's authorized representative.	Article 5.30.1 Article 5.30.2		
Enrollee Welcome Packet	Contractor sends to each new Enrollee a welcome packet that contains the Enrollee Handbook and addresses important topics, such as how to get needed care, a benefits summary, and information about the Complaint, Grievance and Appeal processes.		Article 5.21.8.4		
Enrollee Handbook	The MCO's Enrollee Handbook contains information concerning the MCO's Grievance and Appeals process and the State's Appeal and fair hearing process, including how to register a Grievance or Appeal.		Article 5.21.5.12		

* The BBA states "A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal."

** The Managed Care Reform Patient Rights Act has different timeframes for appeal resolution and notice and acknowledgement standards than the BBA. Extensions are not included in the Act.

Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Review and Amendment	MCO reviews its Grievance and Appeal procedures at least annually for the purpose of amending such procedures when necessary. MCO amends its procedures only upon receiving the written Prior Approval of the Department. This information shall be furnished to the Department†.		Article 5.30.5		
Registration Requirements	All Grievances are registered with MCO.	All Appeals are registered with MCO that may later be appealed to the State.	Article 5.26.1 Article 5.26.2		
General Procedures	Requirements for MCO procedures: 1. Submit to the Department in writing and approved in writing by the Department; 2. Provide for prompt resolution, and 3. Assure the participation of individuals with authority to require corrective action.	Requirements for MCO procedures: 1. Submit to the Department in writing and approved in writing by the Department; 2. Provide for resolution within contractually-specified time frames, and 3. Assure the participation of individuals with authority to require corrective action.	Article 5.30.1.1 through 5.30.1.3 Article 5.30.2.1 through 5.30.2.3	Section 45 (a), (b) and (f); Section 50(a)(1)	438.402(a)
Informal Resolution	MCO attempts to resolve all Grievances informally.		Article 5.30.1.5		
Filing Authority	MCO provides a form and instructions on how an Enrollee may appoint any authorized representative that may include a guardian, caretaker relative, or Provider,* to represent the Enrollee throughout the Grievance process.	MCO provides a form and instructions on how an Enrollee may appoint any authorized representative that may include a guardian, caretaker relative, or Provider*, to represent the Enrollee throughout the Appeal process.	Article 5.30.1.6 Article 5.26.3.2	Section 45(d)	438.402(b)(1)(ii)

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Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Enrollee Information Provision	MCO provides Grievance and fair hearing procedures and timeframes, provided that such information must be submitted to the Department for Prior Approval before distribution.		Article 5.21.1.9		
Telephone Access	MCO has a toll-free number available, at a minimum during the hours of 8:30 a.m. until 5:00 p.m. Central Time on Business Days. This number is used for Enrollees, at a minimum, to file Complaints or Grievances, to request disenrollment, to ask questions or to obtain other administrative information.		Article 5.21.6.2		
Standard Appeal Procedure Filing		MCO permits an Enrollee to file an oral or written Appeal within sixty (60) calendar days following the date of the notice of Action that generates such Appeal.	Article 5.30.3.1		
Expedited Appeal Notification Provision		In the case of an Enrollee-requested expedited Appeal pursuant to 42 CFR 438.410, MCO notifies the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that MCO requires to evaluate the Appeal.	Article 5.30.3.3		

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** The Managed Care Reform Patient Rights Act has different timeframes for appeal resolution and notice and acknowledgement standards than the BBA. Extensions are not included in the Act.

Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Expedited Appeal Decision Notification		MCO renders a decision on an expedited Enrollee Appeal within twenty-four (24) hours after receipt of the required information.	Article 5.30.3.3	Section 45(b)	
Standard Appeal Decision Notification		MCO renders its decision on an Enrollee Appeal that is not filed as an expedited Appeal within fifteen (15) business days after submission of the Appeal.	Article 5.30.3.4	Section 45(c)	
Appeal Extension Provision		MCO grants an Appeal process extension for up to fourteen (14) calendar days upon an Enrollee's request, or if MCO demonstrates to the satisfaction of the appropriate state agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest.**	Article 5.30.3.4		
Appeal to State		MCO provides for final decisions of Appeals not resolved wholly in favor of the Enrollee to be appealed by the Enrollee to the State under its Fair Hearings system within one hundred twenty (120) calendar days after the date of MCO's Decision Notice.	Article 5.30.3.5		

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** The Managed Care Reform Patient Rights Act has different timeframes for appeal resolution and notice and acknowledgement standards than the BBA. Extensions are not included in the Act.

Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Independent Review Procedure		MCO has procedures for allowing an Enrollee to request an external independent review, both standard and expedited timeframes, of Appeals that are denied by MCO within thirty (30) calendar days after the date of MCO's Decision Notice. Such MCO independent review procedures shall not extend to denial of Waiver services that are not subject to review by an external independent entity.	Article 5.30.3.6		
MCO Participation in Appellate State Hearing		If an Appeal is filed with the State Fair Hearing system, MCO participates in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and participates in the hearing, including providing a witness to offer testimony supporting the MCO's decision.	Article 5.30.3.7		
Reversed Decision Enrollee Compensation		MCO pays for Enrollee-disputed services received during the pending Appeal process, in accordance with State policy and regulations in the case of a reversed decision to deny authorization of services by the MCO or State Fair Hearing Officer.	Article 5.30.3.9		

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** The Managed Care Reform Patient Rights Act has different timeframes for appeal resolution and notice and acknowledgement standards than the BBA. Extensions are not included in the Act.

Grievance System

	Grievance Process	Appeal Process	State of Illinois HealthChoice Model Contract	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Enrollee Benefit Continuance		MCO continues Enrollee's benefits during the Appeal process.	Article 5.30.3.10		
Quarterly Reporting		MCO submits quarterly report to the Department summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters (including decisions made following an external independent review).	Article 5.30.3.11	Section 55	
Information to Providers	An MCO's affiliated Providers are furnished with information about MCO's Grievance and Appeal procedures at the time the Provider enters into an agreement with MCO and within fifteen (15) days following any substantive change to such procedures.		Article 5.32.7		
Provider Complaints	The MCO has an established complaint and resolution system for Providers that includes a Provider dispute process.		Article 5.29.7		

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** The Managed Care Reform Patient Rights Act has different timeframes for appeal resolution and notice and acknowledgement standards than the BBA. Extensions are not included in the Act.

ATTACHMENT XIII: REQUIRED DELIVERABLES, SUBMISSIONS, AND REPORTING

NOTE: Separate reports shall be submitted for all populations unless otherwise stated in the report description and requirements. Contractor shall be prepared to report all data by county, provider type, and eligibility category.

Failure to submit required deliverables, submissions and reports outlined in this section will be grounds for the imposition of sanctions as described in Error! Reference source not found..

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Administrative			
Encounter Data	At least monthly	No	**Submission.** Contractor shall submit Encounter Data as provided herein. These data shall include all services received by Enrollees, including services reimbursed by Contractor through a Capitation arrangement. The report must provide the Department with HIPAA Compliant transactions, including the NCPDP, 837D File, 837I File and 837P File, prepared with claims level detail, as required herein, for all institutional and non-institutional Provider services received by Enrollee and paid by or on behalf of Contractor during a given month. Contractor shall submit administrative denials in the format and medium designated by the Department. The report must include all institutional and HCBS Waiver Services. Contractor shall submit Encounter Data such that it is accepted by the Department within one-hundred twenty (120) days after Contractor's payment or final rejection of the claim or, for services paid through a Capitation arrangement, within one-hundred twenty (120) days after the date of service. Any claims processed by Contractor for services provided subsequent to submission of an Encounter Data file shall be reported on the next Encounter Data file. **Testing.** Upon receipt of each submitted Encounter Data file, the Department shall perform two distinct levels of review: The first level of review and edits performed by the Department shall check the data file format. These edits shall include, but are not limited to the following: check the data file for completeness of records; correct

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
			sort order of records; proper field length and composition; and correct file length. To be accepted by the Department, the format of the file must be correct. Once the format is correct, the Department shall then perform the second level of review. This second review shall be for standard claims processing edits. These edits shall include, but are not limited to, the following: correct Provider numbers; valid Enrollee numbers; valid procedure and diagnosis codes; and cross checks to assure Provider and Enrollee numbers match their names. The acceptable error rate of claims processing edits of the Encounter Data provided by Contractor shall be determined by the Department. Once an acceptable error rate has been achieved, as determined by the Department, Contractor shall be instructed that the testing phase is complete and that data must be sent in production. **Production.** Once Contractor's testing of data specified above is completed, Contractor will be certified for production. Once certified for production, Contractor shall continue to submit Encounter Date in accordance with these requirements. The Department will continue to review the Encounter Data for correct format and quality. Contractor shall submit as many files as necessary, in a time frame agreed upon by the Department and Contractor, to ensure all Encounter Data are current. Records that fail the edits described above will be returned to Contractor for correction. Corrected Encounter Data must be returned to the Department for reprocessing. **Electronic data certification.** In a format determined by the Department, Contractor shall certify by the 5th day of each month that all electronic data submitted during the previous calendar month are accurate, complete and true.
Disclosure statement	Initially, annually, on request, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 CFR, Part 455.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Report of transactions with Parties of Interest	Annually	No	Contractor shall report all "transactions" with a "party of interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act.
Adjudicated claims inventory summary	Monthly, no later than fifteen (15) days after the close of the reporting month	No	Contractor shall report the number of claims Contractor adjudicated by claim type, in-network and out-of-network break out, and the number the claims took to process.
Compliance certification	Annually, no later than July 1	No	Contractor shall submit a Certification confirming that Contractor and its subcontractors are in compliance with Section 9.2 and each subsection thereof.
Enrollee Materials			
Certificate of Coverage, Description of Coverage, and any changes or amendments	Initially and as revised	Yes	Contractor shall submit the Certificate of Coverage and Description of Coverage for Prior Approval that comply with the Managed Care Reform and Patient Rights Act (215 ILCS 134) and the Illinois Administrative Code, Title 50, Chapter 1, Subchapter kkk, Part 5421.
Enrollee Handbook	Initially and as revised	Yes	Contractor shall submit an Enrollee Handbook for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Identification Card	Initially and as revised	Yes	Contractor shall submit the Enrollee identification card for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Provider Directory	Initially and as changes occur	Yes	Contractor shall submit separate Provider Directories that are on Contractor's website for Prior Approval. Provider updates shall not be required to be submitted for Prior Approval.
Provider Directory Attestation	Monthly	No	Contractor shall submit an attestation that they have met the provider directory requirements in 305 ILCS 5/5-30.3(b)(1) and 305 ILCS 5/5 30.1(f)(2).

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Fraud and Abuse			
Fraud and Abuse Referral	Immediately upon notification or knowledge of suspected Fraud and Abuse	N/A	Contractor shall report all suspected Fraud and Abuse to the Department as required in Article V and Article IX of this Contract. Contractor shall provide a preliminary investigation report as each occurrence is identified.
Fraud and Abuse Report	Quarterly	No	Contractor shall provide a summary report of referrals made and program integrity activities conducted in the previous quarter.
Recipient Verification Procedure	Initially, annually and as revised	Yes	Contractor shall submit Contractor's plan for verifying with Enrollees whether services billed by Providers were received, as required by 42 CFR 455.20, for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in information conveyed. This does not need to be provided to the Department separately by population.
Recipient Verification Results	Annually and within ten (10) Business Days after the Department's request	No	Contractor shall submit a summary of the results of the Recipient Verification Procedure.
Fraud and Abuse Compliance Plan	Initially and annually	Yes	Per 42 CFR 438.608, Contractor shall submit its compliance plan designed to guard against Fraud and Abuse to the Department for Prior Approval. This does not need to be provided to the Department separately by population.

Name of report/submission	Frequency	HFS Prior Approval	Report description and requirements
Marketing			
Marketing Gifts and Incentives	Initially and within ten (10) Business Days after the Department's request	Yes	Contractor shall submit all plans to distribute gifts and incentives, as well as description of gifts and incentives, for Prior Approval.
Marketing Materials	Initially and as revised	Yes	Contractor shall submit all Marketing Materials for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Marketing Plans and Procedures	Initially and as revised	Yes	Contractor shall submit descriptions of proposed Marketing concepts, strategies, and procedures for Prior Approval.
Community Outreach Events	Monthly, by the last day of the reporting month	No	Contractor shall submit to the Department a list of all previously approved community outreach events that occurred during the submission month. The report must include the Event name, date, time, address/location, county, audience type, estimated number of attendees and date of Department approval.

Provider Network			
Primary care Provider, Hospital, and Affiliated Specialist File (CEB Provider File)	No less often than weekly	Yes	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's PCPs, Hospitals and Affiliated Specialists. The primary care Providers must include, but not limited to, the following information: • Provider name, Provider number, office address, and telephone number; • Type of specialty (e.g., family practitioner, internist, oncologist, etc.), subspecialty if applicable, and treatment age ranges; • Identification of Group Practice, if applicable; • Geographic service area, if limited; • Areas of board-certification, if applicable; • Language(s) spoken by Provider and office staff; • Office hours and days of operation; • Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.); • Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.); • PCP indicator; • Primary care Provider gender and panel status (open or closed); and • Primary care Provider hospital affiliations, including information about where the primary care Provider has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Site Closures/Terminations	As each occurs	No	Contractor shall submit Provider Site Closures/termination reports, in a format and medium designated by the Department.
Provider Grievance-Resolution System and Procedures	Initially and as revised	Yes	Contractor shall submit details of its Provider Grievance-resolution system and related procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Summary of Provider Complaints and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Complaints filed by Providers. Reporting shall include total Provider Grievances per/1,000 Enrollees. The report shall include a summary count of any such Provider Complaints received during the reporting period.

Provider network file (complete)	Monthly	No	Contractor shall submit to the Department or its designee, in a format and medium designated by the Department, an electronic file of Contractor's full provider network.
Pharmacy Formulary Attestation	Annually	No	Contractor shall submit an attestation that they have met pharmacy formulary requirements in 305 ILCS 5/5-30(b)(1).
Quality Assurance/medical			
Grievance and Appeals Procedures	Initially and as revised	Yes	Contractor shall submit Grievance and Appeals Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed.
Summary of Grievances, Appeals and Resolutions and External Independent Reviews and Resolutions – Summary Report	Quarterly	No	Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of quality of care, access to care, medical necessity reviews, transportation, Long Term Services and Supports (LTSS), mental health and substance use disorder parity, and "Other" issues. Reporting shall include total Grievances and Appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Contractor shall report on Covered Services and include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved, and whether the Appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services. Contractor shall also report Grievances and Appeals separately for the categories of: Nursing Facility Services; Persons who are Elderly; Assisted Living, Supportive Living Program; Persons with Physical Disabilities; Persons with HIV/AIDS; and Persons with Brain Injury. The report shall only include Grievances and Appeals related specifically to LTC and Waiver services and providers.

Quality Assurance, Utilization Review and Peer Review (QA/UR/PR) Annual Report / Program Evaluation	Annually, no later than ninety (90) days after close of reporting period	No	Contractor shall submit a QA/UR/PR Annual Report/Program Evaluation reviewing the effectiveness of Contractor's QAP. The summary shall contain Contractor's processes for Quality Assurance, utilization review and peer review. This report shall include a comprehensive description of Contractor's network and an annual work-plan outlining Contractor's intended activities relating to QA, utilization review, peer review and health education. Contractor may submit one report that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
QA/UR/PR Committee Meeting Minutes	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the minutes of its QA/UR/PR Committee meetings.
QA/UR/PR and Health Education Plans	Initially and as revised	Yes	Contractor shall submit the Quality Assurance, Utilization Review, Peer Review and Health Education Plans for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas, activities and performance data that differ among care coordination programs.
Conditions Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit the aggregate count of the primary health conditions of its Enrollees and their associated risk levels. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
Care Management and Disease Management Program Descriptions	Initially and as revised	Yes	Contractor shall submit the descriptions of its Care Management and Disease Management programs for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor shall identify all areas in its CM/DM program that differ among care coordination programs.

Care Coordination effectiveness Summary Report	Monthly	No	Contractor shall track Enrollees based on enrollment date and show the data points of initial screenings completed, comprehensive assessments completed, Enrollee care plans completed, opt outs (Enrollees who declined Care Management), and attempting to locate. Contractor shall report separately for the categories of: Families and Children; Persons with Developmental Disabilities; Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; Assisted Living, Supportive Living Program; LTC; Behavioral Health (by primary diagnoses, including Substance Abuse); ACA Adult; and High-Needs Children. Contractor shall also report on all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including a count of those who are risk-stratified, in process of stratification, attempting to locate, opt out of care management, high ED utilizers, and the percentage of Enrollees at each level. Contractor shall provide summary data for each of the categories listed above.
Care Gap Plan	Annually	No	Contractor shall submit its plan for ensuring provision of services missed by Enrollees, including, but not limited to, annual preventive exams, immunizations, women's healthcare, PAP and missed services for Chronic Health Conditions and Behavioral Health follow-up. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor must clearly identify program-specific activities.
Outreach Summary Report	Quarterly	No	Contractor shall submit a summary report that shows Enrollee outreach for each level of stratification and for top ED utilizers. Enrollees' risk levels will be determined by which level they are in the end of the quarter. Contractor shall report separately for the categories of: Persons with Disabilities; Persons with Brain Injury; Persons with HIV/AIDS; Persons who are Elderly; LTC; and Assisted Living, Supportive Living Program.
Prior Authorization Report	Monthly	No	Contractor shall submit turnaround times for routine, expedited and pharmacy prior authorizations for its Enrollees, by operating region, provider size, and provider type

HEDIS® and State-Defined Plan Goals	Quarterly	No	Contractor shall submit a HEDIS® measures report that is based on the Performance Measures required by this Contract, and that includes HEDIS® measures, modified HEDIS® measures, and State defined measures. This report shall include the numerator, denominator and rate for each measure and will display information in a manner that includes trending data, based on previous quality indicators.
Physician Quality Measurement Report	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report for each Provider or Provider group that shows actual performance relative to measures of performance.
Enrollee Profiles/ Statistics for Care Integration	As needed, and within ten (10) Business Days after the Department's request	No	Contractor shall submit a report that provides comprehensive information on Contractor's care integration systems for Enrollees' care. This report shall include, but not be limited to, an annual summary of physical and behavioral health conditions, service utilization such as primary care Provider and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.
Processes and Procedures to Receive Reports of Critical Incidents	Initially and as revised	Yes	Contractor shall submit Critical Incident Processes and Procedures for Prior Approval. Contractor shall not be required to submit format changes for Prior Approval, provided there is no material change in the information conveyed. Contractor may submit one set of processes and procedures that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Critical Incidents – Detail Report	Monthly	No	Contractor shall submit a detailed report on Critical Incidents providing Enrollee name, Enrollee Medicaid number, incident summary, date received, source, incident date, date referred, referral entity, date resolved, and resolution summary, grouped in the following categories: Abuse; Neglect; Exploitation; and Other. Contractor shall report Critical Incidents for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and HCBS Waiver for Persons with Brain Injury.

Critical Incidents – Summary Report	Quarterly	No	Contractor shall submit a summary report on Critical Incidents that includes the total Critical Incidents and the total Critical Incidents referred. Contractor shall submit a summary count of Critical Incidents in the following categories: Abuse, Neglect, Exploitation, and Other. Contractor shall report Critical Incidents separately for each of the following: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; HCBS Waiver for Persons with Physical Disabilities; HCBS Waiver for Persons with HIV/AIDS; and, HCBS Waiver for Persons with Brain Injury. This report shall only include Critical Incidents specifically related to Enrollees receiving Long-Term Services and Supports (LTSS).
Transition of Care Plan	Initially and as revised	Yes	Contractor shall submit its Transition of Care Plan to the Department for review and Prior Approval. The Transition of Care Plan shall include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an Enrollee's care. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Cultural Competence Plan	At least two (2) weeks prior to the Department's Readiness Review	No	Contractor shall submit its Cultural Competence Plan that addresses the challenges of meeting the healthcare needs of Enrollees. Contractor's Cultural Competence Plan shall contain, at a minimum, the provisions listed in Section 2.7.2 of the Contract. Contractor may submit one plan that includes all care coordination programs in which it participates; however, Contractor shall identify all areas that differ among care coordination programs.
Executive Summary	Quarterly	No	Contractor shall submit an Executive Summary that summarizes the data within the reports submitted to the Department for that quarter (including monthly and quarterly reports). The Executive Summary shall contain, at a minimum, an analysis of the reports submitted during the quarter, an explanation of the data submitted, and highlights from the reports.

Children with Special Health Care Needs (CSHN) Plan	Initially and as revised	No	Contractor shall submit the Children with Special Health Care Needs Plan to conduct timely identification and screening, comprehensive assessments, and appropriate case management services for any CSHN.
Provider-preventable Conditions Report	Quarterly	No	Contractor shall report provider-preventable conditions that are identified in the State Plan to the Department.
Utilization Review			
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of Inpatient and Emergency Services utilization. Inpatient services shall be based on inpatient days and be categorized as follows: Utilization for total Inpatient, Medical/Surgical, Rehabilitation, Mental Health including Substance Use, Emergency Services, and Outpatient visits. Data will be based on utilization per 1,000 Enrollees and Total utilization. Reporting for Inpatient, Emergency Services, and Outpatient visits utilization shall be divided into separate worksheets for LTC, HCBS Waiver for Persons with Developmental Disabilities, HCBS Waiver for Persons with Disabilities, HCBS Wavier for Persons with Brain Injury, HCBS Waiver for Persons with HIV/AIDS, HCBS Waiver for Persons who are Elderly, HCBS Waiver for Assisted Living, Supportive Living Program, and total population as defined by Department standards.
Pharmacy			
Pharmacy Monitoring Report	Monthly	No	Contractor shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim.

Psychotropic Review Report	Monthly	No	Contractor shall submit a summary report of Enrollees' Psychotropic medication utilization and the prescribing patterns of Providers. The report must include information on the following criteria: use of 5 or more psychotropics for 60 or more days, use of 2 or more ADHD medications for 60 or more days, use of 3 or more antidepressants for 60 or more days, use of 5 or more drugs for bipolar disorder (mood stabilizers, atypical antipsychotics, antidepressants) for 60 or more days, use of 2 or more SSRIs for 60 or more days, use of 2 or more antipsychotics for 60 or more days, use of 2 or more atypical antipsychotics for 60 or more days, and use of 2 or more benzodiazepine or benzodiazepine hypnotics for 60 or more days.
Drug Utilization Review Report	Quarterly	No	Contractor shall report its prospective and retrospective Drug Utilization Review activities to the Department.
Subcontracts and Provider agreements			
Executed Subcontracts	Initially and as revised	N/A	Contractor shall submit copies of each executed subcontract relating to an arrangement for the provision of Covered Services, but not those subcontracts for the direct provision of Covered Services. For example, a subcontract with a behavioral health or dental administrator shall be submitted to the Department, but an agreement with a therapist or dentist providing direct care to an Enrollee need not be submitted unless otherwise required or requested by the Department.
Executed Provider Agreements	Within ten (10) Business Days after the Department's request	N/A	Contractor shall submit copies of executed Provider agreements to the Department upon request.
Model Subcontracts and Provider Agreements	Initially and as revised	N/A	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, inclusive of all proposed schedules or exhibits, intended to be used therewith. Contractor shall provide the Department with any substantial revisions to, or deviations from, these model subcontracts and Provider agreements.

Value-Based Payment Arrangements	Quarterly	N/A	Contractor shall report on its progress towards enrolling its providers in arrangements that incentivize value based care. Contractor shall submit description of each model, as well number of providers, number of members, and total spend, with a breakdown of upside-only versus upside and downside risk arrangements for each. Breakdown outlined above shall be reported by region.
Business Enterprise Program Act for Minorities, Females and Persons with Disabilities			
BEP Report	Quarterly and annually	N/A	Contractor shall submit the information required in Section 2.9 of the Contract.

External Quality Review (EQR) Workplan
January 1, 2017 – December 27, 2018

Activities	2017												2018											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
4.3.1.1.1. Administrative Compliance Audit – Includes, FHP/ACA, ICP, MMAI and MLTSS																								
12 Health Plans																								
Meeting with HFS to review the standards and timeline																								
Forward Admin Review materials to health plans																								
Conduct Desk Review																								
Conduct on-site Admin Review																								
Prepare Draft Report																								
Remediation Phase																								
Final Report																								
4.3.1.2.1. Readiness Review																								
Meeting with HFS to review the Readiness Review standards and timeline																								
Forward Readiness Review materials to health plans																								
Conduct Desk Review																								

Admin Review Schedule – Included FHP/ACA, ICP and MMAI

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Conduct on-site Readiness Review																								
Prepare Draft Report																								
Remediation Phase																								
Final Report																								
4.3.1.4.1.4.1.2.1. Evaluation and Validation of Statewide Collaborative PIPs – Behavioral Health and Care Coordination																								
2 PIPs/Plan – (22 PIPs)																								
Submit PIP validation forms																								
Validate PIPs and provide technical assistance																								
Submit PIP report validation																								
4.3.1.5.1. Validation of Performance Measures – MCOs – 5 measures per program – FHP/ACA and ICP only = 95 units – NCQA Timeline Complete by June 15																								
Complete validation of performance measures for 12 health plans																								
Schedule PMV Reviews -																								
On-site Audit																								
Preliminary Report of findings																								

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	2017												2018											
Activities	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Final FAR report						↔	↔										↔	↔						
4.3.1.6.1. Annual Work Plan of Services																								
Develop and submit annual EQR work plan	↔	↔											↔	↔										
4.3.1.6.2. Summary of EQRO activities																								
Quarterly report	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4.3.1.6.3. External Quality Review Technical Report																								
Develop revised report outline as directed by HFS		↔	↔																					
Approval for revised EQR report outline				↔	↔																			
Collect EQR activities data					↔	↔	↔																	
Analysis of data and preparation of draft report									↔	↔	↔	↔												
Submit draft EQR Report													↔	↔										
Forwarded to health plans for review and comment															↔									

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Activities	2017												2018											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Submit final EQR report															↔									
Forward to CMS and post to State Website																↔								
4.3.1.7.1. Evaluation of the State Quality Strategy (QS)																								
Revise Outline																								
Conduct evaluation of QS											↔	↔	↔	↔	↔									
Revise and submit draft QS								↔	↔	↔	↔		↔	↔	↔	↔								
Submit final QS												↔	↔					↔						
4.3.1.8. Technical Assistance																								
As needed and approved by HFS	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4.3.1.9. MCO System Review Report																								
As needed and approved by HFS	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4.3.1.11. EQRO Special Projects																								
As needed and approved by HFS	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

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	2017												2018											
Activities	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
4.3.1.12.1. Corrective Action Plans Template and Oversight																								
As needed and approved by HFS																								
4.3.1.16. CAHPS Survey																								
Prepare admin. Forms and project timeline																								
Select survey sample																								
Survey administration																								
Data analysis and reporting																								
Reporting																								
4.3.1.17. Quarterly HCBS CMS Performance Measures Record Review (ICP; FHP/ACA, MMAI) – MLTSS reviews will begin in Q1 SFY 2018																								
Conduct on-site record review																								
Prepare and submit quarterly reports to HFS and Plans																								
Prepare and submit annual reports																								

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Activities	2017												2018											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
4.3.1.17. Quarterly HCBS CMS Performance Measures Record Review Reporting (ICP; FHP/ACA, MMAI)																								
Schedule and conduct on-site record reviews and submit plan-specific reports to HFS and plans	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Prepare and submit quarterly reports to HFS and Plans			↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		
Prepare and submit annual reports											↔	↔										↔	↔	
Prepare data file and submit to HFS for CMS reporting											↔	↔										↔	↔	
Prepare and submit PowerPoint presentation												↔	↔										↔	↔
4.3.1.19. Network Capacity Reviews – Current SOW																								
NCR update from MCOs	↔	↔	↔				↔	↔	↔				↔	↔	↔				↔	↔	↔			
Quarterly submission and network analysis	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Report findings of quarterly network analysis to HFS and plans.			↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		
Submit Quarterly Network Validation Report to HFS			↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		↔	↔		

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January 1, 2017 – December 27, 2018

	2017												2018											
Activities	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
4.3.1.19. LTSS Staffing Reviews																								
Forward Staffing Workbook to health plans																								
Conduct staffing analysis																								
Prepare and submit staffing report																								
4.3.1.20 – Provider Network Capacity Reviews – Time/Distance Analysis																								
Meetings with HFS to develop scope of the network capacity review																								
Submit scope of work for review and approval																								
Receive network data																								
Receive enrollment data																								
Analyze time/distance standards																								
Prepare time/distance report																								

External Quality Review (EQR) Workplan
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Activities	2017												2018											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
4.3.1.21 – Validation of MLTSS Pay for Performance (P4P) Measures																								
Schedule reviews														↔	↔									
Conduct validation of measures																		↔	↔					
Prepare final report																				↔	↔			
4.3.1.22 – MMAI Validation of Withhold Performance Measures – 3 measures/plan																								
Schedule reviews	↔	↔											↔	↔										
Conduct validation of measures			↔	↔										↔	↔									
Prepare final report					↔	↔									↔	↔								
4.3.1.24 – MMAI Quality Improvement Plans (QIPs) – 2 QIPs/plan																								
Plans submit QIPs to HPMS	↔	↔											↔	↔										
Validate QIPs			↔	↔											↔	↔								
Prepare and submit QIP validation Report				↔	↔											↔	↔							
4.6. Monthly Teleconference Meetings																								
Conduct monthly teleconferences										↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

External Quality Review (EQR) Workplan
January 1, 2017 – December 27, 2018

Activities	2017												2018											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
4.6. Quarterly On-site Meetings																								
Conduct quarterly meetings																								
4.6. Onsite Quality Assurance Meeting with Stakeholders, providers, and MCOs, for both FHP/ACA and ICP to discuss Quality Strategy																								
Conduct QA meeting – (Meeting will be scheduled to coincide with one of the quarterly meetings)																								
4.3.1.5.4. Validation of Performance Measures Audit- PCCM and CHIPRA																								
Develop timeline																								
Conduct validation																								
Prepare report																								
Consumer Report Card																								
Develop and approve methodology																								
Obtain health plan data																								
Prepare and Submit Report Card																								

I. State Standards for Access to Care

A. Standards for access to care are as stringent as those in 42 CFR 438.206–438.210, as detailed below:

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
1. Availability and accessibility of all covered services	• Covered services are available and accessible to enrollees, in sufficient amount, scope and duration to achieve the purpose of the service. • Covered services are detailed in the contract. • MCOs are required to provide for all medically necessary services covered under the contract. • MCOs must comply with "medically necessary," as defined in the contract. • MCOs must establish mechanisms to ensure compliance of access standards (availability and accessibility), taking corrective action, as needed. • MCOs may not impose any financial requirement or treatment limitation, aggregate lifetime or annual dollar limit, or non-quantitative treatment limitation for mental health or substance use disorder benefits.	HealthChoice Model Contract, Article I, Definitions; Article V, 5.1, 5.2, 5.2.1, 5.2.1.1, 5.2.1.2, 5.2.1.3, 5.8.10 to 5.8.10.6 89 Ill. Adm. Code, Part 140 42 CFR 438.206 42 CFR 438.210
a) Network of appropriate providers	• MCOs maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract and meet the health care and service needs of enrollees. • MCOs participate in HFS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, with monitoring of providers to ensure compliance.	HealthChoice Model Contract, Article V, 5.7.1 42 CFR 438.207
b) Primary Care Provider	• Enrollees have a choice for their Primary Care Provider.	HealthChoice Model Contract, Article I, Definitions; Article V, 5.8.5

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
		42 CFR 438.208
c) Women's Health Care Provider	• Female enrollees have a choice of a Women's Health Care Provider or direct access to a women's health care provider within the network for covered services necessary to provide women's routine and preventive health care services.	HealthChoice Model Contract, Article I, Definitions; Article V, 5.8.5 42 CFR 438.208
d) Second opinion	• An enrollee may request and receive a second opinion from a qualified Provider, whether Network or non-Network, at no cost to the Enrollee. MCOs have written policies and procedures governing second opinion processes and mechanisms in place for compliance.	HealthChoice Model Contract, Article V, 5.1 42 CFR 438.206
e) Out-of-network providers and non-affiliated providers f) Coordination of out-of-network providers	• MCOs must arrange for covered services through their network of affiliated providers. • MCOs must provide covered services outside of network, timely and adequately, if unavailable within the network. • MCOs must have policies, procedures and mechanisms in place governing out-of-network providers and services to include, without limitation, verification, authorization, as appropriate, screening, coordination and payment.	HealthChoice Model Contract, Article II, 2.6 Article V, 5.7.6 42 CFR 438.206
g) Credentialed providers	• MCOs verify that their providers are enrolled in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) credentialing and re-credentialing system.	HealthChoice Model Contract, Article V, 5.9.1 (410 ILCS 517/) Health Care Professional Credentials Data Collection Act 42 CFR 438.206 42 CFR 438.214

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
h) Timely access	• MCOs must meet and require their providers to meet HFS' standards for timely access to care and services, taking into account the urgency of the need for services (Refer to the *Other Department Requirements Related to Access* listed below). • MCOs ensure that their providers offer hours that are no less restrictive than the hours of operation for fee-for-service program participants (or the MCO's commercial population). • Services must be available 24 hours per day, 7 days a week, when medically necessary. • MCOs must have mechanisms in place to monitor their providers to determine compliance with access standards, taking appropriate corrective action, if needed.	HealthChoice Model Contract, Article V, 5.8.3, 5.8.4 42 CFR 438.206
i) Cultural considerations	• MCOs must implement a Cultural Competence plan and must promote the delivery of services in a culturally competent manner to all enrollees.	HealthChoice Model Contract, Article I, Definitions; Article II, 2.7 to 2.7.2.13 Article V, 5.10.3, 5.21.4, 5.21.4.2, 5.21.4.4 42 CFR 438.206

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
2. Assurances of adequate capacity and services	• MCOs must demonstrate through assurances and documentation that they have the capacity to serve the expected enrollment in their service areas. • MCOs are required to submit documentation of the network of providers, timely, at the time the MCO enters into a contract; when changes occur; monthly; when the MCO enrolls a new population, covers a new service geographic area or makes changes in benefits or payments.	HealthChoice Model Contract, Article IV, 4.15.1 Article V, 5.7.1.1 42 CFR 438.207
a) Offers an appropriate range of services b) Maintains a sufficient network of providers	• MCOs maintain the capacity and service delivery for all covered services with an appropriate range of preventive services, primary care, Behavioral Health, and specialty services adequate to meet the needs of enrollees. • The MCO's provider network remains sufficient in numbers, mix and geographic distribution, with ongoing MCO monitoring of availability and accessibility.	HealthChoice Model Contract, Article IV, 4.15.2 42 CFR 438.207

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
3. Coordination and continuity of care a) Ongoing source of primary care b) Coordinate services c) Prevent duplication d) Protect enrollees' privacy e) Continuity of Care	• MCOs are required to provide primary care and coordination of health care for all procedures. • MCOs are required to ensure each enrollee has an ongoing source of primary care to meet his or her health needs and a person designated as primarily responsible for coordinating health care services. • MCOs share with other providers serving the enrollees with special health care needs the results of their identification and assessment of that enrollee's needs to prevent duplication. • MCOs are required to ensure that they have a process for coordinating care and that each enrollee's privacy and confidentiality is protected. • MCOs are required to implement mechanisms for identifying, assessing and producing a treatment plan for enrollees with special health care needs. • MCOs assume responsibility for preexisting conditions. • MCOs will manage Transition of Care and Continuity of Care for new enrollees and enrollees moving from an institutional setting to a community setting. • MCOs arrange for continuity of treatment if enrollee is inpatient at the time coverage terminates. • MCOs are required to coordinate with other service providers such as community behavioral health providers, WIC, Head Start, Early Intervention, public health providers, local health departments, school-based clinics and school systems, to the extent allowed by enrollee consent. • MCOs must provide case management services which coordinate and monitor the care of members with specific diagnoses or who require high-cost or extensive services.	HealthChoice Model Contract, Article I, Definitions; Article V, 5.18.1 through 5.18.1.6, 5.19 to 5.19.1.2.5, 5.19.4 through 5.19.6, 5.19.9 Attachment XI, 1.1.3.1.4.1 Attachment XXI, 3.1.4 42 CFR 438.208 42 CFR 438.210 45 CFR parts 160 and 164 subparts A and E

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
f) Additional services for persons with special health care needs (SHCNs)	• MCOs shall offer pregnant Enrollees and Enrollees with Chronic Health Conditions, disabilities, or special health care needs the option of choosing a specialist to be their PCP. • If an Enrollee is homebound or has significant mobility limitations, MCO shall provide access to primary care through home visits by Providers to support the Enrollee's ability to live as independently as possible in the community. • MCOs are required to have a comprehensive network which includes specialists and subspecialists to meet the needs of the Enrollees. • For Enrollees with special healthcare needs who require an ongoing course of treatment or regular care monitoring, MCO must provide mechanism for Enrollee to directly access specialists, as appropriate for the conditions and needs. • MCO must provide Children's Behavioral Health Services to all enrolled Children who meet eligibility criteria.	HealthChoice Model Contract, Article V, 5.7.10, 5.7.12, 5.8.6, 5.8.7 Attachment XXI, 3.1.3.17 42 CFR 438.208 45 CFR parts 160 and 164 subparts A and E

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
4. Coverage and service authorization	• MCOs provide services in amount, duration and scope, as medically necessary, as defined and required by the contract, and sufficient to achieve its purpose. • MCO shall ensure parity in mental health and substance abuse disorder benefits. • MCOs shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the type of illness, diagnosis or condition of the enrollee or place limits on service (outside of medical necessity) for utilization control. • MCOs must follow written procedures for processing requests for initial and continuing authorizations of covered services with mechanisms in place to ensure consistent application of review criteria. • MCOs consult with the enrollee's requesting provider, as appropriate. • MCOs assure that any decision to deny request or to authorize a service in an amount, duration or scope that is less than requested, is made by a health care professional with clinical expertise in treating the enrollee's condition or disease, with notification to the requesting provider and written notice to the enrollee. • MCO's time frame for providing notices meets the requirements for standard and expedited authorizations. • MCO's utilization management activities may not be structured to provide incentives for denying, limiting or discontinuing medically necessary services.	HealthChoice Model Contract, Article V, 5.1, 5.8.10, 5.19.7, 5.19.8, 5.19.9 42 CFR 438.210 42 CFR 438.404 89 Ill. Adm. Code, Part 140 59 Ill. Adm. Code, Part 132

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Provider Networks:	Minimum Network Requirements: • MCO shall establish, maintain and monitor a Provider Network, including PCPs, WHCPs, specialist Physicians, clinical laboratories, dentists, OB/GYNs, oral surgeons, pharmacies, behavioral-health providers, substance-abuse providers, CMHCs, and all other provider types, that is sufficient to provide adequate access to all covered services under the contract, taking into consideration: ▪ The anticipated number of enrollees; ▪ The expected utilization of services, in light of the characteristics and health care needs of MCO's enrollees; ▪ The number and types of providers required to furnish the covered services; ▪ The number of network providers who are not accepting new patients; and ▪ The geographic location of providers and enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for enrollees with disabilities. • All physicians who are Network Providers must have and maintain admitting privileges, and as appropriate, delivery privileges at hospital that is a Network Provider. In lieu of having admitting and delivery privileges, the physicians shall have and maintain a written referral agreement with a physician who is in the network and who has such privileges at a hospital that is a Network Provider. • MCOs shall regularly report on their provider network (Refer to Attachment 2: Summary of Required Reports and Submissions).	HealthChoice Model Contract, Article V, 5.7, 5.32.2.2 42 CFR 438.207(b)(2) Social Security Act, Section 1932(b)(7)

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Primary Care Provider-to-Enrollee Ratio	• For the Families and Children Population and ACA Adult Enrollees, MCO's maximum PCP panel size shall be eighteen hundred (1,800) Enrollees. An additional maximum of nine hundred (900) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant and advanced practice nurse who is 100% FTE. • For Seniors and Persons with Disabilities Enrollees, MCO's maximum PCP panel size shall be six hundred (600) enrollees. An additional maximum of three hundred (300) of such Enrollees is allowed for each resident Physician, nurse practitioner, Physician assistant and advanced practice nurse who is 100% FTE. • If MCO does not satisfy the PCP requirements set forth above, MCO may demonstrate compliance with these requirements by demonstrating that (i) MCO's full time equivalent PCP ratios exceed ninety percent (90%) of the requirements set forth above, and (ii) that covered services are being provided in the contracting area in a manner which is timely and otherwise satisfactory. MCO shall comply with Section 1932(b)(7) of the Social Security Act.	HealthChoice Model Contract, Article V, 5.8.8 42 CFR 438.207(b)(2) Social Security Act, Section 1932(b)(7)
Emergency Care	• Emergency services may be provided by a Network or non-Network provider. • No prior approval requirements for emergency care are allowed. • Coverage when the enrollee is out of contracting area is required for emergency care. • MCOs are required to provide enrollees with ongoing education regarding the appropriate use of emergency services. • MCOs may not condition coverage on the treating provider's notification within 10 calendar days of presentation for emergency services.	HealthChoice Model Contract, Article V, 5.20.1 42 CFR 438.114
Post-stabilization Care	• Coverage for post-stabilization occurs when: authorized; administered to maintain stabilized condition within one hour of a request; the MCO does not respond within one hour; the MCO could not be contacted, or the MCO and treating provider cannot reach an agreement concerning the enrollee's care and an affiliated provider is unavailable for consultation until an affiliated provider is reached and either concurs with the treatment provider or assumes responsibility for the enrollee's care.	HealthChoice Model Contract, Article V, 5.20.1.2 42 CFR 438.114

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Travel Time and Distance	• MCOs must adhere to travel time and distance standards: ▪ Primary Care: MCO shall ensure an Enrollee has access to at least two (2) primary care Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) primary care Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. ▪ Behavioral Health: MCO shall ensure an Enrollee has access to at least two (2) Behavioral Health service Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) Behavioral Health service Provider within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. ▪ OB/GYN: MCO shall ensure an Enrollee has access to at least two (2) OB/GYN Providers within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) OB/GYN Provider within a sixty (60)–mile radius of or sixty (60)– minute drive from the Enrollee's residence. ▪ Dental access for children: MCO shall ensure an Enrollee has access to at least one (1) dentist, who serves Children, within a thirty (30)–mile radius of or thirty (30)– minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) dentist, who serves Children, within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. ▪ Hospital: MCO shall ensure an Enrollee has access to at least one (1) hospital within a thirty (30)–mile radius of or thirty (30)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) hospital within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence.	HealthChoice Model Contract, Article V, 5.8.1.1 42 CFR 438.68

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	▪ Other specialist: MCO shall ensure an Enrollee has access to at least one (1) specialty services Provider within a sixty (60)–mile radius of or sixty (60)– minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) specialty services Provider within a ninety (90)–mile radius of or ninety (90)–minute drive from the Enrollee's residence. ▪ Pharmacy: MCO shall ensure an Enrollee has access to at least one (1) pharmacy within a fifteen (15)– mile radius of or fifteen (15)–minute drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least one (1) pharmacy within a sixty (60)–mile radius of or sixty (60)–minute drive from the Enrollee's residence. ▪ LTSS: For LTSS Provider types that travel to Enrollee to deliver services, MCO shall adhere to the Department-defined standards identified.	
Appointments	• MCOs shall require that time-specific appointments for routine preventive care are available within five (5) weeks from the date of request for such care, and within two (2) weeks for infants under age six (6) months, from the date of request. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day of the request. Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of operation that are no less than the hours of operation offered to persons who are not Enrollees.	HealthChoice Model Contract, Article V, 5.8.3

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Telephone Access	• Toll-free telephone access must be available 24 hours per day, 7 days a week, 365 days per year (to confirm eligibility and seek prior approval. • Primary care and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week, and they shall have a published after-hours telephone number; voicemail alone after hours is not acceptable • Toll-free telephone access must be available no less than from 8:30 a.m.–5 p.m., regular business days (to confirm eligibility for benefits; approval of nonemergency care; enrollees to call to request site, primary care provider or women's health care provider changes; make complaints or grievances; to request disenrollment; and ask questions or receive member services).	HealthChoice Model Contract, Article IV, 4.16.1.6 Article V, 5.8.4, 5.21.6
Pharmacy Formulary	• MCOs shall provide coverage of drugs in all classes of drugs for which the Department's FFS program provides coverage and shall submit the Pharmacy Formulary for Department approval. • MCOs may determine its own utilization controls to ensure appropriate utilization, utilizing the Department's requirements for family planning drugs and devices. • MCOs shall establish and maintain a generic drug Maximum Allowable Cost dispute resolution process. • MCOs shall have a drug utilization program that includes reporting activities. • MCOs shall submit pharmacy data utilization reports based on total utilization, claims summaries, cost summaries and cost per claim. • MCOs shall submit a summary report of enrollees' psychotropic medication utilization and the prescribing patterns of Providers.	HealthChoice Model Contract, Article V, 5.3 Attachment XIII

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Family Planning Services	• MCOs shall ensure provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. • MCO policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements. Contractor shall cover and offer all Food and Drug Administration (FDA)–approved birth control methods with education and counseling on the safest and most effective methods, if clinically appropriate for a particular patient. • MCOs shall provide education and counseling for Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices. • Termination of pregnancy may be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the enrollee's medical record. Termination of pregnancy shall not be provided to enrollees who are eligible under the State Children's Health Insurance Program (215 ILCS 106). • Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and HFS Form 2189 must be completed and filed in the enrollee's medical record. • If a hysterectomy is provided, HFS Form 1977 must be completed and filed in the enrollee's medical record.	HealthChoice Model Contract, Article V, 5.5.1, 5.5.2 Attachment XXI, 3.1.3 745 ILCS 70/1 et seq. 42 CFR Part 441, Subpart E 42 CFR Part 441, Subpart F
Required Minimum Standards of Care	• All covered services shall be in accordance with current Departmental policies and prevailing professional community standards. Minimum covered services include: ▪ EPSDT Services to Enrollees under Twenty-One (21) years ▪ Preventive Medicine Schedule (Services to Enrollees Twenty-One [21] years and older)	HealthChoice Model Contract, Attachment XXI Social Security Act, 1902(a)(43) and 1905(a)(4)(B);

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	▪ Family Planning and Reproductive Healthcare ▪ Coordination with other Service Providers	

II. State Standards for Structure and Operations

A. *S*tandards for structure and operations are as stringent as those in 42 CFR 438.214 - 438.230, as detailed below:

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Performance of services and duties	• MCO shall perform all services and other duties in accordance with, and subject to, applicable Administrative Rules and Department policies including rules and regulations which may be issued or promulgated from time to time.	HealthChoice Model Contract, Article IX, 9.1.25
1. Provider selection and retention a) Credentialing and re-credentialing	• MCO shall contract with a culturally-diverse network of Providers of both genders and prioritize recruitment of bilingual or multi-lingual Providers. Provider contracts will require compliance with MCO's Cultural Competence Plan. During the credentialing and recredentialing process, MCO will confirm the languages used by Providers, including American Sign Language, and physical access to Provider office locations. • MCO shall assure that all Network Providers, including out-of-State Network Providers, are enrolled in the HFS Medical Program, if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. MCO shall make a good faith effort to give written notice of termination of a Provider as soon as practicable, but in no event later than fifteen (15) days following such termination, to each Enrollee who was served by the terminated Provider. • In accordance with 42 CFR 438.214, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in Contractor's provider network, Contractor must verify that provider is enrolled in IMPACT. On a continuing basis, MCO shall verify monitor Enrollee Complaints and Appeals, quality of care and quality of service events, and medical record review.	HealthChoice Model Contract, Article II, 2.7.4 Article V, 5.7.3.2, 5,9.1, 5.9.2, 5.9.3, 5.29, 5.32.2, 5.32.2.2 Article IX, 9.1.34, 9.1.22, 9.1.22.6 Attachment XI, 1.1.7.5, 1.1.8 (410 ILCS 517/) Health Care Professional Credentials Data Collection Act 42 C.F.R. 438.214; 422.204; 422.208; 422.210; 438.206 (b)(1)

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	• MCO shall ensure that only those Providers of Covered Services under HCBS Waivers that are approved and authorized by the State are providing such Covered Services, and that those Providers are providing only such Covered Services for which they are approved and authorized, to Enrollees. The Department will provide MCO with a weekly State extract file containing the list of such approved and authorized Providers. • MCO shall terminate its relations with any Excluded Person immediately upon learning that such Person or Provider meets the definition of an Excluded Person and notify the OIG of the termination. • All Physicians who are Network Providers shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is an Network Provider; or, in lieu of these admitting and delivery privileges, the Physician shall have a written Referral agreement with a Physician who is an Network Provider and who has such privileges at a hospital that is an Network Provider. The agreement must provide for the transfer of medical records and coordination of care between Physicians. • All provider agreements and subcontracts entered into by the MCO must be in writing and must specify the delegated activities, duties or obligations, including any related reporting responsibilities. • Contractor shall make payments to Providers (including the fiscal agent making payments to Personal Assistants under the HCBS Waivers; see Attachment XX) for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. • MCO shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit. • MCOs' written policies shall include procedures for selection and retention of physicians and other providers.	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	• Each MCO will provide each provider or group of providers that it declines to include in its network written notice of the reason for its decision. Nothing in the contract may be construed to require each MCO to contract with providers beyond the number necessary to meet the needs of its enrollees; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees. • No discrimination is allowed related to the population served or the cost of treatment for covered services.	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
2. Enrollee Information	• MCO shall send each new Enrollee an identification card bearing: (i) the name of MCO; (ii) the effective date of enrollment; (iii) the twenty-four (24) hour telephone number to confirm eligibility for benefits and authorization for services; and (iv) the name and phone number of the PCP. • MCO shall have written policies and provide Basic Information to the following Participants and shall notify such Participants that translated materials in Spanish and prevalent languages are available. • Basic information means the following: ▪ Types of benefits, amount, duration and scope ▪ The procedures for obtaining covered services, including authorization and referral requirements ▪ After-hours coverage and emergency services, including the definition of emergency, no prior approval requirement for emergency services, and locations ▪ Post-stabilization services ▪ Policy on referrals for specialty care and other benefits not furnished by the primary care provider ▪ How to access transportation ▪ Cost sharing, if any ▪ Rights, protections and responsibilities of enrollee, including disenrollment rights ▪ Grievance and fair hearing procedures and timeframes ▪ Appeal rights and procedures and timeframes ▪ MCO's website address and the types of information contained on the website ▪ Copy of the MCO's Certificate of Coverage or Document of Coverage and any changes or amendments	HealthChoice Model Contract, Article IV, 4.16.1, 4.16.2, 4.16.3 Article V, 5.21.1, 5.21.2, 5.21.4.1, 5.21.4.2, 5.21.4.3, 5.21.4.4 (215 ILCS 180/) Health Carrier External Review Act 42 CFR 438.10 42 CFR 438.218

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	▪ Names, locations telephone numbers and non-English languages spoken by current Affiliated Providers, including those not accepting new Enrollees ▪ Information on nursing facility covered services and HCBS waiver covered services ▪ Enrollee packets, which the MCO shall distribute to enrollees receiving covered services from Personal Assistants or other Individual Providers under HCBS waiver • Enrollees must be annually notified of their right to request and receive materials. • MCO shall make oral interpretation services available free of charge in all languages to all Potential Enrollees, Prospective Enrollees or Enrollees who need assistance understanding Key Oral Contacts or Written Materials. MCO must include in all Key Oral Contacts and Written Materials notification that such oral interpretation services are available and how to obtain such services. MCO shall conduct Key Oral Contacts with Potential Enrollees, Prospective Enrollees or Enrollees in a language the Potential Enrollees, Prospective Enrollees and Enrollees understand. • MCO's written communications with Potential Enrollees, Prospective Enrollees and Enrollees must be easily understood by individuals with, and produced at, a sixth-grade reading level. MCO will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written Materials will be presented in a layout and manner that enhances Enrollees' understanding in a culturally competent manner. • MCO shall make Key Oral Contacts and Written Materials available in such alternative formats as large print, Braille, sign language interpreters in accordance with the Interpreters for the Deaf Act (225 ILCS 442), CART reporters, audio CDs, TDD/TTY, Video Relay Interpretation or Video Relay Services, and in a manner that takes into consideration the special	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	needs of those who are visually impaired, hearing-impaired or have limited reading proficiency. MCO shall inform Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, that information is available in alternative formats and how to access those formats. MCO must provide TDD/TTY service upon request for communicating with Potential Enrollees, Prospective Enrollees and Enrollees who are deaf or hearing impaired. • MCO shall make all Written Materials distributed to English-speaking Potential Enrollees, Prospective Enrollees and Enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the Department. Where there is a prevalent single-language minority (5%) within the low-income households in the relevant DHS local office area MCO's Written Materials provided to Potential Enrollees, Prospective Enrollees or Enrollees must be available in that language as well as in English.	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
2. Confidentiality	• MCO shall protect the confidentiality and privacy of enrollees and abide by all Federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollee. • No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract. • MCO shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to Providers, facilities, and associations, shall be protected from unauthorized disclosure by MCO and MCO's employees, by MCO's corporate Affiliates and their employees, and by MCO's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E.	HealthChoice Model Contract, Article V, 5.26.3 Article IX, 9.1.6, 9.1.21 305 ILCS 5/11.9; 5/11.10 and 5/11.12 42 U.S.C. 654(2)(b) 42 CFR part 431, Subpart F 45 CFR part 303.21 42 CFR 438.224 42 CFR 422.118 45 CFR Parts 160 and 164 Subparts A and E

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
3. Enrollment and Disenrollment	• All potential enrollees who live in the Contracting Area shall be required to become an enrollee in a health plan, except those potential enrollees who, pursuant to federal law, are subject only to voluntary enrollment or are part of an excluded population. • The Illinois Client Enrollment Service (ICES) shall be responsible for the enrollment of Potential Enrollees, including the provision of all health care plan choice education, enrollment by active choice, and enrollment by auto-assignment. • All Potential Enrollees will have an opportunity to freely choose, from among the available MCOs, the one in which they want to enroll. • A potential enrollee who does not select an MCO will be auto-assigned to an MCO by the Illinois Client Enrollment Service (ICES). The enrollee may change his/her MCO plan on a monthly basis. During the initial ninety (90) calendar days after the effective date of enrollment, whether the enrollee actively selected the MCO or was auto-assigned, the enrollee shall have the opportunity to change MCOs. The enrollee shall not be allowed to change MCOs again until the open enrollment period. • An enrollee may request, orally or in writing, to disenroll from MCO at any time for any of the following reasons: (i) the enrollee moves out of the contracting area; (ii) Contractor, due to its exercise of Right of Conscience, does not provide the covered service that the enrollee seeks; (iii) the enrollee needs related covered services to be performed at the same time, not all of the related services are available through MCO, and the enrollee's PCP or other provider determines that receiving the services separately would subject the enrollee to unnecessary risk; (iv) when a change in enrollee's LTSS provider from a network to a non-network provider results in a disruption to residence or employment; or (v) other reasons, including, poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with the enrollee's health care needs, or, if automatically re-enrolled and such loss of coverage causes the enrollee to miss the open enrollment period.	HealthChoice Model Contract, Article IV, 4.1, 4.2, 4.3, 4.4, 4.10.1, 4.10.3.2, 4.14.1.3, 4.14.5, 4.14.6 42 CFR 438.54 42 CFR 438.56

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	• MCOs may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior as a result of his or her special needs, or as an action in connection with exercising his or her appeal or grievance rights. • MCOs may request disenrollment when an enrollee no longer resides in the MCO's contracting area, with adequate documentation that the enrollee no longer resides in the area.	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
4. Grievance Systems	• MCO shall have a formally structured Grievance system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 C.F.R. Parts 431 Subpart E and 438 Subpart F to handle all Grievances and Appeals subject to the provisions of such sections of the Act and regulations. • MCO shall establish and maintain a procedure for reviewing Grievances by an Enrollee or an Enrollee's authorized representative. A Grievance may be submitted orally or in writing, and all Grievances shall be registered with MCO. MCO's procedures must: (i) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action. • MCO shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) calendar days from receipt of grievance. Plan may inform Enrollee of resolution orally, written or both. • An Enrollee may appoint any authorized representative, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Grievance process. MCO shall provide a form and instructions on how an Enrollee may appoint a representative. • MCO shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances and the responses to and disposition of those matters. • MCO shall establish and maintain a procedure for reviewing Appeals by Enrollees or an Enrollee's authorized representative pursuant to 42 CFR 438 subpart F. An Appeal may be submitted orally or in writing, and all Appeals shall be registered initially with MCO and may later be appealed to the State. MCO's procedures must: (i) be submitted to the Department in writing and approved in writing by the Department; (ii) provide for resolution within the times specified, (iii) provide for only one level of appeal, and (iv) assure the participation of individuals with authority to require corrective action. MCO must have a committee in place for reviewing Appeals made by Enrollees.	HealthChoice Model Contract, Article V, 5.30, 5.30.1, 5.30.2, 5.30.3 42 CFR Part 431, Subpart E 42 CFR Part 438, Subpart F 42 CFR 438.228 42 CFR 438.400 42 CFR 438.402 42 CFR 438.404 42 CFR 438.406 42 CFR 438.408 42 CFR 438.410 42 CFR 438.416 42 CFR 438.420 42 CFR 438.424 (215 ILCS 180/) Health Carrier External Review Act Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.)

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	• An Enrollee may file an oral or written Appeal within sixty (60) calendar days following the date of the notice of Action that generates such Appeal. If the Enrollee does not request an expedited Appeal pursuant to 42 CFR 438.410, MCO may require the Enrollee to follow an oral Appeal with a written, signed Appeal. • An Enrollee may appoint any authorized representative, including a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Appeal process. MCO shall provide a form and instructions on how an Enrollee may appoint a representative. • If an Enrollee requests an expedited Appeal pursuant to 42 CFR 438.410, MCO shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that MCO requires to evaluate the Appeal. MCO shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. • If an Enrollee does not request an expedited Appeal, MCO shall make its decision on the Appeal within fifteen (15) business days after submission of the Appeal. MCO may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension, or if MCO demonstrates to the satisfaction of the appropriate state agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest. • Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its Fair Hearings system within one hundred twenty (120) calendar days after the date of the MCO's Decision Notice. • Except for a denial of Waiver services, which may not be reviewed by an external independent entity, MCO shall have procedures allowing an Enrollee to request an external independent review, both standard and expedited timeframes, of Appeals that are denied by MCO within thirty (30) calendar days after the date of the MCO's Decision Notice.	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	• If an Appeal is filed with the State Fair Hearing system, MCO will participate in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of MCO. • If MCO or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services, and those services were not furnished while the Appeal was pending, MCO must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires. • If MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending, MCO must pay for those services, in accordance with State policy and regulations. • If an Enrollee files an Appeal within ten (10) calendar days after the date of a notice of Action from MCO and the Enrollee asks to have their benefits continued during the Appeal process, MCO must continue the Enrollee's benefits during the Appeal process. Pursuant to 42 CFR 438.420, if the final resolution of the Appeal is adverse to the Enrollee, MCO may recover the cost of the services that were furnished to the Enrollee. • MCO shall submit to the Department, in the format required by the Department, a quarterly report summarizing all Appeals filed by Enrollees and the responses to and disposition of those matters (including decisions made following an external independent review). • MCO shall review its Grievance and Appeal procedures at least annually for the purpose of amending such procedures when necessary. MCO shall amend its procedures only upon receiving the written Prior Approval of the Department. This information shall be furnished to the Department	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
5. Subcontractual Relations and Delegation	• All Provider agreements and subcontracts must be in writing, specifying the delegated activities, duties or obligations, including any related reporting responsibilities and scope of work. • Subcontractors and affiliated providers are bound by the terms of HFS' contract with the MCO. • MCO shall remain responsible for the performance of any of its responsibilities delegated to Affiliated Providers or subcontractors. • No Provider agreement or subcontract can terminate the legal responsibilities of MCO to the Department to assure that all the contracted activities will be carried out. • The Department reserves the right to require MCO to amend any Provider agreement or subcontract as reasonably necessary to conform to MCO's duties and obligations. • With respect to all Provider agreements and subcontracts made by MCO, MCO further warrants: ▪ That such Provider agreements and subcontracts are binding; ▪ That it will promptly terminate all contracts with Providers and Subcontractors, or impose other sanctions, if the performance of the Network Provider or Subcontractor is inadequate; ▪ That it will promptly terminate contracts with Providers that are terminated, barred, suspended, or have voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program; ▪ That all laboratory testing Sites providing services under this Contract must possess a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493; and	HealthChoice Model Contract, Article V, 5.32.2, 5.32.3, 5.32.4, 5.32.10, 5.32.11 42 CFR 438.230 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
	▪ That it will monitor the performance of all Network Providers and Subcontractors on an ongoing basis, subject each Network Provider and Subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Network Provider or Subcontractor take appropriate corrective action.	

III. State Standards for Quality Measurement and Improvement

A. Standards for quality measurement and improvement are as stringent as those in 42 CFR 438.236 – 438.242, as detailed below:

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
1. Practice/Clinical Guidelines	• The Provider Manual shall address topics such as clinical practice guidelines, availability and access standards, Care Management Programs and Enrollee rights. • All services coordinated by Contractor shall be in accordance with Departmental policies and prevailing professional community standards. • MCO shall adopt practice guidelines that meet, at a minimum, the following criteria: ▪ The clinical guidelines shall rely on credible scientific evidence published in peer reviewed medical literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and other relevant factors; ▪ Consider the needs of the Enrollees; ▪ Are adopted in consultation with Network Providers; ▪ Are reviewed and updated periodically, as appropriate; and ▪ Are available to all affected Network Providers, non-Network Providers, Enrollees and Potential Enrollees. • All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by Contractor's QAP Committee with sources referenced and guidelines documented in Contractor's QAP. Contractor's QAP shall be updated no less than annually and when new significant findings or major advancements in evidence-based best practices and standards of care are established. Contractor shall provide ongoing education to Network Providers on required clinical guideline	HealthChoice Model Contract, Attachment XI, 1.1.9 Attachment XXI, 3 42 CFR 438.236

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	application and provide ongoing monitoring to assure that its Network Providers are utilizing them.	

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
2. Quality assessment and performance improvement program	• MCO shall provide to the Department a written description of its Quality Assurance Plan (QAP) for the provision of clinical services (e.g., medical, medically related services, Behavioral Health services) and Care Coordination services (e.g., Care Management, intensive care management, perinatal care management and Disease Management). This written description must meet federal and State requirements and shall contain a detailed set of Quality Assurance objectives that are developed annually and include a workplan and timetable for implementation and accomplishment. • The scope of the QAP shall be comprehensive, addressing both the quality of clinical care and non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care. • MCOs are subject to HFS review of the effectiveness of their quality assessment performance improvement, including oversight and monitoring review by an EQRO. • MCOs measure and submit performance measurement data to HFS, as defined in the contract.	HealthChoice Model Contract, Attachment XI, 1.1.2, 1.1.2.1, 1.1.2.2 42 CFR 417.106 42 CFR 417.418(c) 42 C.F.R. 438.330
a) Performance improvement projects	• The MCO shall conduct Performance Improvement Projects (PIPs)/Quality Improvement Projects (QIPs) shall be designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustained over time, and resulting in a favorable effect on health outcome and Enrollee satisfaction. Performance measurements and interventions shall be submitted to the Department annually as part of the QA/UR/PR Annual Report and at other times throughout the year upon request by the Department. If MCO implements a PIP/QIP that spans more than one (1) year, MCO shall report annually the status of such project and the results thus far. The PIPs/QIPs topics and methodology shall be submitted to the Department for Prior Approval.	HealthChoice Model Contract, Article I, Definitions Attachment XI, 1.1.3.4 42 CFR 438.330

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
b) Performance measurement data	• MCO's Quality Assurance Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The Quality Assurance Program shall include provision for the interpretation and dissemination of such data to MCO's Affiliated Providers. The Quality Assurance Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate health care utilization, and Enrollee health status, per 42 C.F.R. 438.242 (2). MCO shall ensure that data received from Providers and included in reports are accurate and complete by: ▪ Verifying the accuracy and timeliness of reported data; ▪ Screening the data for completeness, logic, and consistency; and ▪ Collecting service information in standardized formats to the extent feasible and appropriate.	HealthChoice Model Contract Attachment XI, 1.1.13 42 CFR 438.330 Section 1915(c) of the Social Security Act
c) Detection of over- and underutilization	• MCOs are required to have mechanisms in place to detect both under- and overutilization.	HealthChoice Model Contract, Article I, 1.1.162.3 42 CFR 438.330
d) Assess quality and appropriateness of care	• MCO have an ongoing fully implemented Quality Assurance Program for health services that: ▪ Monitors the health care services MCO provides, including assessing the appropriateness and quality of care, including between care settings and comparison of authorized to delivered services for those enrollees receiving long-term services and supports; ▪ Stresses health outcomes and monitors Enrollee risks status and improvement in health outcomes;	HealthChoice Model Contract, Article 1, 1.1.162.5 Attachment XI, 1.1.1.2 to 1.1.1.19 42 CFR 438.330

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	▪ Provides a comprehensive program of Care Coordination, Care Management, and Disease Management, with needed outreach to assure appropriate care utilization and community referrals; ▪ Provides review by Physicians and other health professionals of the process followed in the provision of health services; ▪ Includes fraud control provisions; ▪ Establishes and monitors access standards; ▪ Includes written procedures for taking appropriate remedial action and developing corrective action and quality improvement whenever, as determined under the Quality Assurance Program, inappropriate or substandard services have been furnished or Covered Services that should have been furnished have not been provided; ▪ Describes its implementation process for reducing unnecessary emergency room utilization and inpatient services, including thirty (30)–day readmissions; ▪ Describes its process to assure follow-up services from inpatient care for Behavioral Health, with a Behavioral Health provider; follow up for inpatient medical care including delivery care, to assure women have access to contraception and postpartum care, or follow up after an emergency room visit; ▪ Details its process for determining and facilitating Enrollees needing nursing home, supportive living facility (SLF), or ICF/DD level of care, or to live in the community with HCBS supports; ▪ Describes its processes for addressing Abuse and Neglect and unusual incidents in the community setting; ▪ Details any compensation structure, incentives, pay-for-performance (P4P) programs, value-purchasing strategies, and other mechanisms utilized to promote the goals of Integrated Health Homes (IHHs) and accountable, coordinated care;	

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	▪ Describes its process for developing, implementing, and evaluating care plans for children transitioning to adulthood; and ▪ Provides for systematic activities to monitor and evaluate the dental services and Behavioral Health services rendered.	
e) Measure and report performance data	• MCO uses systematic data collection of performance and Enrollee results, provides interpretation of these data to its Network Providers- (including, without limitation, Enrollee-specific and aggregate data provided by the Department, such as HEDIS® and State-defined measures), and institutes needed changes; • MCO describes its process for obtaining clinical results and findings, including emergency room and inpatient care, pharmacy information, lab results, feedback from other care providers, etc., to provide such data and information to the PCP or specialist, or others, as determined appropriate, on a real-time basis; • Quality indicators are measurable variables relating to a specified clinical area, which are reviewed over a period of time to monitor the process of outcomes of care delivered in that clinical area: ▪ MCO shall identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience. ▪ MCO shall document that methods and frequency of data collected are appropriate and sufficient to detect the need for a program change. ▪ For the priority clinical areas specified by the Department, MCO shall monitor and evaluate quality of care through studies which address, but are not limited to, the quality indicators also specified by the Department. • Analysis of clinical care and related services, including behavioral health, Long-Term Care and HCBS Waiver services: Appropriate clinicians shall monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service.	HealthChoice Model Contract, Attachment XI, 1.1.1.9, 1.1.1.12, 1.1.3.2, 1.1.13, 1.1.14, 1.1.15, 1.1.16 42 CFR 438.330 Section 1915(c) of the Social Security Act

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	▪ Multi-disciplinary teams shall be used, where indicated, to analyze and address systems issues. ▪ Clinical and related service areas requiring improvement shall be identified and documented, and a corrective action plan shall be developed and monitored. • MCO's Quality Assurance Program shall systematically and routinely collect data to be reviewed for quality oversight, monitoring of performance, and Enrollee care outcomes. The Quality Assurance Program shall include provision for the interpretation and dissemination of such data to the MCO's Network Providers. The Quality Assurance Program shall be designed to perform quantitative and qualitative analytical activities to assess opportunities to improve efficiency, effectiveness, appropriate healthcare utilization, and Enrollee health status per 42 C.F.R. 438.242 (2). The MCO shall ensure that data received from Providers and included in reports are accurate and complete by (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats to the extent feasible and appropriate. The MCO shall have in effect a program consistent with the utilization control requirements of 42 CFR Part 456. This program will include, when required by the regulations, written plans of care and certifications of need of care. • MCO shall perform and report the quality and utilization measures identified in Table 1 – Performance Measures using the HEDIS® and HEDIS®-like Performance Measure Specifications methodology, as provided by the Department. MCO shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. MCO must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The	

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	Department's External Quality Review Organization will perform an independent validation of at least a sample of MCO's findings. • MCO shall perform and report the performance measures in "Table 2: Service Package II HCBS Wavier performance measures" using measure specifications methodology, as provided by the Department. MCO shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval; and • MCO shall monitor other Performance Measures as required by the Federal CMS in accordance with notification by the Department.	
f) Reporting of the status and results of projects	• MCOs are required to report the status and results of each project (Refer to HFS' Specific Performance Goals and Quality Monitoring Measures and Summary of Required Reports). • The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, shall be documented and reported to appropriate individuals within the organization and through the established QA channels. MCO shall document coordination of QA activities and other management activities.	HealthChoice Model Contract, Attachment XI, 1.1.11
f) Annual review of impact	• The Governing Body shall formally review on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quantity of services rendered, to assess the QAP's continuity, effectiveness and current acceptability. Behavioral Health shall be included in the Annual QAP Review; • There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, appeals, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of the	HealthChoice Model Contract, Attachment XI, 1.1.3.7, 1,1.4.4, 1.1.7.4, 1.1.12 42 CFR 438.330

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	annual audit shall be submitted to the Department as part of the QA/UR/PR Annual Report; • At least annually, MCO shall conduct a regular examination of the scope and content of the QAP to ensure that it covers all types of services, including Behavioral Health services, in all settings, through an Executive Summary and Overview of the Quality Improvement Program, including Quality Assurance (QA), Utilization Review (UR) and Peer Review (PR). At the end of each year, a written report on the QAP shall be prepared by MCO and submitted to the Department as a component part of the QA/UR/PR Annual Report. The report shall include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement. • MCO shall, at the direction of the Department, cooperate with the external, independent quality review process conducted by the EQRO. MCO shall address the findings of the external review through its Quality Assurance Program by developing and implementing performance improvement goals, objectives and activities, which shall be documented in the next quarterly report submitted by MCO following the EQRO's findings.	

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
Quality Assurance/Utilization Review/Peer Review Committee(s)	• MCOs are required to comply with HFS requirements and federal and State regulations. • All services provided, or arranged to be provided, by MCO shall be in accordance with prevailing community standards. MCO must have in effect a program consistent with the utilization control requirements of 42 CFR §456. This program will include, when so required by the regulations, written plans of care and certifications of need of care. • MCO shall have a Utilization Management Program that includes a utilization-review plan, a utilization-review committee, and appropriate mechanisms covering preauthorization and review requirements. • MCO shall establish and maintain a Peer Review program approved by the Department to review the quality of care being offered by MCO and its employees, Subcontractors, and Network Providers. • QA/UR/PR Committees—role, functions and duties include without limitation: ▪ Develop, implement/oversee the Quality Assurance Plan ▪ Determination of the appropriateness and quality of care ▪ Make recommendations for changes, corrective action and quality improvement ▪ Report suspected fraud and abuse to the OIG ▪ Meet at least quarterly ▪ Keep minutes of all meetings and submit to HFS ▪ Prepare written Utilization Management and Peer Review Program descriptions ▪ Ensure that service decisions are documented and available to the enrollee and provider, denials in amount, duration or scope provided to the enrollee in writing	HealthChoice Model Contract, Article V, 5.22.1, 5.22.4, 5.22.5 Attachment XI, 1.1.4, 1.1.5 Attachment XII 42 CFR §456

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	▪ Make timely decisions based on monitoring complaints, grievances and appeals, with ongoing review and corrective action, as needed ▪ Evaluate the effects of the program using satisfaction surveys and other data ▪ Comprise network physicians and include a medical record review and peer review process ▪ Review the QA/UR/PR Plan at regular intervals, but no less than annually	
Quarterly Performance Payment (P4P)	• The Department shall apply a Withhold, defined as a Withhold Arrangement under 42 CFR 438.6(a), percentage of total Capitation rates each month. The withheld amount will be one percent (1%) in the first measurement year, one-and-one-half percent (1.5%) in the second measurement year, and two percent (2%) in the third and subsequent measurement years. Contractor may earn a percentage of the Withhold based on its performance with respect to a Department-determined combination of: (i) quality metrics set forth in Attachment XI; (ii) operational and implementation metrics as defined and published on the Department's website. The Department and Contractor will agree to the measures through a counter-signed letter annually. The letter will include any weighting assigned to quality, operational or implementation metrics as it relates to the withhold.	HealthChoice Model Contract, Article 7, 7.9.1

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
3. Health Information System	• MCOs are required to have in place a health information system that collects, analyzes, integrates and reports data. • The system must provide information on areas including utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. • MCOs must maintain a HIPAA-compliant health information system that collects data on enrollee and provider information and services it furnishes through encounter data. • MCOs must submit all encounter data to HFS. • MCOs must ensure that data received from providers and submitted to HFS are accurate and complete through verification of accuracy and timeliness; screening for completeness, logic and consistency; collecting data from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and Care Coordination efforts; and collecting service information in standardized formats, to the extent possible. • MCO shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of this subpart, taking into account those factors specified in 45 CFR §164.306(b)(2)(i), (ii), (iii), and (iv) [the Security Standards: General Rules, Flexibility of Approach]. • MCO shall meet the ASC X12 5010 electronic transaction standards, including eligibility (270/271), claim status (276/277), referrals/authorizations (278), claims (837), and remittances (835). • HFS provides the MCOs with feedback from encounter data on key performance measures and indicators to MCOs as part of ongoing feedback and requirement for quality improvement, as appropriate.	HealthChoice Model Contract, Article V, 5.27, 5.28 Attachment XIV 42 CFR 438.240 42 CFR 438.242 45 CFR 164.530(j) 45 CFR 164.306(b)(2)(i),(ii),(iii),(iv)

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
	• HFS uses its data system to evaluate certain requirements, including without limitation, provider network adequacy, enrollment, encounter data submission compliance and utilization. • All data will be available upon request to CMS.	

Additional Information Related to the Quality Measurement and Improvement Standards

1. Procedures to assess the quality and appropriateness of care and services to all Medicaid participants
2. Procedures to assess the quality and appropriateness of care and services furnished under the MCO to all enrollees
3. Description of HFS' information system and how it supports the quality strategy

HFS will assess the quality and appropriateness of care and services provided to enrollees by review of key indicators through an analysis of administrative data and comparison to benchmarks; review of reports related to the quality assurance component of managed care; EQRO evaluations; customer satisfaction analysis; a review of the MCO's own findings; and through the performance of other assessments (e.g., network adequacy review, client complaints and resolutions/MCO responsiveness). HFS' specific performance goals and quality monitoring measures required by the contract are detailed below. Each MCO will receive aggregate MCO and fee-for-service data for comparison with their own data. These data includes capture of other than MMIS sources for data (e.g., immunization tracking systems). HFS supplies each MCO with enrollee data on immunizations, well child visits, lead testing, pharmacy utilization and other data, as available. The MCOs have processes in place to disseminate the enrollee-specific data to the enrollee's primary care provider (PCP). HFS will provide ongoing feedback and monitoring of health outcomes and utilization. HFS and MCOs collaborate on an ongoing basis to standardize processes for monitoring, clinical study design and program evaluation, including without limitation, childhood immunization and lead screening studies; health education; medical record review; asthma care; and the annual customer satisfaction survey.

<table>
<tr><th colspan="3">HFS' Specific Performance Goals and Quality Monitoring Measures</th></tr>
<tr><td>Healthcare and quality of life measures</td><td>• MCOs shall perform and report the Healthcare and Quality of Life Performance Measures identified in Attachment XI, Table 1, "Healthcare and quality of life measures," using HEDIS® and HEDIS®-like Quality Measure Specifications methodology, as provided by the Department. MCOs shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. MCOs must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity, e.g., NCQA-certified auditor, as approved by the Department. The Department's External Quality Review Organization will perform an independent validation of at least a sample of Contractor's findings. Performance Measures include:
▪ Adults' Access to Preventive/Ambulatory Health Services
▪ Ambulatory Care
▪ Prenatal and Postpartum Care
▪ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
▪ Well-Child Visits in the First 15 Months of Life
▪ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
▪ Annual Dental Visit
▪ Adult BMI Assessment
▪ Breast Cancer Screening
▪ Cervical Cancer Screening
▪ Chlamydia Screening in Women
▪ Controlling High Blood Pressure
▪ Childhood Immunization Status
▪ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
▪ Immunizations for Adolescents
▪ Comprehensive Diabetes Care
▪ Statin Therapy for Patients with Diabetes
▪ Annual Monitoring for Patients on Persistent Medications
▪ Medication Management for People with Asthma
▪ Metabolic Monitoring for Children and Adolescents on Antipsychotics
▪ Follow-Up After Hospitalization for Mental Illness
▪ Movement of Members Within Service Populations</td><td>HealthChoice Model Contract, Attachment XI, 1.1.14, Table 1

42 CFR 438.240
42 CFR 438.330</td></tr>
</table>

HFS' Specific Performance Goals and Quality Monitoring Measures		
	▪ Screening for Clinical Depression and Follow-Up Plan ▪ Chronic Condition Hospital Admission Composite ▪ Plan All Cause Readmissions ▪ IP Admits per 1,000 ▪ Behavioral Health Related Emergency Department Visits per 1,000 ▪ Inpatient Utilization – Health Home ▪ Mental Health Utilization	
HCBS Waiver Performance Measures	• MCOs shall perform and report the performance measures in "Table 2: Service Package II HCBS Waiver performance measures" using measure specifications methodology, as provided by the Department. MCOs shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Performance measures include: ▪ Number and percent of individual non-compliance findings regarding waiver providers without a Medicaid provider agreement on file at MA that were remediated within 30 days by MCO ▪ Number and percent of waiver service providers utilized by MCO that are an enrolled Medicaid provider ▪ Number and percent of new waiver applicants who have required initial level of care assessment prior to admission ▪ Number and percent of waiver participants' data reviewed to ensure agreement with approved projected waiver capacity ▪ Number and percent of individual non-compliance findings regarding provider qualifications that were remediated within 60 days by MCO ▪ Number and percent of MCOs that initially meet contract requirements prior to furnishing waiver services ▪ Number and percent of MCOs that continue to meet contract qualification requirements ▪ Number and percent of MCOs that offer training as required by policy ▪ Number and percent of MCO case managers who meet waiver provider training requirements ▪ Number and percent of MCO waiver participants' service plans that address all personal goals identified by the assessment ▪ Number and percent of MCO waiver participants' service plans that address all participant needs identified by the assessment	HealthChoice Model Contract, Attachment XI, 1.1.15, Table 2 42 CFR 438.208(c)(2) 42 CFR 438.240 42 CFR 438.330

HFS' Specific Performance Goals and Quality Monitoring Measures		
	▪ Number and percent of MCO participants' service plans that address all health and safety risk factors identified in the assessment ▪ Number and percent of MCO survey respondents in the sample who reported they receive services when they need them ▪ Number and percent of service plans that were implemented pre-authorization by MCO with remediation within 60 days ▪ Number and percent of MCO participants' service plans that were signed and dated by the waiver participant and the case manager ▪ Number and percent of MCO participants who received at least required contact by their case manager in effort to monitor service provision and to address potential gaps in service delivery ▪ Number and percent of MCO participants who have PAs or other independently employed services whose service plan included back up plans ▪ Number and percent of MCO participants who have their service plan updated in a timely manner ▪ Number and percent of overdue service plan renewals that were remediated within 30 days by the MCO ▪ Number and percent of MCO waiver participants that received updates to service plans when participants' needs changed ▪ Number and percent of MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan ▪ Number and percent of MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care ▪ Number and percent of MCO participant records with most recent POC indicating participant had choice between waiver services/institutional care and between/among services and providers ▪ Number and percent of participants who received information from MCO about how and to whom to report abuse, neglect, and exploitation at time of assessment/reassessment ▪ Number and percent of medication errors for participants documented and reported to the Department ▪ Number and percent of participants' APS substantiated incidents that were reported to MCO and resolved within recommended APS timelines	

HFS' Specific Performance Goals and Quality Monitoring Measures		
	▪ Number and percent of participants' substantiated cases of A/N/E where MCO implemented APS recommendations within waiver-specified or regulatory timeframes ▪ Number and percent of participants' deaths as a result of substantiated case of A/N/E where appropriate follow-up actions were implemented by MCO ▪ Number and percent of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by MCO ▪ Number and percent of waiver participants who are free from seclusion or restraints ▪ Number and percent of restraint applications, seclusion or other restrictive interventions where appropriate intervention by MCO occurred in accordance with waiver and within waiver prescribed timeframes ▪ Number and percent of participant survey respondents who reported to MCO of being treated well by direct support staff ▪ Number and percent of HSP Individual Provider evaluations returned reporting satisfaction as stated in the approved waiver ▪ Number and percent of participants who received information from MCO regarding universal precautions ▪ Number and percent of MCO in-home service providers who have p0licy addressing participant back up plans ▪ Number and percent of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered ▪ Number and percent of payments that were paid for services that were specified in the participants' service plan ▪ Number and percent of payments that were paid using the correct rate as specified in the waiver application ▪ Number and percent of rates consistent with the approved rate methodology over the five year waiver cycle	

CMS' right to inspect documentation or perform program review is acknowledged and HFS commits to complete compliance with those reviews (42 CFR 438.207).

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Subassurance C **The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver**								
29C	*# and % of case managers who meet waiver provider training requirements.* N: # of MCO case managers reviewed who meet waiver provider training requirements. D: Total # of MCO case managers reviewed.	MCO	Quarterly and Annually	100%	MA/MCO	Quarterly and Annually	MCO Reports	Completion of case manager training; Moratorium of new waiver cases to non-certified MCO case managers. Remediation within 60 days.
Appendix D - Service Plan Development								
Subassurance A **Service plans address all participants' assessed needs (including health and safety factors) and personal goals, either by the provision of waiver services or through other means**								
31D	*# and % of MCO participants' service plans that address all personal goals*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	identified by the assessment. N: # of MCO service plans reviewed that address all personal goals identified by the assessment. D: Total # of MCO service plans reviewed.							will provide training of case managers. Remediation must be completed within 60 days.
32D	*# and % of MCO participants' service plans that address all participant needs identified by the assessment.* N: # of MCO service plans reviewed that address all participant needs identified by the assessment. D: Total # of MCO service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
33D	*# and % of MCO participants' service plans that address risks identified in the assessment.* N: # of MCO service plans reviewed that address risks identified in the assessment. D: Total # of MCO service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.
34D	*# and % of MCO satisfaction survey respondents in the sample who reported they receive services they need when they need them.* N: # of MCO satisfaction survey respondents who reported they receive services when needed.	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
			Annually	100% (Elderly)			POSM Survey question E.1.a. (Elderly)	

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	D: # of MCO satisfaction survey respondents in the sample.							
Subassurance B **The State monitors service plan development in accordance with its policies and procedures**								
35D	*# and % of MCO participants' service plans that were signed and dated by the waiver participant and the case manager.* N: # of MCO service plans that were signed by the waiver participant and the case manager. D: Total # of MCO service plans reviewed.	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans are not signed by appropriate parties, the MA will require the plans be corrected. The MCO may also provide training in both cases. Remediation must be completed within 60 days.
36D	*# and % of MCO participants who received contact by*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports;	If participants do not receive the required contact by case

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI; and 3 times a month, with 1 contact being face to face, for HIV; in an effort to monitor service provision and to address potential gaps in service delivery. N: # of MCO participants reviewed who received contact by their case manager every 12 months for Persons with Disabilities and Elderly; monthly for BI; and 3 times a month, with 1 contact being face to face, for HIV. D: Total # of MCO participants reviewed.						EQRO Reviews	manager, the MA will require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
Subassurance C **Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs**								
37D	*# and % of MCO waiver participants who have their Service Plan updated every 12 months for Persons with Disabilities and Elderly; every 6 months for BI and HIV.* N: # of MCO waiver participants reviewed who have their Service Plan updated every 12 months for Persons with Disabilities and Elderly; every 6 months for BI and HIV. D: Total # of MCO waiver participants with service plans due during the period reviewed.	EQRO /MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If service plans are untimely, the MA will require completion of overdue service plans and justification from the case manager. If service plans are not updated when there is documentation that a participant's needs changed, the MCO will require an update. In both cases the MCO may also provide training of case managers. Remediation within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
38D	*# and % of MCO waiver participants that received updates to service plans when participants needs changed.* N: # of MCO waiver participants reviewed that received updates to service plans when participants' needs changed. D: Total # of MCO waiver participants identified whose needs changed.	EQRO /MCO	Quarterly and Ongoing	Subset of Representative Sample	MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If plans do not address required items, the MCO will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.
<u>Subassurance D</u> Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan								
39D	*# and % of MCO participants who received services in the type, scope, amount, duration,*	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	If a participant does not receive services as specified in the service plan, the MCO will determine if a

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	and frequency as specified in the service plan. N: # of MCO participants reviewed who received services as specified in the service plan. D: Total # of MCO participants reviewed.							correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the MA to fraud control. Remediation must be completed within 60 days.
40D	*# and % of MCO satisfaction survey respondents in the sample who reported the receipt of all services listed in the plan of care.*	MCO	Annually	CAHPS Guidelines	MA/MCO	Annually	CAHPS Survey	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	N: # of MCO satisfaction survey respondents who reported the receipt of all services listed in the plan of care. D: # of MCO satisfaction survey respondents in the sample.							based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.
Subassurance E **Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers**								
41D	*# and % of MCO participants records with the most recent plan of care indicating the participant had choice between waiver services and institutional care; and between/among services and providers.* N:# of MCO participant records reviewed with a signed POC that	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The MCO may also provide training to case managers. Remediation must be completed within 60 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	indicates participant had choice between waiver services and between services and providers. D:Total # of MCO participant records reviewed.							
Appendix G- Health Safety & Welfare								
<u>Subassurance</u> **The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation**								
42G	*# and % of participants who received information from the MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment-reassessment.* N: # of participant records reviewed where the participant received information from the MCO about how and to whom to	EQRO /MCO	Quarterly and Ongoing	Representative Sample	MA/MCO	Quarterly and Annually	MCO Reports; EQRO Reviews	The MCO will assure that customers know how to report abuse, neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	report abuse, neglect exploitation at the time of assessment-reassessment. D: Total # of MCO participant records reviewed.							
43G	*# and % of participants' DHS-OIG substantiated incidents that were reported to the MCO and resolved within recommended OIG timelines.* N: # of DHS-OIG substantiated incidents reported to the MCO that were resolved within recommended OIG timelines. D: Total # of DHS-OIG substantiated incidents reported to the OA and MCO.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up all outstanding DHS-OIG referrals and Unusual Incident Reports. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
44G	*# and % of participants' substantiated cases of abuse, neglect or exploitation received from DHS-OIG where the MCO implemented the DHS-OIG recommendations.* N: # of substantiated cases of abuse, neglect or exploitation received from DHS-OIG where the MCO implemented the DHS-OIG recommendations. D: Total # of substantiated cases of abuse, neglect or exploitation received by the MCO from DHS-OIG.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will implement the DHS-OIG recommendations for substantiated cases of abuse, neglect or exploitation. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
45G	*# and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the MCO.* N: # of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the MCO. D: Total # of MCO deaths as a result of a substantiated case of A/N/E.	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	The cause of death/circumstances would be reviewed by the MCO and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.
46G	*# and % of restraint applications, seclusion, or other restrictive interventions where*	MCO	Quarterly and Ongoing	100%	MA/MCO	Quarterly and Annually	MCO Reports	Restraint applications, seclusion, or other restrictive interventions will be reviewed by the MCO.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	appropriate intervention by the MCO occurred. N: # of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred. D: Total # of MCO restraint applications, seclusion, or other restrictive intervention.							The need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns.
47G	*# and % of participant satisfaction survey respondents who reported to the MCO of being treated well by direct support staff.* N: # of participant satisfaction survey respondents who reported to the	MCO	Annually	CAHPS Guidelines (BI, HIV, PD)	MA/MCO	Annually	CAHPS Survey (BI, HIV, PD)	If identifying information is available for individual surveys the MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used
			Annually	100% (Elderly)			POSM Survey question E.1.a. (Elderly)	

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
	MCO of being treated well by direct support staff. D: Total # of MCO participant satisfaction survey respondents.							to identify need for system improvement.
48G	*# and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO.* N: # of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO. D: Total # of MCO participants for whom identified critical incidents were reviewed.	MCO	Quarterly and Ongoing	100%	MCO	Quarterly and Annually	MCO Reports	The MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern. Survey responses will be used to identify need for system improvement.

PM #	Waiver Performance Measures	Resp for Data Collection	Frequency of Data Collection/Generation	Sampling Approach	Responsible Party for Data Aggregation and Analysis	Frequency of Data Aggregation and Analysis	Data Source	Remediation
49G	*# and % of MCO participants who have personal assistant or other independently employed services whose service plan included back up plans.* N: # of MCO participants reviewed who have personal assistant or other independently employed services whose service plan included back up plans. D: Total MCO participants reviewed who have personal assistant or other independently employed services.	MCO	Quarterly and Ongoing	Representative Sample	MCO	Quarterly and Annually	MCO Reports	The MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be within 30 days.

Instructions for Completion – Complete only the Care Transitions and Care Management Recommendations Sections

Column Heading	Instructions
Standard/Scope Recommendations	Identifies the recommendation/requirement for improvement (populated from EQR Recommendations)
Description of Current Process and/or Initiatives	Complete a description of the current process associated with the recommendation/quality improvement initiative targeted for improvement.
Goal/Objective	Complete a description of the goals and objectives of each quality improvement initiative.
Description of Proposed Improvement Initiative(s)	Complete a description of the proposed quality improvement initiative. Include a description of the expected outcome and how the quality initiatives will be assessed/managed.
Implementation Date	Record the implementation date and dates for key milestones associated with each targeted area for improvement.
Accountable	Identify the plan lead and staff responsible for the quality improvement initiatives.
Monitoring Status	Complete a description of how the plan will monitor the progress of the initiative and frequency of review.

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase I – Care Transitions Programs – (May– September 2018)						
Transitions of Care[1] and Care Management Programs CFR 438.62 Transition of Care CFR 438.358 – Quality Assurance Performance Improvement (QAPI) Medicaid Model Contract 2018-24-001 (MMC 2018) HealthChoice IL Section 1.1.3.7.9 – QAPI CFR 438.358 – QAPI MMC 2018 HealthChoice IL Section 1.1.3.7.9 – QAPI ***(EQR Technical Report – Executive Summary - Page 1-8)***						
Establish transition of care evaluation measures.						
1.c. Improve communication with hospitals to improve transitions of care.						

[1] https://www.chrt.org/publication/care-transitions-best-practices-evidence-based-programs/

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/Objective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
1.d. 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.						
1.g. Implement dedicated transition of care teams to manage transitions of care for beneficiaries with BH/complex healthcare needs.						
Phase I –Care Management/Care Coordination Programs – (May– September 2018)						
8. Improve compliance with CM/CC requirements by: ***(EQR Technical Report – Executive Summary - Page 1-8)***						
8a. Evaluate effectiveness of the CM/CC programs and enhancing training and oversight of CM/CC activities.						
8.b. Reassignment evaluation – evaluate the effectiveness of the case reassignment process for CM/CCs, i.e. when a CM/CC transfers or terminates employment.						

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase II –Improve Member Satisfaction with Customer Service, Health Plan, and Overall Healthcare – (TBD)						
2. **Consumer Satisfaction with Customer Service, Health Plan and Overall Health Care – CAHPS Measures** CFR Subpart F – Appeals and Grievances CFR 438.358 – QAPI MMC 2018 HealthChoice IL Section 1.1.11.2 – QAPI MMC 2018 HealthChoice IL Section 2.3.3 Training MMC 2018 HealthChoice IL Section 2.3.3 Training Evaluate the need for a [2]service recovery program, complaints and grievances (C/G) tracking system, and standards and service level reporting for customer service. ***(EQR Technical Report – Appendix 2 – Pages A2-20-21)***						

i. [2] 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.

EQR Recommendations – Quality Improvement Plan

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
2.a. Resolve member complaints/grievances quickly and effectively by training and empowering front-line employees.						
2.b. Evaluate Provider Complaint and Enrollee Grievance data to identify failure points/root causes of low satisfaction ratings.						
2.c. Track trends and use data to improve service processes.						
2.d. Evaluate standards and service-level reporting for customer service.						
6.e. Improving oversight and training for grievance and appeal department staff to document follow-up, resolution, and appropriate referral to other internal departments of access-related grievances.						

EQR Recommendations – Quality Improvement Plan

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/Objective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase II – Improve HEDIS Measure Performance – (TBD) ***Comprehensive Diabetes Care and Controlling High Blood Pressure Measures***						
Appropriate Care – Chronic Conditions – *Comprehensive Diabetes Care and Controlling High Blood Pressure Measures* ***(EQR Technical Report – Pages A2-22-23)*** CFR 438.358 – QAPI MMC 2018 HealthChoice IL Section 1.1.3.1.7 – QAPI						
3.a. Evaluate the effectiveness of diabetes disease management programs to determine effectiveness of educational materials for diabetes care.						
3.b. Implement a diabetes interactive voice response (IVR) call campaign to target members who are not compliant with their disease management.						
3.f. Implement diabetes-specific care coordination teams to reach out to diabetic members not enrolled in care coordination.						
3.g. Conduct a root cause analysis of beneficiaries who do not have eye exams performed to determine barriers to accessing vision appointments.						

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
3.h. For the [3]*Controlling High Blood Pressure* measure, health plans could implement a focused project to analyze commonalities and/or barriers to achieving hypertension control. For example, focused outreach to those members with diabetes, those members without hypertensive medications prescribed, or outreach to providers to determine barriers to achieving success with this measure.						

i. [3] Centers for Disease Control and Prevention. High Blood Pressure Facts. Available at: https://www.cdc.gov/bloodpressure/facts.htm. Accessed on: Mar 2, 2018.

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
4. Align plan initiatives and improvement strategies with those of [4]Illinois Department of Public Health (IDPH) Diabetes State Plan 2013–2018 by forming a collaborative partnership to identify and share quality improvement efforts. ***(EQR Technical Report – Appendix 2 – Pages A2-22-23)*** MMC 2018 HealthChoice IL – Section 7.9 Pay for Performance; Table 1 To Attachment XI Healthcare and Quality of Life Performance Measures						

ii. [4] Illinois Department of Public Health. Illinois Diabetes State Plan. Available at: http://www.dph.illinois.gov/sites/default/files/publications/illinois-diabetes-state-plan-2013-2018.pdf. Accessed on: Mar 2, 2018.

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/Objective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase II – Improve HEDIS Measure Performance – (TBD) *Preventive Ambulatory Health Services*						
7. **Improve Access to Care –** ***Preventive Ambulatory Health Services Measure*** ***(EQR Technical Report – Appendix 2 – Page A2-24-26)***						
7.a. Conduct a root cause analysis of beneficiaries who do not access preventive care services to determine barriers to obtaining appointments.						
7.b. Implement targeted outreach campaigns for members who have not accessed preventive care services.						
7.c. Evaluate the effectiveness of the health plans' "Gaps in Care" programs and the role of the PCP in closing care gaps.						
Phase III – Improve Access & Availability Monitoring – (TBD)						
6. Improve health plan monitoring and oversight of access and availability by: ***(EQR Technical Report – Executive Summary - Page 1-8)*** CFR 438.358 – QAPI MMC 2018 HealthChoice IL						

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Section 1.1.3.7.4- QAPI						
6.b. Utilizing provider access and availability survey results to improve monitoring of PCP appointment availability.						
6.c. Improving the accuracy of the provider directory through regular audits and timely updates when changes are identified.						
6.e. Improving oversight and training for grievance and appeal department staff to document follow-up, resolution, and appropriate referral to other internal departments of access-related grievances.						
6.f. Conducting root cause analysis of beneficiary access-related grievances to identify barriers in accessing care and services.						

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase III – Improve Oversight of Delegated Vendors – (TBD)						
9. Improve compliance with subcontracts and delegation contract requirements by: ***(EQR Technical Report – Executive Summary - Page 1-8)*** MMC 2018 HealthChoice IL Section 1.1.3.7.20 – QAPI						
9.b. Improve oversight of delegated vendors through monthly operations meetings and quarterly review of delegate performance.						
9.c. Improve performance feedback to delegated vendors and monitoring remediation actions.						

EQR Recommendations – Quality Improvement Plan

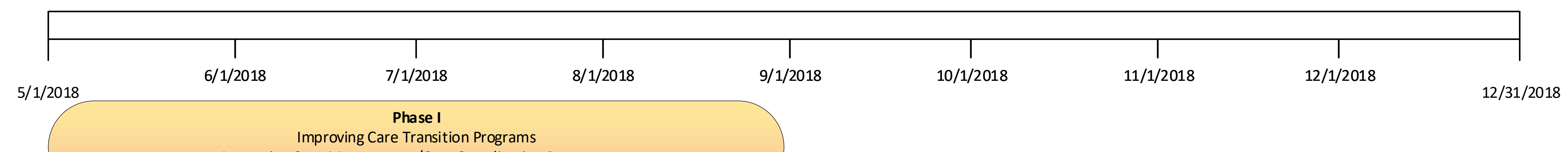
Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase IV – Critical Incidents – (TBD)						
10. Improve compliance with critical incidents requirements by: ***(EQR Technical Report – Executive Summary - Page 1-8*** MMC 2018 HealthChoice IL Section 5.23.2 Critical Incident Reporting MMC 2018 HealthChoice IL Section 1.1.1.2 QAPI						
10.a. Develop and implement a critical incident follow-up protocol.						
10.b. Improve systems used for the intake, processing, tracking, and reporting of critical incidents.						

EQR Recommendations – Quality Improvement Plan

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Phase IV – Health Information Technology – Member & Provider Portals – (TBD)						
11. **Health Information Technology** MMC 2018 HealthChoice IL Section 5.10.5 Provider Portal and Section 5.21.7.3 Enrollee Portal Improve compliance with member and provider portals requirements.						

Standard/Scope Recommendations	Description of current process and/or initiatives	Goal/0bjective	Description of proposed improvement initiative(s)	Implementation Date - Timeline	Accountable	Monitoring Status
Performance Improvement Projects – (TBD)						
5. Performance Improvement Projects (PIPs) – CFR 438.358 – QAPI MMC 2018 HealthChoice IL Section 1.1.3.4 – Performance Improvement Projects Implement the Institute for Healthcare Improvement's (IHI's) rapid cycle performance improvement approach for the health plan PIPs, which places a greater emphasis on improving outcomes using quality improvement science. ***(EQR Technical Report – Executive Summary - Page 1-9)***						
5.a. Improve Breast Cancer Screening rates –						
5.b. Behavioral Health Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up)						

EQR Recommendations Implementation Plan



Phase I
Improving Care Transition Programs
Improving Care Management/Care Coordination Programs
May through August

Phase II
Improving Member Satisfaction – Customer Service and grievance & appeal process
Improving HEDIS Performance Measures – *Comprehensive Diabetes Care (CDC), Preventive Ambulatory Services*
TBD

Phase III
Improving Monitoring of Access & Availability
Improving Oversight of Delegated Vendors
TBD

Phase IV
Improving tracking/logging/follow-up of Critical Incidents
Improving Member & Provider Portals functionality
September through December

The table below reflects the functions managed by the state/IMPACT system and those to be conducted by the plan for the purpose of contracting with the state-credentialed Medicaid practitioners. The IMPACT system produces a pool of state-credentialed practitioners from which the managed care plans can draw for the purposes of building their Medicaid practitioner networks. The requirements (aka factors) outlined under the subhead **Organization Responsibility** pertain to the plan processes associated with adding a practitioner to the network as part of contracting. This does not mean that the plan conducts duplicate primary source verification activities for its practitioners or assessments for its providers.

	Met by State IMPACT System	Organization Responsibility
CR 1: CREDENTIALING POLICIES (specific to the Medicaid organizations' contracting process only)		
Element A: Practitioner Credentialing Guidelines **Documentation: The organization has a process that addresses the following factors.**		
1. The types of practitioners it credentials and recredentials.	✓[1]	
2. The verification sources it uses.	✓[2]	
3. The criteria for credentialing and recredentialing.	✓	
4. The process for making credentialing and recredentialing decisions.	✓	
5. The process for managing credentialing files that meet the organization's established criteria.	✓	
6. The process for delegating credentialing or recredentialing.	✓[3]	
7. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner.	✓	
8. The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.	✓	
9. The process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision.	✓[4]	
10. The medical director or other designated physician's direct responsibility and participation in the credentialing program.	✓	
11. The process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	✓	
12. The process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.		✓[5]
Element B: Practitioner Rights **Documentation: The organization has a process and evidence that addresses the following factors.**		
1. Review information submitted to support their credentialing application.	✓	
2. Correct erroneous information.	✓	
3. Receive the status of their credentialing or recredentialing application, upon request.		✓[6]
CR 2: CREDENTIALING COMMITTEE (aka Contracting Committee)		

[1] The organization's policies outline the types of practitioners who are vetted by the IMPACT system.
[2] For verifications performed by the state due to the IMPACT system, the organization specifies only the credential and that it is within the scope of the IMPACT system.
[3] Medicaid organizations indicate its use of the IMPACT system as a "delegate" in its credentialing policies.
[4] This factor can be synonymous with an IL Medicaid organization's "Contracting Committee" process.
[5] It is the individual plans' responsibility to ensure that its directory reflects information provided by the state.
[6] This applies to the individual plans' contracting process and communicating with the practitioner about being added to the network.

	Met by State IMPACT System	Organization Responsibility
Element A: Credentialing Committee (may go by a different classification for IL Medicaid organizations) **Documentation: The organization has evidence (i.e., committee minutes) that displays the following factors.**		
1. Uses participating practitioners to provide advice and expertise for credentialing decisions.		✓
2. Reviews credentials for practitioners who do not meet established thresholds.		✓
3. Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician.		✓
CR 3: CREDENTIALING VERIFICATION[7]		
Element A: Verification of Credentials **Documentation: The organization undergoes a file review.**		
1. Current and valid license to practice.	✓	
2. Valid DEA/CDS certificate, if applicable to practitioner type.	✓	
3. Education and training, if not verified through licensure.	✓	
4. Board certification status, if applicable.	✓	
5. Work history.	✓	
6. History of professional liability claims.	✓	
Element B: Verification of Sanction Information **Documentation: The organization undergoes a file review.**		
1. State sanctions, restrictions on licensure or limitations on scope of practice.	✓	
2. Medicare and Medicaid sanctions.	✓	
Element C: Verification of Credentialing Application[8] **Documentation: The organization undergoes a file review.**		
1. Reasons for inability to perform the essential functions of the position.	✓	
2. Lack of present illegal drug use.	✓	
3. History of loss of license and felony convictions.	✓	
4. History of loss or limitation of privileges or disciplinary actions.	✓	
5. Current malpractice insurance coverage.	✓	
6. Current and signed attestation confirming the correctness and completeness of the application.	✓	
CR 4: RECREDENTIALING CYCLE LENGTH[5]		
Element A: Recredentialing Cycle Length **Documentation: The organization undergoes a file review.**		
1. The length of the recredentialing cycle is within the required 36-month time frame.	✓	
CR 5: ONGOING MONITORING AND INTERVENTIONS		
Element A: Ongoing Monitoring and Interventions		

[7] All credentialing verifications and timeliness are within the scope of the IMPACT system; therefore, NCQA holds organizations harmless for the file review activities of CR 3 and CR 4.
[8] Although the IMPACT system will not include disclosure questions, organizations will be held harmless for this activity (refer to footnote 5).

	Met by State IMPACT System	Organization Responsibility
Documentation: The organization has a process and evidence for monitoring each practitioner in its network for the following factors.		
1. Collecting and reviewing Medicare and Medicaid sanctions.	✓[9]	
2. Collecting and reviewing sanctions or limitations on licensure.	✓	
3. Collecting and reviewing complaints.		✓
4. Collecting and reviewing information from identified adverse events.		✓
5. Implementing appropriate interventions when it identifies instances of poor quality related to issues from factors 1-4 (i.e., sanctions, limitations, complaints, adverse events).		✓[10]

	Met by State IMPACT System	Organization Responsibility
CR 6: NOTIFICATION TO AUTHORITIES AND PRACTITIONER APPEAL RIGHTS		
Element A: Actions Against Practitioners **Documentation: The organization has a process that outlines when it takes actions against practitioners for quality reasons, when it reports the action to the appropriate authorities and offers practitioners a formal appeal process.**		
1. The range of actions available to the organization.		✓
2. Reporting to authorities.		✓
3. A well-defined appeal process.		✓
4. Making the appeal process known to practitioners.		✓
CR 7: ASSESSMENT OF ORGANIZATIONAL PROVIDERS (FACILITIES)		
Element A: Review and Approval of All Providers (Facilities) **Documentation: The organization has a process for evaluating all providers with which it contracts on the following factors.**		
1. Confirms that the provider is in good standing with state and federal regulatory bodies.	✓	
2. Confirms that the provider has been reviewed and approved by an accrediting body.	✓	
3. Conducts an onsite quality assessment if the provider is not accredited.	✓	
Elements B/D: Review and Assessment of Medical Providers **Documentation: NCQA reviews the organization's process and evidence specifically for the following provider types.**		
1. Hospitals.	✓	
2. Home health agencies.	✓	
3. Skilled nursing facilities.	✓	
4. Free-standing surgical facilities.	✓	
Elements C/E: Review and Assessment of Behavioral Healthcare Providers **Documentation: NCQA reviews the organization's process and evidence specifically for the following provider types.**		
1. Inpatient.	✓	
2. Residential.	✓	
3. Ambulatory.	✓	

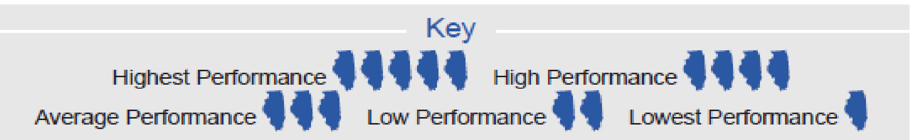
[9] It is the individual plans' responsibility to review for Medicare sanctions.
[10] Individual organizations are only expected to implement interventions for Medicare sanctions, complaints and adverse events.

HealthChoice Illinois

2016 HealthChoice Illinois Plan Report Card

Comparing HealthChoice Illinois Plans

This report card is for individuals in the HealthChoice Illinois Managed Care Program. The report shows how the managed care plans compare to one another in key performance areas. The ratings for each plan are to help an individual pick a plan that is best for them.



Plan	Doctors' Communication and Patient Engagement	Access to Care	Women's Health	Living With Illness	Behavioral Health	Keeping Kids Healthy
Blue Cross Community Health Plans	3	3	3	3	1	1
CountyCare Health Plan*	3	3	3	3	1	5
Harmony Health Plan	2	3	2	1	3	5
IlliniCare Health	3	3	3	4	5	1
Meridian Health Plan	5	5	5	5	5	5
Molina Healthcare	3	3	2	3	1	4
NextLevel Health Partners*	**New	**New	**New	**New	**New	**New

*CountyCare and NextLevel are only available in Cook county.
**Due to NextLevel being a new plan in 2016, data do not allow for comparisons to other plans. NextLevel will be included in future report cards.

What is Rated in Each Performance Area?

Doctors' Communication and Patient Engagement
- Doctors explain things well to members
- Doctors involve members in decisions about their care

Access to Care
- Members get the care they need, when they need it

Women's Health
- Women get screenings and tests for female cancers and diseases
- Women receive care before and after their babies are born

Living With Illness
- Members living with conditions, like diabetes and asthma, get the care they need by getting tests, checkups, and the right medicines

Behavioral Health
- Members with behavioral health conditions get the follow-up care they need

Keeping Kids Healthy
- Children get regular checkups and important shots that help them stay healthy

HealthChoice Report Card

Choosing a HealthChoice Illinois Plan

Choosing the plan that best meets your health care needs is important. Here are some questions to ask before you pick a plan:

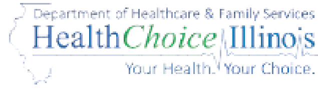
- **How did each plan rate in each area of the report card?**
- **Do the doctors in the plan I like communicate with their members?**
- **Do the members in the plan I like get care when they need it?**
- **Do women get the care they need?**
- **Do members with behavioral health conditions get the care they need?**
- **Do kids get the care they need to stay healthy?**

Have more questions about picking a HealthChoice Illinois plan?

When it is time to pick a plan, you can contact **Illinois Client Enrollment Services** at 1-877-912-8880 (TTY: 1-866-565-8576). The call is free. Or you can go online at enrollhfs.illinois.gov. They will provide you with more information about each plan available to you. They can also tell you what doctors are in a plan and what extra benefits they offer. You can also contact the plans directly for more information about their plan using the information below. Not all plans listed may be available to you.

Plans	Contact Information	Available in the Following Counties
Blue Cross Community Health Plans	1-877-860-2837 | TTY: 1-800-526-0844 www.bcbsil.com/bcchp	Statewide
CountyCare Health Plan	1-855-444-1661 | TTY: 1-800-526-0844 www.countycare.com	Cook
Harmony Health Plan	1-800-504-2766 | TTY: 1-877-650-0952 www.wellcare.com/Illinois	Statewide
IlliniCare Health	1-866-329-4701 | TTY: 1-800-526-0844 www.illinicare.com	Statewide
Meridian Health Plan	1-866-606-3700 | TTY: 1-800-526-0844 www.mhplan.com/IL	Statewide
Molina Healthcare	1-855-687-7861 | TTY: 1-800-526-0844 www.molinahealthcare.com	Statewide
NextLevel Health Partners	1-844-807-9734 | TTY: 1-800-526-0844 www.nextlevelhealthil.com	Cook

Information as of October 2017.



Need More Information on Your HealthChoice Illinois Plan Options?

Visit the Illinois Department of Healthcare and Family Services online at: **www.illinois.gov/hfs/** and Illinois' Client Enrollment Services online at: **enrollhfs.illinois.gov**

About This Report Card

The information in this report card was collected from the plans and their members. The information was reviewed for accuracy by independent organizations. The 2017 National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data were used in this report card to rate the plans. HEDIS® is a registered trademark of NCQA and CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

"HEALTHCHOICE" DE ILLINOIS

Informe de Calificaciones de los Planes de Salud de "HealthChoice" de Illinois del 2016

Comparación de los Planes "HealthChoice" de Illinois

Este informe de calificaciones es dirigido para las personas en el Programa de Manejo de Salud del "HealthChoice" de Illinois. El informe indica cómo los planes de manejo de salud se comparan entre sí en áreas de rendimiento clave. Las calificaciones para cada plan son para ayudar a una persona a elegir el mejor plan que les convengan.

Planes	Comunicación con los Médicos y el Compromiso con el Paciente	Acceso a la Atención Médica	Salud de las Mujeres	Viviendo con la Enfermedad	Salud del Comportamiento	Mantener a los Niños Saludables
Blue Cross Community Health Plans	●●●	●●●	●●●	●●●	●	●
CountyCare Health Plan*	●●●	●●●	●●●	●●●	●	●●●●●
Harmony Health Plan	●●	●●●	●●	●	●●●	●●●●●
IlliniCare Health	●●●	●●●	●●●	●●●●	●●●●●	●
Meridian Health Plan	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Molina Healthcare	●●●	●●●	●●	●●●	●	●●●●
NextLevel Health Partners*	**Nuevo	**Nuevo	**Nuevo	**Nuevo	**Nuevo	**Nuevo

*"CountyCare" y "NextLevel" están solamente disponibles en el Condado de "Cook".
**Debido a que "NextLevel" es un nuevo plan en el año 2016, los datos de información no permiten hacer comparaciones con los otros planes de salud. "NextLevel" se incluirá en futuros informes de calificaciones.

¿Qué se califica en cada área de desempeño?

Comunicación con los Médicos y el Compromiso con el Paciente
- Que tan bien los médicos explican las cosas a sus miembros/pacientes
- A que los médicos incluyan a los miembros/pacientes a participar en las decisiones sobre su cuidado de salud

Acceso a la Atención Médica
- A que los miembros/pacientes obtengan la atención médica que necesitan, cuando la necesitan

Salud de las Mujeres
- A que las mujeres consigan evaluaciones y exámenes de detención de cáncer y enfermedades
- A que las mujeres reciban atención médica antes y después de que sus bebés nazcan

Viviendo con la Enfermedad
- Los miembros/pacientes que viven con condiciones de salud, como la diabetes y el asma, que obtengan la atención que necesitan haciéndose pruebas, chequeos, y los medicamentos adecuados

Salud del Comportamiento
- A que los miembros/pacientes con condiciones de salud del comportamiento obtengan el cuidado de seguimiento que necesitan

Mantener a los Niños Saludables
- A que los niños tengan chequeos regulares y las vacunas importantes para que les ayuden a permanecer saludables

Elegir un plan de "HealthChoice" de Illinois

Es importante elegir el plan que mejor satisfaga a sus necesidades de atención médica. Aquí indicamos algunas preguntas que debe hacer antes de elegir un plan:

- **¿Cómo evaluó cada plan en cada área del informe de calificaciones?**
- **Los médicos del plan que me gusta, ¿se comunican con sus miembros?**
- **¿Obtienen los miembros del plan que me gusta la atención médica cuando lo necesitan?**
- **¿Reciben las mujeres la atención médica que necesitan?**
- **¿Obtienen los miembros con condiciones de salud de la conducta la atención médica que necesitan?**
- **¿Reciben los niños la atención médica que necesitan para mantenerse saludables?**

¿Tiene más preguntas sobre cómo escoger un plan de "HealthChoice" de Illinois?

Cuando llegue el momento de elegir un plan, puede comunicarse con los **Servicios de Inscripción de Clientes de Illinois** al 1-877-912-8880 (TTY: 1-866-565-8576). La llamada es gratuita. O puede ir por Internet a www.enrollhfs.illinois.gov. Le proporcionarán más información sobre cada plan disponible. También, pueden decirle cuáles son los médicos en el plan y qué beneficios adicionales ofrecen. Puede comunicarse directamente con los planes para obtener más información sobre su plan utilizando la siguiente información. No todos los planes indicados a continuación puede que estén disponibles a usted.

Planes	Información de Contacto	Disponible en los Siguientes Condados
Blue Cross Community Health Plans	1-877-860-2837 | TTY: 1-800-526-0844 www.bcbsil.com/bcchp	En todo el estado
CountyCare Health Plan	1-855-444-1661 | TTY: 1-800-526-0844 www.countycare.com	Cook
Harmony Health Plan	1-800-504-2766 | TTY: 1-877-650-0952 www.wellcare.com/Illinois	En todo el estado
IlliniCare Health	1-866-329-4701 | TTY: 1-800-526-0844 www.illinicare.com	En todo el estado
Meridian Health Plan	1-866-606-3700 | TTY: 1-800-526-0844 www.mhplan.com/IL	En todo el estado
Molina Healthcare	1-855-687-7861 | TTY: 1-800-526-0844 www.molinahealthcare.com	En todo el estado
NextLevel Health Partners	1-844-807-9734 | TTY: 1-800-526-0844 www.nextlevelhealthil.com	Cook

Información hasta octubre de 2017.

¿Necesita más información sobre sus opciones de plan de "HealthChoice" de Illinois?

Visite por Internet el Departamento Cuidado de Salud y Servicios Para Familias de Illinois en: www.illinois.gov/hfs/ y los Servicios de Inscripción de Clientes en: enrollhfs.illinois.gov

Información sobre este informe de calificaciones

La información contenida en este boletín fue recolectada de los planes y sus miembros. Las organizaciones independientes revisaron la información con exactitud. En este informe de calificaciones del 2017 se utilizaron los datos del Comité Nacional de Aseguramiento de la Calidad (NCQA, por sus siglas en inglés) Datos e Información Establecidos de Eficacia de Cuidado de Salud (HEDIS®, por su siglas en inglés) y la Evaluación del Consumidor de los Proveedores y Sistemas de Cuidado de la Salud (CAHPS®, por sus siglas en inglés) para calificar los planes de salud. HEDIS® es una marca registrada de NCQA y CAHPS® es una marca registrada de la Agencia de Investigación y Calidad de la Salud (AHRQ, por sus siglas en inglés).

AAAHC .... Accreditation Association for Ambulatory Health Care
AABD .... Aid to the Aged, Blind, and Disabled
ACA .... Affordable Care Act
ACOG .... American College of Obstetricians and Gynecologists
ADA .... Americans with Disabilities Act
ADL .... Activity of Daily Living
ARRA .... American Recovery and Reinvestment Act of 2009
BBA .... Balanced Budget Act of 1997
BBO .... Better Birth Outcomes
BIP .... Balancing Incentive Program
BMC .... Bureau of Managed Care
BQM .... Bureau of Quality Management
CAHPS®[1] .... Consumer Assessment of Healthcare Providers and Systems
CAP .... Corrective Action Plan
CARES .... Crisis Referral Entry Service
CCC .... Children with Chronic Conditions
CCCD .... Care Coordination Claims Data
CCHHS .... Cook County Health and Hospital System
CCM .... Complex Case Management
CCMN .... Children with Complex Medical Needs
CFR .... Code of Federal Regulations
CHIP .... Children's Health Insurance Program
CHIPRA .... Children's Health Insurance Program Reauthorization Act
CMHC .... Community Mental Health Center
CMPQS .... Comprehensive Medical Programs Quality Strategy
CMS .... Centers for Medicare & Medicaid Services
CoIIN .... Collaborative Improvement and Innovation Network
CPT .... Current Procedural Terminology
CQI .... Continuous Quality Improvement

[1] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

CRG .... Clinical Risk Grouping
CSHCN .... Children with Special Health Care Needs
CSN .... Children with Special Needs
CSPI .... Childhood Severity of Psychiatric Illness
CYSHCN .... Children and Youth with Special Health Care Needs
DCFS .... Department of Children and Family Services
DD .... Developmental Disability
DHHS .... The United States Department of Health and Human Services
DHS .... Department of Human Services
DIS .... Division of Information Systems
DoA .... Department on Aging
DON .... Determination of Need
DPH .... Department of Public Health
DRS .... Division of Rehabilitation Services
DSCC .... Division of Specialized Care for Children
EDV .... Encounter Data Validation
EDW .... Enterprise Data Warehouse
EH .... Eligible Hospital
EHDI .... Early Hearing Detection and Intervention
HER .... Electronic Health Record
EPSDT .... Early Periodic Screening, Diagnostic, and Treatment
EQR .... External Quality Review
EQRO .... External Quality Review Organization
FFY .... Federal Fiscal Year
FPL .... Federal Poverty Level
FQHC .... Federally Qualified Health Center
FTE .... Full-Time Equivalent
HCBS .... Home and Community-Based Services
HEDIS®[2] .... Healthcare Effectiveness Data and Information Set

[2] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

HFS .... The Illinois Department of Healthcare and Family Services

HHS .... Health and Human Services

HIE .... Health Information Exchange

HIPAA .... Health Insurance Portability and Accountability Act

HIT .... Health Information Technology

HITECH Act .... Health Information Technology for Economic and Clinical Health Act

HPL .... High Performance Level

HRSA .... Health Resources and Services Administration

IADL .... Instrumental Activity of Daily Living

ICAAP .... Illinois Chapter, American Academy of Pediatrics

ICES .... Illinois Client Enrollment Services

ICF .... Intermediate Care Facility

ICT .... Interdisciplinary Care Team

IDoA .... Illinois Department of Aging

IDPH .... Illinois Department of Public Health

ILCS .... Illinois Compiled Statutes

ILHIE .... Illinois Health Information Exchange

ILPQC .... Illinois Perinatal Quality Collaborative

IMCANS .... Illinois Medicaid Child and Adolescent Needs and Strengths

IMHP .... Illinois Medical Home Project

IQAP .... Internal Quality Assessment Program

IT .... Information Technology

JCAHO .... Joint Commission on Accreditation of Healthcare Organizations

KPI .... Key Performance Indicator

LARC .... Long-Acting Reversible Contraceptive

LTC .... Long Term Care Facility

LTSS .... Long-Term Services and Supports

MAC .... Medical Advisory Committee

MCCN .... Managed Care Community Network

MCH .... Maternal and Child Health

MCHB .... Maternal and Child Health Bureau

MCHIP .... Maternal and Child Health Integrated Program
MCO .... Managed Care Organization
MCS .... Managed Care System
MEDI .... Medical Electronic Data Interchange
MFP .... Money Follows the Person
MFTD .... Medically Fragile/Technology Dependent
MLTSS .... Managed Long-Term Services and Supports
MMAI .... Medicare-Medicaid Alignment Initiative
MMIS .... Medicaid Management Information System
MPL .... Minimum Performance Level
NCPDP .... National Council for Prescription Drug Programs
NCQA .... National Committee for Quality Assurance
NF .... Nursing Facility
P4P .... Pay-For-Performance
PAC .... Provider Advisory Committee
PCCM .... Primary Care Case Management
PCP .... Primary Care Physician
PDSA .... Plan-Do-Study-Act
PIP .... Performance Improvement Project
PMV .... Performance Measure Validation
POSM .... Participant Outcomes and Status Measures
PR .... Peer Review
QA .... Quality Assurance
QAP .... Quality Assessment Plan
QAPI .... Quality Assessment and Performance Improvement
QI .... Quality Improvement
QIP .... Quality Improvement Project
RHC .... Rural Health Clinic
RHIO .... Regional Health Information Organization
SAMHSA .... Substance Abuse and Mental Health Services Administration
SFY .... State Fiscal Year

SHCN .... Special Health Care Needs
SNF .... Skilled Nursing Facility
SSI .... Supplemental Security Income
TPL .... Third Party Liability
UAT .... Uniform Assessment Tool
UR .... Utilization Review
URAC .... (formerly) Utilization Review Accreditation Organization
VIS .... Vaccine Information Statement