ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Memorandum

Date: January 5, 2012

To: Members of the MAC Care Coordination Subcommittee

From: Julie Hamos
Director

Re: MAC Care Coordination Subcommittee Meeting

The next meeting of the Medicaid Advisory Committee's Care Coordination Subcommittee is scheduled for Tuesday, January 10, 2012. The meeting will be held via video-conference from 10:00 a.m. to 12:00 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor video conference room. Those attending in Chicago will meet at 401 South Clinton, 7th floor video conference room.

Attached, please find the agenda for the meeting and the minutes/attachments from the November 15, 2011, meeting. As part of the Department's ongoing efforts to reduce administrative cost, copies of the material will not be available at the meeting. Participants should plan on bringing their own copies.

This notice and the agenda have also been posted to the Department's Web site at: http://www.hfs.illinois.gov/mac/news/index.html

If you have any questions, or need to be reached during the meeting, please call 217-782-2570.

Medicaid Advisory Committee

Care Coordination Subcommittee

401 S. Clinton
7th Floor Video Conference Room
Chicago, Illinois

And

201 South Grand Avenue East
3rd Floor Video Conference Room
Springfield, Illinois

January 10, 2012
10 a.m. – 12 p.m.

Agenda

I. Call to Order

II. Introductions

III. Review of November 15, 2011 Meeting Minutes

IV. Director's Report

V. Update on Dual Medicare/Medicaid Care Integration Financial Model Project

VI. Update on Innovations Project
- Q&A from October 13th Webinar
- Performance and Quality Measures
- Status of Solicitation
- Status of Data Development

VII. Consumer Issues

VIII. Open to Subcommittee

IX. Next Meeting

X. Adjournment

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
November 15, 2011

401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Edward Pont, Subcommittee Chair, M.D., IL Chapter AAP
Kelly Carter, IPHCA
Art Jones, M.D., LCHC & HMA
Gordana Krkic for Vince Keenan, IAFP
Diana Knaebe, Heritage BHC
Divya Moham Little for Kathy Chan, IMCHC
Jerry Kruse, M.D., M.S.H.P., SIU SOM

HFS Staff
Julie Hamos
Sharron Mathews
Jim Parker
Mike Koetting
Michelle Maher
Laura Ray
Mike Jones
Ann Lattig
James Monk

Interested Parties
Salim Al Nurridin. Healthcare Consortium
Mary Pat Ambrosino, SW Community Services
Carol Aronson, Shawnee Alliance for Seniors
Mike Bach, MCMHB
David Beauchaine, HealthSpring
Terry Buford, Magellan
Christine Burnett, IARF
Sandra Bury, Il Optometric Assn.
Bob Cammarata, ICG inc.
Alex Cardona, BilForce
Joseph Cini, AHS
Melinda Clark , Hospital Sisters
Jeffery Collord, Haymarket Center
Brain Dacy, LifeTech
Laura Derks, Consultant
Nancy Diettrich, Resurrection Health Care
Diane Fager, CPS
Andrew Fairgrieve, HMA
Randy Fiks, HealthSpring
Neal Fischer M.D., Humana
Marie Cleary-Fishman, IHA
Alexandra Forrest, Guardian Medical Monitoring
Eric F. Foster, IADDA
Mayumi Fukui, UCMC
Margaret Gaden, Telligen
Ram Gajjela, MHS
Karyn Glugowski, Delta
Robert Gould, UIC Applied Health Sciences
Bobbie Gregg, Du Page County HD

Members Absent
Ann Clancy, CCOHF
Mike O'Donnell, ECLAAA, Inc.
William Gorski, Swedish American Health System
Margaret Kirkegaard, M.D., IHC, AHS
Indru Punwani, D.D.S., M.S.D., Dept of Pediatric Dentistry
Janet Stover, IARF

Interested Parties Continued
Nancy Halverson, Crusader Community Health
Jennifer Walsh Hammer, Attorney
Barbara Hay, FHN
Jennifer Henson, HSHS
Tamar Heller, UIC
George Hovanec, Consultant
Shariful Islam, UIC
Richard Jackson, HSI
Joel Johnson, HRDI
Kiernan Keating, Takeda
Iwona Korzeniowska, ICG Inc.
Keith Kudla, FHN
Azmina Lakhani, SGA
Erin Latham, IARF
Matt Lisovitch, Philips
Peter Lopatin, Heartland Health Outreach
Denise Martinez, Office of the Governor
Kathryn McClain, CFHC
Michelle, McMullin, AID
Ernest McNeil, ELM
Diane Montanez, Alivio Medical Center
Michael Mroz, MADO Health Centers
James Nicholas, Gateway Foundation
Heather O'Donnell, CJE SeniorLife
Lynn O'Shea, AID
Ranall Owen, UIC
Caitlin Padula, Shriver Center
Kristen Pavle, Center for LTC Reform
Maryam Parisian, Haymarket Center
Judy Panko Reis, Access Living
James Rhodes, JASC-ISPC
Miranda Rochol, Walgreen Co.
Marla Robinson, DMHHS
Sam Robinson, Canary Telehealth
Nelson Soltman, LAFMC
Layla Suleiman, DHS
Aneta Tomaszkienia, ICG Rehab
Joseph Turner, DHS/DDD
Cari Vonderhaar, AHS/IHC
Gina Whitener, Lathan Harris
Kuliva Wilburn, Chicago Community Trust
Tom Wilson, Access Living
Abu Zewdie, Ada S. McKinley

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
November 15, 2011

I. Call to Order

Dr. Pont called the meeting to order at 10:05 a.m.

II. Introductions

Committee members and HFS staff in Chicago and Springfield introduced themselves.

III. Review of September 13, 2011 meeting minutes

The minutes were approved.

IV. Director's Report

The department's first, broad outline of the Innovations Project design took place on October 13, 2011. The meeting/webinar was well attended. HFS announced that a key component of care coordination is measuring quality and health outcomes. That means developing performance measures to use in a standardized way to look at how well we are doing on behalf of our Medicaid clients.

V. Dual Medicare/Medicaid Care Integration Financial Model Project

James Parker, Deputy Director of Operations, talked about the plan to bring dual-eligible (Medicaid/Medicare) clients, sometimes referred to as "duals" or "dual-eligibles," into coordinated care in Phase 2 of the Innovations Project. The federal government has offered states the opportunity to test two models of integrated care for duals to enhance quality and reduce cost; a Managed Fee-for-Service (FFS) model and a Capitated Full Risk model. Illinois submitted a letter of intent (LOI) to the feds on September 30, 2011 and were one of the states selected for the project. In the LOI, HFS stated an interest in testing the capitated model mostly in Northern Illinois and the managed FFS model in the rest of the state. Meeting participants were provided with a handout, *CMS Financial Models to Support Efforts to Integrate Care for Medicare-Medicaid Enrollees* (Attachment 1). The federal timeline is extremely accelerated. The current requirements are for HFS to have a proposal published in the next couple of months and issue an RFP in the spring. Enrollment in these programs would be effective at the end of calendar year 2012.

HFS will ask the CMS if a Coordinated Care Entity (CCE) model developed for the Innovations project can be used as the model for the managed FFS model. There hasn't been much specific information about managed FFS, but it is known that if there are savings for Medicare services, some would be shared with the state.

The capitated model would be similar to what is planned for Phase 2 of the Innovations Project, working with the managed care entities with the distinction being a three-way contract with the managed care company, state and federal government. The managed care companies would work with duals to provide a full range of services under both Medicare and Medicaid. The federal guidelines require that all services be included under the capitation payment. Capitation of the Medicaid half would include long-term care, long-term community supports and nursing homes.

HFS wanted to share this information with interested parties and invite comments at the same website that we now accept comments for coordinated care. CMS is encouraging community input. Director Hamos added that Illinois has about 400,000 people in the seniors and people with disabilities (SPD) program (formerly called the AABD program). Of those, about 250,000 are dual-eligible clients. This group represents some of clients with the most complex needs in Illinois.

The federal government is to make demographic Medicare data available, but is having some difficulty in pushing out the data in the format needed. The data is supposed to be available in time to release an RFP. Once available, HFS will share the demographic data; including the disability category.

Currently, the department provides data on elderly and disabled clients by county, but that data has the dual-eligible and non-dual-eligible combined. The department should be able to sort these out. We do collect some data on race and ethnicity, but reporting this information is voluntary, so it tends to be incomplete and not very accurate.

HFS has an understanding with the State Procurement Office that these are purchase for care contracts that are exempt from the strict adherence with the Illinois Procurement Code. At this point, it appears that the federal CMS will not impose any additional federal procurement rules. However, because this is a joint agreement, CMS will need to be satisfied with the RFP. HFS sent CMS a copy of the Integrated Care RFP indicating that it would be used as the building block for the dual RFP. The CMS will develop the actuarial rates for the Medicare part of the RFP. The release of the solicitation for the Innovations Project's Phase 1 is still scheduled for sometime in early 2012, but no specific date has been set. Dual-eligible persons may participate in the Innovations Project, including those living in the Integrated Care Program (ICP) service area. However, persons mandated to participate in the ICP would be excluded from the Innovations Project.

VI. Innovations Project – Performance and Quality Measures

Dr. Pont opened by stating that he would discuss measures for pediatrics and Dr. Jones would discuss measures for adult medicine. After each presentation, questions and comments would be solicited from participants.

Mr. Parker provided an introductory background to the discussion by stating that the Innovations Project needs outcome measures for different purposes. One goal is to simply measure outcomes for each program. Another goal is to develop a core set of measures to compare outcomes across programs. For example, all proposals serving seniors or people with disabilities (SPD), or all proposals serving complex children, would use the same core set of measures. HFS is asking for input on what core set of measures will work across any model serving a particular population.

The department assumes some of the proposals will focus on a very particular subset of the SPD population and include particular interventions. Therefore, innovators would want measures that are particular to their approach. But, there is a need for core measures to compare the same outcomes across different models to see which interventions work best in a certain area.

The Integrated Care Program that serves the SPD population in suburban Cook and the collar counties is one of the models the department will compare with the models under the Innovations Project. One of the handouts provided today is a list of the contractually agreed outcome measures for ICP (Attachment 3).

Dr. Pont's Presentation

In preparing for today's meeting, Dr. Pont stated that he looked for some data to draw on. For example, if a particular performance outcome is met, or a particular performance measure is met, you'll achieve a clinical outcome or perhaps a cost saving. He did a literature search and asked his national academy to do a literature search. In addition, Dr. Pont spoke with doctors in other state programs including a doctor involved with the Michigan state CMS innovations project, Dr Jerome Frankel, a champion of care coordination. After about 20 minutes of discussion on the model in Michigan and how well it is working, when asked what measures he followed, Dr. Frankel responded, "I have no idea."

Dr. Pont stated that for pediatrics, there is good evidence that simply getting a child into a doctor's office or into a medical home does a lot in terms of getting them better quality of care and also in saving money on unnecessary hospitalization and ER care. Asthmatic children are 37% less likely to need a non-emergency ER visit if they have a medical home. In defining measures that everyone should follow,

the consensus is that the state has done a good job in establishing HEDIS measures that we follow as part of Illinois Health Connect. A child should be immunized, have a developmental screening and a lead screen, depending on where they live. These are very good basic measures.

Dr. Pont indicated that quality should not be measured in terms of clinical measures only. There is very good evidence that extending office hours into the early evening, or providing 24-7 call coverage, can impact care. This type of office practice isn't measured now, but should be part of the mix.

The electronic health record (EHR) was referenced at the October 13th Innovations Project meeting. HFS can't really mandate that an office use the EHR. However, a critical mass has been achieved where offices that aren't EHR ready are beginning to recognize that they have to get on this band wagon. Five to ten years from now the vast majority of offices will have EHR. But, you can't say that if you don't have EHR then you can't participate. You can say that adding other measures or following certain clinical outcomes, is much easier with EHR. That along with the federal incentives will push practices to EHR and lead to more effective medical homes.

The department should make the quality measures for the Innovations Project public. There should be a website where a parent can research which network would best serve their child's medical needs. The state would be a great place to organize data to allow and a more consumer based healthcare model; where a parent with a child who has recurring ear infections to be able to find a practice that follow the number of times a child has fluid in their ears. Dr. Pont added that it should be kept in mind that some providers only see about 50-100 Medicaid children and so the requirements shouldn't be too onerous. Dr. Pont indicated that the HEDIS measurements designed for pediatrics would work with any Coordinated Care Entity (CCE) working with children and that the working group on children with special healthcare needs may also have measures they would recommend the state to consider. That would be a good approach on the children's side.

Comments

Dr. Kruse commented that Dr. Pont had provided an excellent summary of what we know and agreed that it is very difficult to find information on specific measures' outcomes and cost savings. It is true that when people have a usual source of longitudinal, comprehensive care that they can recognize, like a primary care provider or medical home, healthcare outcomes improve and costs go down. Dr. Kruse stated that focus should be on ensuring that patients have an opportunity for a medical home and can access the type of referrals needed. Emphasis should be put on some very specific indicators that are burdensome to measure and for which we don't have a good idea on how much they save or outcomes they improve.

Dr. Jones' Presentation

Dr. Jones referred to the handout, *Replacing Quality Measures with Value Measures* (Attachment 2). He stated that access is important, but doesn't go far enough as a quality measure. First, it doesn't deal with the issues of population health. There are currently Medicaid patients that are not accessing or trying to access the system, so incentives need to reach those members. The focus needs to be on quality and what happens once a member gets into the doctor's office. Working with managed care going back to the late 1980s, we didn't measure quality. Over time, we started to measure some quality parameters and over the last several years we have measured things like immunizations, PAP smears and mammograms, which are related to quality. With these we can detect under-utilization and population health and to some extent save the system money downstream.

We should choose parameters that are going to give us short-term savings and recognize that safety-net providers don't have a lot of upfront money to invest in achieving those things. When setting up a shared savings program tied to quality, there needs to be an understanding that if we really expect to get

those outcomes, we have to come up with some short-term payment program, namely pay-for-performance (P4P), to drive the type of behavior that will ultimately lead to shared savings. For example, provide an add-on payment to providers who track a patient after they go to the ER or hospital and then get them to the PCP's office within seven days of discharge. The goal is to achieve short-term savings and improve quality of care. Those savings can be used to drive shared savings program at the end. We need to look at parameters based not just on quality, but on value that includes the cost parameter.

HEDIS is moving toward accessibility and cost savings. The new HEDIS parameters mentioned in the handout are called Relative Resource Use (RRU). They chose parameters with diseases like asthma, cardiovascular conditions, COPD, diabetes and hypertension. HEDIS already has parameters established for these diseases. What they are looking at now for each disease accounting for a large portion of our expense, are a provider's utilization of resources to actually achieve quality. The providers can be divided into four quadrants with the variables of quality and cost. The worst quadrant is a provider that does poorly on the quality parameter and is really expensive. The second quadrant is good quality, but very expensive. The next quadrant is lower quality, but less expensive. The fourth, and most desirable quadrant, offers high quality in a cost effective way. We need to look at not just quality issues but at the value which includes the parameter of cost.

Dr. Jones stated that he had gone over the entire list of measures and that the parameters on the handout for the *Baselines for Year 1 Pay for Performance Measures Performance* (Attachment 3), for the Integrated Care Program, look to be well done as they measure some things that should drive short term savings. For example, #3 and #4, "Follow Up within 30 days After Initial Behavioral Health Diagnosis" and "Follow-Up after Hospitalization for Mental Illness", we know that seeing a patient that has been hospitalized for mental illness within 7 days of discharge reduces the likelihood of readmission.

Dr. Jones indicated that #8 A-C, Comprehensive Diabetic Care, are pretty standard. Ideally HEDIS has these measures that include looking at control of HbAlc levels, but you can't get that off of encounter data. On parameters #9 A-9C, Congestive Heart Failure (CHF), using pharmacy data to track whether the patient actually takes the medication is a good parameter. To reward providers on a short term basis for getting the patient to take their CHF medicine, we would use the state's analytic data system. Medical Health Network (MHN) is using the state's database now and has developed analytic techniques so we may measure that. He recommended changing parameter #9B for beta blockers 80% of the time. The clinical data is that only certain beta blockers, Metoprolol and Carvedilol prolong survival.

Dr. Jones indicated that the department's pharmacy data is timely and that a lot of the measures are driven by pharmacy data. We should move towards being able to produce reports, preferably on a monthly basis, so the provider gets a report showing a patient's medication use. This would give providers back the data in a patient specific way and in a short time frame, so it could be used to drive provider behavior.

Director Hamos advised that HFS shares claims data, but because the data comes from providers submitting claims to us, there can be a delay. HFS is committed as a Medicaid program to create a data analytics function that can work for the provider community by showing progress and success. This is high priority for HFS.

Mr. Parker added that pharmacy data comes to us in real time and that the department feeds that back to providers, but not necessarily in a report that models their panel. Through MEDI providers can look up any patient and get the claims history. But, as the Director stated, there can be delays in the provider submitting the claim and then additional time for the claims data to go through our claims processing system, to the data warehouse, and then to MEDI system. The department is looking for faster turn-

around on claims data, but can't promise there will be reports available in the near future for all the many Innovations Project entities around the state.

Dr. Jones stated that the pharmacy measures for #10A-C Coronary Artery Disease; #10D, Beta blocker treatment after a heart attack and #11A-B, Pharmacotherapy management of COPD, should be included, as long as the data would allow the provider to measure how they are doing and to react on a patient specific basis. In addition, he encouraged the department to use #12 on ED visits as a measure of access. He noted the only concern is making sure it is adjusted for the population by at least making a distinction between the SPD and TANF populations. He suggested including #13 and #16 Ambulatory follow-up with a provider after an ED visit or inpatient discharge, but recommended changing the time frame from 14 days to 7 days after discharge. He would also include #29, Access to member's assigned PCP by an ambulatory or preventive care visit.

Dr. Jones pointed out that in moving forward in developing the dual-eligible program, be aware that Medicare has developed very expensive quality parameters for dual-eligible patients. He referred the group to the CMS Star program in the back of Attachment 3. Consideration should be given to using some of the parameters or adopting the entire program for duals. If we go with a program partnering with managed care companies, the companies are already collecting this data, so it makes sense to use parameters that have already been chosen.

Comments

Dr. Kruse agreed it is important to have incentives to reach those who don't access the system. A population based registry function, which rewards practices for reaching out to patients or people who haven't accessed care, is a really powerful and important tool. He noted some disagreement with the assumption that quality or value care will not take place just because of access. Population based studies tell us far more often than not, that access does equal quality, when access is a usual source of comprehensive longitudinal care. Dr. Kruse added that P4P systems and payment for care coordination are separate and we need to determine how much we are paying for each. Systems that have fee-for-service, care coordination payments and payment for quality indicators are three different incentives that would probably balance each other out. Illinois Health Connect and Your Healthcare Plus using the claims data and the state databases took a good first step toward doing some of these P4P things. Even with incomplete data it gives a pretty good look at the type of care a person is getting when assigned to a doctor and medical home.

Dr Jones responded that care coordination should be changed into P4P and that we should discuss a higher care coordination fee for people that have complex illnesses.

Mr. Parker indicated that for Phase 1 of the Innovations Project, the department is looking for collaborations to organize in a more population based sense with focus on the high cost of those populations. The department can stratify these in three ways: 1) measuring savings in each model and particularly in shared savings, actuaries will determine if a model is saving money; 2) identifying what is driving the savings by looking at utilization measures such as readmission rates and generic utilization rates, and; 3) CMS is looking at shared savings and will want to tie payment to quality measures. For example, payment could be tied to a care coordination measure like "was the patient seen by their PCP within seven days of discharge?" We need to discuss care coordination measures by looking at a function of coordination or outcome data; which for HFS is largely limited to claims data. An example would be "is the patient on the drug we want for them?" We don't have the capability to say is their cholesterol or blood sugar level where we want it to be at.

Dr. Kruse agreed that measures are needed, but pointed out these are surrogate measures and, in and of themselves, not outcome measures. As such, the surrogate measures need to be linked to real outcomes by some studies.

Dr. Sam Robinson commented that what Dr. Jones is proposing will actually drive outcomes and improve quality. He is basically using a "carrot" method.

Gordana Krkic commented that HFS will need to pay incentives from day one as has happened under the PCCM model. The payment would be necessary for safety-net providers, small practices and FQHCs that are operating in the margins, to be successful in being part of the Innovations Project. She asked Dr. Jones what he envisioned as the ability to come back and report on the successes of the program. Dr Jones replied that the Medical Home Network (MHN) had its' grant signed a week ago and should be able to go live in the next month or two. MHN is a pilot project that came out of a study by the Comer foundation looking at healthcare issues for children. The group is composed of six hospitals and six FQHCs to serve about 170,000 enrollees on the south side of Chicago. MHN has developed a shared savings approach and has asked the federal CMS for funding. It will be fee-for-service with shared savings tied to quality parameters. MHN has some unique IT capabilities to take the state data and do data analytics to create reports. We have a system called MHN Connect which allows a hospital to tell a patient's medical home by e-mail when our patients are seen in an ER. This gives us the ability to interact and share medical data with the ER doctor. MHN will report some of the utilization parameters to IAFP and CMS within six months. We can report on some of the process measures like seeing a person within seven days of discharge on a monthly basis and a lot of the quality data will come back on a yearly basis.

Director Hamos asked for clarification on whether the department wanted specific feedback on the Integrated Care Program (ICP) performance measures to use for the Innovations Project for adults. Mr. Parker indicated that, yes, since the Innovations Project also targets the high cost populations, in order for the department to compare all the different models, at least some of the measures used for the Innovations Project will need to be a subset of those currently used under the ICP. The department is not putting forth the entire ICP list to be used by all the entities, but rather asking if there are measures in the ICP, both P4P and not P4P, that the group believes are key and should be used for all innovation entities. Part of the HFS solicitation will indicate that a bidder can propose specific outcome measures for a particular proposal because of its target population needs and design interventions within it.

Dr. Pont restated that these are measures that cut across all adult populations that should be a baseline for any CCE and the rest of them could be picked up by any CCE if they feel that variable is important to their patient population. He added, and Mr. Parker agreed, that if an organization wants to put forth another benchmark, it should be backed up with evidence or data from medical literature.

Tamar Heller stated that she is directing the project that is evaluating the ICP. As part of that project they have developed some measures that might be useful, such as, the consumer survey developed specifically for people with disabilities or part of the aged. It would allow for some comparisons with the ICP. The unique measures were developed because the CAP survey is not specifically geared for people with disabilities in terms of asking about their satisfaction with the services. The survey includes questions on functional aspects that are not typically included in the CAP survey. For example, questions about adaptive behaviors such as using the toilet, eating and accessibility in getting to the doctor's office.

Director Hamos stated that it's interesting that an independent evaluator is working with Public Health to evaluate the ICP with a consumer satisfaction survey. But, not sure how the information from the consumer can be used in determining what performance measures have been achieved, as the reporting would come from claims data reflecting services rendered.

Dr. Jones added that it is a resource issue and we need to ask if resources should be put into consumer surveys. If the answer is yes, we should choose parameters, but if the resources aren't available, then it shouldn't be on the table. Mr. Parker noted that one of our questions was did the department want to put resources into doing a patient survey as part of the ICP. And, a second question was did the department want to tie payments to the outcomes of a survey—which would have been a huge leap for a lot of people. Dr. Jones suggested that the discussion be turned over to Dr. Fischer to talk about that, since Medicare has been paying for survey results in terms of the CMS stars.

Dr. Fischer stated that he works in the Medicare Advantage, which is a managed care program for Medicare. CMS has about fifty measures used for reimbursement to Medicare Advantage plans, including a Health Outcome Survey (HOS) conducted by CMS, as well as a CAP survey. CAP is a private independent company. The surveys, as well as some of the HEDIS measures and pharmacy safety measures, are used as part of the reimbursement structure for Medicare Advantage companies like the Humana plan. The last page of Dr. Jones' handout shows the CMS Star Rating Methodology. Five of the questions are rolled into the reimbursement for the Medicare Advantage plans. Two questions ask people essentially if you are better off physically or mentally than you were a year ago. These are weighed by CMS in determining reimbursement.

Tom Wilson stated that if you are talking about patient-centered or consumer centered health, you have to look at measures of patient satisfaction. Consumers can't be left out of the equation.

Divya Moham Little stated that performance measure #1, Behavioral Health Risk Assessment is very important for the pediatric population. She works with IMCHC and the school health center project. A risk assessment is done at all school health centers and is very important to the school based health community. DHS does collect the risk assessment data.

Dr. Jones advised that a Patient Health Questionnaire (PHQ) tool is used in the adult community to screen for depression. The problem is getting encounter data. You could use EMR data but that doesn't get down to the State. Again, what is important is can we measure it. Like the hemoglobin A1c, it is important, but can we measure it from claims data.

Dr. Pont added that a CCE that devotes their resources to a specific population should be able to say we are going to measure this risk assessment, present data on why it is relevant and show outcome data on how they were able to motivate providers.

Jeffery Collord, of Haymarket Center, stated that about 70% of their clients have a chronic medical condition that may or may not be related to their substance abuse. There are high percentages of patients with diabetes, asthma and hypertension that have gone untreated. Our patients are not going to access any care for these conditions except by emergency if their substance abuse is not stabilized and treated. There is a need to look at how one condition impacts another. There are performance measures listed, but for our population it may be if #1 doesn't happen then #8, 9 and 10 won't happen. This should be taken into account as HFS develops performance measures for the Innovations Project.

Director Hamos asked, using Haymarket as an example, isn't it possible to bring the doctor to you and use Haymarket as the medical home for treatment and care coordinated into other types of care? Mr. Collard replied that yes this is possible. However, the main problem is most patients are not eligible for Medicaid. He added that some patients are in the Integrated Care Program and coming to Haymarket from the collar counties, but the agency has not been able to get into the network fast enough.

Dr. Jones asked where the baseline measurement percentages came from as shown on the *Baselines for Year 1 Pay for Performance Measures.* They are different than the current HEDIS measures. He also asked if HFS would be willing to look at the Relative Resource Use parameters that HEDIS has developed as far as possible use for this program. Mr. Parker advised that these HEDIS measures are

based on HFS claims data for calendar year 2010. This is mean data and the ICP vendors have to exceed these benchmarks. He stated that as far as the Relative Resource Use parameters, the department is willing to look at these.

Peter Lopatin asked if he understood correctly what comments are being requested. The question may not necessarily be about what the metrics are, but what those benchmarks and standards are that we are being held to. For the populations that we serve, when you try to make comparisons across programs we need to be sensitive to what is an achievable goal and what is a realistic goal.

Dr Pont asked that participants identify what performance measures would be relevant to their entire population served and email their comments to the Care Coordination web page at http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/Comments.aspx. He asked for a link from the Care Coordination subcommittee page to the Care Coordination page.

Director Hamos clarified that HFS is going to give meeting participants a chance to digest today's discussion and reflect on it. HFS would like to get participant's comments on the performance measures in the next two week or by December 1, 2011.

Dr. Jones asked, and Mr. Parker agreed, that there is a different time frame to comment on quality parameters for dual-eligibles. There is more of an input process with the federal CMS for the RPF on duals. Mr. Parker added that what the department needs now is input on what to use as the across-the-board measures for the solicitation for phase 1 of the Innovations Project.

VII. Open to Subcommittee

Dr. Pont reiterated that the original charge of the subcommittee was to suggest modifications to the PCCM program so it could participate in the 50% care coordination requirement under the Medicaid Reform law. He had presented the recommended modifications to the MAC and these are on the MAC website as an addendum to the last meeting minutes. If the state responds positively at the MAC meeting scheduled for this Friday, then we will discharge the subcommittee of that responsibility and move on to consumer issues at the next subcommittee meeting. The subcommittee would welcome any other topics participants might want it to consider.

Director Hamos reminded everyone that in Phase 1 of the Innovations Project, the first solicitation is covering adults with complex health needs and their children living with them. We didn't want to fragment families and see them covered by different providers and care coordinators. So today, you gave us early on an idea that their children could be covered using these HEDIS measures that we are already using. In Phase 2, it is going to be the larger population of children as well.

Lynn O'Shea stated that we haven't talked about the measurements for service for long term care that are really more social outcomes rather than medical outcomes. She asked if there is any role for these measures at this step or are we looking at phase 3 for people who need help with basic living skills?

Mr. Parker responded that HFS is open to suggestions along those lines. HFS is trying to take that whole person approach. Innovations will have some core services that must be coordinated. HFS is looking for models with greater comprehensiveness of care coordination and those are ones that will take on coordination of care for the whole person.

Director Hamos added that what HFS is trying is innovative and the department doesn't know exactly how it is going to work. At first, it might be a little spotty, since HFS doesn't know what the interests will be in serving clients under the Innovations Project. HFS has started working with stakeholders in designing the long term care component for Phase 3 under the ICP, as it will be a requirement for managed care companies serving the ICP population. Just as with dental, we contemplated whether there should be a requirement for any CCE to serve more needs, such as long term care. We thought of

making it more comprehensive, but that could possibly exclude some of you from coming into the Innovations Project and trying out a new model of care for Illinois. The department encourages looking at serving multiple needs and believes an application will be stronger if it addresses the larger needs of our clients, but we didn't require it. We will be innovative, flexible and inclusive.

Alex Cardona, of BilForce, stated that one of the things lacking in the measurements is empowering the population we are serving by: 1) promoting and incentivizing patient education; 2) creating patient access to the records, and; 3) incentivizing telemedicine. It is possible to save thousands of dollars through telemedicine, but it is not being reimbursed properly. It could be part of the measurements. We are in an evolution of health care and we need to take advantage of all the tools we have. We see the measurements for HEDIS and have a hard time getting doctors to meet them in the meaningful use of an EHR system. With the 20 measures in the HITECH Act, doctors trying to meet those limits are having a hard time. In the Innovations Project, we need to align these measures with what we already have.

Ms. O'Shea commented about dental services and how HFS felt that dental may be something beyond the scope of what should be required. Those of us that serve persons with serious chronic mental illness, the homeless or persons with developmental disabilities know that not only their life styles but the medications ordered by their physicians cause serious dental problems, which may result in dental being their number one medical issue. She wouldn't like it to be set aside as not as important as some of the other measures.

Director Hamos replied that the department debated this long and hard and decided that a CCE must include primary care physicians, hospitals and behavioral health services. We considered adding dental services. But we were worried as there were just not enough dentists. It is a supply issue. We would be very happy to get a proposal that included dental care as a part of your network and was incentivized.

Dr. Jones asked where HFS is as far as being able to get the data to be able to respond in January and how that process is going as far as finding a vendor for data analytics.

Mr. Parker responded that we are working hard on that with HFS staff, Tia Sawhney. HFS is committed in getting that to innovators in the time frame that we had talked about. We looked at outside resources and have now turned internally. HFS is absolutely committed to making the data available in a format that can be fed into multiple types of systems so Innovations Project bidders can manipulate it.

VIII. Next Steps

The next coordinated care meeting was tentatively set for January 10, 2012.

IX. Adjournment

The session was adjourned at 11:48 a.m.

Illinois Department of Healthcare and Family Services
Division of Medical Programs

CMS Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

On July 8, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors (SMD) letter providing preliminary guidance on opportunities to better align financing between Medicare and Medicaid in an effort to enhance the quality of and reduce the cost of care for individuals enrolled in both programs ("dual eligibles"). The CMS outlined two models – Capitated and Managed Fee-for-Service (FFS) – to help States overcome the financial misalignment between these two programs and to pursue the integration of primary, acute, behavioral health and long-term services and supports for dual eligibles.

On September 30, 2011, the State of Illinois submitted a letter of intent to participate in both models. Below are highlights of the two models:

Capitated Model

- This model will test a capitated payment model utilizing a three-way contract among the State, CMS, and health plans to provide integrated benefits to dual eligibles.

- Plans – selected through a competitive, joint (CMS and State) procurement process – will receive a blended capitated rate for providing the full continuum of benefits across both programs.

- Participating plans will be required to comply with all applicable Medicare and Medicaid rules and regulations as well as program specific and evaluation requirements including established quality thresholds.

- Key objectives of the initiative are to improve access to care and quality, eliminate cost shifting between the two programs, and achieve cost savings.

Managed FFS

- Under the Managed FFS model, States will ensure seamless integration and access to all necessary services, based on the individual's needs, through coordination across the Medicare and Medicaid programs.

- The Managed FFS model is designed to build upon existing FFS delivery systems and new CMS programs that offer States opportunities to improve care coordination for Medicaid beneficiaries including dual eligibles (e.g. Medicaid health homes).

- The State will be eligible to receive – based on the State meeting or exceeding established quality thresholds – a retrospective performance payment based on the level of Medicare savings achieved net of increased Medicaid costs.

- State participation in the Managed FFS model aligns with the State's Innovations Project, which offers new funding incentives and flexibilities to engage community partners in facilitating coordinated, quality care, across provider and community settings to specific Medicaid populations including dual eligibles.

REPLACING QUALITY MEASURES WITH VALUE MEASURES

One of the lessons learned from the managed care programs of the 1980s is that we need to measure, report and reward quality care as well as improved utilization. There has been a gradual progression in the parameters we choose to measure this. HEDIS measures have been developed for this purpose. Initially, they rewarded providers for processes such as measuring HgbA1c. When feasible, these have been replaced with outcomes measures such as achieving a HgbA1c below a particular target. Often this is hampered by current coding issues that don't allow one to collect this information from encounter data. Some parameters have also been chosen to counter and detect any inappropriate underutilization of services. A good example is a pay-for-performance measure that requires at least one face-to-face encounter with each member of a certain age group. In an attempt to correct for population difference, Medicaid specific benchmarks have been determined.

As we migrate from mere quality to value, we should try to choose measures that impact cost as well as quality. Although it is true that provision of mammograms and Pap smears is a value measure in that it ultimately results in cost savings by reducing the chance for advanced malignancy years down the road, there are also measures that can be chosen that can achieve short term cost savings as well as improved quality of care. For example, reduction in 30 day re- hospitalization rates, hospitalization for ambulatory sensitive conditions or emergency room visits for conditions that can be dealt with in the PCP's office are quality measures that result in immediate savings.

Under capitation, MCOs already have a reason to add value measures to the typical HEDIS measures that HFS hold them accountable for. Now that DHFS is adding a shared savings model (CCEs), it also has a financial interest in adding measures that are more value based. Ideally, the incentive program should be structured to encourage providers to invest at least a portion of shared savings into activities that will generate additional value. Shared savings that result from improved utilization under CCEs will only be earned by meeting certain quality parameters. This is the opportunity to design quality parameters that will drive savings. It is also important to recognize that providers will have to invest resources to achieve shared savings. Many safety net providers do not have a cash flow position that allows them to spend dollars now in the hope of achieving shared savings a year later. Pay for performance programs (P4P) can provide more timely reimbursement. Although these will ultimately need to be funded from shared savings, DHFS will need to "prime the pump" by paying these incentives from day one. Since both DHFS and the provider will share in the savings that result from P4P programs, their cost should be paid off the top before shared savings are distributed.

Medical Home Network (MHN) has applied the principles above by designing both P4P and shared savings incentives. Although it may seem like a step back to rewarding process rather than outcome, their P4P program rewards processes that will generate short term savings and then ties payment of those shared savings to other quality measures. Like CCEs, MHN utilizes the current DHFS fee-for-service reimbursement mechanism. Providers will receive an add-on to their fee-for-service payment when they:

1. See their members within 7 days of discharge from the emergency room
2. See their members within 7 days of discharge from the inpatient setting.
3. See a newly assigned IHC member within 90 days of enrollment
4. See newborns within 7 days of delivery

Once IT capability allows tracking, inpatient providers will also be paid for providing PCPs a completed discharge summary within 72 hours of discharge. EDs will be paid for providing completed discharge plans within 24 hours of an ED visit.

There are several general principles that MHN takes into consideration when choosing quality measures that will serve as criteria for access to shared savings:

a. Design for maximum provider participation by making parameters achievable and recognizing improvement as well as achieving ultimate targets

b. Don't unfairly reward those with historical poor performance; use standard benchmarks for similar patient populations

c. Adjust for patient population differences when appropriate and feasible

d. When possible, use parameters that can be measured from claims data

e. Choose a manageable number of parameters based on provider resource availability

f. Avoid an all or none approach by separately paying for each achieved parameter and allow plans to reward high performers even if the overall plan does not reach the goal

g. Make payments significant enough to motivate providers

h. Don't restrict reward to dollars; reward high quality plans by facilitating membership growth

i. Align incentives among provider types whenever possible; recognize that achieving some goals may be counter-intuitive (for example, savings from reduced hospitalizations hit predominantly hospital budgets but are best achieved with cooperation from the hospital) and so financial reward should be distributed not only proportionate to those chiefly responsible for savings but also proportionate to which partner voluntarily gives up the most revenue to achieve overall savings.

j. Focus on population health that recognizes it often takes more effort to go from 85% to 90% compliance than it takes to go from 50 to 65% compliance and reward accordingly

k. Choose parameters that will generate both short and long term savings as well as improved quality; choose some parameters that detect under-utilization

l. Encourage reinvestment of savings into additional parameters by making it financially attractive to do so

m. Don't let incentive structure detract from achieving more general and important goals

n. Be sure payments get to the level of the decision maker, not just the organization he works for

o. Avoid rewarding those who merely hit the target by chance

p. Give regular provider feedback on performance

q. Provide timely and actionable data to providers so their targets are clearly defined and results achievable

r. Be transparent enough to promote healthy competitiveness without embarrassing anyone

s. Create a spirit of cooperation, reminding each that the ultimate goal is to improve the care of the entire population; share best practices

t. When possible, adjust for severity of illness so that providers are rewarded for good management of complex patients, not for cherry picking to avoid them

The following are the HEDIS measures and their mean values for the adult Medicaid population nationally followed by the measures that make up the CMS Star Rating Methodology. There is always the tension of only choosing measures that can be determined by encounter data vs. outcome measures that are more resource intensive to collect. The challenge will be to choose a limited number of quality/value metrics that are relevant to a sizeable part of the population, clinically important for this population, and reasonably easy to measure (i.e., do not involve complex data capture issues that will burn resources).

HEDIS EFFECTIVENESS OF CARE MEASURES

NATIONAL HMO Means—2009

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Safety and Potential Waste			
Imaging Studies for Low Back Pain	73.9	N/A	76.1
Avoiding Antibiotics in Adults: Acute Bronchitis	24.0	N/A	25.6
All Cause Readmission rate	new 2011	new 2011	N/A
Wellness and Prevention			
Adult Body Mass Index Assessment	41.3	38.8	34.6
Smoking Cessation			
Advising Smokers to Quit	79.5	77.9	74.3
Discussion of Smoking Cessation Strategies	50.0	N/A	38.8
Discussion of Smoking Cessation Medications	53.3	N/A	43.4
Flu Shots for Adults	51.3	64.5	N/A
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	93.1	N/A	83.4
Postpartum Visit Between 21 and 56 Days After Delivery	83.6	N/A	64.1
Breast Cancer Screening	71.3	69.3	52.4
Cervical Cancer Screening	77.3	N/A	65.8
Colorectal Cancer Screening	60.7	54.9	N/A
Chlamydia Screening—16–20 Years	41.0	N/A	54.4
Chlamydia Screening—21–24 Years	45.4	N/A	61.6
Chlamydia Screening—Total Rate	43.1	N/A	56.7

Chronic Disease Management

Persistence of Beta-Blocker Treatment After a Heart Attack	74.4	82.6	76.6

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Comprehensive Diabetes Care			
Blood Pressure Control (<130/80 mm Hg)	33.9	33.3	32.2
Blood Pressure Control (<140/90 mm Hg)	65.1	60.5	59.8
Eye Exams	56.5	63.5	52.7
HbA1c Screening	89.2	89.6	80.6
Good Glycemic Control			
(HbA1c <7% for a Selected Population)	42.1	N/A	33.9
(HbA1c <8%)	61.6	63.7	45.7
Poor Glycemic Control (HbA1c >9%)*	28.2	28.0	44.9
LDL Cholesterol Screening	85.0	87.3	74.2
LDL Cholesterol Control (<100 mg/dL)	47.0	50.0	33.5
Medical Attention for Nephropathy	82.9	88.6	76.9
Controlling High Blood Pressure	64.1	59.8	55.3
Cholesterol Management for Patients With Cardiovascular Conditions—			
LDL Cholesterol Screening	88.4	88.4	80.7
Cholesterol Management for Patients With Cardiovascular Conditions—			
LDL Control (<100 mg/dL)	59.2	55.7	41.2
Disease Modifying Anti-Rheumatic Drug Drug Therapy in Rheumatoid Arthritis	86.4	72.3	70.5

Use of Appropriate Medications for				
People with Asthma -	age 12-50 Years	91.4	N/A	86.0
	Overall rate	92.7	N/A	88.6
MEASURE		COMMERCIAL	MEDICARE	MEDICAID
Use of Spirometry Testing in the Assessment		38.8	28.5	28.6
and Diagnosis of COPD				
Pharmacotherapy Management of COPD				
Bronchodilaters		78.0	76.2	80.7
Systemic Corticosteroids		66.1	60.9	61.8
Annual Monitoring for Patients				
on Persistent Medications				
ACE inhibitors or ARBs		80.8	89.6	85.9
Anticonvulsants		62.0	69.7	68.7
Digoxin		83.6	92.0	88.9
Diuretics		80.4	89.8	85.4
Combined		80.3	89.2	83.2
Antidepressant Medication Management				
Acute Phase		62.9	63.7	49.6
Continuation Phase		46.2	50.6	33.0
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days Post-Discharge		58.7	37.3	42.9
Within 30 Days Post-Discharge		76.8	54.8	60.2
Alcohol and Other Drug Dependence Treatment				
Engagement		16.1	4.6	12.3
Initiation		42.7	46.2	44.3

Consumer and patient engagement and experience

The CAHPS 4.0 survey measures members' experiences with their health care in areas such as claims processing and getting needed care quickly, and asks them to rate their health plan on a scale of 1–10.

Medicare Health Outcomes Survey (HOS) measures evaluate the physical and mental health of seniors enrolled in Medicare through a patient-based self-report of health status as a measure of quality of care.

Relative Resource Use

Resource use measures compare health plans' use of services—such as medications, outpatient visits, inpatient care, imaging and surgery—for patients with a given condition. Use of these services by all plans is averaged and risk-adjusted to create an "expected" resource use rate. NCQA then calculates an index showing the ratio of each plan's actual reported resource use to the risk-adjusted rate for the average plan. Plans that use more expensive services, such as inpatient hospital care, have higher actual-to-expected ratios than plans that use medications, outpatient care and other methods to manage conditions less expensively and more effectively. Evaluating resource use in tandem with quality measures for the same condition reveals that some plans deliver higher quality more efficiently than others, such as by avoiding hospital admissions and unneeded surgeries

Health plans report case mix-adjusted measures of resource use related to five chronic illnesses:

Asthma

Cardiovascular conditions

COPD

Diabetes

Hypertension

These measures incorporate cost and service frequency for each eligible member during the measurement year. All services administered to members identified with one of these conditions are attributed to the RRU measure for that condition. Each of the five RRU measures summarizes a health plan's utilization of several service categories:

• Inpatient Facility

• Evaluation and Management (E&M—Inpatient and Outpatient)

• Procedure and Surgery (Inpatient and Outpatient)

• Ambulatory Pharmacy Services

NCQA calculates two observed-to-expected (O/E) ratios for each health plan, one for quality and one for resource use. An O/E ratio is a plan's actual quality level or resource use (the observed"), divided by an

estimate of the quality level or resource use the plan would have if its population was the same as the average population of all other plans submitting data to NCQA (the "expected"). To enable comparison within plan types (HMO or PPO), NCQA indexes O/E ratios by dividing each plan's ratio by the national average O/E for all HMOs or PPOs. For the resource use index, shown as the horizontal axis on RRU scatter plots, a ratio of 1.00 represents the average resource utilization for all HMOs or PPOs nationally. A ratio greater than 1.00 represents higher-than-expected use; a ratio less than 1.00 represents lower-than-expected use. For the quality index, otherwise known as the Effectiveness of Care ratio and shown as the vertical axis on RRU scatter plots, a ratio greater than 1.00 represents better-than-expected performance; a ratio less than 1.00 represents lower-than-expected performance. For example, a PPO with a ratio of 1.12 for quality and 1.15 for resource use delivered quality that was 12 percent better than the average PPO serving similar patients and used 15 percent more resources than the PPO average.

Descriptive statistics are provided for composites with up to 10 indicators. With the exception of the COPD quality RRU composite, the summary statistics for composite measures are the simple, unweighted average of all measures and indicators in the composite. Since 2 of the 3 COPD indicators describe the same dimension of care (Pharmacotherapy Management), each indicator receives a weight of one-half.

Medicare-Medicaid Dual Eligibles

Medicare Advantage plans with higher quality scores (based on a star rating system) will receive higher payments. Plans will also share the savings from providing more efficient care, in the form of lower cost sharing or additional benefits.

CMS Star Rating Methodology

Current Part C Measures

HEDIS

- Adult Access to Primary Care
- Anti-Rheumatic Drug for RA
- Breast Cancer Screening
- Cholesterol – CDC
- Cholesterol – CMC
- Colorectal Cancer Screening
- **Controlling Blood Pressure**
- Diabetes – Eye Exam
- **Diabetes – LDL-C < 100**
- Diabetes – Nephropathy
- **Diabetes – Blood Sugar Control**
- Glaucoma Screening
- Osteoporosis Management
- All Cause Readmissions*
- Adult BMI Assessment*
- COA[1] – Medication Review*
- COA[1] – Functional Status Assessment*
- COA[1] – Pain Screening*

CMS

- Complaints Tracking Module
- Corrective Action Plans
- Call Center – Foreign Language, TTY/TDD
- Voluntary Disenrollment *

CAHPS

- Annual Flu Vaccine
- Pneumonia Vaccine
- Getting Needed Care without Delays
- Getting Appointments and Care Quickly
- Customer Service
- Overall Rating of Healthcare Quality
- Overall Rating of Plan

HOS

- **Improving or Maintaining Physical Health**
- **Improving or Maintaining Mental Health**
- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

IRE

- Timely Decisions about Appeals
- Reviewing Appeals Decisions

Part C Summary

- 36 Measures
- 5 at 3x weighting
- 12 at 1.5x weighting
- 19 at 1x weighting

Notes:
*New Measure for Bonus Year 2013
1) Care of Older Adults (COA)

Legend
- 1x Weighted Measures
- 1.5x Weighted Measures
- **3x Weighted Measures**

CMS Star Rating Methodology

Current Part D Measures

CMS
- Call Center – Pharmacy Hold Time
- Call Center – Foreign Language, TTY/TDD
- Drug Plan Provides Accurate Info for Plan Finder Website
- Enrollment Timeliness*

CAHPS
- Getting Information from Drug Plan
- Members' Overall Rating of Drug Plan
- Members' Ability to Get Prescriptions Filled Easily

IRE
- Appeals Auto-Forward
- Appeals Upheld

Patient Safety / Pharmacy Related
- **High Risk Meds**
- **Blood Pressure Medications for Diabetics**
- **Medication Adherence for Oral Diabetes Medication***
- **Medication Adherence for Hypertension (ACEI or ARB)***
- **Medication Adherence for Cholesterol (Statins)***

Part D Summary
- 14 Measures
- 5 at 3x weighting
- 7 at 1.5x weighting
- 2 at 1x weighting

Legend
- 1x Weighted Measures
- 1.5x Weighted Measures
- **3x Weighted Measures**

Notes:
*New Measure for Bonus Year 2013

* Change in technical specs from previous

Table 1 - ICP Performance Measures

#	Performance Measure	Specification Source	Quality Monitoring	P4P	Yrl	Yr2	Yr3
1	**Behavioral Health Risk Assessment and Follow-up**						
	1) Behavioral Screening/ Assessment within 60 days of enrollment	State	X				
	2) Behavior Health follow-up within 30 days of screening	State	X				
2	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**	HEDIS®	X				
3	**Follow-Up with a Provider within 30 Days After an Initial Behavioral Health Diagnosis**	State	X	X	X	X	X
4	**Follow-Up After Hospitalization for Mental Illness (FUH)**						
	Follow-up in 7 days	HEDIS®	X				
	Follow-up in 30 days	HEDIS®	X	X	X	X	X
5	**Care Coordination - Influenza Immunization Rate**	State	X				
6	**Annual Dental Visit**						
	Annual Dental Visit -All	State	X				
	Annual Dental Visit-DD only	State	X	X	X	X	X
7	**Dental ER Visit**	State	X				
8	**Comprehensive Diabetes Care (CDC) (Measure 8A-8C): Meet two Measures out of Measures 8A-8C**						
	A) HbA1 c testing 1 x per year	HEDIS®	X	X	X	X	X
	B) Microalbuminuria testing 1 X per year	HEDIS®	X	X	X	X	X
	C) Cholesterol testing 1X per year	HEDIS®	X	X	X	X	X
	DD Waiver Program Support -Services for Enrollees in DD Waiver and Enrollees with DD Diagnostic History - HbAI c testing 1x per year	HEDIS®	X				
	Comprehensive Diabetes Care Administrative Method (Measure 8D-8E): Meet one Measure out of Measures 8D and 8E						
	D) Statin Therapy 80% of the time	State	X	X	X	X	X
	E) ACE/ARB 80% of the time	State	X	X	X	X	X
9	**Congestive Heart Failure (Measure 9A-9C): Meet two Measures out of Measures 9A-9C**						
	A) ACE/ARB 80% of the time	State	X	X	X	X	X
	B) Beta Blocker 80% of the time	State	X	X	X	X	X
	C) Diuretic 80% of the time	State	X	X	X	X	X
10	**Coronary Artery Disease (Measure 10A-10C): Meet two measures out of Measures 10A-10D**						
	A) Cholesterol testing 1X per year	State	X	X	X	X	X
	B) Statin Therapy 80% of the time	State	X	X	X	X	X
	C) ACE/ARB 80% of the time	State	X	X	X	X	X
	D) Persistence of Beta Blocker Treatment After Heart Attack (PBH)	HEDIS®	X	X	X	X	X

11	**Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (PCE) (Measure 11A-11B): Meet two Measures out of Measures 11 A-11C**						
	A) Acute COPD Exacerbation w/corticosteroid	HEDIS®	**X**	**X**	**X**	**X**	**X**
	B) History of hospitalizations for COPD with a bronchiodilator medications	HEDIS®	**X**	**X**	**X**	**X**	**X**
	C) Use of Spirometry Testing in the Assessment and Diagnosis of COPD(SPR)	HEDIS®	**X**	**X**	**X**	**X**	**X**

#	Performance Measure	Specification Source	Quality Monitoring	P4P	Yrl	Yr2	Yr3
12	**Ambulatory Care (AMB)**	**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**				
13	**Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department (ED) Visit**	**State**	**X**	**X**	**X**	**X**	**X**
14	**Inpatient Utilization- General Hospital/ Acute Care (IPU)**	**HEDIS®**	**X**				
15	**Mental Health Utilization (MPT)**	**HEDIS®**	**X**				
16	**Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge**	**State**	**X**	**X**	**X**	**X**	**X**
17	**A) Inpatient Hospital 30-Day Readmission Rate**	**State**	**X**				
	B) Inpatient Mental Hospital 30-Day Readmission Rate	**State**	**X**				
18	**Long Term Care Urinary Tract Infection Admission Rate**	**State**	**X**				
19	**Long Term Care Bacterial Pneumonia Admission Rate**	**State**	**X**				
20	**Prevalence of Pressure Ulcers**	**State**	**X**	**X**			**X**
21	**Annual Monitoring for Patients on Persistent Medications (MPM)**	**HEDIS®**	**X**				
22 & 23	**Antidepressant Medication Management (AMM)**	**HEDIS®**	**X**	**X**	**X**	**X**	**X**
24	**Medication Monitoring for Patients with Schizophrenia**	**State**	**X**				
25	**Colorectal Cancer Screening (COL)**	**HEDIS®**	**X**				
26	**Breast Cancer Screening (BCS)**	**HEDIS®**	**X**				
27	**Cervical Cancer Screening (CCS) (Administrative Method Only)**	**HEDIS®**	**X**				
28	**Adult BMI Assessment (ABA) (Administrative Method Only)**	**HEDIS®**	**X**				
29	**Access to Member's Assigned PCP**	**State**	**X**	**X**	**X**	**X**	**X**
30 & 31	**Retention Rate for Long Term Care (LTC) and DD Enrollees Served in the Community**	**State**	**X**	**X**		**X**	**X**

Baselines for Year 1 Pay for Performance Measures

Measure#	Name	Numerator Desc	Numerator	Denominator Desc	Denominator	Percentage	
03	Follow Up with Mental Health Provider within 30 Days After Initial Behavioral Health Diagnosis	Followup with provider within 30 days of Initial BHD	1,550	Eligible Population	3,073	50.44%	
04	Follow-Up After Hospitalization for Mental Illness	Follow up within 7 days	608	Eligible Population	1,267	47.99%	
		Follow up within 30 days	823	Eligible Population	1,267	64.96%	
06	Annual Dental Visit	Age 19-20; Dental Visit during the measurement year	190	Eligible Population	743	25.57%	
		Age 21 and older; Dental Visit during the measurement year	7,158	Eligible Population	31,436	22.77%	
		All ages; Dental Visit during the measurement year	7,348	Eligible Population	32,179	22.83%	
		DD only: Age 19-20; Dental Visit during the measurement year	186	Eligible DD Population	595	31.26%	
		DD only: Age 21 and older; Dental Visit during the measurement year	1,760	Eligible DD Population	6,740	26.11%	
		DD only: All ages; Dental Visit during the measurement year	1,946	Eligible DD Population	7,335	26.53%	
8A-C	Comprehensive Diabetes Care	Hemoglobin (HbA1c) Testing	4,859	Members 18-75 with Diabetes	6,347	76.56%	
		DD Only: Hemoglobin (HbA1c) Testing	321	DD only: Members 18-75 with Diabetes	462	69.48%	
		Nephropathy	4,768	Members 18-75 with Diabetes	6,347	75.12%	
		LDL-C screening	4,758	Members 18-75 with Diabetes	6,347	74.96%	
8D-E	Comprehensive Diabetes Care Admin Method	Statin Therapy (80% of Eligible days)	2,750	Members 18-75 with Diabetes	6,137	44.81%	
		ACE/ARB Therapy (80% of Eligible days)	2,729	Members 18-75 with Diabetes	6,342	43.03%	

Measure#	Name	Numerator Desc	Numerator	Denominator Desc	Denominator	Percentage	
9A-C	Congestive Heart Failure	ACE/ARB Therapy (80% of Eligible days)	1,322	Members 19 and older with CHF	3,640	36.32%	
		Beta Blocker (80% of eligible days)	580	Members 19 and older with CHF	1,669	34.75%	
		Diuretic (80% of eligible days)	1,357	Members 19 and older with CHF	3,612	37.57%	
10A-C	Coronary Artery Disease	Cholesteral Testing during measurement year	2,881	Members 19 and older with CAD	3,828	75.26%	
		Received Statin 80% of enrolled time	1,352	Members 19 and older with CAD	3,646	37.08%	
		Received ACE/ARB 80% of enrolled time	1,117	Members 19 and older with CAD	3,735	29.91%	
10D	Persistence of Beta-blocker Treatment After a Heart Attack	Persistant Beta Blocker treatment	11	Discharged alive/AMI diagnosis	21	52.38%	
11A-B	Pharmacotherapy Management of COPD Exacerbation	Dispensed a system corticosteroid within 14 days	331	Acute inpatient discharges and ED visits for COPD	520	63.65%	
		Dispensed a bronchodilator within 30 days	408	Acute inpatient discharges and ED visits for COPD	520	78.46%	
11C	Use of Spiromotry Testing in the Assessment and Diagnosis of COPD	Newly diagnosed COPD who received Spirometry testing	63	Eligible Population with newly diagnosed COPD	212	29.72%	
12	Ambulatory Care	Outpatient Visits	29,583	Member months	371,793	79.57	**Rate per 1000
		DD only: Outpatient Visits	5,518	DD only: member months	66,850	82.54	**Rate per 1000
		ED Visits	12,050	Member months	371,793	32.41	**Rate per 1000
		DD only: ED Visits	2,448	DD only: member months	66,850	36.62	**Rate per 1000
13	Amulatory 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	8,302	ED visits for Eligible Population	21,040	39.46%	
16	Amulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge	Ambulatory Care visit with a Provider within 14 days of Inpatient Discharge	3,019	Inpatient Discharges for Eligible Population	6,361	47.46%	
20	Prevalence of Pressure Ulcers	ON HOLD	0		0		

Measure#	Name	Numerator Desc	Numerator	Denominator Desc	Denominator	Percentage	
22 - 23	Antidepressant Medication Management	Efffective Acute Phase Treatment (at least 84 days)	83	Eligible Population newly diagnosed with depression	178	46.63%	
		Efffective Continuation Phase Treatment (at least 180 days)	61	Eligible Population newly diagnosed with depression	178	34.27%	
29	Access to member's Assigned PCP	Ambulatory or Preventive Care visit with PCP	12,723	Eligible Population (who had a PCP in meas. year)	14,488	87.82%	