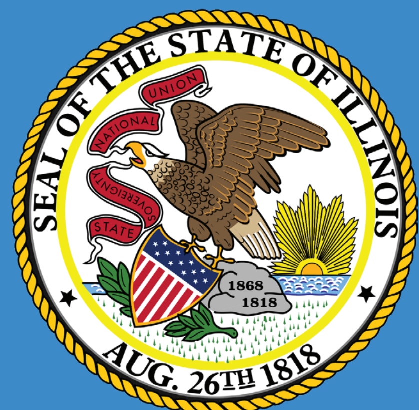
Illinois Department of Healthcare and Family Services

Division of Medical Programs

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

2012–2013



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AAAHC .... Accreditation Association for Ambulatory Health Care
AABD .... Aid to the Aged, Blind, and Disabled
ACOG .... American College of Obstetricians and Gynecologists
ARRA .... American Recovery and Reinvestment Act of 2009
BBA .... Balanced Budget Act of 1997
BMC .... Bureau of Managed Care
CAHMI .... Child and Adolescent Health Measurement Initiative
CAHPS .... Consumer Assessment of Healthcare Providers and Systems
CAP .... Corrective Action Plan
CCHHS .... Cook County Health and Hospital System
CCM .... Complex Case Management
CCMS .... CareEnhance Clinical Management Software
CFR .... Code of Federal Regulations
CHF .... Congestive Heart Failure
CHIPRA .... Children's Health Insurance Program Reauthorization Act
CMQCC .... California Maternal Quality Care Collaborative
CMS .... Centers for Medicare & Medicaid Services
COPD .... Chronic Obstructive Pulmonary Disease
CQI .... Continuous Quality Improvement
CSHCN .... Children with Special Health Care Needs
CYSHCN .... Children and Youth with Special Health Care Needs
DHHS .... The United States Department of Health and Human Services
DSCC .... Division of Specialized Care for Children
EDOPC .... Enhancing Developmentally Oriented Primary Care
EHR .... Electronic Health Record
EIS .... Executive Information System
EPSDT .... Early Periodic Screening, Diagnosis, and Treatment
EQR .... External Quality Review
EQRO .... External Quality Review Organization
FHN .... Family Health Network
FPL .... Federal Poverty Level
HCBS .... Home and Community Based Services
HEDIS .... Healthcare Effectiveness Data and Information Set
HFS .... The Illinois Department of Healthcare and Family Services
HIE .... Health Information Exchange
HIT .... Health Information Technology

HITECH Act .... Health Information Technology for Economic and Clinical Health Act
HMO .... Health Maintenance Organization
HPL .... High Performance Level
ICAAP .... Illinois Chapter, American Academy of Pediatrics
ICF .... Intermediate Care Facility
ICP .... Integrated Care Program
IHC .... Illinois Health Connect
ILHIE .... Illinois Health Information Exchange
IMHP .... Illinois Medical Home Project
IQAP .... Internal Quality Assurance Program
IT .... Information Technology
JCAHO .... Joint Commission on Accreditation of Healthcare Organizations
MAC .... Medical Advisory Committee
MCCN .... Managed Care Community Network
MCO .... Managed Care Organization
MCS .... Managed Care System
MEDI .... Medical Electronic Data Interchange
MMAI .... Medicare-Medicaid Alignment Initiative
MMIS .... Medicaid Management Information System
MPL .... Minimum Performance Level
NCQA .... National Committee for Quality Assurance
P4P .... Pay-for-Performance
PAC .... Provider Advisory Committee
PCCM .... Primary Care Case Management
PCP .... Primary Care Physician
PCPI .... Physician Consortium for Performance Improvement
PDSA .... Plan-Do-Study-Act
PIP .... Performance Improvement Project
PR .... Peer Review
PTT .... Performance Tracking Tool
QA .... Quality Assurance
QAP .... Quality Assurance Program
QAPI .... Quality Assessment and Performance Improvement
QAPIS .... Quality Assessment and Performance Improvement Strategy
QISMC .... Quality Improvement System for Managed Care
SAMHSA .... Substance Abuse and Mental Health Services Administration

CHIP .... Children's Health Insurance Program
CHIPRA .... Children's Health Insurance Program Act
SCM .... Short-Term Case Management
SFY .... State Fiscal Year
SNF .... Skilled Nursing Facility
SSI .... Supplemental Security Income
UIC .... University of Illinois at Chicago
UR .... Utilization Review
VMC .... Voluntary Managed Care
VMCO .... Voluntary Managed Care Organization

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

The Illinois Department of Healthcare and Family Services (HFS) developed this Medicaid Managed Care Quality Assessment and Performance Improvement Strategy (QAPIS or Quality Strategy) in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.200 et. seq.

The Quality Strategy provides a framework to accomplish HFS' mission of empowering individuals enrolled in managed care programs to improve their health status while simultaneously containing costs and maintaining program integrity.

HFS is committed to providing quality health services through an integrated and coordinated delivery system that promotes and focuses on health outcomes, cost controls, accessibility to providers, accountability, and customer satisfaction. HFS, in conjunction with its vendors, seeks to improve the overall quality of care through better access to primary and preventive care, specialty referrals, enhanced care coordination, utilization management, and outreach programs leading to measurable quality improvement initiatives in all areas of managed care contracting and service delivery.

The Quality Strategy ensures the delivery of the highest quality and most cost-effective services possible by establishing a framework for ongoing assessment and identification of potential opportunities for health care 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.

Scope

The following are included in the scope of the Quality Strategy:

- All Medicaid managed care recipients in all demographic groups and in all service areas for which the managed care organizations (MCOs) are approved to provide Medicaid managed care services.
- All aspects of care, including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by Illinois Medicaid MCOs.
- All aspects of MCO performance related to access to care, quality of care, and quality of services—including networking, contracting, and credentialing; medical recordkeeping practices; environmental safety and health; health and disease management; and health promotion.

- All services covered, including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, and prescription drugs.
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings that serve managed care enrollees.
- All providers and any other delegated or subcontracted provider types that contract with MCOs.
- All aspects of MCO internal administrative processes related to service and quality of care, including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.

Illinois Medicaid Overview

The Department of Healthcare and Family Services (HFS) is responsible for the Medicaid program in Illinois. In conjunction with the federal government, the State provides medical services to about 20 percent of its population. HFS was formerly known as the Illinois Department of Public Aid.

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

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

Eligibility

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

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

Necessary medical benefits, as well as preventive care for children, are covered for eligible persons when provided by a health care provider enrolled with HFS. Eligibility requirements vary by program. Most people who enroll are covered for comprehensive services, including, but not limited to, doctor visits, well-child care, immunizations for children, mental health and

substance abuse services, hospital care, emergency services, prescription drugs, and medical equipment and supplies. Some programs, however, cover a limited set of services.

Medical Assistance Programs

To be eligible for medical benefits, a person must meet certain eligibility requirements. Broadly, the categories are (1) families, children, or pregnant women, and (2) aged, blind, or disabled persons. Medical coverage is provided to children, parents, or relatives caring for children, pregnant women, veterans, seniors, persons who are blind, and persons with disabilities. To be eligible, adults must be a U.S. citizen or a qualified immigrant, residing in Illinois. Noncitizens, age 19 or over, who do not meet citizenship/immigration criteria may qualify for emergency medical. Children are eligible regardless of immigration status. Individuals and families must also meet income and resource requirements. If the household meets all the non-financial requirements but has excess income and/or resources, then it may qualify for medical assistance under the spend down program.

The following lists eligibility requirements for Medical Assistance Programs:

1. *FamilyCare/All Kids* covers children through 18 years of age. Adults must be either a parent or caretaker relative with a child under 19 years of age living in their home, or be a pregnant woman. For all plans, non-pregnant adults must live in Illinois and be U.S. citizens or lawful permanent residents in the country for a minimum of five years. Children and pregnant women must live in Illinois and are eligible regardless of citizenship or immigration status.

2. *Aid to Aged, Blind, and Disabled* (AABD) provides medical benefits to persons 65 or older, persons who are blind, and persons with disabilities. The income standard for AABD is 100 percent of the federal poverty level (FPL). The resource standard for AABD is $2,000 for one person and $3,000 for a couple.

Primary Care Case Management (PCCM)

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

Under IHC, recipients can choose their own medical home/PCP while receiving the advantages of care coordination and case management. The program is mandatory statewide for most recipients with the exception of those who choose to enroll in the VMC program or those who are required to enroll in the Integrated Care Program.

IHC has over 5,600 medical homes with total available panel capacity to serve over 5.3 million HFS medical assistance program-eligible recipients statewide. The tables below present enrollment information for the IHC program. Table 1-1 presents the gender and age bands of IHC Medicaid, and Table 1-2 shows CHIP-enrolled recipients as of June 2012. Table 1-3 presents the non-match figures and Table 1-4 shows the ethnic composition of IHC enrollees.

Table 1-1—Illinois Health Connect Enrollment

GENDER/AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
<1 year	382,222	52,946
1–2 years	1,671,310	139,242
3–14 years	9,104,390	758,410
Females 15–18	1,075,053	89,978
Males 15–18	1,056,585	88,331
Females 19–34	2,663,908	226,029
Males 19–34	565,475	49,661
Females 35+	2,207,451	186,672
Males 35+	1,140,815	98,202
Total Medicaid	**19,867,208**	**1,689,471**

Table 1-2—Illinois Health Connect CHIP Enrollment

GENDER/AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
<1 year	78,879	11,159
1–2 years	165,307	13,828
3–14 years	542,131	46,282
Females 15–18	95,964	8169
Males 15–18	97,550	8293
Females 19–34	68,996	8256
Males 19–34	1013	85
Females 35+	16,582	2096
Males 35+	19	2
Total CHIP	**1,066,441**	**98,170**
TOTAL MEDICAID AND CHIP	**20,933,649**	**1,787,641**

Table 1-3 Illinois Health Connect Non-Match

GENDER/ AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
<1year non-match	2,798	400
1–2 years non-match	25,026	2248
3–14 years non-match	461,511	39,395
Females 15–18 non-match	133,448	11,258
Males 15–18 non-match	138,217	11,672
Females 19–34 non-match	6,733	563
Males 19–34 non-match	3,353	292
Females 35+ non-match	4,991	422
Males 35+ non-match	3,329	295
Total Non-Match	**779,407**	**66,545**
GRAND IHC TOTAL	**21,713,056**	**1,854,186**

Table 1-4—Illinois Health Connect Ethnic Composition

	Cook County			Downstate		
RACE	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO
American Indian/Alaska Native	10	57	67	32	100	45
Asian	5,946	27,163	1,304	3,231	16,532	533
Black	20,219	244,500	5,685	9,779	160,981	2,355
Did Not Answer/ Unknown	35,248	19,441	233,182	35,750	18,366	163,787
Hawaiian Native/ Other Pacific Islander	231	1,520	746	115	741	187
Multi-Race	1,448	1,357	113	512	3,651	273
White	20,875	109,444	73,942	48,798	527,114	58,806
TOTAL	**83,977**	**403,482**	**315,039**	**98,217**	**727,485**	**225,986**

Children's Health Insurance Program (CHIP)

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

1. *All Kids Share* covers children whose family income is over 133 percent and at or below 150 percent of the FPL.

2. *All Kids Premium Level 1* covers children whose family income is over 150 percent and at or below 200 percent of the FPL.

3. *All Kids Premium Level 2* covers children whose family income is above 200 percent and at or below 300 percent of the FPL.

4. *All Kids Rebate* provides families with full or partial reimbursement of premium costs, up to $75 per person per month, for private or employer-sponsored health insurance coverage of eligible children. To be eligible, families must have countable family income over 133 percent and at or below 200 percent of the FPL. To qualify, they must have health insurance that covers physician and inpatient hospital care.

5. *Moms and Babies* provides a full range of health benefits to eligible pregnant women and their babies up to one year of age. To be eligible, pregnant women living in Illinois must have countable family income at or below 200 percent of the FPL. Babies under one year of age are eligible at any income level if the mother was receiving medical benefits at the time of the child's birth.

Managed Care

The State's overall goal in utilizing managed care and other care coordination services is to improve the lives of participants by purchasing quality health services through an integrated and coordinated delivery system that promotes and focuses on health outcomes, cost controls, accessibility to providers, accountability, and customer satisfaction. HFS, in conjunction with its vendors, seeks to improve the overall quality of care through better access to primary and preventive care, specialty referrals, enhanced care coordination, utilization management, and outreach programs leading to measurable quality improvement initiatives in all areas of managed care contracting and service delivery.

Voluntary managed care (VMC) has been a health care option for medical assistance participants in Illinois since 1976 and continues to be a choice even with the implementation of

newer managed care models. The State contracts with MCOs to manage the provision of health care for HFS beneficiaries. MCOs include health maintenance organizations (HMOs) and managed care community networks (MCCNs). The State's contracts require the MCOs to offer the same comprehensive set of services to HFS beneficiaries that are available to the fee-for-service population, except certain services which are carved out and available through fee-for-service.

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

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

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

Voluntary Managed Care (VMC)

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

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

There are currently three MCOs that participate in VMC in Illinois: Family Health Network, Inc. (FHN), Harmony Health Plan of Illinois, Inc. (Harmony), and Meridian Health Plan, Inc. (Meridian). Enrollment figures for the VMC program are displayed in the tables below. Table 1-5 presents the gender and age bands of VMC Medicaid enrollment. Table 1-6 displays enrollment figures for CHIP-enrolled recipients as of June 2012. Table 1-7 presents non-match figures, and Table 1-8 presents the ethnic composition of VMC enrollees.

Table 1-5—Voluntary Managed Care Enrollment

GENDER/AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
<1 year	45,426	6,572
1–2 years	216,808	18,256
3–14 years	1,206,539	101,343
Females 15–18	150,881	12,691
Males 15–18	139,314	11,694
Females 19–34	386,151	32,857
Males 19–34	27,649	2,459
Females 35+	183,065	15,551
Males 35+	37,556	3,299
Total Medicaid	**2,393,389**	**204,722**

Table 1-6—Voluntary Managed Care CHIP Enrollment

GENDER/AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
<1 year	7,155	1,022
1–2 years	11,558	970
3–14 years	19,514	1,705
Females 15–18	4,114	353
Males 15–18	4,343	373
Females 19–34	2,858	336
Males 19–34	72	6
Females 35+	543	65
Total CHIP	**47,699**	**4,830**
TOTAL MEDICAID AND CHIP	**2,441,088**	**209,552**

Table 1-7—Voluntary Managed Care Non-Match

GENDER/AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
<1year non-match	101	13
1–2 years non-match	905	81
3–14 years non-match	32,376	2,747
Females 15–18 non-match	10,997	925
Males 15–18 non-match	13,236	1,111
Females 19–34 non-match	1,975	166
Males 19–34 non-match	325	28
Females 35+ non-match	372	31
Males 35+ non-match	51	5
Total Non-Match	**60,338**	**5,107**
GRAND VMC TOTAL	**2,501,426**	**214,659**

Table 1-8— Voluntary Managed Care Ethnic Composition

	Cook County			Downstate		
RACE	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO
American Indian/Alaska Native	5	10	19	0	6	0
Asian	124	704	77	14	120	14
Black	4,959	117,486	2,184	182	5,411	44
Did Not Answer/Unknown	4,234	2,171	44,914	276	166	2,235
Hawaiian Native/Other Pacific Islander	27	135	138	0	26	1
Multi-Race	41	159	20	2	47	13
White	1,266	7,268	12,373	469	6,508	811
TOTAL	**10,656**	**127,933**	**59,725**	**943**	**12,284**	**3,118**

Integrated Care Program (ICP)

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

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

With integrated care, members have:

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

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

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

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

Service Package II: Effective January 1, 2013, Service Package II of the ICP will deliver care coordination and waiver services through a mandatory managed care delivery system for participants in several 1915 c) HCBS waivers who are enrolled in the ICP.
Service Package II includes all long-term care services and the care provided through HCBS waivers, excluding waivers designed for individuals with developmental disabilities, including skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

Service Package III: Service Package III, scheduled for implementation in 2013, includes long-term care services and/or HCBS wavier services for enrollees with developmental disabilities. ICP participants in Illinois must choose between two health plans: Aetna Better Health (Aetna) and IlliniCare Health Plan, Inc. (IlliniCare). The contracts with these health plans contain 30 performance measures. These measures create an incentive for the health plans to direct money toward care that produces valued outcomes. The plans are rewarded for meeting pre-established targets for delivering quality health care services that result in:

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

Enrollment figures for the ICP are displayed in the tables below. Table 1-9 presents the gender and age bands of ICP enrollees as of June 2012, and Table 1-10 shows the non-match figures. Table 1-11 presents the ethnic composition of ICP enrollees.

Table 1-9—Integrated Care Program Enrollment

GENDER/AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
Females 19–34	38,599	3,244
Males 19–34	57,832	4,855
Females 35+	186,556	15,822
Males 35+	138,264	11,701
Total Medicaid	**421,251**	**35,622**

Table 1-10—Integrated Care Program Non-Match

GENDER/ AGE BAND	FY12 MEMBER MONTHS	JUNE 2012 MEMBERS
Females 19–34	24	2
Males 19–34	42	4
Females 35+	72	6
Males 35+	24	2
Total Non-Match	**162**	**14**
GRAND ICP TOTAL	**421,413**	**35,636**

Table 1-11—Integrated Care Program Ethnic Composition

	Cook County			Downstate		
RACE	**ETHNICITY UNKNOWN**	**NOT HISPANIC-LATINO**	**HISPANIC-LATINO**	**ETHNICITY UNKNOWN**	**NOT HISPANIC-LATINO**	**HISPANIC-LATINO**
American Indian/Alaska Native	5	1	1	0	2	1
Asian	209	1291	15	245	1662	14
Black	1,687	6,804	107	618	2,981	58
Did Not Answer/Unknown	720	716	1,710	641	348	1,785
Hawaiian Native/Other Pacific Islander	2	56	7	0	36	5
Multi-Race	0	4	1	0	15	0
White	1,368	5,099	930	1272	4,581	639
TOTAL	**3,991**	**13,971**	**2,771**	**2,776**	**9,625**	**2,502**

Enrollment

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

On average, each month HFS' programs cover nearly 1.7 million children; 168,000 seniors; 260,000 persons with disabilities; 636,000 non-disabled, non-senior adults; and approximately 297,000 additional enrollees with partial benefit packages (such as Illinois Healthy Women). Enrollment figures for SFY 2011 are displayed in Table 1-12 below.

Table 1-12—Illinois Medicaid Enrollment SFY 2011

TYPE OF BENEFITS	ENROLLMENT
Comprehensive Benefits	
Children	1,677,575
Adults with Disabilities	260,228
Other Adults	636,531
Seniors	168,943
Total Comprehensive	2,743,277
Partial Benefits	
Enrollees With Partial Benefits	309, 387
Total Enrollees	
Total Enrollees	3,052,664

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

Future of Managed Care

Coordinated Care Innovations Project

In 2012, Governor Pat Quinn and HFS launched the Coordinated Care Innovations Project with the aim of transforming how the State provides health care to low-income Illinoisans. The Innovations Project is an effort to redesign the health care delivery system to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and safety; and to implement IL Public Act 96-15011. The Innovations Project works to form alternative models of delivering care to Medicaid recipients through provider-organized networks, initially organized around the needs of the most complex recipients who are seniors and persons with disabilities. These provider-based networks will be organized as care coordination entities (CCEs) and managed care community networks (MCCNs). Under this project, Illinois will begin a shift toward moving at least 50 percent of its recipients into coordinated care programs that organize care around recipients' medical needs by 2015 as called for by the Medicaid reform law (PA 96-1501).

Medicare-Medicaid Alignment Initiative (MMAI)

Due to the fragmented care dual eligible beneficiaries often receive, Medicare and Medicaid often work at cross purposes and impede care coordination resulting in high costs of providing care to this population. In partnership with states, CMS is improving quality of care Medicare-Medicaid dual eligible enrollees receive by expanding access to seamless, integrated programs. The State is focusing efforts on improving care for dual eligible beneficiaries while reducing cost growth through its Innovations Project initiatives.

In Illinois, full dual eligible beneficiaries make up 10.3 percent of Medicaid full benefit enrollment as of December 31, 2010, and 30.0 percent of Medicaid calendar year 2010 net claims-based costs. The MMAI Demonstration will integrate Medicare and Medicaid benefits and services to create a unified delivery system that is easier for beneficiaries to navigate. In addition, integrated financing streams will help to improve care delivery and coordination by eliminating conflicting incentives between Medicare and Medicaid that encourage cost shifting, reduce beneficiary access to high-quality care and community-based services, and result in a lack of care management for chronic conditions. The State and CMS will contract with managed care entities that will be accountable for the care delivered to dual eligible beneficiaries including robust care coordination efforts where performance will be measured and payment will be tied to quality measurement goals. The Demonstration, if approved will ensure access to all Medicare and Medicaid benefits and comprehensive services that address enrollees' full range of needs.

HFS anticipates enrolling up to an estimated 137,000 seniors and persons with disabilities in the Greater Chicago and Central Illinois regions. Participation will be voluntary. The State is working with CMS to develop an implementation timeline, including time for extended stakeholder input. Care delivery will be anchored in a medical home and supported by care teams that are tailored and personalized to meet individual care needs and focused on providing a multidisciplinary approach to care delivery, care coordination, and care management for those with complex needs.

The focus on a population such as the dual-eligible, particularly one where an innovative approach is needed, creates both opportunities and challenges with respect to measurement. Although there is increased awareness that the next generation of performance measurement should more nimbly follow a patient through many care experiences, rather than one disease in one setting at a time, this measurement vision will take time to achieve. HFS uses its external quality review organization (EQRO) to assist with literature reviews to determine measures being developed or existing measures that can be adapted for use. As an example, HFS, the EQRO, and the ICP plans worked collaboratively to develop measures specific to ICP members. Through this collaboration, 30 performance measures were identified along with a data specifications document that outlines the measure specifications.

HFS will continue its effort to stay abreast of current trends, research, and best practices regarding the development of measures for integrated care programs, including care coordination entities and dual eligible populations, and use these resources in future program enhancements.

Managed Care Organization Acronyms

Throughout this document, the health plans that serve Illinois Medicaid recipients are referred to as Managed Care Organizations (MCOs). However, due to Illinois' different managed care delivery systems (as detailed above), it is sometimes necessary to distinguish between MCOs that offer services through Illinois' Voluntary Managed Care from the MCOs that participate in the Integrated Care Program. For example, HFS has targeted distinct performance measures for each of these programs. The terms voluntary MCO (VMCO) and ICP will be used to refer to the health plans in mention.

For more information about Illinois' managed care programs, visit the following Web site: http://www.hfs.illinois.gov/managedcare/.

Goals and Strategies

Consistent with its mission, HFS has identified the following goals for its Quality Strategy. Additionally, in an effort to ensure consistent focus on the accomplishment of Quality Strategy goals, HFS has identified target strategies toward each goal.

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

1.1 Geo-Access Network Reporting

1.2 Appointment Availability Monitoring

1.3 24/7 Nurse Advice Line Access

1.4 Healthcare Effectiveness Data and Information Set (HEDIS®[1]) and HEDIS-like Performance Measures

1.5 Cultural Considerations

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

2.1 Clinical Quality Focused Studies

2.2 Age-Appropriate Preventive Care

2.3 Early Periodic Screening, Diagnosis and Treatment (EPSDT) Performance Improvement Project (PIP)

2.4 Preconception and Interconceptual Care

2.5 Pay-for-Performance (P4P) Programs

2.6 HEDIS and HEDIS-like Performance Measures

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

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

3.1 Medical Home—Intensive Case Management for Chronically Ill Recipients

3.2 Care and Disease Management Programs

3.3 EPSDT Collaborative PIP

3.4 Perinatal Care and Depression Screening PIP

3.5 Behavioral Health PIP

3.6 Special Health Care Needs (SHCNs)

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

4.1 NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Consumer Satisfaction Survey

4.2 Member Grievances, Appeals, and Complaints

4.3 State Fair Hearings

Goal 5: Ensure efficient and effective administration of Illinois Medicaid Managed Care Programs.

5.1 Quality Assurance Program (QAP)

5.2 Performance Improvement Projects (PIPs)

5.3 Monitoring of Performance Measures

5.4 Comprehensive Administrative Review

5.6 Over- and Underutilization

5.7 Program Integrity—Fraud and Abuse

5.8 Practice Guidelines

5.9 Health Information Systems

Priority Measures

To focus continuous quality improvement efforts toward the aims of the Quality Strategy, HFS has identified the following priority measures to align with the goals of the Quality Strategy. The measures will help MCOs focus their quality improvement efforts. It is HFS' expectation that by targeting specific priorities, more consistent improvement in these areas can be

achieved. Performance for many of these measures is determined using the Quality Improvement System for Managed Care (QISMC) hybrid method.

To establish minimum performance goals (benchmarks), HFS uses a QISMC hybrid methodology. This methodology takes into consideration high performance levels (HPLs) and minimum performance levels (MPLs) and is used when HEDIS scores are above the established goals. The goal for all measures to increase performance by 10 percent refers to the QISMC hybrid methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent or fall below the national 25th percentile for the measure.

For example, if a plan had a goal of 80 percent and reached 90 percent, the QISMC method would call for an improvement of 1 percent (i.e., 10 percent of the adverse outcome rate of 10 percent), indicating an expectation of reaching 91 percent. In contrast, the QISMC hybrid method expects only that the MCO will stay above the 80 percent goal. Similarly, the hybrid method allows for “bottom” goals. If, for example, an MCO is at 10 percent and the national benchmark for the 25th percentile is 23 percent, the QISMC method calls for an improvement of 9 percent (i.e., 10 percent of the adverse outcome rate of 90 percent), indicating a goal of 19 percent. In contrast, the hybrid method calls for the MCO to perform at least at the MPL of 23 percent. When the MPL is achieved, the normal QISMC calculation would apply.

The VMC priority measures table in Appendix A identifies the priority measures for VMC, the 2011 and 2012 HEDIS performance rate for each health plan, as well as the 2013 hybrid QISMC goal for 2013 (which is calculated based on the 2012 rate).

The ICP priority measures table in Appendix B identifies priority measures for the ICP and a 2013 QISMC goal. The ICPs have only been in operation since May 2012, so they were not able to report baseline rates in 2012. For purposes of measuring the priority measures, calendar year 2010 will be considered the initial baseline year. HFS used the rates reported for members who were previously enrolled in the fee-for-service program but who are now enrolled in an ICP to derive a baseline rate. These rates represent the performance on these measures while these members were participating in the fee-for-service program. This baseline rate was then used to calculate a QISMC goal for 2013. By developing a QISMC goal via this method, the State was able to establish a baseline for performance for the new program. For the first two years, the target goal will be set as a percentage above the baseline equal to 10 percent of the difference between the baseline score and 100 percent. When the ICPs report actual baseline rates in 2013, these will be used to calculate future QISMC target goals. For example, if the baseline is 50 percent, 10 percent of the difference between 50 percent and 100 percent is 5 percent; therefore, the goal will be set at 55 percent.

Each priority measure has been identified in accordance with the Quality Strategy goals. The tables below chart this alignment and identify the specific improvement target. For many measures, the QISMC calculation is used to target a 10 percent improvement in performance from the previous year (as calculated in the QAPIS table).

Table 1-13—Priority Measures for Voluntary Managed Care

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	GOAL ALIGNMENT	IMPROVEMENT TARGET
Child and Adolescent Care	*Childhood Immunization Status—Combination 3*	1.4	10% improvement from previous year using QISMC methodology
	Lead Screening in Children		
	Well-Child Visits in the First 15 Months (0 visits)		
	Well-Child Visits in the First 15 Months (6 or More Visits)		
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
	Adolescent Well-Care Visits		
Access and Availability	*Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years*	1.4	
Preventive Screening for Women	*Cervical Cancer Screening*	2.2, 2.5, 2.6	
Maternity-Related Care	*Timeliness of Prenatal Care*	1, 2, 3	
	Postpartum Care		
Chronic Conditions/Disease Management	*Comprehensive Diabetes Care—HbA1c Testing*	2	
	Comprehensive Diabetes Care—Poor HbA1c Control		
	Comprehensive Diabetes Care—Monitoring Nephropathy		
	Asthma—Combined Rate		
Behavioral Health	*Follow-up After Hospitalization for Mental Illness—30 days*	2	
Consumer Satisfaction	*Getting Needed Care*	4	VMCOs establish performance goals based on the results of the prior year's survey
	Getting Care Quickly		
	Rating of Health Plan		
	Rating of Personal Doctor		
	Rating of Specialist Seen Most Often		

Table 1-14—Priority Measures for Integrated Care Program[2]

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	GOAL ALIGNMENT	IMPROVEMENT TARGET
Behavioral Health	*Follow-Up With a Provider Within 30 Days After an Initial Behavioral Health Diagnosis*	2	10% improvement from baseline rate using QISMC methodology
	Follow-up After Hospitalization for Mental Illness Within 30 days of Discharge		
	Antidepressant Medication Management		
Dental	*Annual Dental Visit—DD only*	1,2	
Diabetes	*Comprehensive Diabetes Care*	2	
Cardiovascular Conditions	*Congestive Heart Failure*	2	
	Coronary Artery Disease	2	
Respiratory Conditions	*Pharmacotherapy Management of COPD Exacerbation*	2	
Use of Services	*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Enrollees*	5	
	Ambulatory Care—Follow-up With a Provider Within 14 Days of ED Visit	1,2	
	Ambulatory Care—Follow-up With a Provider Within 14 Days of Inpatient Discharge	1,2	
Access and Availability	*Access to Enrollee's Assigned PCP*	1	
Consumer Satisfaction	*Getting Needed Care*	4	ICPs establish performance goals based on the results of the prior year's survey
	Getting Care Quickly		
	Rating of Health Plan		
	Rating of Personal Doctor		
	Rating of Specialist Seen Most Often		

[2] Please see Appendix C for a more detailed list of ICP performance measures.

Quality and Appropriateness of Care and Services Delivered to Enrollees

As required by the Code of Federal Regulations (CFR) 438.202(d), this section describes how the State assesses how well the managed care program is meeting the objectives outlined in the introduction. The Illinois Department of Healthcare and Family Services (HFS) has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure Managed Care Organization (MCO) compliance with contract requirements and to evaluate MCO performance. Reporting is required on a monthly, quarterly, and annual basis. HFS holds monthly conference calls and quarterly face-to-face meetings with MCOs to review performance. HFS contracts with an External Quality Review Organization (EQRO) to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR 438.356, HFS contracts with an EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR 438.358. The EQRO performs services in accordance with 42 CFR, parts 430, 433, 434, and 438, and the Balanced Budget Act (BBA) of 1997.

The following are key areas related to assessment that the BBA regulations designate as required components of the HFS' overall Quality Strategy. The subject of each segment is followed by its relevant federal citation as a reference.

Procedures for Race, Ethnicity, and Primary Language Data Collection and Communication (42 CFR 438.204[b][2])

To comply with the regulatory requirement for State procedures for race, ethnicity, and primary language spoken (CFR 438.206-438.210), HFS requires the MCOs to participate in Illinois' efforts to promote the delivery of service in a culturally competent manner to all enrollees. This includes those with limited English proficiency and diverse cultural and ethnic backgrounds. HFS identifies the race, ethnicity, and primary language spoken for each Medicaid enrollee and provides this information to the MCOs at the time of enrollment as Section 438.204 of the BBA requires. This statute requires HFS to establish a methodology for identifying the race, ethnicity, and prevalent non-English languages for MCO enrollees. HFS has defined prevalent non-English language as one in which 5 percent or more of families within the low-income households in the relevant Department of Human Services local office area speak a language other than English (as determined by HFS according to published Census Bureau data).

At this time, Spanish is the only prevalent non-English language in the areas covered by the Illinois MCO contracts. HFS will pass an indicator designating the language to the MCOs in the 834 transaction, loop 2100A (Member Language), Segment LUI02. HFS will pass the race/ethnicity indicator to the MCOs in the 834 transaction, loop 2100A (Member Demographics), Segment DMG05.

To promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, HFS requires the MCOs to develop and implement a cultural competency plan. The written cultural competency plan may be a component of the MCO's written quality improvement program or a separate document incorporated by reference. The MCOs are required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is a non-English language.

Marketing materials, enrollee handbooks, and any information or notices must be easily understood by individuals who have a sixth-grade reading level. HFS and the EQRO reviews and approves all member materials as part of a readiness review for all new MCOs entering the Illinois Medicaid managed care program. In addition, the EQRO monitors compliance with requirements during the comprehensive compliance review.

Identification of Members With Special Health Care Needs (42 CFR 438.204[b][1])

HFS monitors quality and appropriateness of services for enrollees with special health care needs through compliance monitoring activities and regular review of MCO deliverables. HFS also monitors services provided to enrollees with special health care needs to identify the need for continued services throughout treatment to ensure that all services are medically necessary according to federal Medicaid regulations at CFR 440.110.

MCOs coordinate health care services for Medicaid and Children's Health Insurance Program (CHIP) recipients who are identified as Children with Special Health Care Needs (CSHCN) and who remain voluntarily enrolled in the plan. MCOs are required to submit a CSHCN plan, which is reviewed and approved by HFS. HFS' contractual requirements hold the MCOs responsible for the following:

- Establishing a CSHCN program with the goal of conducting timely identification and screening, assuring a thorough and comprehensive assessment, and providing appropriate and targeted case management services.

- Implementing mechanisms to identify CSHCNs who are in need of a follow-up assessment, including PCP referrals, outreach, and contacting newly enrolled children.
- Assessing members identified as CSHCN members, including, but not limited to the following: use of a CSHCN Standard Assessment Tool and completion of the assessment by a physician (or other allowable medical professional).
- Providing all CSHCN members with case management services, including the components required for case management and the elements listed in the case management requirements.
- Notifying all CSHCN members with a positive assessment and determined to need case management of their right to directly access a specialist.

Arrangement for External Quality Review (42 CFR 438.204[d])

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, HFS contracts with an EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR 438.358. The EQRO performs services in accordance with 42 CFR, parts 430, 433, 434, and 438, and the Balanced Budget Act of 1997. The EQRO is required to use the tools published by the Centers for Medicare & Medicaid Services (CMS) for the development of its oversight and monitoring process, to the extent possible and applicable to HFS' managed care program. The EQRO updates its monitoring assessment tools, as necessary, to assess each MCO's compliance with its quality assurance program (QAP), as federally mandated.

To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, HFS' EQRO conducts the following mandatory EQR activities.

Compliance Review. HFS' EQRO conducts comprehensive internal quality assessment program (IQAP) on-site compliance reviews of the MCOs at least once in a three-year period. HFS' EQRO reviews MCO compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.

Validation of Performance Measures. In accordance with 42 CFR 438.240(b)(2), HFS requires MCOs to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. HFS uses performance measures to assess compliance with care standards and level of enrollee satisfaction. To comply with 42 CFR 438.240(b)(2), HFS' EQRO validates the performance measures through Healthcare

Effectiveness Data and Information Set (HEDIS®) Compliance Audits™. The HEDIS Compliance Audits focus on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. As part of the HEDIS Compliance Audits, the Department's EQRO also explores the issue of completeness of claims and encounter data to evaluate reported rates for the performance measures.

HFS uses HEDIS and HEDIS-like methodologies to develop, collect, and report data for most performance measures. HEDIS measures are standardized, nationally accepted measures for specific health indicators. HEDIS-like measures are HEDIS measures that have been modified to reflect data limitations in Illinois. Non-HEDIS measures have been developed by HFS in cases where no such HEDIS measure exists. The performance measures provide trend information, which may provide guidance in designing focused interventions for quality improvement by MCOs. To establish minimum performance goals (i.e., benchmarks), HFS uses a Quality Improvement System for Managed Care (QISMC) methodology. The QISMC methodology takes into consideration high performance levels (HPLs) and minimum performance levels (MPLs) and is used when HEDIS scores are above the established goals or fall below the national 25th percentile for the measure. If MPLs are not achieved, MCOs are required to develop and submit corrective action plans with interventions that will assist them in meeting MPLs.

HEDIS Benchmarks and Percentiles. A benchmark is a standard by which something can be measured or judged. Benchmarks are used to compare HFS' performance measures to national standards in order to improve performance. A percentile identifies where a particular score is relative to the other scores being reported to a measure. Percentiles provide a comparative understanding of where a score, or measure, falls relative to others. A percentile represents the percentage of scores that are below a particular score. For example, the 75th percentile is the point where 75 percent of the scores fall below that point.

CMS 416 Measures. The CMS 416 is an annual report that measures federally-mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children enrolled in Medicaid (Title XIX). The CMS 416 measures compare the number of children eligible for EPSDT services to the number of children who received those services.

NCQA Benchmarking. HFS uses HEDIS data whenever possible to measure MCO performance with specific indicators of quality, timeliness, and access to care. HFS is committed to working with CMS in the development process of national performance measures. It is HFS'

NCQA HEDIS Compliance Audit ™ is a trademark of the National Committee for Quality Assurance (NCQA).

understanding that there have been no national performance measures for managed care developed by CMS and the health care industry for states to monitor at the current time. It is understood that the State will be consulted in each phase of the development process at the point CMS undertakes their development. HFS is currently monitoring the performance measures recognized by CMS as being important in other areas, such as EPSDT participation (CMS 416), childhood immunization rates, adequate prenatal care, adult preventive care, and behavioral health utilization.

Validation of Performance Improvement Projects (PIPs). As described in 42 CFR 438.240(b)(1), HFS requires MCOs to conduct PIPs in accordance with 42 CFR 438.240(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR 438.358(b)(1), HFS' EQRO validates PIPs required by the State to comply with the requirements of 42 CFR 438.240(b)(1). HFS' EQRO validation determines 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 enrollee satisfaction.

EQR Technical Report. The BBA, Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed, and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCOs. HFS' EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed. The EQR technical report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid. In accordance with 42 CFR 438.364, the report includes the following information for each mandatory activity conducted:

- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data

The report also includes an assessment of MCO strengths and weaknesses, as well as recommendations for improvement. HFS uses the information obtained from each of the mandatory EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the Quality Strategy.

Non-duplication of Mandatory External Quality Review Activity. The federal managed care regulations, at 42 CFR §438.360, provide an optional mechanism for states to use to prevent

duplication of the mandatory compliance monitoring activities for its managed care plans when a plan has had a similar review performed by either Medicare or an approved national accrediting organization. Managed care organizations, therefore, can be considered to have "deemed" compliance. Standards reviewed by the accrediting organization must be duplicative of the state's standards for access, structure and operations, and measurement and improvement. Two areas that may not be considered to be deemed compliant on the basis of this alternative review are conducting PIPs and the calculation of performance measures.

CMS has received and approved deeming applications from the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC) as of January 24, 2003. On May 26, 2006, CMS also approved URAC as an accrediting organization with deeming authority. Both NCQA and URAC have published crosswalks of their standards with the CMS Medicaid regulations, and HFS is aware that these crosswalks are published on the NCQA and URAC Web sites.

MCOs have a requirement to submit quality assurance information to the Illinois Department of Public Health. That agency accepts the documentation prepared for HFS to satisfy, in part, their requirements to avoid duplication of effort on the part of the MCOs.

State Monitoring and Evaluation of MCO Requirements (42 CFR 438.204[b][3])

HFS holds MCOs accountable for effective and efficient administration of quality health care services to the Medicaid population. The State has developed a robust system to monitor, evaluate, and ensure compliance with standards to improve the quality of services Medicaid managed care members receive. HFS has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure MCO compliance with contract requirements and evaluate MCO performance. Reporting is required on a monthly, quarterly, and annual basis for both Voluntary Managed Care Organizations (VMCOs) and Integrated Care Program (ICP) plans as demonstrated in the reporting tables found in Appendix D (VMCO) and Appendix E (ICPs).

Performance Standards

Access to Care Standards

The contracts between HFS and the MCOs detail Illinois Medicaid standards for access to care, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. HFS' standards

for access to care are as stringent as those in 42 C.F.R. 438.206–438.210. MCOs are required to implement the following standards for access to care:

- Availability and accessibility of all covered services (42 CFR 438.206)
- Assurances of adequate capacity and services (42 CFR 438.207)
- Coordination and continuity of care (42 CFR 438.208)
- Coverage and authorization of services (42 CFR 438.210)

For a detailed description of Illinois' access to care standards and MCO contractual requirements, please see Appendix F.

Other HFS Requirements Related to Access. Additional Information related to the access to care standard regarding mechanisms HFS uses to identify persons with special health care needs can be found in Appendix F.

Structure and Operations Standards

State standards for structure and operations are as stringent as those in 42 C.F.R. 438.214–438.230, as detailed below.

- Provider selection and retention (42 CFR 438.214)
- Enrollee information (42 CFR 438.218)
- Enrollee rights (42 CFR 438.100)
- Confidentiality (42 CFR 438.224)
- Enrollment and disenrollment (42 CFR 438.226)
- Grievance systems (42 CFR 438.228)
- Subcontractual relations and delegation (42 CFR 438.230)

For a detailed description of the grievance system, see Appendix G. Illinois' structure and operations standards and MCO contractual requirements are detailed in Appendix F.

Other HFS Requirements Related to Structure and Operations. Additional information related to the structure and operation standards regarding HFS' procedures for the review of records of MCO grievance and appeals can be found in Appendix F.

Quality Measurement and Improvement Standards

Standards for quality measurement and improvement are as stringent as those in 42 C.F.R. 438.236–438.242, as detailed below.

- Practical/clinical guidelines (42 CFR 438.236)
- Quality assessment and performance improvement program (42 CFR 438.240)
- Health information system (42 CFR 438.242)

For a detailed description of Illinois' quality measurement and improvement standards and MCO contractual requirements, please see Appendix F.

Other HFS Requirements Related to Quality Measurement and Improvement. Additional information related to the quality measurement and improvement standards, including how the State determines MCO compliance with contract requirements (performance goals) can be found in Appendix F.

Measurement of Recipient Satisfaction

HFS also uses consumer satisfaction surveys to monitor MCO and provider performance, measure recipient satisfaction with services and access to care, and evaluate program characteristics. Each year, the MCOs are required to independently administer a consumer satisfaction survey. MCOs administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®[1]) 4.0 surveys. The Primary Care Case Management (PCCM) program uses a hybrid survey to assess patient satisfaction with the medical home. The primary objective of the CAHPS and hybrid surveys is to obtain information effectively and efficiently on the level of satisfaction Medicaid Illinois recipients have with their health care experiences. The surveys ask recipients to report on and evaluate their experiences with health care and cover topics important to recipients, such as the communication skills of providers, the accessibility of services, and satisfaction with the health plan. MCOs survey two populations: adults and children.

Performance Measures

HFS has also identified HEDIS, HEDIS-like, and other State-defined performance measures to drive continuous quality improvement in strategic target areas. Some of these measures are identified as pay-for-performance (P4P) measures, which create an incentive for health plans to spend money on care that produces valued outcomes. The health plans are rewarded for meeting pre-established targets for delivering quality health care services that result in (1) better health for the member, (2) better quality of life for the member, and (3) reduction in the cost of the service over time.

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

Summary of Voluntary Managed Care (VMC) Requirements

The contracts for Voluntary Managed Care with Family Health Network, Inc. (FHN), Harmony Health Plan of Illinois, Inc. (Harmony), and Meridian Health Plan, Inc. (Meridian) contain performance measures, of which eight are P4P measures. Current and trended performance can be found in Appendix H (FHN, trended), Appendix I (Harmony, trended) and Appendix J (all VMCOs, 2012). Below, Table 2-1 outlines the performance standards, consumer satisfaction survey measures, and performance measures (including P4P) for VMC. Required PIPs are also identified. See Appendix J for a more detailed full list of VMC performance measures including P4P measures.

Table 2-1—Performance Standards and Measures for VMC

PERFORMANCE STANDARDS	QUALITY	TIMELINESS	ACCESS
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations		√	√
Measurement and Improvement	√		
Grievance System		√	√
CONSUMER SATISFACTION SURVEYS	**QUALITY**	**TIMELINESS**	**ACCESS**
Getting Needed Care		√	√
Getting Care Quickly		√	√
Rating of Health Plan	√		
Rating of Personal Doctor	√		
Rating of Specialist Seen Most Often	√		

CATEGORY	HEDIS PERFORMANCE MEASURES	QUALITY	TIMELINESS	ACCESS
Child and Adolescent Care	*Childhood Immunization Status (Combinations 2 and 3)*	√	√	√
	Lead Screening in Children	√		
	Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)	√	√	√
	Adolescent Well-Care Visits	√	√	√
	Immunizations for Adolescents (Combined Rate)	√	√	√
Access to Care	*Children's and Adolescents' Access to Primary Care Practitioners*			√
	Adults' Access to Preventive/Ambulatory Care			√
Maternity-Related Care	*Frequency of Ongoing Prenatal Care (0–21 Percent and 81–100 Percent of Visits)*	√		

Table 2-1—Performance Standards and Measures for VMC (cont.)

CATEGORY	HEDIS PERFORMANCE MEASURES	QUALITY	TIMELINESS	ACCESS
Preventive Screening for Women	*Breast Cancer Screening*	√		√
	Chlamydia Screening in Women (Combined Rate)	√		√
Chronic Conditions/ Disease Management	*Controlling High Blood Pressure (Combined Rate)*	√		
	Comprehensive Diabetes Care	√		
	Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day)	√		
P4P MEASURES				
Child and Adolescent Care	*Childhood Immunization Status—Combination 3*	√	√	√
	Well-Child Visits in the First 15 months (6 or More Visits)	√	√	√
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	√	√	√
Preventive Screening for Women	*Cervical Cancer Screening*	√		√
Maternity-Related Care	*Timeliness of Prenatal Care*	√	√	√
	Postpartum Care	√	√	√
Chronic Conditions/ Disease Management	*Diabetes—HbA1c Testing*	√		
	Use of Appropriate Medications for People With Asthma (Combined Rate)	√		
QUALITY IMPROVEMENT PROJECTS		**QUALITY**	**TIMELINESS**	**ACCESS**
Statewide Collaborative PIP—EPSDT		√	√	√
Statewide Collaborative PIP—Perinatal Care and Depression Screening		√	√	√
Statewide Collaborative PIP—Improving Ambulatory Follow-Up and Communication		√	√	√

Summary of Integrated Care Program (ICP) Requirements

The Integrated Care Program contracts with Aetna and IlliniCare contain 30 performance measures. Of the measures, 12 are P4P measures, as displayed in the table below. Because the ICP was implemented in 2011, performance on the HEDIS, HEDIS-like, and State-defined measures will not be available until 2013. Below, Table 2-2 outlines the performance standards, consumer satisfaction survey measures, performance measures (including P4P), and required PIPs. See Appendix C for a more detailed full list of ICP performance measures including P4P measures.

Table 2-2—Performance Standards and Measures for ICP

PERFORMANCE STANDARDS		QUALITY	TIMELINESS	ACCESS	UTILIZATION
Enrollee Rights and Protections Standards			√	√	
Access Standards			√	√	
Structure and Operations			√	√	
Measurement and Improvement		√			
Grievance System			√	√	
CONSUMER SATISFACTION SURVEYS		**QUALITY**	**TIMELINESS**	**ACCESS**	**UTILIZATION**
Getting Needed Care			√	√	
Getting Care Quickly			√	√	
Rating of Health Plan		√			
Rating of Personal Doctor		√			
Rating of Specialist Seen Most Often		√			
CATEGORY	**PERFORMANCE MEASURES**	**QUALITY**	**TIMELINESS**	**ACCESS**	**UTILIZATION**
Behavioral Health	*Behavioral Health Risk Assessment and Follow-Up*	√	√	√	
	Follow-Up after Hospitalization Mental Illness	√			
	Initiation of Alcohol and Other Drug Dependence Treatment			√	
	Engagement of Alcohol and Other Drug Dependence Treatment			√	
Immunization	*Care Coordination Influenza Immunization Rate*	√			

Table 2-2—Performance Standards and Measures for ICP (cont.)

CATEGORY	PERFORMANCE MEASURES	QUALITY	TIMELINESS	ACCESS	UTILIZATION
Dental	*Dental Emergency Room (ER) Visit*				√
	Annual Dental Visit	√			
Diabetes	*Comprehensive Diabetes Care*	√			
Use of Services	*Inpatient Utilization—General Hospital/Acute Care*				√
	Mental Health Utilization				√
	Inpatient Hospital 30-Day Readmission Rate	√			
	Inpatient Mental Hospital 30-Day Readmission Rate	√			
Retention Rate for LTC and HCBS Waiver Enrollee Services in the Community	*LTC and HCBS Waiver Enrollees in the Community at the Beginning of the Year and Continued to Be Served in the Community During the Year*	√			
Long Term Care	*Long-Term Care Urinary Tract Infection Admission Rate*				√
	Long-Term Care Bacterial Pneumonia Admission Rate				√
	Long-Term Care Residents That Have Category II or Greater Pressure Ulcers	√			
Medication Management	*Annual Monitoring for Patients on Persistent Medications*	√			
	Medication Monitoring for Patients With Schizophrenia (12 Months Antipsychotics)	√			
	Medication Monitoring for Patients With Schizophrenia (6 Months Antipsychotics)	√			
Prevention and Screening	*Colorectal Cancer Screening*	√			
	Breast Cancer Screening	√			
	Cervical Cancer Screening	√			
	Adult BMI Assessment	√			

Table 2-2—Performance Standards and Measures for ICP (cont.)

CATEGORY	PERFORMANCE MEASURES	QUALITY	TIMELINESS	ACCESS	UTILIZATION
P4P MEASURES					
Behavioral Health	*Follow-Up With Any Provider Within 30 Days After an Initial Behavioral Health Diagnosis*	√	√	√	
	Follow-Up With a Mental Health Provider Within 30 Days of Discharge for Mental Illness	√	√	√	
	Antidepressant Medication Management	√			
Dental	*Annual Dental Visit—DD Only*	√		√	
Diabetes	*Comprehensive Diabetes Care*	√			
Cardiovascular Conditions	*Congestive Heart Failure*	√			
	Coronary Artery Disease	√			
Respiratory Conditions	*Pharmacotherapy Management of COPD Exacerbation*	√			
Use of Services	*Ambulatory Care—Emergency Department (ED) Visits per 1,000 Enrollees*				√
	Ambulatory Care Follow-up With a Provider Within 14 Days of ED Visit	√	√	√	
	Ambulatory Care Follow-up With a Provider Within 14 Days of Inpatient Discharge	√	√	√	
Access and Availability	*Access to Member's Assigned PCP*			√	
QUALITY IMPROVEMENT PROJECTS		**QUALITY**	**TIMELINESS**	**ACCESS**	**UTILIZATION**
Statewide Collaborative PIP—Community-Based Care Coordination		√	√	√	

Summary of CHIPRA Requirements

Due to receiving a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant, HFS is undergoing program restructuring to improve the quality of services delivered through CHIP programs. To ensure quality improvement, HFS has identified CHIPRA performance measures that the VMCOs are required to report. Results for the CHIPRA

measures will not be available until 2013. Below, Table 2-3 outlines the performance standards, consumer satisfaction survey measures, and performance measures for the CHIPRA program. Required PIPs are also identified. See Appendix K for a more detailed full list of CHIPRA core measures.

Table 2-3—CHIPRA Performance Standards and Measures

PERFORMANCE STANDARDS	QUALITY	TIMELINESS	ACCESS
Enrollee Rights and Protections Standards		√	√
Access Standards		√	√
Structure and Operations		√	√
Measurement and Improvement	√		
Grievance System		√	√
CONSUMER SATISFACTION SURVEYS[2]	**QUALITY**	**TIMELINESS**	**ACCESS**
Getting Needed Care		√	√
Getting Care Quickly		√	√
Rating of Health Plan	√		
Rating of Personal Doctor	√		
Rating of Specialist Seen Most Often	√		

CATEGORY	HEDIS PERFORMANCE MEASURES	QUALITY	TIMELINESS	ACCESS
Child and Adolescent Care	*Childhood Immunization Status (Combinations 2–10)*	√	√	√
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	√		
	Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)	√	√	√

[2] CAHPS 4.0 Children with Chronic Conditions (CCC).

Table 2-3—CHIPRA Performance Standards and Measures (cont.)

CATEGORY	HEDIS PERFORMANCE MEASURES	QUALITY	TIMELINESS	ACCESS	UTILIZATION
Child and Adolescent Care	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	√	√	√	
	Developmental Screening in the First Three Years of Life	√	√	√	
	Adolescent Well-Care Visits	√	√	√	
	Immunizations for Adolescents (Combined Rate)	√	√	√	
Access to Care	*Children's and Adolescents' Access to Primary Care Practitioners*			√	
Maternity-Related Care	*Frequency of Ongoing Prenatal Care (0–21 percent and 81–100 Percent of Visits)*	√			
	Timeliness of Prenatal Care	√	√	√	
	Timeliness of Postpartum Care	√	√	√	
Preventive Screening	*Chlamydia Screening in Women (Combined Rate)*	√		√	
Chronic Conditions/ Disease Management	*Annual Pediatric Hemoglobin A1C Testing*	√			
	Appropriate Testing for Children With Pharyngitis	√			
Use of Services	*Emergency Department Visits*				√
	Annual Number of Asthma Patients Ages 2–20 with ≥1 Asthma-related ER Visit				√
Behavioral Health	*Antidepressant Medication Management Follow-up Care for Children Prescribed ADHD Medication*	√	√	√	
	Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day)	√	√	√	
QUALITY IMPROVEMENT PROJECTS		**QUALITY**	**TIMELINESS**	**ACCESS**	**UTILIZATION**
Statewide Collaborative PIP—EPSDT		√	√	√	

Evaluating MCO Compliance

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

The areas described below are reviewed on an ongoing basis.

- Assuring the MCO (Health Maintenance Organization [HMO]) has a certificate of authority (license), an approved certificate of coverage from the Illinois Department of Insurance, and an approval from the Illinois Department of Public Health to provide managed care services to enrollees.
- Assuring the MCO (Managed Care Community Network [MCCN]) meets HFS' regulatory requirements.
- Coordinating monitoring of the fiscal components of the contract that are performed by HFS' Office of Health Finance.
- Performing the initial, comprehensive readiness review and prior approval of the MCO's products and plans to comply with each aspect of the contract.
- Providing prior approval on all enrollee and potential enrollee written materials, including marketing materials.
- Ensuring that an information management system exists with sufficient resources to support MCO operations.
- Reviewing and providing approval (or requiring revision) on the MCO's submission of required reports or documentation on the following schedule, as appropriate: initially, as each event occurs; as revised; and on a monthly, quarterly, and/or annual basis.

- Performing on-site compliance monitoring visits, such as attendance at MCO meetings for performance reviews of quality assurance, or compliance checks, such as calling to assess after-hours availability.
- Maintaining a historical registry of marketing representatives, tracking marketing meeting schedules, handling marketing complaints, and addressing marketing concerns.
- Performing network adequacy reviews, including prior approval of primary care providers to assure that they are enrolled in, and in good standing with, the Medical Assistance Program in one of the five primary care specialties allowed in the contract.
- Monitoring physician terminations and site closures to assure appropriate transfers and network adequacy.
- Monitoring encounter data for data file format, error rate of claims processing, and completeness.
- Monitoring of utilization data.
- Maintaining ongoing dialogue with, and providing technical assistance to, each MCO by conducting monthly conference calls and quarterly face-to-face meetings with the medical directors and quality assurance staff in a collaborative forum to coordinate quality assurance activities, identify/resolve issues and barriers, and share best practices.
- Assessing customer satisfaction through MCO customer satisfaction surveys, problem and complaint resolution through HFS' hotline, direct calls to the BMC, referrals from the CMS regional office, and interaction with the enrollee and MCO's member services or key MCO administrative staff members.
- Monitoring the MCO's progress toward achieving the performance goals detailed in the contract and its focus on improving health outcomes.
- Requiring quality improvement projects, corrective action plans, and sanctions for contract noncompliance when the "cure" does not occur sufficiently and/or timely, as defined by HFS.
- Monitoring the MCO's compliance with its operation of a grievance and appeals process.
- Communicating recommendations to the MCOs.
- Providing oversight for the quality improvement plan.
- Contracting with and monitoring the EQRO for the provision of external oversight and monitoring of the quality assurance component of managed care.

According to 42 CFR 438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid

MCO's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. To meet this requirement, HFS contracts with its EQRO to perform a comprehensive on-site review of compliance of the MCOs.

Compliance Review (42 CFR 438.204[g])

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

The purpose of the compliance review is to determine MCO compliance with various quality assessment/improvement standards in 13 areas of compliance. The 13 compliance standards are derived from requirements in the Department of Human Resources Division of Health Care Financing and Policy Request for Proposal No. 04-02 for Managed Care and all attachments effective July 1, 2003; amendments as of June 30, 2011; as well as the BBA, with revisions effective June 14, 2002. The 13 compliance standards are:

- Internal Quality Assurance Program (IQAP)
- Credentialing and Recredentialing
- Recipient Rights and Responsibilities
- Member Information
- Availability and Accessibility of Services
- Continuity and Coordination of Care
- Grievance and Appeals
- Subcontracts and Delegation
- Cultural Competency
- Coverage and Authorization of Services
- Provider Participation and Program Integrity
- Confidentiality and Record Keeping
- Provider Information

In addition, the EQRO conducts a review of individual files for the areas of delegation, credentialing/recredentialing, grievances, appeals, denials, and continuity of care/case management to evaluate implementation of the standards. On-site evaluations adhere to guidelines detailed in the February 11, 2003, CMS final protocol.

The State and the individual MCOs use the information and findings from the compliance reviews to:

- Determine MCO compliance with the contract.
- Identify any areas of the contract that need modification or strengthening to ensure that MCOs have the ability to achieve the goals and objectives identified in the Quality Strategy.
- Evaluate the quality and timeliness of, and access to, health care furnished by the MCOs to medical assistance program participants.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Performance Tracking Tool (42 CFR 438.204[f])

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

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

- Compliance monitoring activities, including areas for targeted improvement for the VMCOs.
- Benchmarks for performance measures.
- HEDIS tables for VMCOs to automatically trend, graph, determine HEDIS percentile rankings, and determine next goals.

- PIP summary tables to determine the validation status and improvements for individual PIP quality indicators.
- Chi-square and *p* value calculator to facilitate the VMCOs' ability to determine if changes are statistically significant.

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

Health Information Technology (42 CFR 438.204[f])

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act establishes a plan for advancing the meaningful use of health information technology (HIT) to improve quality of care through the adoption of certified electronic health records (EHRs) and the facilitation of health information exchange (HIE).

In response to the ARRA, the Illinois Office of Health Information Technology is working with Illinois Health Information Exchange Authority to build The Illinois Health Information Exchange (ILHIE). ILHIE is a statewide, secure electronic network for sharing clinical and administrative data among health care providers in Illinois. ILHIE will allow health care providers and professionals to exchange electronic health information in a secure environment, which will help prevent duplicate tests and procedures, and ensure the accuracy of prescriptions and other medical orders.

Section 4210 of the HITECH Act established an EHR provider incentive payment program, which allows Medicaid to pay an incentive to eligible professionals who adopt, implement, and meaningfully use certified EHR technology. In September 2011, HFS began accepting registrations from eligible providers to begin implementing this program in Illinois. To date, HFS has received more than 200 registrations and expects the numbers to continue to grow. The State estimates the 100 percent federally funded payments to eligible providers to be $116 million the first year (beginning in February 2012), and $489 million over the life of the program, which continues through 2021.

Quality Improvement Interventions and Strategies

Based on the results of the assessment activities outlined in Section 2, Illinois Department of Healthcare and Family Services (HFS) is attempting to improve the quality of care delivered by the Managed Care Organizations (MCOs) through the following types of improvement interventions and strategies described in this section:

- Cross-state agency collaboratives/initiatives
- Statewide improvement strategies
- External quality review report
- Evaluation of the effectiveness of the quality assessment and performance improvement (QAPI) program
- Validation of performance improvement projects (PIPs)
- Validation of performance measures
- Pay-for-performance (P4P) incentives
- Corrective/remedial actions
- MCO sanctions
- Electronic health record (EHR) initiatives

Based on the results of the above quality improvement activities, HFS may elect to conduct any or all of the following additional monitoring activities:

- Assessing consumer satisfaction surveys
- Conducting collaborative PIPs
- Validating encounter data reported by MCOs
- Conducting a readiness review of new MCOs
- Providing technical assistance
- Conducting consumer-focused quality studies and quality of life studies
- Administering access and availability surveys

Cross-State Agency Collaboratives/Initiatives

Coordinated Care Innovations Project

In 2012, Governor Pat Quinn and HFS launched the Innovations Project with the aim of transforming how the State provides health care to low-income Illinoisans. This project calls for health care providers to collaborate to develop innovative approaches to coordinating care for

Illinois' Medicaid recipients, focusing on improved preventive and follow-up treatments. The Innovations Project stems from last year's Medicaid reforms and is part of the administration's commitment to moving Illinois toward a health care system that provides incentives for improved health outcomes.

Under this project, Illinois will begin a shift toward moving at least 50 percent of its Medicaid recipients into coordinated care programs that organize care around recipient's medical needs by 2015 as called for by the Medicaid reform law (PA 96-1501). This means at least 1.5 million of Illinois' Medicaid recipients—children, parents, seniors, and disabled persons—will be assigned to an integrated health care delivery system, replacing the current fragmented system. State officials anticipate that this shift to coordinated care will result in significant savings over time by doing a better job of keeping people healthy and providing more efficient and effective care to those who need it.

The Care Coordination Innovations Project works to form alternative models of delivering care to Medicaid recipients through provider-organized networks, initially organized around the needs of the most complex recipients who are seniors and persons with disabilities. These provider-based networks will be organized as care coordination entities (CCEs) and managed care community networks (MCCNs). Illinois' goal is a redesigned health care delivery system that is more patient-centered, with a focus on improved health outcomes, enhanced patient access, and patient safety.

Five Home and Community-Based Services (HCBS) waiver programs will be included in the Medicare-Medicaid Alignment Initiative as follows: persons who are elderly, persons with disabilities, persons with HIV or AIDS, persons with brain injury, and persons in supportive living facilities.

HFS, in collaboration with the Cook County Board and the Cook County Health and Hospital System (CCHHS), has also requested an 1115 CMS waiver, effective July 2012, to cover the current uninsured population that will become eligible for Medicaid in 2014. While this waiver application was written with a focus on Cook County, the waiver could provide for any willing county in Illinois to participate if HFS and CMS standards are met. This waiver will allow CCHHS to decrease its uninsured population and provide funds to improve the quality, coordination, and cost-effectiveness of the care it provides. The 1115 waiver would be entirely funded by local county resources and federal matching funds for eligible services.

For more information about the Care Coordination Innovations Project, go to: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant

Illinois, in conjunction with the state of Florida, was awarded 1 of 10 CHIPRA Quality Demonstration Grants by CMS to experiment with and evaluate ideas for improving the quality and delivery systems for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Illinois is using the funds to collect and report on the CHIPRA core measure set, improving quality through the use of health information technology, enhancing and improving medical homes and care coordination, and developing interventions and strategies to improve birth outcomes.

CHIPRA is working closely with the Voluntary Managed Care Organizations (VMCOs) on the collection and reporting of applicable CHIPRA core measures. The VMCOs are represented on each of the CHIPRA workgroups and actively participate in the grant activities.

Illinois Project Launch

Illinois Project LAUNCH is a grant program of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) that seeks to promote the wellness of young children from birth to 8 years of age. Using a public health approach, Project LAUNCH focuses on improving the systems that serve young children and address their physical, emotional, social, cognitive, and behavioral growth. The goal of the project is that all children reach physical, social, emotional, behavioral, and cognitive milestones. Project LAUNCH aims to have all young children reach their developmental potential, enter school ready to learn, and experience success in the early grades.

Illinois is one of 16 SAMHSA-funded states. Illinois Project LAUNCH will work on the west side of Chicago over the next five years to test evidence-based practices, improve collaboration among child-serving organizations, and integrate physical and mental health services and supports for children and their families. Lessons learned from these communities will guide State-level systems change and policy development.

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

Enhancing Developmentally Oriented Primary Care (EDOPC)

EDOPC is a statewide, comprehensive effort to increase primary care providers' use of validated tools for developmental, social/emotional, and maternal depression screening, with strong partnerships between the primary care medical community, HFS' All Kids program, Early Intervention, community service agencies, advocates, and local philanthropists. Between 2005 and 2010, EDOPC conducted 686 live training sessions – over 110 each year – for diverse primary care sites including private practices, hospitals, and academic training programs. Most importantly, over 80% of the state's federally qualified health care (FQHC) clinics participated in at least one training, thus ensuring that EDOPC reached the population of children with the greatest need. In the state of Illinois alone, training has reached more than 1,250 primary care providers and 3,200 of their allied healthcare staff. The professionals and their staff provide care for approximately 425,000 children between birth and age three, which is approximately 78 % of the birth-to-3 population in the state of Illinois. EDOPC continues to be a resource for health care providers in Illinois by offering online training on care coordination, developmental screening, domestic violence screening, perinatal maternal depression screening, and social/emotional screening, as well as hosting educational teleconferences and technical assistance calls and providing links and resources. As an ongoing quality improvement effort, EDOPC strives to improve the delivery and financing of preventive health and developmental services for children from birth to 3 years of age.

Bright Futures[3-1]

HFS is partnering with the Illinois Chapter, American Academy of Pediatrics (ICAAP) to promote Bright Futures as a standard of care in Illinois, to assist in integrating Bright Futures into state programs, and to improve awareness of Bright Futures among primary care providers, families, and advocates. Bright Futures seeks to improve the health and well-being of children through culturally competent approaches to addressing both current and emerging health promotion needs at the family, clinical practice, community, health system, and policy levels. Bright Futures is considered the gold standard for pediatric care because it encompasses a set of principles, strategies, and tools that are theory-based, evidence-driven, and systems-oriented.

This partnership has enabled ICAAP to review and submit recommendations to HFS that will make the Handbook for Providers of Healthy Kids Services and other HFS policies more consistent with Bright Futures guidelines and best practices; enable HFS-enrolled providers to more easily implement Bright Futures; and promote some key elements of Bright Futures, such as anticipatory guidance and care coordination, to providers and payers alike. As part of this

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[3-1] Bright Futures is a national health promotion and disease prevention initiative developed by the Health Resources and Service Administration with the American Academy of Pediatrics.

effort, ICAAP convened a committee that made content and policy recommendations to help ensure compliance and improve the distribution of Bright Futures tools. ICAAP works with HFS to create educational materials and provider notices for physicians and other health care professionals, and communicates the Bright Futures guidelines and recommendations to private insurers. ICAAP will develop similar resources and promotional materials for stakeholder groups including HFS contractors, advocates, and families to increase awareness of Bright Futures across systems and communities.

Integrated Systems of Services for Illinois Children and Youth with Special Health Care Needs (CYSHCN) and Their Families

HFS is proud to partner with this ICAAP initiative, which was awarded one of six new State Implementation Grants for Integrated Community Systems for Children with Special Health Care Needs. This three-year State implementation grant is funded by DHHS, the Health Resources and Services Administration (HRSA), and the Maternal and Child Health Bureau (MCHB) at HFS. This program will improve access to quality, comprehensive, coordinated community-based services for CYSHCN and their families by working in collaboration with State partners to provide resources and training to build medical homes and transition youth with special needs into adult service systems.

Medical Home Primer for Community Pediatricians and Family Physicians

HFS' Illinois Health Connect program collaborated with The Illinois Academy of Physicians and ICAAP to publish the *Medical Home Primer for Community Pediatricians and Family Physicians*. This publication provides an overview on the medical home approach and a step-by-step roadmap to improving care through medical home practice. In addition to descriptions of approaches to evaluating the degree of "medical homeness" offered by a practice, the publication suggests strategies to improve quality of care, negotiate contracts with health plans, and use proper Current Procedural Terminology (CPT) codes for appropriate reimbursement. The third edition was published as an online version and included a section with "Diagnostic Modules" containing information for managing 13 pediatric medical conditions by the primary care physician. More than 150 links to Web-based references are also included. This active, online resource continues to forward HFS' quality improvement efforts toward promoting the medical home model. This program has been expanded to other quality improvement initiatives.

Statewide Improvement Strategies

Family Planning

Illinois Healthy Women (IHW) helps eligible, low-income women ages 19 through 44 access family planning and related health care services. IHW offers a limited package of services specific to family planning, birth control, and family planning-related reproductive health care. The program is voluntary and services are confidential and free for enrolled women. Through the promotion of IHW, HFS emphasizes the importance of educating providers on the use of highly effective contraceptive methods such as intrauterine device, implant, pill, patch, ring, or injectable contraceptive. Additionally, the MCOs are required to include preconception and interconception information in their health education programs that address pregnancy planning and care of medical conditions.

High-Risk Pregnancy

In response to the rising rate of preterm births over the last 15 years, HFS supports the American College of Obstetricians and Gynecologists (ACOG) initiative to support the need to provide physician education regarding the increased rates of preterm births and the opportunity that 17 Alpha Hydroxyprogesterone Caporate (17P) offers to prevent prematurity. ACOG reports that a number of studies have shown 17P therapy in women with a documented history of a previous spontaneous preterm birth to be significantly effective in reducing preterm birth.

External Quality Review (EQR) Report

The BBA (Balanced Budget Act of 1997), Public Law 105-33, requires states to prepare an annual EQR technical report that focuses on contract compliance, validation of performance measures, and performance improvement projects, and includes the following:

- The manner in which the data were aggregated and analyzed, and conclusions that were drawn as to the quality, timeliness, and access to the care furnished by MCOs
- An assessment of the MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services
- Recommendations for improving the quality of health care services
- An assessment of the degree to which the MCOs implemented the previous year's EQR recommendations for quality improvement and the effectiveness of the recommendations

HFS uses the information obtained from the EQR technical report to make programmatic changes and modifications to the HFS Quality Strategy. Each year, once the report is approved

by HFS, it is posted on the State's Web site. To review the most current EQR technical report, go to http://www2.illinois.gov/hfs/ManagedCare/Pages/EQRTR.aspx.

Evaluation of the Effectiveness of the Quality Assurance Program (QAP)

HFS requires MCOs to have an ongoing QAP that assesses the quality of care and adjusts processes and operations to improve the quality of care provided to members. The QAPs consist of monthly and quarterly face-to-face meetings, adoption and monitoring of MCOs' results using industry standards such as Healthcare Effectiveness Data and Information Set (HEDIS) measures and benchmarks, contract compliance, and performance improvement projects. Additionally, HFS contracts with an external quality review organization (EQRO) to provide the following services: oversight and monitoring of quality assurance components of the MCO contract, identifying areas needing improvement with the MCOs, technical assistance to HFS and the MCOs, identifying best practices, and improving health care outcomes of MCO enrollees. The EQR technical report also addresses the effectiveness of an MCO's QAP.

As a part of the QAP, MCOs are required to develop a QAP. To ensure continuous quality improvement, HFS requires health plans to conduct regular (annually at a minimum) examinations of the scope and content of the QAP to ensure that it covers all types of services, including behavioral health services in all settings, as required. At the end of each year, MCOs are required to submit a written report on the QAP. This report must include, at a minimum, the following information:

- 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
- Quality assurance (QA)/utilization review (UR)/peer review (PR) plan
- Major initiatives to comply with the State Quality Strategy, quality improvement, and work plan monitoring
- Provider network access and availability
- Cultural competency
- Fraud and abuse monitoring
- Population profile
- Improvements in care and clinical services/programs
- Findings on initiatives and quality reviews
- Effectiveness of quality program structure

Validation of Performance Improvement Projects (PIPs)

HFS requires each MCO to conduct PIPs in accordance with 42 Code of Federal Regulations (CFR) 438.240(b)(1). The purpose of a PIP is to achieve through ongoing measurements and intervention significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving MCO processes can have a favorable effect on health outcomes and member satisfaction. In accordance with 42 CFR 438.358(b)(1), HFS' EQRO validates PIPs required by the State to comply with the requirements of 42 CFR 438.240(b)(1). HFS' EQRO validation determines 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 enrollee satisfaction.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) Screening **PIP**

EPSDT is a comprehensive health care program within Medicaid for beneficiaries from birth to 20 years of age. HFS required each VMCO to participate in a mandatory statewide PIP focused on improving performance related to EPSDT screenings and visits designed to identify, assess, and treat children with early signs of physical and mental conditions that could affect growth and development. This includes the content of care for children younger than 3 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and treatment becomes more costly. The goals of the PIP are as follows:

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

The state fiscal year (SFY) 2011 results are shown in Table 3-1 below. The *EPSDT Screening* PIP will be continued until the indicators demonstrate sustained improvement.

Table 3-1—SFY 2011 Performance Improvement Project Outcomes for the *EPSDT Screening* PIPs (N=3)

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

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

Perinatal Care and Depression Screening PIP

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

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

The SFY 2011 results are shown in Table 3-2 below. The *Perinatal Care and Depression Screening* PIP will be continued until the indicators demonstrate sustained improvement.

Table 3-2—SFY 2011 Performance Improvement Project Outcomes for the *Perinatal Care and Depression Screening* PIPs (N=3)

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

[1] The number of study indicators that demonstrated sustained improvement.
‡ The PIP(s) did not progress to this phase during the review period and could not be assessed for sustained improvement.
*The rates did not change between the prior measurement period and the current measurement period.
¥The plan did not report Study Indicators 8 and 9.

Improving Ambulatory Follow-Up and PCP Communication PIP

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

This PIP monitored follow-up after hospitalization for mental health within 7 and 30 days, and the percentage of PCPs receiving written/verbal communication from the behavioral health provider. With the new Illinois law that allows sharing of information for purposes of care coordination without the member's consent, the major barrier in this PIP was eliminated. In addition, all VMCOs demonstrated improvement and satisfactory achievement levels on the goals of this PIP, so it was retired in the first quarter of 2012. Best practices and procedures adopted as a result of this PIP will continue to be implemented by the VMCOs and monitored for effectiveness.

Community Based Care Coordination **PIP**

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

The Integrated Care Program Managed Care Organizations (ICPs) are conducting a *Community Based Care Coordination* PIP which focuses on medically high-risk members with a recent hospital discharge who are actively receiving care coordination with linkage to community resources. This PIP will explore the relationship between care coordination in conjunction with community resources and hospital readmission, with the goal of increasing access to community resources that provide education, physician assessments, and pharmacological interventions to decrease hospital readmissions and improve health outcomes.

With technical assistance from the EQRO and through a collaborative effort, the ICPs developed the study question and indicators, record abstraction tool, and instruction. Baseline measurement data for this PIP will be collected in SFY 2013.

Validation of Performance Measures

In accordance with 42 CFR 438.240(b)(2), HFS requires the MCOs to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with 42 CFR 438.358(b)(2), HFS' EQRO validates the performance measures through HEDIS Compliance Audits™. The HEDIS compliance audits focus on the MCOs' ability to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. HFS' EQRO validates each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCO. As part of the HEDIS compliance audits, HFS' EQRO also explores the issue of completeness of claims and encounter data to evaluate reported rates for the performance measures. The results of the VMC performance measure rates can be found in Appendices H, I, and J.

NCQA HEDIS Compliance Audit ™ is a trademark of the National Committee for Quality Assurance (NCQA).

Pay-for-Performance (P4P) Incentives

Voluntary Managed Care Organization P4P

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

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

HFS has also established an additional pay-for-performance bonus/incentive program under which VMCOs may receive additional compensation of up to one-half of 1 percent (0.5 percent) of its annual capitation payments for reaching the most recent 75th percentile for identified HEDIS measures.

Integrated Care Program P4P

In its ICP contracts, HFS has established a process for health plans to earn incentive payments for performance. If an ICP health plan reaches the target goal on a P4P metric, it will earn the percentage of the incentive pool assigned to that P4P metric. HFS has created the incentive pool by withholding a portion of the contractual capitation rate, which will be combined with an additional bonus amount funded by HFS so that total funding of the incentive pool shall be equal to 5 percent of the capitation rate. An equal portion of the incentive pool is allocated to each P4P metric.

ICPs are not eligible to receive any incentive payments if they fail to meet a minimum performance standard. The minimum performance standard will require ICPs' measurement year performance to be no lower than 1 percent below that year's baseline on all P4P

measures, except that ICPs may regress more than 1 percent in three P4P quality metrics in the first measurement year.

Corrective/ Remedial Actions

HFS contractually requires each MCO to include written procedures in its QAP for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, including in the area of behavioral health, or services that should have been furnished but were not. Quality assurance actions that result in remedial or corrective actions must be timely forwarded by the MCO to the State.

Written remedial/corrective action procedures include:

- Specification of the types of problems requiring remedial/corrective action.
- Specification of the person(s) or body responsible for making the final determinations regarding quality problems.
- Specific actions to be taken.
- A provision for feedback to appropriate health professionals, providers, and staff members.
- The schedule and accountability for implementing corrective actions.
- The approach to modifying the corrective action if improvements do not occur.
- Procedures for notifying a primary care provider group that a particular physician is no longer eligible to provide services to enrollees.

MCOs are required to monitor and evaluate corrective actions taken to assure that appropriate changes have been made and follow up on identified issues to ensure that actions for improvement have been effective. MCOs are also required to provide documentation on this process.

MCO Sanctions

HFS may impose sanctions when an MCO fails to substantially comply with the terms of the contract. Monetary sanctions may be imposed, as detailed in the contract, with the determination of the amount of any sanction at the sole discretion of HFS, within the ranges set forth in the contract. Self-reporting by an MCO is taken into consideration in determining the sanction amount. At its sole discretion, HFS may waive the imposition of sanctions for failures that it judges to be minor or insignificant.

Upon determination of substantial noncompliance, HFS gives written notice to the MCO describing the noncompliance; the opportunity to cure the noncompliance, where a cure is

allowed under the contract; and the sanction that HFS will impose. The following areas are subject to sanction:

- Failure to report or submit
- Failure to submit encounter data
- Failure to meet minimum standards of care
- Failure to submit quarterly performance measures
- Failure to participate in the PIPs
- Failure to demonstrate improvement in areas of deficiencies
- Imposition of prohibited charges
- Misrepresentation or falsification of information
- Failure to comply with the physician incentive plan requirements
- Failure to meet access and provider ratio standards
- Failure to provide covered services
- Discrimination related to pre-existing conditions and/or medical history
- Pattern of marketing failures
- Other failures

Electronic Health Record (EHR) Initiatives

Health Information Exchange (HIE)

The recent implementation of direct secure messaging to enable electronic information sharing across primary care, acute care, and the broad behavioral health care community is improving the treatment and maintaining the privacy of mental health patients in Chicago. The HIE Program highlights the meaningful impact of health information technology (IT) on an often overlooked segment of the patient population. Given how important time is to the treatment of mental health and substance abuse patients, the national push to increase the adoption of EHR systems and enable the sharing of EHRs via HIEs is showing tangible benefits in more efficient coordination of care in Illinois.

Another added benefit of electronic exchange to providers and patients is mobility in both senses of the term. Because the point of care is constantly shifting as a result of referrals or happenstance, providers continue to lean on mobile technology to reach their patients while maintaining a secure link to their practice.

EHR Community Projects for Integrated Patient Care

The Illinois Health Information Exchange (ILHIE) announced six innovative demonstration projects to advance Illinois' efforts to integrate behavioral health and medical care by employing new solutions in health information exchange. These demonstration projects aim to address co-occurring conditions afflicting largely the poor and youth with suicidal tendencies, the severely mentally ill, and individuals with substance use disorders. Care coordination provides integrated medical and behavioral services through managed care networks to improve the quality of care and has begun this work with the most complicated patient groups, like seniors and persons with disabilities, whose care drives costs. Care coordination is the centerpiece of Illinois' Medicaid reform that is aligned with the federal Affordable Care Act, which has triggered health care reform across the nation.

Health information exchange will allow for the safe and secure transfer of medical and behavioral health records. In Illinois, the ILHIE serves as a transport network that transmits health records from one provider to the next. The grantees are community behavioral health care providers located across Illinois that offer mental health and substance use treatment services and coordinate care with medical providers.

Additional Monitoring Activities

Assessing Consumer Satisfaction Surveys

Each year, the MCOs are required to independently administer a consumer satisfaction survey. As part of the EQR technical report, the EQRO evaluates the results of adult and child CAHPS surveys conducted by the MCOs to identify trends, strengths, and opportunities for improvement.

Conducting Collaborative PIPs

MCOs are required to initiate a new quality improvement project each year, and projects typically have a cycle of two to four years. HFS contracts with an EQRO to provide support and assistance to the MCOs in developing, implementing, and evaluating each of the improvement initiatives.

Validating Encounter Data Reported by MCOs

Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates. However, for encounter data to effectively serve these purposes, it must be valid (i.e., complete and accurate). HFS is working closely with the MCOs to enhance the quality of encounter data. At present, completeness and accuracy of encounter data vary across the Medicaid programs; and HFS will continue to work with the MCOs to improve the accuracy and completeness of the encounter data. An encounter data validation study may be conducted to evaluate completeness and accuracy of encounter data. It also can assist in the improvement of the processes associated with the collection and submission of encounter data to State Medicaid agencies.

Conducting Readiness Reviews of New MCOs

Readiness reviews are intended to provide the State with an independent assessment of the readiness of its contractors to provide services to the Medicaid program. The reviews are also intended to be a helpful feedback loop for health plan management on operational readiness issues. HFS contracts with its EQRO to conduct the readiness reviews.

Providing Technical Assistance

As requested by HFS, an EQRO has provided ongoing technical guidance to the MCOs to assist them in conducting the mandatory EQR activities—particularly to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). The EQRO also provides technical assistance training to the MCOs in conducting root-cause analyses and implementing meaningful interventions to address the findings outlined in the MCO annual program evaluations and the results of PIPs and performance measures. The EQRO may also conduct a re-evaluation of the CAPs for progress toward compliance with expected performance levels.

Conducting Consumer-Focused Quality Studies and Quality of Life Studies

The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of health plan members. HFS may use the contracted EQRO to assist in defining the study and then compiling the results and creating a report of the study findings. An agreed-upon managed care intervention to improve an aspect of care is then implemented. The areas of focus may differ from the VMCO and ICP populations.

Administering Access and Availability Surveys

Access and availability surveys are conducted to determine participant access and availability for specific appointment standards, including routine appointment, nonurgent appointment, sick appointment, and after-hours accessibility to a provider.

State Monitoring of Progress Toward Meeting Objectives

Since development and implementation of the Illinois Quality Strategy, HFS, its EQRO, and the MCOs have continuously monitored the goals and objectives of the Quality Strategy during monthly teleconference and quarterly face-to-face MCO meetings. HFS, the EQRO, and the MCOs use these collaborative forums to share information on emerging best practices and present performance measure and utilization data to continuously track the progress toward meeting the State's goals and objectives.

HFS will annually review the performance of the Quality Strategy. Both qualitative and quantitative methods will be used to collect data designed to assess the impact of the Quality Strategy. HFS will use qualitative data such as focus groups and interviews as well as quantitative data from surveys and performance measures to assess performance. Finally, performance measures will be compared with targets to determine the impact of the Quality Strategy. As the Quality Strategy evolves, HFS will document challenges and successes that result in changes to the Quality Strategy, including interim performance results as available for each strategy objective.

HFS will assess whether or not the objectives identified in the introduction have been met by comparing results of performance measures over time. Based on the results of the assessment activities, HFS will attempt to improve the quality of care provided by the MCOs.

Examples of interventions that might be applied include but are not limited to the following:

- Cross-agency collaborative/initiatives
- Performance improvement projects
- Changes in benefits for program participants

- Information system or electronic health record initiatives
- Implementing optional EQRO activities

To address the goals of improving care coordination for Illinois Medicaid beneficiaries and to align with the national priorities for improved care coordination, HFS, its EQRO, and the MCOs have focused their efforts throughout 2011–2012 to improve case management information systems and coordination of care for their enrollees. To monitor the case management and disease management programs within the MCOs, HFS requires the EQRO to conduct reviews of the programs and the MCOs to submit monthly, quarterly, and annual reports. These reports describe the MCOs' efforts to identify and intervene for enrollees with special health care needs, or with social circumstances or behavioral health issues that place the enrollee at risk for poor health outcomes.

Using an internal algorithm and systems to determine the conditions and risk levels of enrollees, MCOs are required to identify at-risk enrollees; assign a stratification level such as high, moderate, or low; and report the risk stratification level for its enrollees. The risk stratification information reported by the MCOs enables HFS to monitor risk levels of the MCOs' enrollees and subsequent trends and movement of the MCOs' enrollees to higher or lower risk levels. In addition, the MCOs submit reports measuring the outreach efforts employed to locate and engage enrollees, including telephone calls, mailings, and home visits. MCOs provide detailed data, including the number of interventions implemented to help the enrollees self-manage a chronic condition, and address the barriers to improved health outcomes and the number of enrollees refusing enrollment into case management or disease management programs.

By continuing to monitor the Quality Strategy, HFS will have opportunities to highlight its successes and share what has been found to be effective in improving health care quality and/or service. HFS does not expect all strategy objectives to be met. In these instances, HFS will share the barriers that it encountered and whether the responses to these barriers were effective.

Future of Quality Improvement in Illinois

HFS is committed to a continuous quality improvement (CQI) approach to help individuals improve their health status by ensuring the highest quality and most cost-effective services possible through ongoing assessment and analysis of potential opportunities for health care coordination and improvement. HFS recognizes that having a robust CQI system is important to consistently improve services and ensure the most effective use of resources.

CQI is the complete process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions. This collaborative, proactive approach is dependent upon the active inclusion and participation of staff members at all levels of the participating agencies, stakeholders, and health care consumers.

Core concepts of CQI include:

- Quality is defined as meeting and/or exceeding the expectations of enrollees.
- Success is achieved through meeting the needs of Medicaid recipients.
- The focus of improvements is processes, not the people who implement those processes.
- Variation in processes must be minimized to avoid unwanted variation in outcomes.
- It is possible to achieve continuous quality improvement through small, incremental changes using the scientific method of experimentation and measurement.
- Continuous improvement is most effective when it becomes a natural part of the way everyday work is done.

Core steps of CQI include:

- Form a team that has knowledge of the system needing improvement.
- Define clear objectives.
- Understand the needs of the people who are served by the system.
- Identify and define measures of success.
- Brainstorm potential change strategies for producing improvement.
- Plan, collect, and use data for facilitating effective decision making.
- Apply the scientific method to test and define changes.

CQI is an ongoing process that involves the Plan-Do-Study-Act (PDSA) cycle. This model for improvement is based on building knowledge (of what works and does not work) and applying it appropriately. It employs a “trial and learning” approach in small, cost-effective settings to reveal outcomes. The following steps, as illustrated in the diagram below, are used in the PDSA cycle to test a change on a small scale:

- Step 1: Plan—Plan the test or observation, including a plan for collecting data.
- Step 2: Do—Try out the test on a small scale.
- Step 3: Study—Set aside time to analyze the data and study the results.
- Step 4: Act—Refine the change, based on what was learned from the test.

Continuous Quality Improvement with the Plan-Do-Study-Act Cycle

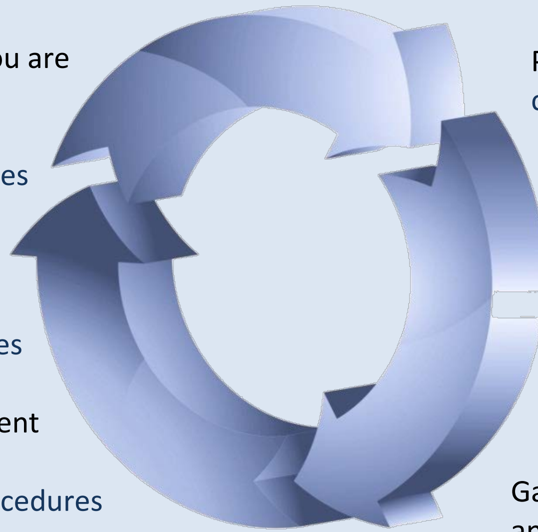
Plan

Set specific aims for what you are trying to accomplish

Create performance measures

Do

Prioritize, select, and implement change on a small scale (pilot test)



Study

Test and record change to identify challenges, opportunities, and achievements

Gain feedback from diverse stakeholders and data sources

Create structural change objectives

Act

Implement structural changes to address challenges and opportunities for improvement

Standardize policies and procedures to support broad, systematic improvement

Review of the Quality Strategy

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

The Quality Strategy has evolved over time based on community concerns and feedback, participant health needs, federal and State law, industry standards, lessons learned, and best practices, and in collaboration with the MCOs to establish objectives, priorities, and achievable timelines. The Quality Strategy is viewed as a "work in progress" as the state of health care quality (e.g., clinical practice and improved methods for quality measurement and monitoring accountability) is continuously evolving.

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

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

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

Strategy Updates

HFS updates the Quality Strategy as necessary based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program. To ensure the effectiveness of the Quality Strategy, HFS reviews the Quality Strategy at least annually to assess appropriateness of goals and objectives for the following year and determine if any updates are needed.

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

The annual evaluation includes an assessment of:

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

Prior to each update, HFS solicits stakeholder input on the goals and objectives of the Quality Strategy. The revised Quality Strategy will be shared with all pertinent stakeholders and posted on the HFS Web site for public view, as well as forwarded to the Centers for Medicare & Medicaid Services (CMS).

Documenting Challenges, Successes, and Quality Strategy Changes

HFS uses two methods to continuously track the progress toward achieving the goals and objectives outlined in this Quality Strategy. The first is the performance tracking tool (PTT). As shown in Appendix L, the PTT lists each of the performance measures, including the priority measures and progress toward achievement of those goals. In addition, the External Quality Review (EQR) work plan found in Appendix M outlines all EQR activities anticipated during the contract period. This includes a timeline for review of the Quality Strategy, meetings with stakeholders for diverse feedback, and the Quality Strategy revision process.

HFS and its External Quality Review Organization (EQRO) update the Quality Strategy goals and the PTT annually. In addition to sharing the revised PTT and Quality Strategy with the MCOs and other stakeholders, the EQRO includes the PTT as part of the annual Quality Strategy evaluation, which is included as a section in the annual EQR technical report.

State Achievements

Integrated Care Plan Model

Illinois Department of Healthcare and Family Services (HFS) implemented the State's first integrated health care program on May 1, 2011. The Integrated Care Program (ICP) is built on a foundation of well-resourced medical homes with an emphasis on wellness; preventive care; effective, evidence-based management of chronic health conditions; and coordination and continuity of care. ICP brings together local primary care physicians, specialists, hospitals, nursing homes, behavioral health, and other providers to organize and coordinate care for older adults and adults with disabilities who are eligible for Medicaid but not Medicare. It keeps enrollees healthy through more coordinated and better medical care, helping prevent unnecessary health care costs. The goal of the Integrated Care Program is to provide better care; healthier Medicaid recipients will save health care dollars over the long term. The savings/cost avoidance over the five-year contract period is estimated at nearly $200 million as a result of:

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

Illinois Medical Home Project (IMHP)

Using measures of practice behaviors and an outcomes-based, continuous quality improvement process, the IMHP was implemented between 2004 and 2009 and provided training and technical assistance to 19 practices or public health clinics implementing the medical home model. The IMHP informed Illinois providers and families about the medical home, provided access to an effective strategy for improving practices, encouraged family involvement, collaborated with State leaders and policymakers to implement medical homes, improved reimbursement for care coordination, and measured the impact of the project. The IMHP is administered by Illinois Chapter, American Academy of Pediatrics (ICAAP) in collaboration with the Illinois Title V agency, the Division of Specialized Care for Children (DSCC), University of Illinois at Chicago (UIC). Representatives from Family Voices of Illinois, Illinois Academy of Family Physicians, Illinois Council on Developmental Disabilities, and HFS serve on the Provider Advisory Committee (PAC). More than 20 Illinois State agencies and private organizations contribute to the project.

Achievements of participating health systems included greater parent participation and increased family-centered care, implementation of new care coordination tools for patients who see multiple providers, and greater clinic accessibility for patients. The IMHP initiative earned one participating hospital, La Rabida Children's Hospital, National Committee for Quality Assurance (NCQA) recognition as a Patient-Centered Medical Home—the first hospital in Illinois to receive this recognition.

Initiatives such as IMHP continue to position Illinois as a leader in the establishment of medical homes for children and the development of programs that support the crucial early childhood years.

Medical Home Network

In an unprecedented effort to improve medical care, the Cook County Health and Hospitals System, five private hospitals, and dozens of clinics and physician practices have agreed to cooperate in bolstering basic care for Medicaid patients. Their venture, known as the Medical Home Network, represents one of the most ambitious attempts in the United States to restructure the way care is delivered to vulnerable families covered by Medicaid.

The Medical Home Network started by establishing working relationships among dozens of medical providers who had a previous track record of competition, not cooperation. Some participating hospitals were formerly involved in the IMHP initiative (described above), which demonstrates the proliferation of HFS' efforts to introducing more coordination of care into its 2.9 million-member Medicaid program.

Providers participating in the Medical Home Network will focus on poor women and children who seek medical attention in emergency rooms and then return home, often with an insufficient understanding of necessary follow-up care. As a result, many patients experience health problems and are readmitted to medical centers, frequently at great expense.

The Medical Home Network plans to address the problem by linking hospitals and medical clinics that provide basic care to Medicaid patients through an Internet portal. This will allow participating clinic providers to quickly follow up with patients and direct them to primary care. The goal is to help patients realize they have "medical homes" that can manage their ongoing care, provide recommended preventive services, and reduce inappropriate use of hospital emergency rooms.

Primary Care Case Management—Medical Home Model

The Illinois Health Connect (IHC) program that Illinois adopted uses a patient-centered medical home model to deliver care to over 1.8 million of the State's 2.6 million Medicaid recipients.

Implemented in 2007, IHC is a health plan that is available to most persons covered by an HFS medical program, including children in the All Kids program and adults. IHC was the Department's first step toward implementing managed care throughout the State. As the Department expands its managed care program, it will continue to promote and sustain the primary care provider (PCP) relationships that are already established in IHC.

In IHC, recipients receive education and assistance in selecting a medical home and in locating specialists when needed. To ensure that recipients are connecting with their PCP at their medical home and receiving the necessary preventive and primary care, such as immunizations and health screenings, IHC enlists various outreach strategies to educate recipients on health and wellness. IHC assists recipients in making appointments with their PCP for primary and preventive check-ups when needed. IHC recipients must visit their IHC PCP (or affiliated PCP or clinic) first for most of their primary health care. If recipients want to see a different IHC PCP, they will need a referral from their PCP. All of these strategies have resulted in increased access to care as well as recipients connecting with their medical homes and receiving needed services in the most appropriate setting—their PCP's office.

IHC also works with its PCPs to ensure they have the most current information and tools to coordinate care for their patients and improve quality of care efforts. IHC offers an array of support services and educational opportunities for PCPs and their staff, including a toll-free Provider Service Help Desk line, dedicated Provider Service representatives and Quality Assurance nurses in the field throughout the State who work one-on-one with PCPs and their staff, access to a specialty resource database to connect recipients to specialists when needed, and monthly Webinars and training opportunities on topics that impact providers' practices. Often, these educational opportunities are provided by IHC in conjunction with support from community-based organizations. During FY 2012, IHC's Provider Service Representatives make about 1200 visits to providers' offices each month to assist with billing/coding questions, program administration, Early and Periodic Screening, Diagnosis and Treatment **(**EPSDT) standards, and quality improvements efforts, as well as to provide Medical Electronic Data Interchange System (MEDI) training. In addition, Quality Assurance Nurses have over 300 contacts with providers either through office visits or telephone outreach. IHC has also made quality tools available to PCP offices to assist in improving recipients' quality of care. These quality tools include IHC panel rosters, claims history summaries, and provider profiles.

PCPs enrolled in IHC automatically qualify for the enhanced maternal and child health rates for specific primary and preventive services, in addition to a monthly care management fee. The monthly care management fee is paid for each recipient whose care the PCP is responsible for managing and coordinating. The fees are $2 per child (under age 21), $3 per adult, and $4 per senior or adult with disabilities. To increase quality and access to care for recipients, the Department also established an annual Bonus Payment for High Performance program. This bonus program encourages PCPs to provide primary and preventive services in accordance with established quality measurements to drive the adoption of quality improvement within their practices. Under the most recent bonus program, calendar year 2011, enrolled PCPs received over $5.3 million in bonuses for qualifying events.

Healthy Women Waiver

Based on the 2011 Interim Waiver Evaluation Report, which uses the Centers for Medicare & Medicaid Services (CMS) births averted methodology, it is estimated that 19,971 births have been averted during the first six years of the Illinois Healthy Women federal demonstration waiver due to the increased availability and utilization of family planning services, resulting in an estimated net cost savings of approximately $175 million.

Managed Care Organization (MCO) Achievements and Initiatives

Annually, MCOs are required to evaluate the effectiveness of the quality improvement (QI) programs toward meeting strategic objectives as outlined by the State's Quality Strategy. The annual evaluation is a written evaluation that includes a description of ongoing QI activities that address quality and safety of clinical care and quality of service. Initiatives and achievements highlighted in these evaluations are outlined below as demonstrated progress toward meeting Quality Strategy goals.

Cross Agency Collaboration

Illinois Project LAUNCH is a collaborative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a partnership between the Illinois Department of Human Services, Divisions of Community Health and Prevention and Mental Health, and 40 local agencies. The focus of Illinois Project LAUNCH is to promote mental health wellness, to link families with community-based programs, and to encourage families and providers to regularly access and use services that promote family wellness. The Voluntary Managed Care Organizations (VMCOs) joined the partnership with Illinois Project LAUNCH to connect with hard-to-reach enrollees who reside in a targeted low-income, high-violence geographic area in Chicago. The extraordinary social issues in this area cause significant barriers for enrollees in

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

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

Case Management Programs—VMCOs and ICPs

Care coordination is an important aspect of health and health care services. When care is poorly coordinated, it can lead to inaccurate communication of information and inappropriate follow-up care. The effects of poorly coordinated care are particularly evident for people with chronic conditions such as diabetes, asthma, and hypertension and those at risk for multiple illnesses who often are expected to navigate the complex health care system.

To address the goals of improving care coordination for Illinois Medicaid beneficiaries and to align with the national priorities for improved care coordination, HFS, its External Quality Review Organization (EQRO), and the MCOs have focused their efforts throughout 2011–2012 on improving case management information systems, programs, and coordination of care for their enrollees. Initiatives specific to this effort are highlighted below.

To monitor the case management and disease management programs within the MCOs, HFS requires the MCOs to submit monthly, quarterly, semiannual, and annual reports. These reports describe the MCOs' efforts to identify and intervene with enrollees with special health care needs or with social circumstances or behavioral health issues that place the enrollees at risk for poor health outcomes. All MCOs comply with the reporting requirements, and HFS plans to continue working with the MCOs to continuously improve reporting in an effort to monitor the effectiveness of the MCOs' case and disease management programs.

VMCOs

Family Health Network (FHN)

- The FHN Medical Management Department used the CareEnhance Clinical Management Software (CCMS), implemented in October 2010, to automate work flow and clinical decision support criteria. CCMS allowed for integration of utilization, care, and disease management information. The CareEnhance software is used to document, track, support, and monitor the case management processes including health risk assessments, care treatment plans, case manager contact logs, and scanned letter storage. In addition, FHN has hired additional staff for the medical management and member services departments to assist with outreach and engagement of members in case management services. This effort has significantly increased the number of members actively engaged in case management services.

  In addition, FHN has hired a perinatal case manager dedicated to perinatal case management, who works with its contracted behavioral health provider to provide intensive case management programs for members with behavioral health conditions.

Harmony Health Plan (Harmony)

- Harmony redesigned its case management program to integrate a team-specific telephonic and field-based model comprised of short-term case management and complex case management differentiation. The team consists of RNs and licensed clinical social workers to meet members' medical, behavioral, and socio-economic needs. Short-term case management (SCM) ensures that the hospital-to-home program focuses on members with complex discharge needs with the goal of decreasing hospital inpatient readmissions, and the plan reported that this approach continues to be successful. The SCM staff screens members to confirm that the discharge plan has been implemented, identifies gaps and barriers in care that may negatively impact members' health status, and provides resolution of issues identified. SCM refers members to complex case management (CCM) as appropriate.
- In addition, Harmony has implemented the following enhancements to its case and disease management programs:
  - Standardized documentation and workflows for all of case management and an improved process for the identification of members for case management through a case and disease management claims/encounters algorithm.
  - Added a congestive heart failure (CHF) disease management program with Alere, providing members with a monitoring device that tracks their weight and

symptoms, allowing for early preemptive interventions by the nurse and/or provider in order to help reduce complications and decrease preventable hospitalizations/emergency room (ER) visits.

- Implemented standalone smoking cessation and weight management programs that focus on helping members develop self-management strategies to promote healthy behaviors and reduce the risks and complications associated with their chronic conditions.

Meridian Health Plan (Meridian)

- Implemented an innovative care coordination program that is designed to integrate a whole-person approach to care management with cutting edge technology. The program incorporates the medical, social, emotional, and pharmaceutical needs of enrollees, in addition to provider engagement to mobilize the necessary services at the right time in the appropriate setting. The program is embedded in a single information managed care system (MCS) database, which enhances the efficiencies of care coordination through sophisticated predictive analytics, real-time updated plans of care, and streamlined integration with providers. The end result is a unified approach to care delivery that drives quality while reducing spending and increasing member satisfaction.

ICPs

To enhance their care management systems and programs to comply with State expectations for the aged, blind, and disabled members that the ICPs serve, both health plans are undergoing upgrades and restructuring. These efforts are described below.

IlliniCare Health Plan (IlliniCare)

- Developed a structured care plan note within the member record to document the member's consent to care coordination, member participation in the development of the care plan, agreement to the care plan, and consent to share the care plan with the member's guardian, caregiver, and PCP. The care plan will be mailed to the member's PCP for feedback with the member's consent and documented in this note. In addition, IlliniCare's Integrated Care Team staff implemented a process to document all problems, goals, and interventions identified for high- and moderate-risk members in the care plan as identified by the health risk assessment. The problems, goals, and interventions will be prioritized based on a start date and revised as the member's condition warrants. A work process was developed and audits conducted to ensure compliance with the documentation requirements and the need for additional training. Finally, IlliniCare

updated the provider portal to allow for care plan distribution, immunization history, and lab results.

Aetna Better Health Plan (Aetna)

- Transitioned to a more robust case management system (Dynamo) and trained care management staff members on the new platform. The training consists of instructions to staff members regarding the importance of entering goals and measurable benchmarks for all assigned care plans, and covers formulating, executing, and monitoring members' care plans. Aetna also developed community-based case management for intensive or difficult-to-reach individuals (i.e., telephones are disconnected, migratory members, no telephone number, etc.). Claims information for these members can be reviewed and tracked back to the physicians, pharmacies, and/or hospitals; and a care manager goes in to the community to try to locate members in an effort to assist with their needs, educate them, and coordinate their care.

Initiatives Aligned With Quality Strategy Priority Measures—VMCOs

Preventive Care

- **FHN** implanted a pay-for-performance program with its providers as an incentive to encourage providers to submit encounter data. FHN has also increased its efforts to communicate with providers through quarterly reports that identify incomplete or missing preventive services for their members.
- **Harmony** initiated the Healthcare Effectiveness Data and Information Set (HEDIS) Inbound Care Gap program in which members who called inbound to customer service and were identified as having a HEDIS care gap received education on preventive care services and assistance in scheduling their doctor appointment via a three-way telephone call to the member's physician office. In addition, Harmony also initiated a new mailing in which all new members receive a preventive care booklet.
- **Meridian** enhanced its provider education program, including updating the online provider portal with HEDIS alerts and reports by provider and office, the addition of the "hot list" to monthly HEDIS reports to quickly identify members with time-sensitive HEDIS needs, automated faxes to providers based on members with missing HEDIS needs, quarterly HEDIS report cards for providers to track their performance against national benchmarks, and implementation of a patient-centered medical home (PCMH) incentive program.

Child and Adolescent Care

- **The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Performance Improvement Project (PIP)** was redesigned in calendar year 2012. Although this redesigned PIP still focuses on the promotion of preventive health care and screenings for infants and children, the study indicators have been revised for this project. The primary goal of this project is to determine if interventions are successful in improving the HEDIS well-child visits and the CHIPRA developmental screening measures. The VMCOs have revised all parts of this PIP, including the data collection tool and instructions for the CHIPRA measure.

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

- **Harmony** conducted centralized telephonic outreach to parents/caregivers of children regarding the importance of scheduling well-child visits and childhood immunizations.

- **Meridian** created and provided EPSDT forms for all providers to use during well visits. The forms provide specific information for various age groups, ranging from 1 week to 17 years of age. Meridian also created an EPSDT tool kit for providers to have access to tools and subjective developmental screenings in an effort to promote each aspect of the EPSDT program.

Maternity-Related Care

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

- **FHN's** Brighter Beginnings program for pregnant members and their babies provided gift and financial incentives for keeping prenatal and postpartum appointments. Brighter Beginnings was a URAC Best Practice Awards Finalist in 2012.
- **Harmony** conducted the HEDIS Postpartum Discharge Planning initiative to contact members who recently delivered a baby to provide education about well-child visits and assist them in scheduling a postpartum appointment. Harmony's Maternity Education and Reward Program provides educational materials to pregnant members in order to improve preventive care and compliance with preventive screenings/services. Harmony also has the "Harmony Hugs" case management support and education program for pregnant Harmony members. The program identifies members with potential risk factors (behavioral, social, and medical) that may adversely affect the outcome of their pregnancy and encourages practice of good prenatal care through direct mailings of educational materials and availability of a face-to-face assessment with a Harmony Hugs field case manager.
- **Meridian** revised its prenatal assessment to collect information on preventive care related to Pap tests and mammography (if appropriate) and introduced new member incentives for prenatal/postpartum care in conjunction with a diaper raffle.

Chronic Conditions/Disease Management (Diabetes and Asthma)

- **FHN** implemented a diabetes gift card incentive and continued its partnership with the Sinai Urban Health Institute's Asthma Program. This is an intensive education program in which trained community educators schedule home visits with those referred. The home visits allow for a true assessment of environmental triggers.
- **Harmony's** HEDIS Education and Screening Program (ESP) is used to contact members identified by Harmony who have asthma, diabetes, high cholesterol, or chronic obstructive pulmonary disease (COPD) and have a care gap as defined by the HEDIS measures, *Appropriate Asthma Medication Management* and *Comprehensive Diabetes Care*. HEDIS review nurses contact members identified with a care gap and provide education regarding the care gap and the disease process. The nurses screen the members for case management, stratify for additional disease management as needed, and schedule appointments via three-way calls with the provider office. The goal of the ESP is to improve compliance with screenings and a corresponding improvement in HEDIS rates.
- **Meridian** educated providers and members about the importance of lowering high blood pressure and how it contributes to diabetes, and implemented an asthma fax program to providers. This program ensures providers are notified if members do not fill

a prescription for controller medications and receive asthma action plans for members prior to scheduled office visits.

Behavioral Health

- **The Improving Ambulatory Follow-Up and PCP Communication Collaborative PIP** monitors follow-up after hospitalization for mental health within 7 and 30 days, and the percentage of PCPs receiving written/verbal communication from the behavioral health provider. With the new Illinois law that allows sharing of information for purposes of care coordination without the member's consent, the major barrier in this PIP was eliminated. In addition, all VMCOs demonstrated improvement and satisfactory achievement levels on the goals of this PIP, so it was retired in the first quarter of 2012. Best practices and procedures adopted as a result of this PIP will continue to be implemented by the VMCOs and monitored for effectiveness.
- **FHN's** behavioral health vendor (PsycHealth) implemented Bridges to Health, an identification and referral initiative that links medically treated members to mental health services. The integrative and collaborative program uses a Health Risk Assessment to identify members who may be at risk or in need of behavioral health services (as well as medical services) and refer them to behavioral health for outreach and follow-up. The Bridges to Health initiative was a URAC Best Practice Awards Finalist in 2012. In addition the FHN/PsycHealth Readmission Outreach Project targeted those members who have been hospitalized in the past year for outreach. The goals of this program are to connect members with the necessary services at the appropriate time and in this manner support treatment in the least restrictive setting and decrease recidivism.
- **Harmony** participated in an intensive case management (ICM) workgroup with Magellan (behavioral health vendor) to identify ICM best practices and develop model Magellan ICM programs based on best practices. All ICM staff members received internal Magellan training specific to cultural diversity and ethics, as well as training on URAC accreditation standards.
- **Meridian** implemented two communication forms that were modified to enhance communication between the PCP and behavioral health specialist.

Consumer Satisfaction

The VMCOs implemented the following initiatives to address those areas where consumer satisfaction fell below expected performance. FHN and Harmony administered the Adult CAHPS and Child surveys, while Meridian was allowed to create and administer its own consumer

satisfaction survey as the plan did not have a membership large enough to conduct the CAHPS survey. The ICP plans will begin conducting the CAHPS surveys in 2013.

- **FHN** has continued to increase the specialty provider network in response to member satisfaction with access to specialists. In addition, FHN has upgraded its telephone system and added additional staffing resources to the member services department in an effort to improve member access and satisfaction with the health plan.
- **Harmony** implemented a Member Escalation Team in which eight representatives within the member services department were designated to solely handle escalated issues, member concerns related directly to desiring disenrollment, and all PCP changes. Harmony implemented other initiatives such as contracting with a vendor to conduct welcome calls to newly enrolled members and also contracted with a new dental vendor in an effort to increase member satisfaction.
- **Meridian** met or exceeded the goal of 80 percent in nine of the fourteen Member Experience Survey questions and restructured the outbound dialer system to create maximum efficiency and improve reach rates to members. In addition, member services hours were expanded in an effort to allow improved access times for members to call.

Opportunities to Improve Outcomes

Improving health care outcomes can provide a “win-win” situation for the State and the individual enrollees. Better care outcomes will result in improved health status and a higher quality of life for the enrollees and their families. Better care outcomes will provide a much higher value for expenditure of the State’s precious resources. To pursue better care outcomes, the reimbursement structures for many providers need to be updated and redesigned.

Beginning in March 2011, HFS embarked on a collaborative approach with the broader community to initiate a dialogue on the development of a reimbursement system that better promotes coordination of care and quality outcomes. Better management of care should result in more efficient use of State resources by focusing funds on those aspects of care providing the highest return and, in truth, by focusing funds on currently underfunded areas critical to achieve better management of care. This, in turn, can act as a lever to stabilize the cost of care to the Medicaid program as well as the private payer and commercial payer community. In order to achieve this, HFS must restructure its reimbursement methodologies to take into consideration the complexity of health care needs, the quality of care, and the health outcomes of enrollees.

Illinois Medicaid Reform Law and Efforts

The Illinois Medicaid reform law (PA 096-1501) requires that by January 1, 2015, at least 50 percent of enrolled individuals must be participating in a care coordination program that organizes care around enrollees' medical needs. In addition, HFS care coordination models must include some degree of risk-sharing by providers. The law also requires HFS to report on the impact current hospital reimbursement models have on the ability to comply with the care coordination requirement. As the State moves toward a care coordination delivery model, it must maintain compliance with applicable federal Medicaid requirements as well.

Federal law (1) requires that payments under capitated contractual arrangements be actuarially sound, appropriate to the populations covered, and certified by an actuary, and (2) prohibits other payments to providers (in this instance hospitals) for services that are covered under the capitated contract. As a consequence, additional funding, replacing the value of previous supplemental hospital payments in the overall fee-for-service reimbursement structure, needs to be included in the capitation rates.

HFS currently manages three capitated MCOs in the voluntary managed care program for the All Kids, Moms & Babies, and FamilyCare populations, which include approximately 213,000 participants. HFS manages two capitated plans in the mandatory ICP for senior and persons with disabilities, which will total approximately 36,000 participants. HFS also has approximately 1.9 million participants enrolled in a medical home with the Primary Care Case Management (PCCM) program.

Quality Assessment Performance Improvement Strategy
Priority Measures—FY 2012–2013
Voluntary Managed Care Organizations (VMCOs)

Performance Measure	Family Health Network, Inc.				Harmony Health Plan of Illinois, Inc.				Meridian Health Plan, Inc.			
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012	2013 Hybrid QISMC Goal	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012	2013 Hybrid QISMC Goal	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012	2013 Hybrid QISMC Goal
Child and Adolescent Care	**Improve the health and wellness of children and adolescents by increasing access to preventive services.**											
Childhood Immunization Status—Combo 3	70.37	73.33	69.91	72.92	61.56	64.40	63.99	64.40	NA	64.40	83.33	76.70
Lead Screening in Children	81.94	80.50	82.87	80.50	78.10	80.29	79.08	81.17	NA	55.50	92.21	80.50
Well-Child Visits First 15 Months of Life (Zero Visits)*	3.46	2.70	2.31	2.08	5.35	2.70	4.62	2.70	NA	2.70	0.00	0.00
Well-Child Visits First 15 Months of Life (6 or More Visits)	53.81	58.43	50.12	52.20	51.34	52.20	51.34	52.20	NA	52.20	82.00	68.90
Well-Child Visits Third, Fourth, Fifth, and Sixth Years of Life	67.44	70.69	72.98	75.68	71.78	74.60	65.21	66.10	NA	66.10	84.94	77.60
Adolescent Well-Care Visits	43.88	49.49	44.11	49.70	38.93	39.60	35.52	39.60	NA	39.60	66.67	57.20
Access and Availability	**Improve the health and wellness of adults by increasing access to preventive/ambulatory services.**											
Adults' Access to Preventive /Ambulatory Health Services—Ages 20–44 Years	64.59	78.50	69.22	78.50	69.29	78.50	70.81	78.50	90.54	86.40	89.14	86.40
Prevention and Screening for Women	**Improve the health and wellness of women by ensuring access to screening and preventive services.**											
Cervical Cancer Screening	69.44	72.50	71.50	74.35	69.83	72.85	71.53	74.38	NA	64.00	84.44	74.20
Maternity-Related Care	**Improve the health and wellness of new mothers and infants and and ensure timely access to prenatal and postpartum care.**											
Timeliness of Prenatal Care	62.36	80.30	69.75	80.30	64.72	80.30	64.72	80.30	98.18	90.00	93.88	90.00
Postpartum Care	40.18	59.60	45.03	59.60	48.66	59.60	49.64	59.60	85.45	70.60	76.19	70.60
Chronic Conditions/Disease Management	**Promote effective prevention and treatment practices to enable healthy living.**											
Comprehensive Diabetes Care—HbA1c Testing	79.23	81.31	79.45	81.50	69.59	77.60	71.05	77.60	NA	77.60	NA	87.10
Comprehensive Diabetes Care—Poor HbA1c Control*	69.95	52.10	63.64	52.10	65.94	52.10	62.53	52.10	NA	52.10	NA	42.63
Comprehensive Diabetes Care—Monitoring Nephropathy	84.70	82.50	85.77	82.50	67.40	73.90	67.64	73.90	NA	73.90	NA	82.50
Asthma—Combined Rate	90.26	91.24	88.07	89.26	85.95	86.60	79.89	86.60	NA	86.60	NA	86.60
Behavioral Health	**Improve follow-up with a mental health practitioner after discharge from a hospital to facilitate successful transition from the hospital to the home or work environment.**											
Follow-up After Hospitalization for Mental Illness—30 days	80.18	74.60	80.50	74.60	56.14	57.10	57.10	57.10	NA	57.10	NA	57.10

* Lower rates indicate better performance for these measures

Quality Assessment Performance Improvement Strategy
Priority Measures—FY 2012–2013
Integrated Care Program (ICP)

Performance Measure	Measure Description	Numerator	Denominator	2012 Baseline Rate	2013 QISMC Goal
Access and Availability of Care					
Annual Dental Visit	DD only: Age 19–20; Dental Visit During the Measurement Year	80	266	30.08	37.07
	DD only: Age 21 and older; Dental Visit During the Measurement Year	1,415	5,573	25.39	32.85
	DD only: All ages; Dental Visit During the Measurement Year	1,495	5,839	25.60	33.04
Access to member's Assigned PCP	Ambulatory or Preventive Care Visit with PCP	12,722	14,488	87.81	89.03
Prevention and Screening/Diabetes					
Comprehensive Diabetes Care	Hemoglobin (HbA1c) Testing	4,859	6,346	76.57	78.91
	DD Only: Hemoglobin (HbA1c) Testing	321	461	69.63	72.67
	Nephropathy	4,768	6,346	75.13	77.62
	LDL-C screening	4,758	6,346	74.98	77.48
Comprehensive Diabetes Care Admin Method	Statin Therapy (80% of Eligible days)	2,151	6,137	35.05	41.54
	ACE/ARB Therapy (80% of Eligible days)	2,076	6,342	32.73	39.46

Quality Assessment Performance Improvement Strategy
Priority Measures—FY 2012–2013
Integrated Care Program (ICP)

Performance Measure	Measure Description	Numerator	Denominator	2012 Baseline Rate	2013 QISMC Goal
Prevention and Screening/Cardiovascular					
Congestive Heart Failure	ACE/ARB Therapy (80% of Eligible days)	976	3,640	26.81	34.13
	Beta Blocker (80% of Eligible Days)	259	1,030	25.15	32.63
	Diuretic (80% of Eligible Days)	1,034	3,612	28.63	35.76
Coronary Artery Disease	Cholesterol Testing During Measurement Year	2,881	3,828	75.26	77.74
	Received Statin 80% of Enrolled Time	1,352	3,646	37.08	43.37
	Received ACE/ARB 80% of Enrolled Time	1,117	3,735	29.91	36.92
Persistence of Beta-blocker Treatment After a Heart Attack	Persistent Beta Blocker Treatment	11	32	34.38	40.94
Prevention and Screening/Respiratory					
Pharmacotherapy Management of COPD Exacerbation	Dispensed a System Corticosteroid Within 14 Days	331	520	63.65	67.29
	Dispensed a Bronchodilator Within 30 Days	408	520	78.46	80.62
Use of Spiromotry Testing in the Assessment and Diagnosis of COPD	Newly Diagnosed COPD who Received Spirometry Testing	63	212	29.72	36.75

Quality Assessment Performance Improvement Strategy
Priority Measures—FY 2012–2013
Integrated Care Program (ICP)

Performance Measure	Measure Description	Numerator	Denominator	2012 Baseline Rate	2013 QISMC Goal
Utilization					
Ambulatory Care	ED Visits	65,669	371,805	176.62	NA
Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Dept Visit	Ambulatory Care visit with a provider within 14 days of ED visit	11,729	29,367	39.94	45.95
Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge	Ambulatory Care visit with a Provider within 14 days of Inpatient Discharge	4,114	8,824	46.62	51.96
Behavioral Health					
Follow-Up with Mental Health Provider within 30 Days After Initial Behavioral Health Diagnosis (BHD)	Follow-Up with Provider Within 30 Days of Initial BHD	1,934	3,823	50.59	55.53
Follow-Up After Hospitalization for Mental Illness	Follow-Up Within 30 Days of Discharge	917	1,657	55.34	59.81
Antidepressant Medication Management	Effective Acute Phase Treatment (at least 84 Days)	83	178	46.63	51.97
	Effective Continuation Phase Treatment (at least 180 Days)	61	178	34.27	40.84

Quality Assessment Performance Improvement Strategy
Performance Measures—Full List
FY 2011–2014
Integrated Care Program

Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
Behavioral Health Risk Assessment (BHRA) and Follow-Up—*New enrollees who completed a behavioral health assessment (BHRA) within 60 days of enrollment. Also measures percentage of enrollees with a positive finding on BHRA who receive follow-up with a mental health provider within 30 days of assessment.*							
1) Behavioral Screening/ Assessment within 60 Days of Enrollment		State	X				
2) Behavioral Health Follow-Up within 30 Days of Screening		State	X				
Alcohol and other Drug Dependence Treatment	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS	X				
Behavioral Health Support	Appropriate follow-up with any Provider within 30 days after initial BH diagnosis.	State	X	X	X	X	X
Behavioral Health Support—*Follow-Up After Hospitalization for Mental Illness*							
1) Follow-Up in 7 days		HEDIS	X				
2) Follow-Up in 30 days		HEDIS	X	X	X	X	X
Care Coordination Influenza Immunization Rate	Enrollees who received at least one influenza immunization annually.	State	X				

Quality Assessment Performance Improvement Strategy
Performance Measures—Full List
FY 2011–2014
Integrated Care Program

Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
Dental Utilization—*Enrollees who receive an annual dental visit.*							
1) Annual Dental Visit—All		State	X				
2) Annual Dental Visit—DD Only		State	X	X	X	X	X
Dental ER Utilization	Emergency Room Visits for Enrollees with Dental Primary diagnoses.	State	X				
Diabetes Care—*Increased Utilization of Disease Specific Therapies.* ***Meet two of numbers 1, 2, and 3 and one of numbers 4 and 5.***							
1) Hemoglobin A1c (HbA1c) Testing 1x Per Year		HEDIS	X	X	X	X	X
2) Microalbuminuria Testing 1 x Per Year		HEDIS	X	X	X	X	X
3) Cholesterol Testing 1 x Per Year		HEDIS	X	X	X	X	X
4) Statin Therapy 80% of the Time		State	X	X	X	X	X
5) ACE/ARB 80% of the Time		State	X	X	X	X	X

Quality Assessment Performance Improvement Strategy
Performance Measures—Full List
FY 2011–2014
Integrated Care Program

Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
6) DD Waiver Program Support	Services for Enrollees in DD Waiver and Enrollees with DD Diagnostic History—HbA1c Testing 1 x Per Year	HEDIS	X				
Congestive Heart Failure—*Increased Utilization of Disease-Specific Therapies* ***(meet 2 of 3).***							
1) ACE/ARB 80% of the Time		State	X	X	X	X	X
2) Beta Blocker 80% of the Time		State	X	X	X	X	X
3) Diuretic 80% of the Time		State	X	X	X	X	X
Coronary Artery Disease—*Increased Utilization of Disease-Specific Therapies* ***(meet 2 of 4).***							
1) Cholesterol Testing 1 x Per Year		HEDIS	X	X	X	X	X
2) Statin Therapy 80% of the Time		State	X	X	X	X	X
3) ACE/ARB 80% of the Time		State	X	X	X	X	X
4) Beta Blocker Post MI for 6 Months following MI		HEDIS	X	X	X	X	X

Quality Assessment Performance Improvement Strategy
Performance Measures—Full List
FY 2011–2014
Integrated Care Program

Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
Chronic Obstructive Pulmonary Disease (COPD)—*Increased Utilization of Disease-Specific Therapies* ***(meet 2 of 3).***							
1) Acute COPD Exacerbation w/Corticosteroid		HEDIS	X	X	X	X	X
2) History of Hospitalizations for COPD with a Bronchodilator Medications		HEDIS	X	X	X	X	X
3) Spirometry Testing (1 time in last three years)		HEDIS	X	X	X	X	X
Ambulatory Care	Emergency Department Visits per 1,000 Enrollees	HEDIS	X	X	X	X	X
1) Waiver Program Support	Services for Population in DD Waiver and Clients with Diagnostic History—Emergency Department Utilization Rate per 1,000	HEDIS	X				
Ambulatory Care follow-up after Emergency Department Visit	Follow-Up with any Provider Within 14 days Following Emergency Department Visit	State	X	X	X	X	X
Inpatient Utilization—General Hospital/Acute Care	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	HEDIS	X				
Mental Health Utilization	Mental Health Services Utilization per 1,000 Enrollees	HEDIS	X				

Quality Assessment Performance Improvement Strategy
Performance Measures—Full List
FY 2011–2014
Integrated Care Program

Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
Ambulatory Care Follow-Up after Inpatient Discharge	Ambulatory Care Follow-Up Visit Within 14 days of every Inpatient Discharge	State	X	X	X	X	X
Inpatient Hospital Re-Admission	Inpatient Hospital 30-day Readmissions. In addition, Mental Health Readmissions Reported Separately	State	X				
Long Term Care Residents—Urinary Tract Infection Hospital Admission	Hospital Admissions due to Urinary Tract Infections for LTC Residents	AHRQ	X				
Long Term Care—Bacterial Pneumonia Hospital Readmission	Hospital Admission due to Bacterial Pneumonia for LTC Residents	HSAG	X				
Long Term Care Residents—Prevalence of Pressure Ulcers	LTC Residents that have Category /Stage II or greater Pressure Ulcers	State	X	X			X
Medication Reviews	Annual Monitoring for Enrollees on Persistent Medications	HEDIS	X				
	Antidepressant Medication Management—At least 84 days continuous treatment with antidepressant medication during 114-day period following Index Episode Start Date (IESD)	HEDIS	X	X	X	X	X

Quality Assessment Performance Improvement Strategy
Performance Measures—Full List
FY 2011–2014
Integrated Care Program

Category	Performance Measure	Specification Source	Quality Monitoring	P4P	Yr1	Yr2	Yr3
	Antidepressant Medication Management—At least 180 days continuous treatment with antidepressant medication during 231-day period following IESD	HEDIS	X	X	X	X	X
	Percentage of Enrollees Diagnosed with Schizophrenia who maintain Medication Adherence at 6 Months and 12 Months	State	X				
Preventive Services	Colorectal Cancer Screening	HEDIS	X				
	Breast Cancer Screening	HEDIS	X				
	Cervical Cancer Screening	HEDIS	X				
	Adult BMI Assessment	HEDIS	X				
Access to Enrollee's Assigned PCP	Enrollees who had an Annual Ambulatory or Preventive Care Visit with Enrollee's Assigned PCP	State	X	X	X	X	X
Retention Rate for LTC and HCBS Waiver Enrollee Services in the Community	LTC and HCBS Waiver Enrollees served in the community at the beginning of the year and continued to be served in the community during the year	State	X	X		X	X

VMCOs Required Reports and Submissions
FY 2012–2013

Report names, information submission requirements, and corresponding frequencies are listed herein. These shall be due to the Department no later than thirty (30) days after the close of the reporting period unless otherwise stated. Reports and submissions include hard copy reports and/or any electronic medium as designated by the Department.

Report frequencies are defined as follows:

- Annually—The State fiscal year of July 1–June 30.
- Quarterly—The last day of the fiscal quarter grouped as: J/A/S (1st qtr), O/N/D (2nd qtr), J/F/M (3rd qtr), and A/M/J (4th qtr).
- Monthly—The last day of a calendar month.

VMCOs—Summary of Required Reports and Submissions		
Name of Report/Submission	**Frequency**	**HFS Prior Approval**
Administrative		
Disclosure Statements	Initially, annually, on request, and as changes occur	No
Encounter Data Report	At least monthly	No
Financial Reports	Concurrent with submissions to Department of Financial and Professional Regulation	No
Report of Transactions with Parties of Interest	Annually	No
Electronic Data Certification	Monthly, no later than 5 days after the close of the reporting month	No
Enrollee Materials		
Certificate or Document of Coverage and Any Changes or Amendments	Initially and as revised	Yes
Enrollee Handbook	Initially and as revised	Yes
Identification Card	Initially and as revised	Yes
Provider Directory	Initially and annually	Yes (only initially)

VMCOs Required Reports and Submissions
FY 2012–2013

VMCOs—Summary of Required Reports and Submissions		
Name of Report/Submission	**Frequency**	**HFS Prior Approval**
Fraud/Abuse		
Fraud and Abuse Report	Immediately upon identification or knowledge of suspected fraud or abuse, and quarterly as specified in Section 5.25.	NA
Marketing		
Marketing Allegation Investigation Disclosure	Monthly, on the first day of each month	No
Marketing Allegation Notification	Weekly	No
Marketing Gifts and Incentives	Initially and upon request	Yes
Marketing Materials	Initially and as revised	Yes
Marketing Plans and Procedures	Initially and as revised	Yes
Marketing Representative Listing	Monthly, on the first day of each month	No
Marketing Representative Termination Notification	As they occur	No
Marketing at Site Permission Statement	Annually	No
Marketing at Site Schedule	Monthly, on the first day of each month, and as revised	No
Marketing Schedule at Retail Locations	Monthly, on the first day of each month, and as cancellations occur during the month	No
Marketing Training Manuals	Initially and as revised	Yes
Marketing Training Schedule and Agenda	Quarterly, 2 weeks prior to the beginning of each quarter, and as revised	No

VMCOs Required Reports and Submissions
FY 2012–2013

VMCOs—Summary of Required Reports and Submissions		
Name of Report/Submission	**Frequency**	**HFS Prior Approval**
Provider Network		
PCP, Hospital and Affiliated Specialist File (electronic)	Department's designee, monthly and daily updates only when changes occur	Yes
Enrollee Site Transfer	As each occurs	No
PCP, Hospital and Affiliated Specialist File (electronic)	Department's designee, monthly and daily updates only when changes occur	Yes
Enrollee Site Transfer	As each occurs	No
Provider Affiliation File (electronic)	Monthly, on the first day of each month	No
Site/PCP Approvals (paper format—A & B forms)	Initially, and as new sites/PCPs are added	Yes
Site Terminations	As each occurs	No
Quality Assurance/Medical		
Grievance Procedures	Initially and as revised	Yes
PCP Ratio Report	Quarterly	NA
QA/UR/PR Annual Report	Annually, no later than 60 days after close of reporting period	NA
QA/UR/PR Committee Meeting Minutes	Quarterly	No
Quality Assurance, Utilization Review and Peer Review Plan (includes health education plan)	Initially and as revised	Yes
Summary of Grievances or Appeals and Resolutions and External Independent Reviews and Resolutions	Quarterly	NA
Case Management/Disease Management Plan	Initially and as revised	Yes
Case Management/Disease Management Summary Report	Monthly, no later than 5 days after the close of the reporting month	No

VMCOs Required Reports and Submissions
FY 2012–2013

VMCOs—Summary of Required Reports and Submissions		
Name of Report/Submission	**Frequency**	**HFS Prior Approval**
CSHCN Plan	Initially and annually	Yes
Recall Systems Plan	Annually	NA
Subcontracts and Provider Agreements		
Copies of Executed Subcontractor Agreements	Upon request	NA
Model Subcontractor Agreements	Initially and as revised	NA

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

Report names, information submission requirements, and corresponding frequencies are listed herein. These shall be due to the Department no later than thirty (30) days after the close of the reporting period unless otherwise stated. Reports and submissions include hard copy reports and/or any electronic medium as designated by the Department.

Report frequencies are defined as follows:

- Annually—The State fiscal year of July 1–June 30.
- Quarterly—The last day of the fiscal quarter grouped as: J/A/S (1st qtr), O/N/D (2nd qtr), J/F/M (3rd qtr), and A/M/J (4th qtr).
- Monthly—The last day of a calendar month.

ICP—Required Deliverables, Submissions, and Reporting			
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. This 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. Beginning in Phase 2, 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 fifty (150) 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:

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
			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 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 name. 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 Data 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 re-processing. **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 Statements	Initially, annually, on request, and as changes occur	No	Contractor shall submit disclosure statements as specified in 42 C.F.R., Part 455.
Financial Reports	Concurrent with submission to Department of Insurance	No	Contractor shall provide the Department with copies of all financial reports. Contractor is required to file with the Department of Insurance and the Department of Financial and Professional Regulation.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
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 for both paper and electronic claims, in-network and out-of-network break out, and the number of days the claims took to process.
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 the Provider Directory that is on Contractor's website for Prior Approval. Provider updates shall not be required to be submitted for Prior Approval.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Fraud and Abuse			
Fraud and Abuse Report	Immediately upon notification or knowledge of suspected fraud and abuse, and quarterly	NA	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 and a quarterly summary report of 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 C.F.R. 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.
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.
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.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Provider Network			
PCP, 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 PCPs 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; ♦ PCP gender and panel status (open or closed); and ♦ PCP hospital affiliations, including information about where the PCP has admitting privileges or admitting arrangements and delivery privileges (as appropriate).
Provider Affiliation with Sites	Monthly by the first business day of the month	Yes	Contractor shall submit the Provider Affiliation with Sites report in the format given to Contractor by the Department, which shall include monthly updating of those Providers who have either become a Provider in Contractor's network or who have left the network since the last report.
Provider Site Requests	As each occurs	No	Contractor shall submit the Provider Site Requests, in a format and medium designated by the Department, as new Sites are added.
Enrollee Site Transfers	As each occurs	No	Contractor shall submit Enrollee Site Transfer files to the Department, using the HIPAA compliant 834 transaction.
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.

ICP Required Deliverables, Submissions and Reporting FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
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—Detail Report	Monthly	No	Contractor shall submit a detailed report on Grievances and Appeals providing Enrollee Medicaid number, Enrollee name, description of Grievance, date received, incident date, date resolved, source of Grievance, status (open or closed), reason closed, incident summary and resolution summary, grouped by incident type. Reporting will be limited to quality of care (as defined by: misdiagnosis, bad prescription, quality of service, balance billing, poor office conditions, poor treatment by staff), access to care (as defined by: cannot find provider, inconvenient hours, Provider capacity, out of area Providers, refusal to take Medicaid, ADA non-compliance, unable to address language needs, not meeting appointment times requirements), medical necessity, transportation and dental issues. All other issues shall only be categorized and reported as "Other" as part of the quarterly summary report.
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, dental and "Other" issues. Reporting shall include total grievance and appeals per/1,000 Enrollees. The report shall include a summary count of any such Grievances or Appeals resolved during the reporting period including any resolution by external independent reviews, types of Grievances and Appeals and the levels at which the Grievances or Appeals were resolved, the types of resolutions and the number pending resolution by category.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Quality Assurance, Utilization Review and Peer Review Annual Report (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.
QA/UR/PR Committee Meeting Minutes	Quarterly	No	Contractor shall submit the minutes of the QA/UR/PR meetings.
Quality Assurance, Utilization Review, Peer Review 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.
Conditions Report	Semi-annually	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.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Care Management/ Disease Management Summary Report	Monthly	No	Contractor shall submit an aggregate report of all Enrollees who are assigned to Contractor's Care Management and Disease Management interventions, including risk stratification count and percent of Enrollees at each level. Contractor shall also provide summary data for the categories of (i) Aged, Blind and Disabled, (ii) HCBS Developmentally Disabled Waiver, (iii) Long Term Care, and (iv) Behavioral Health (by primary diagnoses, including Substance Abuse). These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.
Case Management/ Disease Management Active Participants Report	Monthly	No	Contractor shall submit the risk stratification levels for all Enrollees in an aggregate report. This report shall track Enrollees based on enrollment date and show the data points of initial screening completed, stratification level and assessment and Enrollee Care Plan developed for the first twelve (12) months of enrollment. Stratification levels are to be reported as follows: Active (moderate and high risk); Attempting to locate (moderate and high risk); Light condition support (low risk) and opt out (moderate or high risk who refused Care Management). Contractor shall report separately for the categories of (i) Aged, Blind and Disabled, (ii) HCBS Developmentally Disabled Waiver, (iii) Long Term Care and (iv) Behavioral Health (by primary diagnoses, including Substance Abuse).
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.
Outreach Summary Report	Quarterly	No	Contractor shall submit a summary report that shows Enrollee outreach for each level of stratification. Enrollees' risk levels will be determined by what level they are in the end of the quarter. Inclusive in this report are Enrollees who were unable to be contacted and those who were contacted but refused to be in Care Management.
Risk Stratification Trend Report	Monthly	No	Contractor shall submit aggregate Enrollees' risk group assignments and shall analyze movement and trends. These reports may be generated utilizing Contractor's unique internal algorithms and systems to determine primary conditions and risk level of Enrollees.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Prior Authorization and Pre-Certification Report	Monthly	No	Contractor shall submit turnaround times for routine and expedited prior authorizations and pre-certifications for Enrollees.
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.
Executive Summary on Enrollee Profiles/ Statistics for Care Integration	Annually	No	Contractor shall submit an executive summary 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 PCP and specialist visits, Emergency Services, inpatient hospitalizations and pharmacy utilization.

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Utilization Review			
Utilization Management Report	Monthly	No	Contractor shall submit an analysis of inpatient and Emergency Service utilization. Inpatient services shall be based on inpatient days and be categorized as follows: utilization for total inpatient, medical/surgical, Rehabilitation, and mental health including substance abuse. Emergency Services will be based on utilization per 1,000 Enrollees. Reporting for inpatient and Emergency Service utilization shall be divided into separate worksheets for long term care, the population served in the HCBS Waiver for persons with DD, and total population as defined by Department standards.
Pharmacy Reports			
Pharmacy Rebate Report	Quarterly	NA	Contractor shall submit a pharmacy rebates report that sets forth the pharmaceutical rebates received by it or its Pharmacy Benefit Manager (PBM) from pharmaceutical manufacturers or labelers for the drug utilization covered under this Contract. Rebates include all revenue or credits from manufacturers or labelers that is paid or credited as a result of formulary placement or that is paid or credited based on the volume of drugs sold.
Pharmacy Monitoring Reports	Monthly	Yes	Contractor shall submit pharmacy data utilization reports (to be determined, in a format that has received Prior Approval.
Psychotropic Review Reports	Monthly	No	Contractor shall submit summary reports of Enrollees Psychotropic medication utilization and the prescribing patterns of Providers, including efforts to change unsafe, redundant or atypical prescribing patterns, as decided by all parties.

ICP Required Deliverables, Submissions and Reporting
FY 2012–2013

ICP—Required Deliverables, Submissions, and Reporting			
Name of Report/Submission	**Frequency**	**HFS Prior Approval**	**Report Description and Requirements**
Subcontracts and Provider Agreements			
Executed Subcontracts	Upon execution and as revised	NA	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, 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	NA	Contractor shall submit copies of an executed Provider agreement to the Department upon request.
Model Subcontracts and Provider Agreements	Initially and as revised	NA	Contractor shall submit copies of model subcontracts and Provider agreements related to Covered Services, assignment of risk and data reporting functions, including the form 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.
Business Enterprise Program Act for Minorities, Females, and Persons with Disabilities			
Business Enterprise Program Act (BEP) Plan	Initially, prior to the start of each State Fiscal Year, and as revised	Yes	Contractor shall submit the Business Enterprise Program Plan specifying how Contractor will meet the goals set forth in the Contract relating to expenditures for BEP certified subcontractors for Prior Approval initially and as revised. Refer to Section 2.9.
Business Enterprise Program Reports	Quarterly	NA	Contractor shall submit, in a format specified by the Department, its expenditures for BEP certified sub-contractors.

I. State Standards for Access to Care

A. Standards for access to care are as stringent as those in 42 C.F.R. 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.	MCO Contract, Article I, Definitions; Article V, 5.1, 5.13 Article II, 2.8 ICP Contract, Article I, Definitions; Article V, 5.1, 5.1.1, 5.5.8 Attachment XI, 2.b and 7 89 Ill. Adm. Code, Part 140 42 C.F.R. 438.206 42 C.F.R. 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.	MCO Contract, Article V, 5.2, 5.6, 5.17, Exhibit A, 4.g.ii ICP Contract, Article I, Definitions; Article V, 5.5, 5.9.3, 5.18.4; Article II, 2.7, 2.7.1.4 42 C.F.R. 438.206

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
b) Primary Care Provider	• Enrollees have a choice for their Primary Care Provider.	MCO Contract, Article IV, 4.2(a), 4.7; Article V, 5.17 ICP Contract, Article I, Definitions; Article V, 5.6.5 42 C.F.R. 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.	MCO Contract, Article IV, 4.1 (a); 4.2(a); 4.7; Article V, 5.17 ICP Contract, Article I, Definitions; Article V, 5.6.5 42 C.F.R. 438.206
d) Second opinion	• An enrollee may request and receive a second opinion from a qualified health care professional within the network, or the MCO will arrange for the enrollee to obtain one outside of the network, at no cost to the enrollee. MCOs have written policies and procedures governing second opinion processes and mechanisms in place for compliance.	MCO Contract, Article V, 5.1(a) ICP Contract, Article V, 5.1 42 C.F.R. 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.	MCO Contract, Article II, 2.8; Article V, 5.1(a), (h), (i), 5.2 ICP Contract, Article II, 2.6 Article V, 5.5.5, 5.22.2, 5.25.1, 5.25.2, 5.25.3, 5.25.4 42 C.F.R. 438.206

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
g) Credentialed providers	• MCOs demonstrate that their providers are credentialed.	MCO Contract, Article V, 5.22(c),(d); Exhibit A, 9 ICP Contract, Article V, 5.7.2 (410 ILCS 517/) Health Care Professional Credentials Data Collection Act 42 C.F.R. 438.206 42 C.F.R. 438.214
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.	MCO Contract, Article 5.1 (a), (g), (h), (j); 5.13(e); Article IX; Exhibit A ICP Contract, Attachment XI, 2. b, 2.g; Article V, 5.6.3, 5.6.4 42 C.F. R. 438.206
i) Cultural considerations	• MCOs must promote the delivery of services in a culturally competent manner to all enrollees.	MCO Contract, Article II, 2.4; Article IX,9.2; Exhibit A, 4.g.ii ICP Contract, Article I, Definitions; Article II, 2.3.8, 2.7; Article V, 5.9.3, 5.18.4, 5.18.4.2; Attachment XI, 3.g.ii. (f) 42 C.F.R 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 (provider affiliation site report. (Refer to the *Summary of Required Reports and Submission* listed below); when the MCO enrolls a new population, covers a new service geographic area or makes changes in benefits or payments.	MCO Contract, Article 5.1(a); 5.2; 5.11 (5) ICP Contract, Article I, Definitions; Article IV, 4.14.2; Article V, 5.5.1.1 42 C.F.R. 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, primary 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.	MCO Contract, Article V, 5.1; 5.11; 5.16; 5.17; Exhibit A ICP Contract, Article I, Definitions; Article IV, 4.14.2; Attachment XI, 3.g.ii.(e) 42 C.F.R. 438.207
3. Coordination and continuity of care a) Ongoing source of primary care b) Coordinate services c) Prevent duplication d) Protect enrollees' privacy	• 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.	MCO Contract, Article IV, 4.1, 4.5, 4.6; Article V, 5.13; 5.14; 5.15, 5.16 Exhibit A (#4) ICP Contract, Article I, Definitions; Article V, 5.5.1.1, 5.5.7, 5.5.8, 5.11.3, 5.12.1, 5.12.3, 5.12.4, 5.13, 5.13.2, 5.15.3, 5.16, 5.16.1, 5.33; Article VI, 6.4; Article IX, 9.1.21; Attachment XII, 2.b

Access Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
e) Continuity of Care	• MCOs assume responsibility for preexisting conditions. • MCOs remain responsible for management of care if the enrollee is inpatient at time enrollment begins. • 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.	42 C.F.R. 438.208 45 CFR parts 160 and 164 subparts A and E
f) Additional services for persons with special health care needs (SHCNs)	• MCOs are required to establish a Special Health Care Needs (CSHCN) program with the goal of conducting timely identification and screening, assuring a thorough and comprehensive assessment and providing appropriate and targeted case management services. Additional services for persons with special health care needs include direct access to specialists as appropriate for each enrollee's condition and identified needs.	MCO Contract, Article IV, 4.1, 4.5, 4.6; Article V, 5.12; 5.13; 5.14; 5.15, 5.16 Exhibit A (#4) 42 C.F.R. 438.208 45 CFR parts 160 and 164 subparts A and E
f) Additional services for persons with special health care needs (SHCNs) *(cont.)*	• It is understood that in some instances enrollees will require specialty care not available from an Affiliated Provider and that MCO will arrange that such services be provided by a non-Affiliated Provider. • MCO shall establish a comprehensive network to ensure the availability and accessibility of specialists and subspecialists to meet the needs of enrollees. Care Coordinators shall have authority to authorize services and will not require approval by contractor's Medical Director for the majority of services.	ICP contract, Article V, 5.5.5, 5.5.8

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. • 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.	MCO Contract, Article I, Definitions; Article V, 5.1; 5.14 ICP Contract Article V, 5.1, 5.19.8, Attachment XII, 2.c.iii, 2.c.v, 2.c.vi, 2.c.vii 42 C.F.R. 438.210 42 C.F.R. 438.404 42 C.F.R. §438.206(b) 89 Ill. Adm. Code, Part 140

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Provider Networks: Physicians (VMCO)	• Minimum Network Requirements: ▪ 1 FTE Physician for each 1,200 enrollees, including 1 FTE Primary Care Provider for each 2,000 enrollees. ▪ 1 FTE Women's Health Care Provider for each 2,000 female enrollees between the ages of 19 and 44. ▪ 1 FTE Physician specializing in obstetrics for each 300 pregnant enrollees. ▪ 1 FTE Pediatrician for each 2,000 enrollees under age 19. • All physicians providing services must have and maintain admitting privileges, and as appropriate, delivery privileges at an affiliated hospital or nearby hospital. In lieu of having admitting and delivery privileges, the physicians shall have and maintain a written referral agreement with the physician who is in the network and who has such privileges at an affiliated or nearby hospital. • MCOs shall regularly report on their provider network (Refer to Attachment 2: Summary of Required Reports and Submissions).	MCO Contract, Article V, 5.17
Provider Networks: Physicians (ICP)	• Minimum Network Requirements: ▪ MCO shall establish, maintain and monitor a network of affiliated providers, including PCPs, WHCPs, mid-level practitioners, specialists, dentists, hospitals and behavioral health providers, 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 contractor's enrollees; ◆ The number and types of providers required to furnish the covered services; ◆ The number of affiliated 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.	ICP Contract Article V, 5.1.1, 5.1.2, 5.28.1.2, 5.5.3, 5.6.8 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**
Physicians (ICP) *(cont.)*	• Primary Care Provider to Enrollee Ratio. Contractor's maximum PCP panel size shall be six hundred (600) enrollees. If MCO does not satisfy the PCP requirements set forth above, MCO may demonstrate compliance with these requirements by demonstrating that (i) contractor'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. • All physicians providing services must have and maintain admitting privileges, and as appropriate, delivery privileges at an affiliated hospital or nearby hospital. In lieu of having admitting and delivery privileges, the physicians shall have and maintain a written referral agreement with the physician who is in the network and who has such privileges at an affiliated or nearby hospital. • MCOs shall regularly report on their provider network (Refer to Attachment 2: Summary of Required Reports and Submissions).	
Emergency Care	• Emergency services may be provided by an affiliated or non-affiliated provider. • No prior approval requirements for emergency care are allowed. • Coverage when the enrollee is out of contracting area is required for emergency care. • Ongoing education regarding the appropriate use of emergency services is required of MCOs. • MCOs may not condition coverage on the treating provider's notification within 10 calendar days of presentation for emergency services.	MCO Contract, Article V, 5.1(g) ICP Contract, Article V, 5.17.1, 5.17.1.1, 5.17.1.2, 5.17.1.5, 5.17.1.6
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.	MCO Contract, Article V, 5.1(h) ICP Contract, Article V, 5.17.2

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Urgent Care (VMCO)	• Enrollees with serious problems not deemed an emergency shall be triaged and provided same day service, as determined medically necessary.	MCO Contract, Article V, 5.13(e)
Urgent Care (ICP)	• Enrollees with more serious problems not deemed emergency medical conditions shall be triaged and, if necessary, medically necessary care will be provided within twenty-four (24) hours. (IlliniCare). • 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. (Aetna).	ICP Contract, Article V, 5.6.3
Appointment—Preventive Care for Infants under six (6) months (VMCO)	• Preventive care appointments for infants under six (6) months shall be provided within two (2) weeks of the date of the request.	MCO Contract, Article V, 5.13(e)
Appointment—Preventive Care	• Routine, preventive care appointments are to be provided within five (5) weeks of the date of the request.	MCO Contract, Article V, 5.13(e) ICP Contract, Article V, 5.6.3
Appointment—Non-Serious Problems/ Complaints	• Appointments for non-serious problems and non-serious complaints are to be provided within three (3) weeks of the request.	MCO Contract, Article V, 5.13(e) ICP Contract, Article V, 5.6.3
Prenatal Care	• Enrollees in their first trimester without expressed problems shall receive an appointment within two (2) weeks of their request. • Enrollees in their second trimester without expressed problems shall receive an appointment within one (1) week of their request. • Enrollees in their third trimester without expressed problems shall receive an appointment within three (3) days of their request.	MCO Contract, Article V, 5.13(e) ICP Contract, Article V, 5.6.3
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; and assure 24 hour access for consultation to obtain medical care). • Toll-free telephone access must be available no less than from 9 a.m.–5 p.m.,	MCO Contract, Article V, 5.1(j) ICP Contract, Article V, 5.18.6.1, 5.18.6.2

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Telephone Access *(cont.)*	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).	
In-Office Wait Time	• No more than a one (1) hour wait time to be seen by a provider should occur (for a scheduled appointment).	MCO Contract, Article V, 5.13(e) ICP Contract, Article V, 5.6.3
Provider Appointments/Scheduling	• No more than six (6) scheduled appointments per provider/per hour should occur.	MCO Contract, Article V, 5.13(e) ICP Contract, Article V, 5.6.3
Pharmacy Formulary (VMCO)	• The pharmacy benefit provided by pharmacists is excluded from the MCO contract, and instead, is covered by HFS' Fee-For-Service delivery system. Pharmacy utilization information for each enrollee is provided to the respective MCO. • Pharmaceutical products provided by an entity other than a pharmacy are covered by the MCO and must be no more restrictive than the Fee-For-Service delivery system.	MCO Contract, Article V, 5.1(b), 5.1(d)
Pharmacy Formulary (ICP)	• MCO's Enumerated Covered Services in Service Package I includes Pharmacy Services. • MCO shall authorize or deny covered services, including pharmacy services, that require prior authorization as expeditiously as the enrollee's health condition requires. • All of MCO's initial provider compensation models shall be structured on a Fee-For-Service basis. MCO shall give the Department advance written notice of all provider agreements reimbursed on a sub-capitated basis. Department acknowledges and agrees that MCO may reimburse various vendors on a sub-capitated basis to provide, or arrange for the provision of, vision, dental, behavioral health, pharmacy, nurse telephone triage, transportation and radiology.	ICP Contract, Article I, 1.93 Article V, 5.5.6, 5.16.6; Attachment I, Service Package I Covered Services; Attachment XIII

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Pharmacy Formulary (ICP) *(cont.)*	• National Council for Prescription Drug Program (NCPDP) means the electronic HIPAA transaction that MCO transfers to the Department that identifies health care claims for pharmacy claims and encounters. • MCO shall submit a pharmacy rebates report that sets forth the pharmaceutical rebates received by it or its pharmacy benefit manager (PBM) from pharmaceutical manufacturers or labelers for the drug utilization covered under this contract. Rebates include all revenue or credits from manufacturers or labelers that are paid or credited as a result of formulary placement or that are paid or credited based on the volume of drugs sold.	
Family Planning Services (VMCO)	• Includes services and supplies, including physical examination and counseling provided during the visit, annual physical examination for family planning purposes, pregnancy testing, voluntary sterilization, insertion or injection of contraceptive drugs or devices, and related laboratory and diagnostic testing. • Enrollee has freedom of choice (if outside network paid by Department). • MCO's Right of Conscience, if applicable, must be made known to potential enrollees, prospective enrollees and enrollees within 90 days after adopting such policy.	MCO Contract, Article V, 5.1(b); 5.1(e); 5.1(f); 5.5 725 ILCS 70/1 et seq.
Family Planning Services (ICP)	• Includes services and supplies, including physical examination and counseling provided during the visit, annual physical examination for family planning purposes, pregnancy testing, insertion or injection of contraceptive drugs or devices, and related laboratory and diagnostic testing; excluded services include diagnostic and therapeutic procedures related to infertility or sterility. • 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	ICP Contract, Article V, 5.2.7, 5.3, 5.3.1, 5.3.2, 5.3.3, 5.4, 5.17.3, 5.18.1.3 745 ILCS 70/1 et seq. State Children's Health Insurance Program (215 ILCS 106) 42 C.F.R. Part 441, Subpart E 42 C.F.R. Part 441, Subpart F

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Family Planning Services (ICP) *(cont.)*	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. • Information, as provided by the Department, regarding any benefits to which an enrollee may be entitled under the HFS Medical Program that are not provided under Contractor's plan and specific instructions on where and how to obtain those benefits, including any restrictions on an enrollee's freedom of choice among affiliated providers, is provided. • MCO's Right of Conscience, if applicable, must be made known to potential enrollees, prospective enrollees and enrollees within 90 days after adopting such policy.	
Required Minimum Standards of Care	• Consistent with prevailing community standards. • For children, in accordance with the AAP and AAFP guidelines. • For pregnant women, in accordance with the ACOG or AAFP guidelines. • At locations serving the contracting area that assure availability and accessibility to enrollees. • Ongoing notification of the need for and benefits of health screenings and physical examinations. • EPSDT services provided to children (under age 21) in compliance with federal and State regulations and guidelines, including without limitation, the *Handbook for Healthy Kids Providers*, at periodicity schedules no less frequent than required by those regulations and guidelines, with appropriate anticipatory guidance, follow-up and referral. • Preventive medicine and age schedule for adults, detailed in the contract, or as Department-approved, such as the U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services.* • Maternity Care for pregnant women**,** detailed in the contract.	MCO Contract, Article II, 2.3; Article V, 5.13(a),(b),(c); Exhibit A ICP Contract, Attachment I, Service Package I Covered Services, 1.7; Attachment XI, 2.b, 3.a.iv.b), 3. a. iv. e), 9; Article V, 5.11.6; Ill. Adm.Code 140.485 Handbook for Providers of Healthy Kids Services, Illinois Department of Healthcare and Family Services Social Security Act, 1902(a)(43) and 1905(a)(4)(B);

Additional Information Related to the Access to Care Standard Regarding Mechanisms HFS Uses to Identify Persons With Special Health Care Needs		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Identification of enrollees with special health care needs and chronic conditions	• MCOs shall have procedures in place to identify enrollees with special health care needs in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring, with appropriate health care professionals making such assessments. • MCOs shall have procedures in place to identify enrollees with chronic diseases or conditions in order to assess the enrollee's condition; to ensure that a treatment plan is developed with input from the enrollee, primary care physician and other providers, such as specialists, as applicable, and that the PCP approves the treatment plan; to coordinate services; to work with the enrollee and all providers involved in the enrollee's care to ensure compliance with the treatment plan • MCOs will keep all treatment plans on file. • MCOs will be provided with health profile information of enrollees upon enrollment in the MCO to assist in the identification of enrollees with special health care needs. • MCOs will be provided access to historical claims information to assist them in the identification of enrollees with special health care needs through use of the MEDI system.	MCO Contract, Article V, 5.13(d); 5.15; 5.16 ICP Contract, Article I, Definitions, 1.56; Attachment X, 3. a. iv, c)1; 5.6.6, 5.15.3, 5.23.3; Article V, 5.10.1(Aetna); 5.10.6(IlliniCare); 42 C.F.R. 438.208
Preconception and Interconceptional Care (new)	• The MCO shall provide preconception and interconceptional care that addresses pregnancy planning and care of medical conditions.	MCO Contract, Article V, 5.13(c) ICP Contract, Attachment I, Service Package I, Covered Services Article V; 5.16.4; 5.17.3; 5.18.5.7; 5.25.3 Section 25 of the Managed Care Reform and Patient Rights Act

Other HFS Requirements Related to Access:		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
Objective Developmental and Risk Assessment Screening and Treatment	• The MCO shall provide appropriate objective developmental and risk assessment screening and treatment for children; risk assessment and perinatal depression screening and treatment, as needed, for women during pregnancy and up to one year following delivery.	MCO Contract, Article V, 5.13(b)(c)
Referral to Level III Tertiary Care Center for Pregnant Women	• The MCO shall require its providers to identify maternity cases presenting the potential for high risk for maternal or neonatal consultations and arrange appropriate referral to physician specialists or transfer to Level III Perinatal facilities, as required. Standards of Care for this high-risk population shall include the Statewide Perinatal Program.	MCO Contract, Article V, 5.13(c)

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

II. State Standards for Structure and Operations

A. *S*tandards for structure and operations are as stringent as those in 42 C.F.R. 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	• Managed care services must be in accordance with, and subject to, HFS' Administrative Rules; departmental materials including notices, policies, handbooks, rules and regulations.	MCO Contract, Article II, 2.3 ICP Contract, Article I, Definitions Article IX, 9.1.25
1. Provider selection and retention a) Credentialing and re-credentialing	• MCOs' written policies shall include procedures for selection and retention of physicians and other providers. • MCOs (VMCOs only) must allow participation by physicians licensed to practice medicine in all of their branches; licensed by the State. • Each MCO (ICPs only) 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. • No discrimination is allowed, including without limitation, discrimination related to the population served or the cost of treatment for covered services. • MCOs must follow a documented process for uniform credentialing of providers who have signed contracts or participation agreements. • MCOs are required to have a recredentialing process (at least once every three years), with performance appraisal process, and MCOs' monitoring quality of care is a required component of the MCOs' Peer Review process. • MCOs must not contract with providers excluded for participation in federal health programs. • MCOs comply with Physician Incentive Plan Regulations. • MCOs' affiliated providers must be enrolled in the Medical Assistance Program.	MCO Contract, Article I, Definitions; Article V, 5.6; 5.7; 5.19(d); 5.21; 5.22;9.2 (b); Exhibits A and B ICP Contract, Article I, Definitions Article II, 2.2, 2.7.3 Article V, 5.22, 5.28, 5.28.1, 5.28.4, 5.5.2, 5.7.1 Article VII, 7.11.2.3 Article IX, 9.1.22 Attachment XI, 8 Attachment XI, 7.e Attachment XII, 2, a (410 ILCS 517/) Health Care Professional Credentials Data Collection Act 42 C.F.R. 438.214; 422.204; 422.208; 422.210

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
1. Provider selection and retention ***(cont.)***	• All Physicians providing services shall have and maintain admitting privileges and, as appropriate, delivery privileges at an Affiliated or nearby hospital; or, in lieu of these admitting and delivery privileges, the Physicians shall have a written referral agreement with a Physician who is in the Contractor's network and who has such privileges at an Affiliated or nearby hospital. • MCO's maintain and monitor a network of appropriate providers that is supported by written agreements.	MCO Contract, Article V, 5.17 (a). 42 CFR. 438.206 (b)(1)
2. Enrollee Information	• MCOs provide key oral contacts in a language that enrollee understands—interpretive services as needed supplied by the MCO. • HFS contracts with the Illinois Client Enrollment Broker (ICEB) to maintain a hotline to help enrollees and potential enrollees understand the managed care program, including the voluntary MCO program, mandatory Primary Care Case Management (PCCM) Program, and the Integrated Care Program (ICP). • Written materials (marketing materials, enrollment notices, handbooks, informational materials, notices, education and instructional materials) shall be provided in a manner and format that is easily understood, at a sixth-grade reading level. • Written materials must be available in alternative formats for the visually impaired and those with limited reading proficiency/special needs populations, including how to access the materials. ▪ Available in English, and other "prevalent" non-English languages where there is a prevalent single-language minority within the low income households in the relevant DHS local office area as defined as 5% or more such families speak a language other than English (e.g., Spanish). ▪ With HFS' approval, materials in non-English shall be provided, based on the accompanying certification that the translation is accurate and complete. • Oral interpretation services shall be available through the MCOs free of	MCO Contract, Article I, Definitions; Article II, 2.4; Article IV, 4.1; Article V, 5.5,; Article VI, 6.1 ICP Contract, Article I, Definitions, 1.76 Article IV, 4.15 Article V, 5,18,2, 5.18.2.1, 5.18.3, 5.18.4, 5.18.4.1-5, 5.18.5.1-17, 5.18.6, 5.18.6.1-7 (215 ILCS 180/) Health Carrier External Review Act 42 C.F.R. 438.218 42 C.F.R. 438.10

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
2. Enrollee Information ***(cont.)***	charge in all languages, with written notification to enrollees. • Written policies to provide basic information within 30 days of enrollment, or 30 days in advance of the date of a significant change, to a potential enrollee or enrollee who requests it, and includes the: ▪ Basic features of managed care ▪ Excluded populations ▪ Enrollment provisions ▪ Types of benefits, amount, duration and scope ▪ MCO responsibilities for coordination of services ▪ Service area ▪ Restrictions on enrollee's freedom of choice among network providers ▪ After-hours and emergency services, including the definition of emergency, no prior approval requirement for emergency services, locations, use of the 911 emergency telephone system (Refer to Access) ▪ Post-stabilization and locations (Refer to Access) ▪ 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 ▪ Procedures for obtaining covered services, including authorization requirements ▪ How and where to access services not covered under the MCO contract, including cost sharing and transportation resources for those services ▪ Information about family planning services being available from out-of-network providers and how enrollees may obtain those benefits ▪ Extent to which, and how, after-hours coverage and emergency services are provided, including information on what constitutes an emergency	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
2. Enrollee Information *(cont.)*	medical condition, that prior authorization is not needed for emergency services, and the process and procedures for obtaining emergency services, including use of 911 telephone system and locations of emergency and post-stabilization ▪ Complaint, grievance and appeal rights—procedures and time frames (Refer to Grievance and Appeals, in the attachment) ▪ Fair hearing procedures and time frames (Refer to Grievance and Appeals, in the attachment) ▪ Names, locations, telephone numbers and non-English languages spoken by current affiliated providers, including identification of those who are not accepting new patients ▪ Copy of the MCO's Certificate of Coverage or Document of Coverage and any changes or amendments ▪ MCO and health care facility licensure ▪ Practice guidelines ▪ Information about affiliated providers of health care services, including education, board certification and recertification ▪ Written notification of termination of a provider, within 15 days following the termination ▪ Written policies and procedures for advance directives ▪ Written notification about a significant change, at least 30 days before the intended effective date ▪ Information upon request about the MCO's structure and operation and physician incentive plan ▪ Results of quality and performance indicators, including enrollee satisfaction survey, to the extent available • Mechanisms must be in place to help enrollees and potential enrollees understand the managed care program (e.g., ICEB hotline, Department materials, and at the MCO, member services).	

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
2. Enrollee Information *(cont.)*	• Enrollees must be annually notified of their right to request and receive materials. • Enrollees receive information annually and upon request. Potential enrollees receive information when they first become eligible to enroll in HFS' voluntary managed care program. • Enrollees must receive an MCO-specific Identification Card in addition to their HFS Medical Card. • HFS has a methodology for identifying the prevalent non-English spoken language by enrollees and potential enrollees, in connection with the application for Medical Assistance (Refer to VI below).	
3. Enrollee Rights	• Enrollee rights and protections must be provided to enrollees, potential enrollees and requestors by the MCO and shall include a minimum of those specified in 42 C.F.R. 438.100.	MCO Contract, Article V, 5.5 (d)(9) ICP Contract, Article II, 2.5 Article V, 5.9.4, 5.18.1.8, 5.18.5.2, 5.18.5.2.1-6 Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.) Balanced Budget Act of 1997 (Public Law 105-33) 42 C.F.R. 438.100
4. Confidentiality	• MCOs shall have written policies and procedures in place to protect confidentiality (e.g., medical records, other health and enrollment information) ensuring enrollees' confidentiality protections from unauthorized disclosures, as provided by law, including HIPAA compliance.	MCO Contract, Article V, 5.9; 5.29; 6.4; 8.5; Article IX, 9.3; Attachment III ICP Contract, Article V, 5.23.3 Article IX, 9.1.6, 9.1.21

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
4. Confidentiality *(cont.)*		305 ILCS 5/11.9; 5/11.10 and 5/11.12 42 U.S.C. 654(2)(b) 42 C.F.R., part 431, Subpart F 45 C.F.R., part 303.21 42 C.F.R. 438.224 42 C.F.R. 422.118 45 C.F.R. Parts 160 and 164 Subparts A and E
5. Enrollment and Disenrollment	• MCOs shall comply with enrollment and disenrollment requirements and limitations set forth in the regulation as detailed in the contract. • Enrollment and disenrollment is voluntary and the enrollee may request enrollment or disenrollment at any time (VMCO only). • All potential enrollees (ICP only) who live in the contracting Area shall be required to become an enrollee in a plan participating in the Integrated Care Program, except those potential enrollees who, pursuant to federal law, are subject only to voluntary enrollment. • All potential enrollees (ICP only) will have an opportunity to freely choose, from among the available MCOs, the one in which they want to enroll. • A potential enrollee (ICP only) who does not select an MCO will be auto-assigned to an MCO by the Illinois Client Enrollment Broker (ICEB). The enrollee (VMCO only) may change his/her MCO plan on a monthly basis. During the initial ninety (90) calendar days after the effective date of enrollment (ICP only), whether the enrollee actively selected the MCO or was auto-assigned, the enrollee shall have the opportunity to change MCOs. If the enrollee makes a change of MCO during that time period, the enrollee shall have another ninety (90) days after the effective date of enrollment in the second MCO to change back to the original MCO. Except as provided in Section 4.9.3, the enrollee shall not be allowed to change MCOs again until the open enrollment period.	MCO Contract, Article IV, 4.1, 4.2, 4.3, 4.4; Article V, 5.4 42 C.F.R. 438.226 ICP Contract, Article I, Definitions, 1.17, 1.57, 1.64, 1.76, 1.100, 1.113, 1.116 Article IV, 4.1, 4.2, 4.3, 4.4,4.5, 4.13.5

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
5. Enrollment and Disenrollment ***(cont.)***	• The enrollee (VMCO only) may enroll and disenroll through the ICEB. An enrollee (ICP only) may request, orally or in writing, to disenroll from Contractor 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 pursuant to Section 5.4, 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 Contractor, and the enrollee's PCP or other provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or (iv) other reasons, including, but not limited to, 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 pursuant to Section 4.10 and such loss of coverage causes the enrollee to miss the open enrollment period. • 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, developmental 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.	
6. Grievance Systems	• HFS approval is required for the MCO's system and procedures for handling complaints, grievances and appeals (Refer to Grievance and Appeal, in the attachment). • MCOs must have in place a system that includes written policies and procedures for the resolution of complaints, grievances and appeals and access to HFS' fair hearing process, and is consistent with all State and federal requirements. • The MCO's Grievance Committee must include 25% enrollee representation. • The system must include: informal system, formal structured system for	MCO Contract, Article V, 5.19 ICP Contract, Article V, 5.26 42 C.F.R. Part 438, Subpart F 42 C.F.R. 438.228 42 C.F.R. 438.400

Structure and Operations Standards		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
6. Grievance Systems ***(cont.)***	grievances not handled informally or through grievance process, and appeal system. • Appeal procedures must be in place, and may be filed either orally or in writing, and in compliance with specific time requirements. • Prompt resolution is required. • Independent external review allowing the enrollee to appoint guardian, caretaker relative, primary care provider, women's health care provider or other physician to represent him or her throughout the grievance process. • MCOs are required to perform a review of the complaints, grievances and appeals at regular intervals. • Decisions may be appealed to HFS' Fair Hearings system. • MCOs must allow for grievances or appeals to be made orally or in writing, and unless requests expedited resolution, follows oral filing with a written, signed appeal. • MCOs must allow for the provider, acting on behalf of enrollee, and with enrollee's written consent, to represent him or her throughout the grievance process. • MCOs must meet specified time frames for notices. • MCOs must provide enrollees reasonable assistance in completing forms or taking other procedural steps including providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. • MCOs must implement policies to assure appropriate review of a grievance or appeal, including without limitation, the individuals reviewing the grievance or appeal were not involved in any previous level of review and they have appropriate clinical expertise in treating the enrollee's condition or disease. • MCOs must follow required timelines for resolution for grievances and appeals, both standard and expedited. • MCOs must have a complaint and resolution system for providers that includes a provider dispute process (Refer to Attachment 1: Grievance and Appeal Procedure).	42 C.F.R. 438.406 (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**
7. Subcontractual Relations and Delegation a) Oversees and accountable for delegated functions a) Oversees and accountable for delegated functions *(cont.)*	• Agreements and subcontracts must be in writing, specifying the scope of work. • Subcontractors and affiliated providers are bound by the terms of HFS' contract with the MCO. • Model subcontract and provider agreements must be provided to HFS initially, and as revised; and specific subcontracts and agreements shall be provided to HFS, upon request. • MCOs are responsible for delegated activities—must oversee and remain accountable. • MCOs remain responsible to ensure the subcontractor's (continued) ability to perform the delegated activities. • MCOs must evaluate subcontractor performance regularly, consistent with industry standards. • Written delegation agreement clearly defines expectations/requirements and sanctions and provides for revoking delegation or imposing other sanctions. • MCOs' monitoring is required to be consistent with HFS' requirements. • Corrective action plan for deficiencies required for areas identified with deficiencies or needing improvement.	MCO Contract, Article V, 5.14; 5.21; Exhibit A ICP Contract, Article V, 5.28 42 C.F.R. 438.230 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act

Additional Information Related to the Structure and Operation Standards Regarding HFS' Procedures for the Review of Records of MCO Grievance and Appeals		
Performance Standard	**Provision**	**Contract Reference and, as appropriate, State and Federal Citations**
8. **HFS' review of MCO grievance and appeals**	• MCOs must provide to HFS a summary of grievances, appeals and resolutions and external independent reviews and resolutions. • HFS and its EQRO review MCO complaints, grievances and appeals, and may request medical records for review.	MCO Contract, Article V, 5.19; Exhibit C ICP Contract, Article V, 5.18.1.9, 5.18.1.10, Attachment XI, 12, 14 42.F.R. Section 438.358

III. State Standards for Quality Measurement and Improvement

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

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
1. Practice/Clinical Guidelines a) Based on valid and reliable evidence b) Considers the needs of enrollees c) Adopted in consultation with contracting health care providers d) Reviewed and updated, as appropriate	• MCOs must ensure practice guidelines meet the following requirements: ▪ Based on community standards of care ▪ Scientifically based on valid and reliable clinical evidence or consensus in the field ▪ Consider needs of enrollees ▪ Adopted in consultation with affiliated providers ▪ Are reviewed regularly to determine the continued appropriateness and effectiveness ▪ Updated periodically, based on review and assessment • Practice guidelines must be disseminated to all affected affiliated providers and upon request, to potential enrollees and enrollees, and others. • There shall be consistent application of guidelines for decisions for utilization management, enrollee education, service coverage and other areas to which the guidelines apply.	MCO Contract, Article V, 5.6(b); 5.14; Exhibit A; Exhibit B, 2(c) ICP Contract, Article I, Definitions 1.119 Article V, 5.9.4, 5.19.3 Attachment XI, 9 Attachment XII, 2.c.ii Attachment XIII 42 C.F.R. 438.236
2. Quality assessment and performance improvement program	• MCOs have an ongoing quality assessment and improvement program that includes a written Quality Assurance Plan**,** consistent with contractual obligations and State and federal requirements. • 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.	MCO Contract, Article V, 5.6; Exhibits A and B ICP Contract, Article I, Definitions, 1.119, 1.120, 1.121 Attachment XI 42 C.F.R. 438.240

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
2. Quality assessment and performance improvement program *(cont.)*		HMO Federal qualification regulations (42 C.F.R. 417.106) Medicare HMO/CMP regulations (42 C.F.R. 417.418(c)); Balanced Budget Act of 1997 (42 C.F.R. 438.200 et seq.)
a) Performance improvement projects	• MCOs must have an ongoing program of performance improvement projects that focus on nonclinical and clinical areas and to conduct those performance improvement projects, as detailed in the respective MCO's Quality Assurance Plan. • The quality improvement projects, including focused clinical studies, must be approved by HFS and designed to achieve improvement and sustained over time, and must be completed in a reasonable time period so as to allow information on the success of the performance projects in the aggregate to produce new information on the quality of care each year. • The performance improvement projects must have a favorable effect on health outcomes or enrollee satisfaction. • The performance improvement projects involve: ▪ Measurement of performance using objective quality indicators ▪ Evaluation of the effectiveness of interventions ▪ Planning and initiating activities for increasing or sustaining improvement • MCOs report the status and results of each performance improvement project, with information produced on the quality of care, each year. • MCOs shall participate in the annual collaborative performance improvement project, as mutually agreed upon and directed by HFS.	MCO Contract, Article V, 5.6; Exhibits A and B ICP Contract, Article I, Definitions, 1.123 Attachment XI, 3.d, 4, 5 42 C.F.R. 438.240

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
b) Submit performance measurement data	• HFS may specify performance measures and topics for required MCO performance improvement projects, in addition to those identified by the MCO. • MCOs provide a written description of how they will address clinical program initiatives specified by HFS, including without limitation, ongoing reports, initially, when changes occur, quarterly, semiannually, and annually. • MCOs are required to have mechanisms in place to assess the quality and appropriateness of care furnished to enrollees, including enrollees with special health care needs. • MCOs must annually measure and report to HFS performance measurements.	MCO Contract, Article V, 5.6; 9.10. Exhibits A and B ICP Contract, Attachment XI, 3.b, 3.c, 3.g Attachment XIII 42 C.F.R. 438.240 Section 1915(c) of the Social Security Act Attachment II Service Package II Covered Services
c) Detection of over- and underutilization	• MCOs are required to have mechanisms in place to detect both under- and overutilization.	MCO Contract, Article V, 5.6; Exhibit B ICP Contract, Attachment XI Attachment XII, 2.b 42 C.F.R. 438.240
d) Assess quality and appropriateness of care	• MCOs are required to have mechanisms in place to assess the appropriateness and quality of care furnished to all enrollees, including enrollees with special health care needs.	MCO Contract, Article V, 5.6; Exhibits A and B ICP Contract. Article I, Definitions, 1.120 Attachment XI,1.b, 1.c, 1.d, 1.i 42 C.F.R. 438.240

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
e) Measure and report performance data	• MCOs must have an ongoing program of performance improvement projects that focus on measuring objective quality indicators and implement systems of intervention to achieve improvement in quality and evaluate the effectiveness of those interventions. • HFS requirements include measuring specific HEDIS or HFS-defined indicators and monitoring specific measures related to pregnant women, children and adults (Refer to HFS' Specific Performance Goals and Quality Monitoring Measures). • MCOs are required to implement interventions to achieve improvement in quality and evaluate the effectiveness of interventions. • Each performance improvement project must be completed in a reasonable time period.	MCO Contract, Exhibits A and B ICP Contract, Attachment XI,1.h, 3.b, 3.c, 3.g, 14 Attachment XIII Table 1-Performance Measures 42 C.F.R. 438.240 Section 1915(c) of the Social Security Act Attachment II Service Package II Covered Services
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).	MCO Contract, Article V, 5.6; Exhibits A and C ICP Contract, Attachment XI
g) Annual review of impact	• HFS performs ongoing monitoring to assess the MCO's compliance with contract specifications, and overall impact and effectiveness of each MCO's quality assessment and performance improvement program (Refer to Summary of Required Reports). • HFS contracts with an EQRO for annual assessment of the impact and effectiveness of each MCO's quality assessment and improvement program (Refer to State Monitoring and Evaluation, EQRO). • HFS requires the MCOs to have in effect a process for evaluation of its own quality assessment and performance improvement program. • MCO performance on standard measures required by HFS and each MCO's results of the performance improvement projects will be evaluated.	MCO Contract, Exhibits A and C ICP Contract, Attachment XI, 3.g, 3.i, 12, 13, 14, 15 42 C.F.R. 438.240 (1)(i)(ii)

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. • 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 ▪ 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	MCO Contract, Article V, 5.6; Exhibits A and B ICP Contract, Article I, Definitions, 1.122 Article V, 5.7.3, 5.18.6.5, 5.26.1, 5.26.2, 5.28.9.5 Attachment XI, 1, 4, 5, 6, 7, 8, 9 Attachment XIII

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
Quarterly Performance Payment (P4P)	Withhold during each CY of contract (2010, 2011 and 2012) of 1% of each capitation payment. These withholds will be used to make quality performance payments: • Childhood Immunization Status—Combo 3 • Well Child Visits in the First 15 Months of Life—Six or More visits • Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Cervical Cancer Screening • Timeliness of Prenatal Care • Comprehensive Diabetes Care—HbA1C testing • Use of Appropriate Medications for Enrollees With Asthma (ages combined)	MCO Contract, Article VII, 7.8 ICP Contract, Article VII, 7.10, 7.11 Attachment XI
3. Health Information System a) Collect data on enrollee and provider characteristics b) Ensure complete and accurate data	• MCOs are required to have in place a health information system that collects, analyzes, integrates and reports data. • MCOs must establish and maintain a computer system compatible with HFS' system, and maintain staff with proficient knowledge in telecommunications, to collect and complete data on enrollees, providers and services. • 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 the accuracy and timeliness; screening for completeness, logic and consistency; and collecting service information in standardized formats, to the extent possible. • 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.	MCO Contract, Article V, 5.10; 5.29; 9.69; Exhibit A ICP Contract, Article I, Definitions, 1.126, 1.193 Article II, 2.3.10 Article VII, 7.10.3, 7.11.2.1, 7.11.3, 7.16.3 Article IX, 9.1.21, 9.1.34, 9.1.35 Attachment VI Attachment XI 42 C.F.R. 438.242 45 C.F.R. 164.530(j) 42 C.F.R. 438.240

Quality Measurement and Improvement Standards		
Performance Standard	**Provision**	**Federal Citation and Contract Reference**
b) Ensure complete and accurate data *(cont.)*	• 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.

HFS' Specific Performance Goals and Quality Monitoring Measures		
Performance Goals	• MCOs must make a documented effort to meet or make progress toward meeting the performance goals, as follows: ▪ EPSDT Services to Enrollees Under Twenty-One (21) Years. All Enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program. At a minimum, the Contractor shall provide or arrange to provide all appropriate screening and vaccinations in accordance with OBRA 1989 guidelines to eighty percent (80%) of Enrollees younger than twenty-one (21) years of age. ▪ Preventive Medicine Schedule (Services to Enrollees Twenty-One (21) Years of Age and Over): For Years One and Two of the Contract, the Contractor is required to achieve the 50th percentile for the HEDIS measure; Adults' Access to Preventive/Ambulatory Health Services. For Year Three of the Contract, the Contactor is required to achieve the 75th percentile for this measure. Maternity Care: For Years One and Two of the Contract, the Contractor is required to achieve the 50th percentile for the following HEDIS measures: the Frequency of Ongoing Prenatal Care; Timeliness of Prenatal Care; and Postpartum Care. For Year Three of the Contract, the Contactor is required to achieve the 75th percentile for these measures.	MCO Contract, Article V, 5.13(a)-(d) 42 C.F.R. 438.240
Performance Measures	• Contractor 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. Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. Performance Measures include: ▪ Behavioral Health ◆ Behavioral Health Risk Assessment and Follow-Up ◆ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ◆ Follow-Up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis ◆ Follow-Up After Hospitalization for Mental Illness ▪ Immunizations	ICP Contract, Article I, Definitions, 1.104, 1.121 Attachment XI Table I 42 C.F.R. 438.240

HFS' Specific Performance Goals and Quality Monitoring Measures		
Performance Measures *(cont.)*	◆ Care Coordination – Influenza Immunization Rate ▪ Dental ◆ Annual Dental Visit ◆ Dental ER Visit ▪ Diabetes ◆ Comprehensive Diabetes Care ◆ Comprehensive Diabetes Care Administrative Method ▪ Cardiovascular Conditions ◆ Congestive Heart Failure ◆ Coronary Artery Disease Persistence of Beta-Blocker Treatment After a Heart Attack Pharmacotherapy Management of COPD Exacerbation Use of Spirometry Testing in the Assessment and Diagnosis of COPD ▪ Use of Services ◆ Ambulatory Care ◆ Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit Inpatient Utilization – General Hospital/Acute Care ◆ Mental Health Utilization Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge ◆ Inpatient Hospital 30-Day Readmission Rate ◆ Inpatient Mental Hospital 30-Day Readmission Rate ▪ Long Term Care ◆ Long Term Care Urinary Tract Infection Admission Rate ◆ Long Term Care Bacterial Pneumonia Admission Rate ◆ Prevalence of Pressure Ulcers ▪ Medication Management ◆ Annual Monitoring for Patients on Persistent Medications ◆ Antidepressant Medication Management ◆ Medication Monitoring for Patients with Schizophrenia ▪ Prevention and Screening ◆ Colorectal Cancer Screening ◆ Breast Cancer Screening ◆ Cervical Cancer Screening ◆ Adult BMI Assessment	

HFS' Specific Performance Goals and Quality Monitoring Measures		

Performance Measures *(cont.)*	▪ Access
	  ◆ Access to Member's Assigned PCP
	  ◆ Retention Rate for Long Term Care (LTC) and DD Enrollees Served in the Community
	▪ Additional Measures to be Considered for Future Review
	  ◆ Care for Older Adults
	  ◆ Identification of Alcohol and Other Drug Services
	  ◆ Medication Reconciliation Post Discharge
	• Contractor 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 the Contractor's findings.	

Outcome and Utilization Indicators to Be Measured and Reported
 	
MCOs must trend and track required HEDIS measures each year
	HEDIS or HFS-defined (in consultation with the MCOs)—HFS expects its MCOs to achieve no less than the National HEDIS Medicaid 50th percentile on each of the HEDIS measures and will require a quality improvement plan for each of the measures that are below that goal.
	• Effectiveness of Care
	  ▪ Childhood Immunization Status—Combo 3
	  ▪ Breast Cancer Screen
	  ▪ Cervical Cancer Screening
	  ▪ Use of Appropriate Medications for Enrollees with Asthma
	  ▪ Comprehensive Diabetes Care
	  ▪ Controlling High Blood Pressure; Rates for <140/90
	  ▪ Chlamydia Screening in Women
	  ▪ Follow-up after Hospitalization for Mental Illness; 7-day and 30-day Follow-up
	  ▪ Antidepressant Medication Management
	  ▪ Childhood Lead Screening
	  ▪ Adolescent Immunization Status
	  ▪ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents
	  ▪ Developmental Screening in the First Three Years of Life
	• Access/Availability of Care
		MCO Contract, Exhibit A
		
		ICP Contract, Attachment XI Table I
		
		42 C.F.R. 438.240

HFS' Specific Performance Goals and Quality Monitoring Measures		
Outcome and Utilization Indicators to Be Measured and Reported *(cont.)*	▪ Prenatal and Postpartum Care ▪ Frequency of ongoing prenatal care ▪ Adults' Access to Preventive/Ambulatory Health Services: Total Rate ▪ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Combined Rate ▪ Children's and Adolescents' Access to Primary Care Providers • Use of Services ▪ Well Child Visits During the First 15 Months of Life: 6 or More Visits ▪ Well Child Visits in the Third, Fourth, Fifth, and Sixth years of Life ▪ Ambulatory Care ▪ Adolescent Well Care Visits CAHPS 4.0	
Ongoing Tracking and Monitoring: Pregnant Women	• Number of prenatal visits • Provision of ACOG recommended prenatal screening tests • Neonatal deaths • Birth outcomes • Length of hospitalization for mother • Length of newborn hospital stay for infant	MCO Contract, Exhibit A ICP Contract, Attachment XI Table I 42 C.F.R. 438.240
Ongoing Tracking and Monitoring: Children	• Number of well-child visits, appropriate for age • Immunization status • Lead screening status • Number of hospitalizations • Length of hospitalizations • Medical management for complicated conditions (e.g., asthma, childhood diabetes)	MCO Contract, Exhibit A ICP Contract, Attachment XI Table I 42 C.F.R. 438.240
Ongoing Tracking and Monitoring: Adults	• Initial health history and physical exam • Mammography • Pap tests	MCO Contract, Exhibit A ICP Contract, Attachment XI Table I 42 C.F.R. 438.240

HFS' Specific Performance Goals and Quality Monitoring Measures		
Ongoing Tracking and Monitoring: Medically Complicated Conditions/Chronic Care	• Timely identification and assessment • Identification of enrollees with special health care needs. The MCOs are required to identify enrollees with special health care needs. A general definition for enrollees with special health care needs that is acceptable to HFS: Enrollees who are experiencing a serious and chronic physical, developmental or behavioral condition requiring medically necessary health and related services of a type or amount beyond that by enrollees generally. • Ongoing source of primary care appropriate to the enrollee's needs • Appropriate treatment, follow-up care, and care coordination (minimum requirement by HFS: enrollees with asthma and diabetes to be monitored, outcomes measured and coordination of care required) • Case management • Chronic care action plan • Processes to assure direct access to specialists • HFS monitors the quality and appropriateness of care/services for enrollees with special needs or medically complicated or with chronic conditions through annual review.	MCO Contract, Article V, 5.13; Exhibit A ICP Contract, Article V, 5.6.6 Attachment II 42 C.F.R. 438.240
Ongoing Tracking and Monitoring: Behavioral Health	• Behavioral health network adequate to service the behavioral health care needs of enrollees including services specifically for Enrollees under age 21 and pregnant women • Access to timely behavioral health services • Individuals' plan of treatment and provision of appropriate level of care • Coordination of Care between CBHPs, MCO Behavioral Health subcontractor or internal program, and the PCP • Mental Health Utilization • Follow-up care and continuity of care • Involvement of the PCP in aftercare • Member satisfaction with access to, and the quality of, behavioral health services • Chemical Dependency Utilization • Chemical Dependency Follow-up	MCO Contract, Exhibit A ICP Contract, Attachment XI Table I 42 C.F.R. 438.240

HFS' Specific Performance Goals and Quality Monitoring Measures		
Studies	• MCO shall conduct medical record reviews. • Two medical evaluation studies per year (at least one clinical or diagnostic category; one may be administrative) shall be performed. • The EQRO will review the appropriateness, soundness and effectiveness of medical record reviews and medical evaluation studies (Refer to State Monitoring and Evaluation, EQRO).	MCO Contract, Exhibits A and B ICP Contract, Attachment XI Table I 42 C.F.R. 438.240
Health Education	• Must be ongoing and submitted annually to HFS • Must be reviewed and approved by the MCO medical director • Must be reviewed, at regular intervals • Must have a single individual appointed to be responsible for the coordination and implementation of the program • Must advise Enrollees concerning appropriate health care practices and the contributions they can make to the maintenance of their own health • Must include documented efforts to educate Primary Care Providers on the importance of being active participants in the health education program and must ensure that such Primary Care Providers participate in the health education program • Must include the following information in the form of printed, visual or personal communication and provided in language that the Enrollee understands: ▪ How to use the Plan, including information on how to receive Emergency Services in and out of the Contracting Area. ▪ Must include Information on preventive care including the value and need for screening and preventive maintenance. ▪ The need for pre- and interconceptional care to improve birth outcomes and on the need to seek prenatal care as early as possible. ▪ Counseling and patient education as to the health risks of obesity, smoking, alcoholism, substance abuse and improper nutrition, and specific information for persons who have a specific disease. ▪ Disease states that may affect the general population.	MCO Contract, Article V, 5.12 ICP Contract, Attachment XI Table I 42 C.F.R. 438.240
Performance Improvement Projects (PIPs)	• Well Child Screening for Children Including Developmental Screening • Prenatal Care Including Perinatal Depression Screening	MCO Contract, Exhibit A ICP Contract, Article I, Definitions, 1.103, 1.119

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

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 MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Procedures:	1. MCO submits to Department in writing for approval; Department approves in writing.	1. MCO submits to Department in writing for approval; Department approves in writing	Article 5.11(a)(6)(A) *Article 5.18.1.9*	Section 45 (a), (b) and (f); Section 50(a)(1)	438.402(a)
	2. Must include individuals with the authority to require corrective action.	2. Must include individuals with the authority to require corrective action.	Article 5.19 *Article 5.26*		
	3. Must include process for attempting to resolve issues informally.		Article 5.18 *Article 5.26.1.1*		
	4. Complaints and/or disputes concerning payments for the provision of services as described in Article 5.18 shall be subject to the Contractor's Provider grievance resolution system		Article 5.18 Article 5.19(d) *Article 5.25*		

* ICP Contract Citations are in *italics*
** 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 MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Procedures: ***(cont.)***	5. Must include formal process for resolving issues that can't be handled informally.		Article 5.19(a)(1) and (3)		
	6. Formal process must be compliant with 42 CFR Part 438 Subpart F. Grievances being reviewed through the formal grievance process must be in writing and be sent to the Grievance Committee for review.	3. Process must be compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Part 438 Subpart F.	Article 5.19(a)(2) Article 5.19(b)(2) and (3) *Article 5.26.2.2*		
		4. Must include a process for expediting the decision making process when an enrollee's health so necessitates.	*Article 5.26.2.2*		
		5. Must include a process for allowing for an external independent review of appeals which remain denied.	Article 5.19(b)(2) *Article 5.26.2.2*		
		6. Must include a process for effectuation of reversed appeal resolutions.			438.424
	7. Formal process must include a formally structured Grievance Committee composed of at least 25 percent representation by members, with at least one member being an enrollee of the MCO under the State of Illinois MCO contract.	7. Must include a committee in place for reviewing Appeals made by its Enrollees.	Article 5.19(a)(3) and (4) Article 5.19(b) *Article 5.26.1.3.1* *Article 5.26.2*		

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Grievance System

	Grievance Process	Appeal Process	State of Illinois MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Procedures: ***(cont.)***	8. Must include mechanism for informing enrollees of formal grievance process.	8. Must include mechanism for informing enrollees of the MCO's appeal process.	Article 5.5(d) *Article 5.18.5.12* *Article 5.26.1.3*		
	9. Must include mechanism for regular review of process and revisions as needed with prior written consent of the Department.	9. Must include mechanism for regular review of process and revisions as needed with prior written consent of the Department.	Article 5.11(a)(6)(A) *Article 5.26.3*		
	10. Must include a provider dispute resolution process.		*Article 5.26.4*		
Filing Authority:	Enrollee may appoint a guardian, caretaker relative, Primary Care Provider, Women's Health Care Provider or other treating physician to represent him/her throughout the grievance process.	Enrollee may appoint a guardian, caretaker relative, Primary Care Provider, Women's Health Care Provider or other treating physician to represent him/her throughout the appeal process.**	Article 5.19(a)(7) *Article 5.26.1.6* *Article 5.26.2.5*	Section 45(d)	438.402(b)(1)(ii)
Filing Procedure and Timing:	All grievances shall be registered initially with the MCO.	File orally or in writing to MCO initially and if not expedited follow oral filing with a written signed appeal. Must be filed no less than 20 days and not to exceed 90 days from date of MCO's notice of action.	Article 5.19(a)(2) Article 5.19(b)(1) *Article 5.26.1* *Article 5.26.2.1*		438.402(b)(2) 438.402(b)(3)

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Grievance System

	Grievance Process	Appeal Process	State of Illinois MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Acknowledge-ment:	All grievances must be acknowledged.	Standard: Acknowledge receipt of each appeal and notify enrollee of all information that the MCO requires to evaluate the appeal within 3 business days of submission.	Article 5.19(a)(2)	Section 45 (c)	438.406(a)(2)
		Expedited: Acknowledge receipt of each appeal and notify the enrollee of all information that the MCO requires to evaluate the appeal as soon as possible, but no later than 24 hours of submission.		Section 45(b)	
Handling of Grievance and Appeals:	Must be in accordance with 42 CFR section 438.406 and Section 45 of the Managed Care Reform and Patient Rights Act.	Must be in accordance with 42 CFR section 438.406 and Section 45 of the Managed Care Reform and Patient Rights Act.	Article 5.19(a)(2) Article 5.19(b)(2) *Article 5.26.1.2* *Article 5.26.2.2*	Sections 45 and 50	438.406
Resolution and Notification:	Must dispose of and provide notice as expeditiously as the enrollee's health requires, within state established timeframes, not to exceed BBA timeframes. Formal grievances require written notice.	Must resolve and provide written notice as expeditiously as the enrollee's' health requires, within state established timeframes in Section 45 of the Managed Care Reform and Patient Rights Act and not to exceed BBA timeframes.			438.408(a) 438.408(d)(2)

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Grievance System

	Grievance Process	Appeal Process	State of Illinois MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Timing of Disposition/ Resolution and Notice:	Within 90 days after receipt of information requested to evaluate the grievance.	Standard: Within 15 business days after receipt of information requested to evaluate the appeal.		Section 45 (c)	438.408(b)(1) 438.408(b)(2) 438.408(c)
		Expedited: Within 24 hours after receipt of information requested to evaluate the appeal. For expedited appeals, the MCO must make reasonable efforts to provide oral notice. For denied requests for expedited resolution of an appeal requests, the MCO must transfer the appeal to the standard appeal process and timeframes and make reasonable efforts to provide prompt oral notice followed within 2 calendar days with written notice.		Section 45(b)	438.408(b)(3) 438.410(c)
		Extension: MCO may extend timeframe up to 14 calendar days if enrollee requests it or the MCO shows the State the need for additional information & how delay is in enrollee's interest.***			
		Enrollee must be notified in writing of the reason for the delay if he/she did not request the extension.			

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Grievance System

	Grievance Process	Appeal Process	State of Illinois MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Format and Content of Notice:	For an oral grievance that does not relate to quality of care, the MCO may provide oral notice, unless the enrollee requires that it be written.	Written notice of resolution including the following: ♦ Date of completion and clear, detailed reasons for the determination. ♦ Medical or clinical criteria for the determination. ♦ Appeals not resolved wholly in favor of enrollee—right to request anexternal independent review and how to do so. ♦ If the notice includes the finding of the external independent review and the appeal was not resolved wholly in favor of the enrollee, then the notice must include the right to request a fair hearing and how to do so. ♦ Right to request to receive benefits while hearing is pending & how to make the request. ♦ That the enrollee may be held liable if state upholds MCO action.	Article 5.19(b)(2) *Article 5.26.2.2*	Section 45(d)	438.408(d)(1) 438.408(d)(2) 438.408(e) 438.410 (c)(2)
Access to State Fair Hearing:	Final decisions under the Managed Care Reform and Patient Rights Act procedures and the MCO Grievance Committee may be appealed by the enrollee or the enrollee's representative to the Department under the Fair Hearing process.	Final decisions of Appeals not wholly in favor of the enrollee may be appealed by the enrollee to the Department under the State's Fair Hearing process not less than 20 or in excess of 90 days from the date of the MCO's notice of resolution.	Article 5.19(a)(5) Article 5.19(b)(3) *Article 5.26.1.4* *Article 5.26.2.3*		438.408(f)(1) and (2)

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Grievance System

	Grievance Process	Appeal Process	State of Illinois MCO and ICP* Contract Citation	Managed Care Reform and Patient Rights Act 215 ILCS 134 Citation	BBA Citation, 42 CFR Part 438 Subpart F—Grievance Systems
Record Keeping and Reporting Requirements:	1. MCOs must submit a summary of all Grievances heard by the Grievance Committee and by independent external reviewers, including the responses and disposition of the issues, to the Department quarterly. 2. The Department will review the information as part of the State quality strategy.	1. MCOs must submit a summary of all Appeals and independent external reviews, including the responses and disposition of the appeals/reviews, to the Department quarterly. 2. The Department will review the information as part of the State quality strategy.	Article 5.11(a)(6)(F) Article 5.19(a)(6) *Article 5.26.1.5* *Article 5.26.2.4*	Section 55	438.416

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HEDIS Measures Rates for 2008–2012
Family Health Network—Trended Results

HEDIS Measures	HEDIS Rates for Family Health Network					HEDIS 2011 National Medicaid Percentiles				
	2008	2009	2010	2011	2012	10th	25th	50th	75th	90th
Child and Adolescent Care										
Childhood Immunizations—Combo 2	68.9	72.0	75.5	75.7	71.99	62.3	69.0	75.1	80.7	85.8
Childhood Immunizations—Combo 3	53.0	65.8	69.7	70.4	69.91	56.8	64.4	71.0	76.7	82.6
Lead Screening in Children	70.4	69.5	82.2	81.9	82.87	34.6	55.5	72.2	80.5	87.6
*Well-Child Visits in the First 15 Months (0 Visits)**	10.0	7.7	5.1	3.5	2.31	0.5	0.8	1.6	2.7	4.4
Well-Child Visits in the First 15 Months (6+ Visits)	29.0	43.5	48.4	53.8	50.12	41.9	52.2	61.3	68.9	77.1
Well-Child Visits (3–6 Years)	68.4	74.8	79.2	67.4	72.98	60.9	66.1	72.3	77.6	82.9
Adolescent Well-Care Visits	32.2	36.9	45.7	43.9	44.11	35.0	39.6	46.1	57.2	64.1
*Immunizations for Adolescents***	NA**	NA**	18.2	40.5	44.80	33.8	40.0	49.8	63.7	75.5
Children's Access to PCPs (12–24 Months)	77.3	81.8	84.1	82.2	91.84	92.6	95.1	97.0	97.8	98.6
Children's Access to PCPs (25 months–6 Years)	65.2	68.9	70.6	69.9	77.22	82.0	86.8	89.6	91.2	92.7
Children's Access to PCPs (7–11 Years)	52.4	49.5	47.8	51.1	53.08	85.2	87.9	91.3	93.3	94.7
Adolescents' Access to PCPs (12–19 Years)	48.4	49.9	46.7	53.0	54.61	81.1	86.5	89.7	91.9	93.4
Adults' Access to Preventive/Ambulatory Care										
20–44 Years of Age	56.6	59.4	65.4	64.6	69.22	69.3	78.5	83.2	86.4	88.4
45–64 Years of Age	48.6	58.8	69.9	67.4	74.11	78.7	84.5	87.4	89.8	91.0
Preventive Screening for Women										
Breast Cancer Screening	27.8	33.9	44.9	47.7	48.90	38.7	45.3	52.4	57.4	62.9
Cervical Cancer Screening	68.0	55.4	63.9	69.4	71.50	53.0	64.0	69.7	74.2	78.7
Chlamydia Screening (16–20 Years of Age)	47.7	53.6	55.4	62.5	59.00	42.9	48.7	53.6	60.6	66.7
Chlamydia Screening (21–24 Years of Age)	47.7	53.8	57.5	70.7	68.13	50.5	57.6	62.5	68.7	72.2
Chlamydia Screening (Combined Rate)	47.7	53.7	56.4	66.3	63.42	46.0	51.5	57.2	63.4	69.1

HEDIS Measures Rates for 2008–2012
Family Health Network—Trended Results

HEDIS Measures	HEDIS Rates for Family Health Network					HEDIS 2011 National Medicaid Percentiles				
	2008	2009	2010	2011	2012	10th	25th	50th	75th	90th
Maternity-Related Measures										
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	29.4	39.3	16.9	18.2	15.94	1.8	4.0	7.7	11.5	19.1
Frequency of Ongoing Prenatal Care (81–100% of Visits)	33.4	25.6	26.1	42.3	42.96	34.7	50.8	64.4	74.9	81.8
Timeliness of Prenatal Care	45.4	49.4	49.2	62.4	69.75	71.4	80.3	86.0	90.0	93.2
Postpartum Care	32.3	32.9	39.3	40.2	45.03	53.7	59.6	64.6	70.6	75.2
Chronic Conditions/Disease Management										
Controlling High Blood Pressure	45.3	54.6	27.0	45.6	43.37	42.1	47.9	56.4	63.7	67.6
Diabetes Care (HbA1C Testing)	68.5	66.9	77.6	79.2	79.45	73.6	77.6	82.2	87.1	90.9
*Diabetes Care (Poor HbA1c Control)**	56.5	65.5	69.1	69.9	63.64	29.1	34.9	42.6	52.1	60.4
Diabetes Care (Good HbA1c Control)	12.0	27.0	30.9	31.7	36.36	33.8	39.9	47.4	54.8	59.1
Diabetes Care (Eye Exam)	22.8	24.3	25.0	31.7	44.66	34.0	43.8	52.8	63.7	70.6
Diabetes Care (LDL-C Screening)	56.5	60.8	69.1	68.9	69.57	63.7	70.4	75.4	80.3	84.2
Diabetes Care (LDL-C Level <100 mg/dL)	15.2	19.6	27.0	29.5	27.67	21.5	27.3	35.2	41.4	45.9
Diabetes Care (Nephropathy Monitoring)	57.6	79.7	85.5	84.7	85.77	68.1	73.9	78.5	82.5	86.9
*Diabetes Care (BP < 140/80)***	NA	NA	NA	NA	30.83	25.0	32.0	38.5	44.2	54.8
Diabetes Care (BP < 140/90)	51.1	45.3	40.8	54.6	52.57	43.8	54.3	61.2	68.3	76.0
Appropriate Medications for Asthma (Combined)	79.3	85.0	93.0	90.3	88.07	83.6	86.6	88.9	90.5	93.2
Follow-up After Hospitalization for Mental Illness—7 Days	56.4	64.2	66.9	70.9	69.15	23.0	33.1	45.1	53.9	68.3
Follow-up After Hospitalization for Mental Illness—30 Days	67.9	76.5	79.8	80.2	80.50	36.0	57.1	66.6	74.6	82.6

*Lower rates indicate better performance for these measures.

**HEDIS measure has not been available or has not been reported for all the trending years.

	Pay-for-Performance Measures

HEDIS Measures Rates for 2008–2012
Harmony Health Plan. —Trended Results

HEDIS Measures	HEDIS Rates for Harmony Health Plan					HEDIS 2011 National Medicaid Percentiles				
	2008	2009	2010	2011	2012	10th	25th	50th	75th	90th
Child and Adolescent Care										
Childhood Immunizations—Combo 2	53.8	62.5	67.4	65.9	68.86	62.3	69.0	75.1	80.7	85.8
Childhood Immunizations—Combo 3	42.8	51.6	60.6	61.6	63.99	56.8	64.4	71.0	76.7	82.6
Lead Screening in Children	65.9	69.8	74.7	78.1	79.08	34.6	55.5	72.2	80.5	87.6
*Well-Child Visits in the First 15 Months (0 Visits)**	9.2	4.6	4.1	5.4	4.62	0.5	0.8	1.6	2.7	4.4
Well-Child Visits in the First 15 Months (6+ Visits)	21.7	40.4	45.7	51.3	51.34	41.9	52.2	61.3	68.9	77.1
Well-Child Visits (3–6 Years)	57.4	65.9	69.8	71.8	65.21	60.9	66.1	72.3	77.6	82.9
Adolescent Well-Care Visits	37.7	37.7	37.2	38.9	35.52	35.0	39.6	46.1	57.2	64.1
*Immunizations for Adolescents***	NA**	NA**	23.4	29.9	38.69	33.8	40.0	49.8	63.7	75.5
Children's Access to PCPs (12–24 Months)	82.5	83.3	82.2	86.5	88.82	92.6	95.1	97.0	97.8	98.6
Children's Access to PCPs (25 months–6 Years)	65.7	70.1	73.1	73.3	74.20	82.0	86.8	89.6	91.2	92.7
Children's Access to PCPs (7–11 Years)	60.7	61.6	69.3	70.5	70.95	85.2	87.9	91.3	93.3	94.7
Adolescents' Access to PCPs (12–19 Years)	58.7	60.8	68.6	71.4	72.32	81.1	86.5	89.7	91.9	93.4
Adults' Access to Preventive/Ambulatory Care										
20–44 Years of Age	57.5	66.3	67.3	69.3	70.81	69.3	78.5	83.2	86.4	88.4
45–64 Years of Age	54.6	63.3	67.6	68.8	71.33	78.7	84.5	87.4	89.8	91.0
Preventive Screening for Women										
Breast Cancer Screening	35.5	32.5	31.5	30.7	34.37	38.7	45.3	52.4	57.4	62.9
Cervical Cancer Screening	59.1	62.0	69.3	69.8	71.53	53.0	64.0	69.7	74.2	78.7
Chlamydia Screening (16–20 Years of Age)	45.1	44.5	45.6	46.1	50.06	42.9	48.7	53.6	60.6	66.7
Chlamydia Screening (21–24 Years of Age)	53.3	54.8	56.2	57.2	59.73	50.5	57.6	62.5	68.7	72.2
Chlamydia Screening (Combined Rate)	49.3	48.8	49.9	50.9	54.02	46.0	51.5	57.2	63.4	69.1

HEDIS Measures Rates for 2008–2012
Harmony Health Plan. —Trended Results

HEDIS Measures	HEDIS Rates for Harmony Health Plan					HEDIS 2011 National Medicaid Percentiles				
	2008	2009	2010	2011	2012	10th	25th	50th	75th	90th
Maternity-Related Measures										
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	21.9	27.0	17.8	16.5	14.84	1.8	4.0	7.7	11.5	19.1
Frequency of Ongoing Prenatal Care (81–100% of Visits)	31.4	33.6	39.4	39.9	42.09	34.7	50.8	64.4	74.9	81.8
Timeliness of Prenatal Care	56.4	56.4	65.2	64.7	64.72	71.4	80.3	86.0	90.0	93.2
Postpartum Care	35.0	40.1	49.6	48.7	49.64	53.7	59.6	64.6	70.6	75.2
Chronic Conditions/Disease Management										
Controlling High Blood Pressure	34.3	39.7	43.3	42.6	37.23	42.1	47.9	56.4	63.7	67.6
Diabetes Care (HbA1C Testing)	57.7	68.1	67.0	69.6	71.05	73.6	77.6	82.2	87.1	90.9
*Diabetes Care (Poor HbA1c Control)**	72.7	67.3	64.2	65.9	62.53	29.1	34.9	42.6	52.1	60.4
Diabetes Care (Good HbA1c Control)	15.6	24.6	28.8	29.4	29.44	33.8	39.9	47.4	54.8	59.1
Diabetes Care (Eye Exam)	9.0	13.3	15.0	18.2	27.49	34.0	43.8	52.8	63.7	70.6
Diabetes Care (LDL-C Screening)	52.3	58.0	58.2	63.7	59.85	63.7	70.4	75.4	80.3	84.2
Diabetes Care (LDL-C Level <100 mg/dL)	12.4	17.7	18.6	17.5	22.38	21.5	27.3	35.2	41.4	45.9
Diabetes Care (Nephropathy Monitoring)	59.9	69.9	68.4	67.4	67.64	68.1	73.9	78.5	82.5	86.9
*Diabetes Care (BP < 140/80)***	NA	NA	NA	NA	31.14	25.0	32.0	38.5	44.2	54.8
Diabetes Care (BP < 140/90)	45.0	54.0	51.3	49.6	48.66	43.8	54.3	61.2	68.3	76.0
Appropriate Medications for Asthma (Combined)	84.1	86.6	86.5	86.0	79.89	83.6	86.6	88.9	90.5	93.2
Follow-up After Hospitalization for Mental Illness—7 Days	20.0	43.2	49.2	42.7	41.81	23.0	33.1	45.1	53.9	68.3
Follow-up After Hospitalization for Mental Illness—30 Days	32.3	55.6	58.7	56.1	57.10	36.0	57.1	66.6	74.6	82.6

*Lower rates indicate better performance for these measures.

**HEDIS measure has not been available or has not been reported for all the trending years.

	Pay-for-Performance Program Measures

Quality Assessment Performance Improvement Strategy
HEDIS 2012 Medicaid Rates
Voluntary Managed Care Organizations (VCMOs)

Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Care Measures

HEDIS Measures	MER	FHN	HAR	National Medicaid HEDIS 2011 Percentiles				
				10th	25th	50th	75th	90th
Child and Adolescent Care								
Childhood Immunizations—Combo 2	87.04	71.99	68.86	62.3	69.0	75.1	80.7	85.8
Childhood Immunizations—Combo 3	83.33	69.91	63.99	56.8	64.4	71.0	76.7	82.6
Lead Screening in Children	92.21	82.87	79.08	34.6	55.5	72.2	80.5	87.6
*Well-Child Visits in the First 15 Months (0 Visits)**	0.00	2.31	4.62	0.5	0.8	1.6	2.7	4.4
Well-Child Visits in the First 15 Months (6+ Visits)	82.00	50.12	51.34	41.9	52.2	61.3	68.9	77.1
Well-Child Visits (3–6 Years)	84.94	72.98	65.21	60.9	66.1	72.3	77.6	82.9
Adolescent Well-Care Visits	66.67	44.11	35.52	35.0	39.6	46.1	57.2	64.1
Immunizations for Adolescents	NA	44.80	38.69	33.8	40.0	49.8	63.7	75.5
Children's Access to PCPs (12–24 Months)	100.00	91.84	88.82	92.6	95.1	97.0	97.8	98.6
Children's Access to PCPs (25 months–6 Years)	92.05	77.22	74.20	82.0	86.8	89.6	91.2	92.7
Children's Access to PCPs (7–11 Years)	81.25	53.08	70.95	85.2	87.9	91.3	93.3	94.7
Adolescents' Access to PCPs (12–19 Years)	90.00	54.61	72.32	81.1	86.5	89.7	91.9	93.4
Adults' Access to Preventive/Ambulatory Care								
20–44 Years of Age	89.14	69.22	70.81	69.3	78.5	83.2	86.4	88.4
45–64 Years of Age	91.07	74.11	71.33	78.7	84.5	87.4	89.8	91.0
*** Lower rates indicate better performance for this measure.**								

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75—89	90–100
Color Code for Percentiles						

Quality Assessment Performance Improvement Strategy
HEDIS 2012 Medicaid Rates
Voluntary Managed Care Organizations (VCMOs)

Preventive Screening for Women and Maternity-Related Measures

HEDIS Measures	MER	FHN	HAR	National Medicaid HEDIS 2011 Percentiles				
				10th	25th	50th	75th	90th
Preventive Screening for Women								
Breast Cancer Screening	NA	48.90	34.37	38.7	45.3	52.4	57.4	62.9
Cervical Cancer Screening	84.44	71.50	71.53	53.0	64.0	69.7	74.2	78.7
Chlamydia Screening (16–20 Years of Age)	NA	59.00	50.06	42.9	48.7	53.6	60.6	66.7
Chlamydia Screening (21–24 Years of Age)	67.35	68.13	59.73	50.5	57.6	62.5	68.7	72.2
Chlamydia Screening (Combined Rate)	60.81	63.42	54.02	46.0	51.5	57.2	63.4	69.1
Maternity-Related Measures								
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	1.37	15.94	14.84	1.8	4.0	7.7	11.5	19.1
Frequency of Ongoing Prenatal Care (81–100% of Visits)	94.52	42.96	42.09	34.7	50.8	64.4	74.9	81.8
Timeliness of Prenatal Care	93.88	69.75	64.72	71.4	80.3	86.0	90.0	93.2
Postpartum Care	76.19	45.03	49.64	53.7	59.6	64.6	70.6	75.2
*** Lower rates indicate better performance for this measure.**								

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Quality Assessment Performance Improvement Strategy
HEDIS 2012 Medicaid Rates
Voluntary Managed Care Organizations (VCMOs)

Chronic Conditions / Disease Management Measures

HEDIS Measures	MER	FHN	HAR	National Medicaid HEDIS 2011 Percentiles				
				10th	25th	50th	75th	90th
Chronic Conditions/Disease Management								
Controlling High Blood Pressure	NA	43.37	37.23	42.1	47.9	56.4	63.7	67.6
Diabetes Care (HbA1C Testing)	NA	79.45	71.05	73.6	77.6	82.2	87.1	90.9
*Diabetes Care (Poor HbA1c Control)**	NA	63.64	62.53	29.1	34.9	42.6	52.1	60.4
Diabetes Care (Good HbA1c Control)	NA	36.36	29.44	33.8	39.9	47.4	54.8	59.1
Diabetes Care (Eye Exam)	NA	44.66	27.49	34.0	43.8	52.8	63.7	70.6
Diabetes Care (LDL-C Screening)	NA	69.57	59.85	63.7	70.4	75.4	80.3	84.2
Diabetes Care (LDL-C Level <100 mg/dL)	NA	27.67	22.38	21.5	27.3	35.2	41.4	45.9
Diabetes Care (Nephropathy Monitoring)	NA	85.77	67.64	68.1	73.9	78.5	82.5	86.9
Diabetes Care (BP < 140/80)	NA	30.83	31.14	25.0	32.0	38.5	44.2	54.8
Diabetes Care (BP < 140/90)	NA	52.57	48.66	43.8	54.3	61.2	68.3	76.0
Appropriate Medications for Asthma (Combined)	NA	88.07	79.89	83.6	86.6	88.9	90.5	93.2
Follow-up After Hospitalization for Mental Illness—7 Days	NA	69.15	41.81	23.0	33.1	45.1	53.9	68.3
Follow-up After Hospitalization for Mental Illness—30 Days	NA	80.50	57.10	36.0	57.1	66.6	74.6	82.6
*** Lower rates indicate better performance for this measure.**								

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Quality Assessment Performance Improvement Strategy
Core Performance Measures—FY 2012–2013
Children's Health Insurance Program Act (CHIPRA)

	Measure	MCO Reporting	Measure Steward	Data Source/Measure Method	Comments
1	Prenatal and Postpartum Care: Timeliness of prenatal care	Required	NCQA/HEDIS	Hybrid	
2	Frequency of ongoing prenatal care	Required	NCQA/HEDIS	Hybrid	
3	Percent of live births weighing less than 2,500 grams	Not Required	CDC	Birth Certificate Data and Medical Records	
4	Cesarean rate for nulliparous singleton vertex	Not Required	CMQCC[1]	Birth Certificate Data and Medical Records	
5	Childhood immunization status	Required	NCQA/HEDIS	Hybrid	CHIPRA requires reporting of Combos 2–10 and each individual vaccine
6	Immunizations for adolescents	Required	NCQA/HEDIS	Hybrid	
7	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Required	NCQA/HEDIS	Hybrid	
8	Developmental screening in the first three years of life	Required	NCQA/CAHMI[2]	Hybrid	
9	Chlamydia screening	Required	NCQA/HEDIS	Administrative	
10	WCVs in the first 15 months of life	Required	NCQA/HEDIS	Hybrid	
11	WCVs in the third, fourth, fifth and sixth years of life	Required	NCQA/HEDIS	Hybrid Administrative	
12	WCVs for adolescents	Required	NCQA/HEDIS	Hybrid	
13	Total eligibles who received preventive dental services	Not Required	CMS 416	Administrative	
14	Children's and adolescents' access to primary care practitioners	Required	NCQA/HEDIS	Administrative	
15	Appropriate testing for children with Pharyngitis	Required	NCQA/HEDIS	Administrative	
16	Otitis Media with Effusion (OME)-avoidance of inappropriate use of systemic antimicrobials in children ages 2–12	Not Required	AMA/PCPI[3]	Administrative, EHR	CMS TA requested Pending CMS Guidance
17	Total eligibles who received dental treatment services	Not Required	CMS 416	Administrative	

[1] California Maternal Quality Care Collaborative
[2] Child and Adolescent Health Measurement Initiative
[3] Physician Consortium for Performance Improvement

Quality Assessment Performance Improvement Strategy
Core Performance Measures—FY 2012–2013
Children's Health Insurance Program Act (CHIPRA)

	Measure	MCO Reporting	Measure Steward	Data Source/Measure Method	Comments
18	Ambulatory Care: Emergency Department Visits	Required	NCQA/HEDIS	Administrative	
19	Pediatric central line associated blood stream infection (NICU and PICU)	Not Required	CDC	Medical Records	CMS TA requested Pending CMS Guidance
20	Annual number of asthma patients ages 2–20 with ≥1 asthma-related ER visit	Required	Alabama Medicaid	Administrative	
21	Follow-up care for children prescribed ADHD medication	Required	NCQA/HEDIS	Administrative	
22	Annual pediatric hemoglobin A1C testing	Required	NCQA	Hybrid, EHR	
23	Follow-up after hospitalization for mental illness	Required	NCQA/HEDIS	Administrative	
24	CAHPS 5.0 (child version including Medicaid and children with chronic conditions and supplemental items)	Required	NCQA/HEDIS	Survey	

- The measures in the shaded rows are not reported by the VMCOs.

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
All VMCO Measures

Performance Measure	Family Health Network		
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012
Childhood Immunization Status - Combo 2	75.69	78.13	71.99
Childhood Immunization Status - Combo 3	70.37	73.33	69.91
Lead Screening in Children	81.94	80.50	82.87
Well-Child Visits First 15 months (zero visits)*	3.46	2.70	2.31
Well-Child Visits First 15 months (6 or more visits)	53.81	58.43	50.12
Well-Child Visits Third, Fourth, Fifth, and Sixth Year of Life	67.44	70.69	72.98
Adolescent Well Care	43.88	49.49	44.11
Immunizations for Adolescents (Combined Rate)	40.51	46.46	44.80
Children's Access to PCP (12-24 months)	82.18	95.10	91.84
Children's Access to PCP (25 months-6 years)	69.85	86.80	77.22
Children's Access to PCP (7-11 years)	51.08	87.90	53.08
Adolescent's Access to PCP (12-19 years)	52.99	86.50	54.61
Adult's Access 20-44	64.59	78.50	69.22
Adult's Access 45-65	67.41	84.50	74.11
Breast Cancer Screening (Combined)	47.66	52.89	48.90
Cervical Cancer Screening	69.44	72.50	71.50
Chlamydia Screening (Ages 16-20)	62.50	60.60	59.00
Chlamydia Screening (Ages 21-25)	70.69	68.70	68.13
Chlamydia Screening (Combined)	66.34	63.40	63.42
Frequency of Ongoing Prenatal Care <21%*	18.24	11.50	15.94
Frequency of Ongoing Prenatal Care 81%+	42.26	50.80	42.96
Timeliness of Prenatal Care	62.36	80.30	69.75
Postpartum Care	40.18	59.60	45.03
Controlling High Blood Pressure (Combined)	45.58	47.90	43.37
Diabetes - HbA1c Testing	79.23	81.31	79.45
Diabetes - Poor HbA1c Control*	69.95	52.10	63.64
Diabetes - Good HbA1c Control	31.69	39.90	36.36
Diabetes - Eye Exams	31.69	43.80	44.66
Diabetes - LDL-C Screening	68.85	70.40	69.57
Diabetes - <100 LDL-C Level	29.51	36.56	27.67
Diabetes - Blood Pressure <140/80**	34.43	40.98	30.83
Diabetes - Blood Pressure <140/90	54.64	59.18	52.57
Diabetes - Monitoring Nephropathy	84.70	82.50	85.77
Asthma - Combined Rate	90.26	91.24	88.07
Follow-up After Hospitalization for Mental Illness - 7 days	70.93	53.90	69.15
Follow-up After Hospitalization for Mental Illness - 30 days	80.18	74.60	80.50

* Lower rates indicate better performance for these measures

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
All VMCO Measures

Performance Measure	Harmony Health Plan		
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012
Childhood Immunization Status - Combo 2	65.94	69.00	68.86
Childhood Immunization Status - Combo 3	61.56	64.40	63.99
Lead Screening in Children	78.10	80.29	79.08
Well-Child Visits First 15 months (zero visits)*	5.35	2.70	4.62
Well-Child Visits First 15 months (6 or more visits)	51.34	52.20	51.34
Well-Child Visits Third, Fourth, Fifth, and Sixth Year of Life	71.78	74.60	65.21
Adolescent Well Care	38.93	39.60	35.52
Immunizations for Adolescents (Combined Rate)	29.93	40.00	38.69
Children's Access to PCP (12-24 months)	86.50	95.10	88.82
Children's Access to PCP (25 months-6 years)	73.28	86.80	74.20
Children's Access to PCP (7-11 years)	70.51	87.90	70.95
Adolescent's Access to PCP (12-19 years)	71.42	86.50	72.32
Adult's Access 20-44	69.29	78.50	70.81
Adult's Access 45-65	68.83	84.50	71.33
Breast Cancer Screening (Combined)	30.74	45.30	34.37
Cervical Cancer Screening	69.83	72.85	71.53
Chlamydia Screening (Ages 16-20)	46.10	48.70	50.06
Chlamydia Screening (Ages 21-25)	57.23	57.60	59.73
Chlamydia Screening (Combined)	50.88	51.50	54.02
Frequency of Ongoing Prenatal Care <21%*	16.55	11.50	14.84
Frequency of Ongoing Prenatal Care 81%+	39.90	50.80	42.09
Timeliness of Prenatal Care	64.72	80.30	64.72
Postpartum Care	48.66	59.60	49.64
Controlling High Blood Pressure (Combined)	42.58	47.90	37.23
Diabetes - HbA1c Testing	69.59	77.60	71.05
Diabetes - Poor HbA1c Control*	65.94	52.10	62.53
Diabetes - Good HbA1c Control	29.44	39.90	29.44
Diabetes - Eye Exams	18.25	43.80	27.49
Diabetes - LDL-C Screening	63.75	70.40	59.85
Diabetes - <100 LDL-C Level	17.52	27.30	22.38
Diabetes - Blood Pressure <140/80**	31.14	32.00	31.14
Diabetes - Blood Pressure <140/90	49.64	54.30	48.66
Diabetes - Monitoring Nephropathy	67.40	73.90	67.64
Asthma - Combined Rate	85.95	86.60	79.89
Follow-up After Hospitalization for Mental Illness - 7 days	42.69	48.42	41.81
Follow-up After Hospitalization for Mental Illness - 30 days	56.14	57.10	57.10

* Lower rates indicate better performance for these measures

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
All VMCO Measures

Performance Measure	Meridian Health Plan		
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012
Childhood Immunization Status - Combo 2	NA	69.00	87.04
Childhood Immunization Status - Combo 3	NA	64.40	83.33
Lead Screening in Children	NA	55.50	92.21
Well-Child Visits First 15 months (zero visits)*	NA	2.70	0.00
Well-Child Visits First 15 months (6 or more visits)	NA	52.20	82.00
Well-Child Visits Third, Fourth, Fifth, and Sixth Year of Life	NA	66.10	84.94
Adolescent Well Care	NA	39.60	66.67
Immunizations for Adolescents (Combined Rate)	NA	40.00	NA
Children's Access to PCP (12-24 months)	100.00	97.80	100.00
Children's Access to PCP (25 months-6 years)	92.08	91.20	92.05
Children's Access to PCP (7-11 years)	33.33	87.90	81.25
Adolescent's Access to PCP (12-19 years)	86.67	88.00	90.00
Adult's Access 20-44	90.54	86.40	89.14
Adult's Access 45-65	100.00	89.80	91.07
Breast Cancer Screening (Combined)	NA	45.30	NA
Cervical Cancer Screening	NA	64.00	84.44
Chlamydia Screening (Ages 16-20)	NA	48.70	NA
Chlamydia Screening (Ages 21-25)	NA	57.60	67.35
Chlamydia Screening (Combined)	NA	51.50	60.81
Frequency of Ongoing Prenatal Care <21%*	NA	11.50	1.37
Frequency of Ongoing Prenatal Care 81%+	NA	50.80	94.52
Timeliness of Prenatal Care	98.18	90.00	93.88
Postpartum Care	85.45	70.60	76.19
Controlling High Blood Pressure (Combined)	NA	47.90	NA
Diabetes - HbA1c Testing	NA	77.60	NA
Diabetes - Poor HbA1c Control*	NA	52.10	NA
Diabetes - Good HbA1c Control	NA	39.90	NA
Diabetes - Eye Exams	NA	43.80	NA
Diabetes - LDL-C Screening	NA	70.40	NA
Diabetes - <100 LDL-C Level	NA	27.30	NA
Diabetes - Blood Pressure <140/80**	NA	32.00	NA
Diabetes - Blood Pressure <140/90	NA	54.30	NA
Diabetes - Monitoring Nephropathy	NA	73.90	NA
Asthma - Combined Rate	NA	86.60	NA
Follow-up After Hospitalization for Mental Illness - 7 days	NA	33.10	NA
Follow-up After Hospitalization for Mental Illness - 30 days	NA	57.10	NA

* Lower rates indicate better performance for these measures

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
VMCO P4P Measures

Performance Measure	Family Health Network				
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012	2013 Hybrid QISMC Goal	Rate for HEDIS 2013
Childhood Immunization Status - Combo 3	70.37	73.33	69.91	72.92	
Well-Child Visits First 15 months (6 or more visits)	53.81	58.43	50.12	52.20	
Well-Child Visits Third, Fourth, Fifth, and Sixth Year of Life	67.44	70.69	72.98	75.68	
Cervical Cancer Screening	69.44	72.50	71.50	74.35	
Timeliness of Prenatal Care	62.36	80.30	69.75	80.30	
Postpartum Care	40.18	59.60	45.03	59.60	
Diabetes - HbA1c Testing	79.23	81.31	79.45	81.50	
Asthma - Combined Rate	90.26	91.24	88.07	89.26	

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
VMCO P4P Measures

Performance Measure	Harmony Health Plan				
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012	2013 Hybrid QISMC Goal	Rate for HEDIS 2013
Childhood Immunization Status - Combo 3	61.56	64.40	63.99	64.40	
Well-Child Visits First 15 months (6 or more visits)	51.34	52.20	51.34	52.20	
Well-Child Visits Third, Fourth, Fifth, and Sixth Year of Life	71.78	74.60	65.21	66.10	
Cervical Cancer Screening	69.83	72.85	71.53	74.38	
Timeliness of Prenatal Care	64.72	80.30	64.72	80.30	
Postpartum Care	48.66	59.60	49.64	59.60	
Diabetes - HbA1c Testing	69.59	77.60	71.05	77.60	
Asthma - Combined Rate	85.95	86.60	79.89	86.60	

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
VMCO P4P Measures

Performance Measure	Meridian Health Plan				
	Rate for HEDIS 2011	2012 Hybrid QISMC Goal	Rate for HEDIS 2012	2013 Hybrid QISMC Goal	Rate for HEDIS 2013
Childhood Immunization Status - Combo 3	NA	64.40	83.33	76.70	
Well-Child Visits First 15 months (6 or more visits)	NA	52.20	82.00	68.90	
Well-Child Visits Third, Fourth, Fifth, and Sixth Year of Life	NA	66.10	84.94	77.60	
Cervical Cancer Screening	NA	64.00	84.44	74.20	
Timeliness of Prenatal Care	98.18	90.00	93.88	90.00	
Postpartum Care	85.45	70.60	76.19	70.60	
Diabetes - HbA1c Testing	NA	77.60	NA	87.10	
Asthma - Combined Rate	NA	86.60	NA	86.60	

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
MCO Other Measures

	FHN 2011	QISMC Goal	FHN 2012	QISMC Goal	FHN 2013	HAR 2011	QISMC Goal	HAR 2012	QISMC Goal	HAR 2013	MER 2011	QISMC Goal	MER 2012	QISMC Goal	MER 2013
Effectiveness of Care Measures															
Childhood Immunizations—Combo 2	75.7					65.9					NA				
Lead Screening in Children	81.9					78.1					NA				
Well-Child Visits in the First 15 Months (0 Visits)*	3.5					5.4					NA				
Adolescent Well-Care Visits	43.9					38.9					NA				
Immunizations for Adolescents	40.5					29.9					NA				
Breast Cancer Screening	47.7					30.7					NA				
Chlamydia Screening (16–20 Years of Age)	62.5					46.1					NA				
Chlamydia Screening (21–24 Years of Age)	70.7					57.2					NA				
Chlamydia Screening (Combined Rate)	66.3					50.9					NA				
Controlling High Blood Pressure	45.6					42.6					NA				
Diabetes Care (Poor HbA1c Control)*	69.9					65.9					NA				
Diabetes Care (Good HbA1c Control)	31.7					29.4					NA				
Diabetes Care (Eye Exam)	31.7					18.2					NA				
Diabetes Care (LDL-C Screening)	68.9					63.7					NA				
Diabetes Care (LDL-C Level <100 mg/dL)	29.5					17.5					NA				
Diabetes Care (Nephropathy Monitoring)	84.7					67.4					NA				
Diabetes Care (BP < 140/90)	54.6					49.6					NA				
Access/Availability of Care Measures															
Children's Access to PCPs (12–24 Months)	82.2					86.5					100.0				
Children's Access to PCPs (25 months–6 Years)	69.9					73.3					92.1				
Children's Access to PCPs (7–11 Years)	51.1					70.5					NA				
Adolescent's Access to PCPs (12–19 Years)	53.0					71.4					NA				
Adults' Access to Preventive/Ambulatory Care 20–44 Years of Age	64.6					69.3					90.5				
Adults' Access to Preventive/Ambulatory Care 45–64 Years of Age	67.4					68.8					NA				
Use of Services Measures															
Frequency of Ongoing Prenatal Care (<21% of Visits)*	18.2					16.5					NA				
Frequency of Ongoing Prenatal Care (81–100% of Visits)	42.3					39.9					NA				
Behavioral Health															
Follow-up After Hospitalization for Mental Illness—7 Days	70.9					42.7					NA				
Follow-up After Hospitalization for Mental Illness—30 Days	80.2					56.1					NA				
* Lower rates indicate better performance for these measures.															

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
MCO CHIPRA Measures

	FHN 2011	QISMC Goal	FHN 2012	QISMC Goal	FHN 2013	HAR 2011	QISMC Goal	HAR 2012	QISMC Goal	HAR 2013
Effectiveness of Care Measures										
Weight Assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents										
Developmental screening in the first three years of life										
Appropriate testing for children with pharyngitis										
Annual number of asthma patients ages 2-20 with ≥ asthma-related ER visit										
Follow-up care for children prescribed ADHD medication										
Annual pediatric hemoglobin A1C testing										
Effectiveness of Care: Childhood Immunization Status - Combos 2-10										
Access/Availability of Care Measures										
Ambulatory care: Emergency Department Visits										

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
MCO CHIPRA Measures

	MER 2011	QISMC Goal	MER 2012	QISMC Goal	MER 2013
Effectiveness of Care Measures					
Weight Assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents					
Developmental screening in the first three years of life					
Appropriate testing for children with pharyngitis					
Annual number of asthma patients ages 2-20 with ≥ asthma-related ER visit					
Follow-up care for children prescribed ADHD medication					
Annual pediatric hemoglobin A1C testing					
Effectiveness of Care: Childhood Immunization Status - Combos 2-10					
Access/Availability of Care Measures					
Ambulatory care: Emergency Department Visits					

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
ICP P4P Measures

	Aetna 2011	QISMC Goal	Aetna 2012	QISMC Goal	Aetna 2013	IlliniCare 2011	QISMC Goal	IlliniCare 2012	QISMC Goal	IlliniCare 2013
Behavioral Health										
Objective:										
Follow-Up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis										
Follow-Up After Hospitalization for Mental Illness										
Dental										
Objective:										
Annual Dental Visit										
Diabetes										
Objective:										
Comprehensive Diabetes Care										
Cardiovascular Conditions										
Objective:										
Congestive Heart Failure										
Coronary Artery Disease										
Pharmacotherapy Management of COPD Exacerbation										
Use of Services										
Objective:										
Ambulatory Care										
Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit										
Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge										
Access										
Objective:										
Access to Member’s Assigned PCP										

Quality Assessment Performance Improvement Strategy (QAPIS)
PTT Tool FY 2012-2013
ICP Other Measures

	Baseline 2011	QISMC Goal	Aetna 2012	QISMC Goal	Aetna 2013	Baseline 2011	QISMC Goal	IlliniCare 2012	QISMC Goal	IlliniCare 2013
Behavioral Health										
Behavioral Health Risk Assessment and Follow-Up	On hold					On hold				
Initiation of Alcohol and Other Drug Dependence Treatment	45.0					45.0				
Engagement of Alcohol and Other Drug Dependence Treatment	8.7					8.7				
Immunizations										
Care Coordination – Influenza Immunization Rate	9.6					9.6				
Dental										
Dental ER Visit	1.1					1.1				
Diabetes										
Comprehensive Diabetes Care Administrative Method	None					None				
Cardiovascular Conditions										
Persistence of Beta-Blocker Treatment After a Heart Attack	None					None				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	None					None				
Use of Services										
Inpatient Utilization – General Hospital/Acute Care	16.6					16.6				
Mental Health Utilization	21.0					21.0				
Inpatient Hospital 30-Day Readmission Rate	8.6					8.6				
Inpatient Mental Hospital 30-Day Readmission Rate	24.7					24.7				
Long Term Care										
Long Term Care Urinary Tract Infection Admission Rate	0.2					0.2				
Long Term Care Bacterial Pneumonia Admission Rate	0.2					0.2				
Medication Management										
Annual Monitoring for Patients on Persistent Medications	82.8					82.8				
Antidepressant Medication Management	None					None				
Medication Monitoring for Patients with Schizophrenia (12 months antipsychotics)	45.4					45.4				
Medication Monitoring for Patients with Schizophrenia (6 months antipsychotics)	76.0					76.0				
Prevention and Screening										
Colorectal Cancer Screening	33.4					33.4				
Breast Cancer Screening	32.5					32.5				
Cervical Cancer Screening	39.5					39.5				
Adult BMI Assessment	4.5					4.5				

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Activities	2011							2012												2013				
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
Oversight and Monitoring of the QAP (42CFR 438.358)—Comprehensive Administrative Reviews/Corrective Action Plan (CAP) Monitoring—VMCOs																								
Report of On-site Focused Review Findings—FHN							↔	↔																
Report of On-site Focused Review Findings—Meridian																								
Report of On-site Focused Review Findings—Harmony							↔	↔																
Conference Calls for CAP Follow-up								↔																
Follow up on Focused Review CAP Findings and Comprehensive On-site—FHN										↔	↔													
Follow up on Focused Review CAP Findings and Conduct Comprehensive On-site— Meridian										↔	↔													
Follow up on Focused Review CAP Findings and Conduct Comprehensive on-site—Harmony										↔	↔													
Follow up on Comprehensive Review CAP Findings—FHN														↔	↔	↔	↔							
Follow up on Comprehensive Review CAP Findings—Meridian														↔	↔	↔	↔							
Follow up on Comprehensive Review CAP Findings—Harmony														↔	↔	↔	↔							

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Readiness Review and Corrective Action Plan Monitoring—Integrated Care Programs (ICPs)																								
Request Documents for Desk Review—Aetna and IlliniCare	↔																							
On-Site Readiness Review—Aetna		↔																						
Prepare Draft and Final RR Report—Aetna						↔	↔																	
Corrective Action Plan Technical Assistance (TA)—Aetna										↔	↔	↔												
On-Site Readiness Review—IlliniCare			↔																					
Prepare Draft and Final RR Report—IlliniCare						↔	↔																	
Corrective Action Plan Technical Assistance (TA)—IlliniCare										↔	↔	↔	↔	↔	↔	↔	↔							
Readiness Review and Corrective Action Plan Monitoring—REACH Program—PIHP																								
Request Documents for Desk Review—REACH Program	↔	↔																						
On-Site Readiness Review—REACH Program			↔																					
Prepare Draft and Final RR Report—REACH Program			↔	↔																				
Corrective Action Plan Technical Assistance (TA)—REACH Program						↔	↔																	

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Validation of Performance Improvement Project (PIPs) (42CFR 438.358)—VMCO—EPSDT, Perinatal Care and Depression Screening, Behavioral Health PIPs																								
MCOs Notified of PIP Submission				↔												↔								
PIP Documents to HSAG					↔												↔							
Validation of PIPs					↔	↔											↔	↔						
D1 PIP Tools to HFS and MCOs					↔	↔											↔	↔						
Follow-up Conference Calls if Needed					↔	↔											↔	↔						
Submit Revised PIP for Re-review					↔	↔											↔	↔						
F1 Tools to HFS and MCOs						↔	↔												↔					
Validation of Performance Improvement Project (PIPs) (42CFR 438.358)—ICPs—Care Coordination																								
PIP Documents to ICPs and Initial PIP Design		↔		↔	↔	↔	↔	↔	↔	↔														
PIP Documents to HSAG for Initial Validation											↔													
ICPs Notified of PIP Submission																	↔	↔						
Validation of PIPs											↔						↔	↔						
D1 PIP tools to HFS and MCOs											↔						↔	↔						
Follow-up Conference Calls if Needed												↔					↔	↔						

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Activities	2011							2012												2013				
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
Submit Revised PIP for Re-review												↔					↔	↔						
F1 Tools to HFS and MCOs												↔							↔					
Validation of Performance Measures—VMCO																								
Schedule On-site HEDIS Compliance Audit						↔		Meridian-2/28/12; FHN-3/2/12; Harmony-4/19/12										↔						
MCOs Submit Completed Roadmap									↔												↔			
MCOs Submit Completed Source Code										↔												↔		
On-site HEDIS Compliance Audit										↔	↔											↔	↔	
HSAG Conducts Validation of Medical Record Review												↔												↔
Initial Report of Findings												↔												↔
MCOs Complete Corrective Action and Follow-up Documentation Request												↔	↔											
MCOs Submit Preliminary DST													6/15 ↔											
MCOs Submit Final DST	↔												↔											
Final HEDIS Compliance Audit Reports		↔												↔										

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Performance Measure Validation—PCCM, ICP, and HFS Calculated																								
Schedule On-site Performance Measure Validation Audit						↔	↔											↔						
HFS Submits ISCAT								↔	↔												↔			
HFS Submits Source Code								↔	↔													↔		
On-Site Performance Measure Validation Audit										↔												↔	↔	
Technical Assistance—Revisions to Source Code and Technical Specifications										↔	↔													↔
Draft Report of Findings											↔	↔												↔
Final Report of Findings												↔	↔											
MCO/Integrated Care Plans/PCCM State Quality Strategy—Technical Assistance																								
HFS Completes Revisions to the State Quality Strategy and Forwards to the MCOs, ICPs, and PCCM Program for Review and Input											↔	↔	↔	↔	↔									
MCOs, ICPs, and PCCM Program Provide Input Into State Quality Strategy																↔								
HFS Incorporates Feedback Into the Draft State Quality Strategy																↔	↔							

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MCOs, ICPs, and PCCM Program Forward Stakeholder Participant List to HFS															↔									
Plan and Conduct Quality Strategy Stakeholders Meeting															↔	↔	↔							
Incorporate Stakeholder Feedback Into State Quality Strategy																	↔	↔						
Prepare Final Quality Strategy and Forward to CMS																		↔	↔					
MCO/ICP—External Quality Review (EQR)Technical Report (42 CFR 435.364)																								
Prepare EQR Report Outline	↔	↔					↔	↔										↔	↔					
Prepare EQR Technical Report Timeline							↔	↔										↔	↔					
Incorporate HFS Feedback Into EQR Technical Report Outline	↔	↔																						
Request CAHPS Reports from MCOs	↔	↔							↔											↔				
Prepare Draft Report			↔	↔	↔				↔	↔	↔									↔	↔	↔		
Submit Draft EQR Technical Report to HFS				↔	↔						↔	↔										↔	↔	
Incorporate HFS Feedback Into EQR Technical Report				↔	↔							↔											↔	

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	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
Forward Draft EQR Technical Report to MCOs				↔	↔								↔											↔
Incorporate MCO Feedback Into EQR Technical Report					↔	↔							↔											
Submit Final EQR Technical Report					↔	↔							↔											
Monthly Meetings—VMCO and Integrated Care Plans																								
Monthly HFS/MCOs/ICPs/HSAG Conference Calls	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Quarterly Meetings—VMCO and Integrated Care Plans																								
Quarterly On-site Meetings	↔			↔			↔			↔			↔			↔			↔			↔		