HealthChoice Illinois
Illinois Department of Healthcare and Family Services

HFS
Illinois Department of Healthcare and Family Services

Division of Medical Programs

2024 – 2027

Comprehensive Medical Programs

Quality Strategy

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Contents

Contents i

Section 1. Quality Framework 1

Section 2. Introduction 5

Section 3. Quality of Care 26

Section 4. Monitoring and Compliance 50

Section 5. External Quality Review Arrangements 63

Section 6. Improvement and Interventions 66

Section 7. Conclusions 74

Appendix A. List of Acronyms

Appendix B. Enrollment

Appendix C. State Directed Payments

Appendix D. Pay-for-Performance and Pay-for-Reporting Measures

Section 1. Quality Framework

Vision

We Improve Lives

- We address social and structural determinants of health.[1]
- We empower customers to maximize their health and well-being.
- We provide consistent, responsive service to our colleagues and customers.
- We make equity the foundation of everything we do.

Purpose

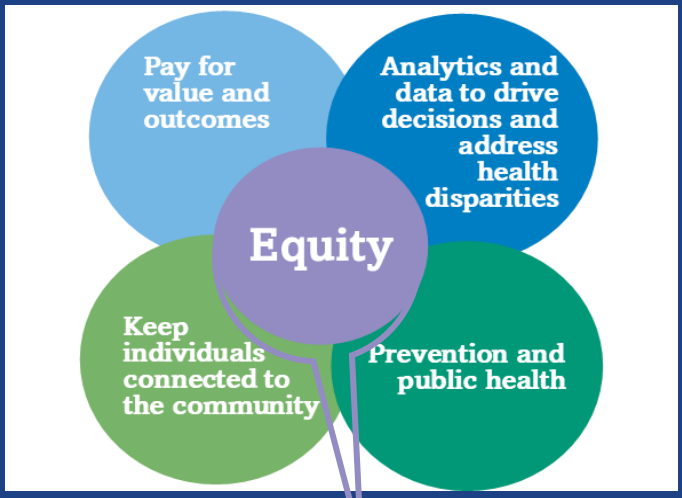
The Illinois Department of Healthcare and Family Services (HFS) developed a transformative person-centered, integrated, equitable *Comprehensive Medical Programs Quality Strategy* (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level. The Quality Strategy provides a framework to accomplish HFS' mission.

Mission

HFS is committed to improving lives by addressing social and structural determinants of health, by empowering customers to maximize their health and well-being, and by maintaining the highest standards of program integrity on behalf of Illinoisans. HFS is committed to making equity the foundation of quality improvement. We work together to help Illinoisans access high quality health care and fulfill child support obligations to advance their physical, mental, and financial well-being.[2]

Objectives

HFS' Quality Strategy puts a strong focus on equity, prevention, and public health; pays for value and outcomes rather than volume and services; proactively uses analytics and data to drive decisions and address health disparities; and works to move individuals from institutions to the community in an effort to keep individuals in the least restrictive environment and to keep them more closely connected with families and communities.



Health Equity

As the framework demonstrates, HFS is committed to making equity the foundation of everything it does. HFS defines equity as providing every employee, individual, community, or population what is needed to succeed, so everyone can reach their full potential by examining differences in outcomes for various populations and working to mitigate negative impacts.

[1] Illinois Department of Healthcare and Family Services. *Our Mission, Vision, and Values*. Available at: https://hfs.illinois.gov/about.html. Accessed on: June 10, 2024.
[2] Ibid.

Vision for Improvement

The vision for improvement and goals and objectives are inclusive of the populations served by Medicaid, including maternal and infant health, consumers with behavioral health needs, consumers with chronic conditions, and healthy children and adults with a central focus on health equity.

The Quality Strategy framework includes five pillars of improvement: Adult Behavioral Health, Child Behavioral Health, Maternal and Child Health, Equity, and Improving Community and Health Promotion. To support health equity and HFS' mission, HFS strives to drive progress in the five pillars of improvement.

Goals

HFS has identified six goals that fall within the five pillars. HFS prioritizes equity across all goals by analyzing data to strategically pinpoint improvement needs and efforts.

Pillar: Adult Behavioral Health

1. Improve the health outcomes and management of behavioral health services and supports for adults.

Pillar: Child Behavioral Health

2. Improve the health outcomes and management of behavioral health services and supports for children.

Pillar: Maternal and Child Health

3. Improve the health outcomes of birthing persons, babies, and children.

Pillar: Equity

4. Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.

Pillar: Community and Health Promotion

5. Provide person-centered services and supports to ensure care is delivered in the least restrictive care setting.
6. Promote whole person wellness, preventive care, and management of chronic conditions.

Objectives

To drive progress in the five pillars of improvement, HFS selected specific measures as program objectives. These selected measures are comprised of a subset of all performance measures collected and assessed overall,[3] and represent priority areas. To align and focus improvement efforts, HFS has identified SMART (Specific, Measurable, Attainable, Realistic, and Trackable) objectives for all of its goals.

Objective		Quality Measure	Statewide Performance Baseline (2021)	Statewide Performance Target (2026)
Goal 1: Improve the health outcomes and management of behavioral health services and supports for adults.				
1.1	Adults receiving hospital services for select mental illnesses receive follow-up visits within 30 days.	*Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up (Ages 18+)*	41.34%	43.41%
1.2	Opioid use disorder (OUD) pharmacotherapy treatment events among members ages 16 years and older continue for at least 180 days.	*Use of Pharmacotherapy for OUD*	22.04%	23.14%
Goal 2: Improve the health outcomes and management of behavioral health services and supports for children.				
2.1	Children receiving hospital services for select mental illnesses receive follow-up visits within 30 days.	*FUH—30-Day Follow-Up (Ages 13–17)*	69.08%	72.53%
Goal 3: Improve the health outcomes of birthing persons, babies, and children.				
3.1	Women have a prenatal care visit in the first trimester.	*Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*	86.10%	90.41%
3.2	Women have a postpartum care visit within 12 weeks of delivery.	*PPC—Timeliness of Postpartum Care*	78.96%	82.91%
3.3	Children receive two or more primary care visits between 15–30 months of age.	*Child and Adolescent Well-Care Visits—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits (W30)*	60.48%	63.50%
3.4	Children and adolescents receive a well-care visit at least once per year.	*Child and Adolescent Well-Care Visits (WCV)*	51.60%	54.18%

[3] HFS also requires health plans to submit results for a variety of quality measures in order to assess performance, as displayed in the Quality Metrics and Performance Targets section of this report.

Objective		Quality Measure	Statewide Performance Baseline (2021)	Statewide Performance Target (2026)
Goal 4: Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.				
4.1	Adults with hypertension have adequately controlled blood pressure.	*Controlling High Blood Pressure*	50.03%	52.53%
4.2	Adults receive an ambulatory or preventive care visit at least once per year.	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*	73.27%	76.93%
Goal 5: Provide person-centered services and supports to ensure care is delivered in the least restrictive care setting.				
5.1	After a long-term stay in a facility, residents are successfully transitioned to a community residence.	*Long-Term Services and Supports (LTSS)—Successful Transition after Long-Term Facility Stay*	14.84%	15.58%
Goal 6: Promote whole person wellness, preventive care, and management of chronic conditions.				
6.1	Adults with diabetes demonstrate hemoglobin A1c (HbA1c) levels of less than 8.0%.	*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*	40.98%	43.03%
6.2	Adults receive an ambulatory or preventive care visit at least once per year.	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*	73.27%	76.93%

Section 2. Introduction

Scope

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

The Quality Strategy is designed to foster the delivery of the highest-quality, most cost-effective services possible by establishing a framework for ongoing assessment and the identification of potential opportunities for healthcare coordination and improvement. See Section 1 for further details. The Quality Strategy is focused on enhancing Illinois' healthcare delivery system to address root causes of health disparities by focusing on health-related social needs (HRSN) to address structural inequities including housing insecurity, food insecurity, and violence in tangible ways that will improve health outcomes.

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

Transforming Medicaid in Illinois

The State of Illinois has articulated an ambitious vision of an equitable, sustainable healthcare delivery system and has launched several initiatives designed to cultivate such a system. This section describes initiatives aimed at transforming the managed care system to create sustainable, person-centered, integrated, equitable change that reimagines healthcare delivery at the community level.

Behavioral Health

Certified Community Behavioral Health Clinics (CCBHCs): HFS submitted an application on March 20, 2024, to the Substance Abuse and Mental Health Services Administration to participate in the federal Demonstration initiative to implement CCBHCs. HFS was informed on June 3, 2024, that Illinois was selected as one of the first cohorts of 10 new states added to the CCBHC Demonstration Program. Illinois has completed all reviews of prospective CCBHCs and has provisionally certified 19 sites to participate in Demonstration year one (DY1). HFS continues to work with sister agencies and other stakeholders on policy guidance for CCBHCs. Monthly operations meetings will continue through DY1, and one-on-one technical assistance meetings will be provided to the 19 provisionally certified sites. CCBHCs are operational and providing services as of October 1, 2024. Beginning in the second quarter of Fiscal Year 2025, HFS will begin hosting learning collaboratives for prospective CCBHC sites for DY2. DY2 begins October 1, 2025.[4]

[4] Illinois Department of Healthcare and Family Services. *Medical Providers: Certified Community Behavioral Health Clinic (CCBHC) Initiative*. Available at: Certified Community Behavioral Health Clinic (CCBHC) Initiative | HFS (illinois.gov). Accessed on: Dec 4, 2024.

Behavioral Health Clinics: Illinois continues to expand the State's provider network of behavioral health clinics (BHCs) under HFS' administrative rule 89 Illinois Administrative Code 140. HFS utilizes the services of the Medicaid Technical Assistance Center with the Office of Medicaid Innovation to perform desk and on-site certification reviews for both prospective and current BHCs. Furthermore, under the American Rescue Plan Act of 2021 section 9817, HFS released a Notice of Funding Opportunity (NOFO), new behavioral health clinic/community mental health center (CMHC) for underserved areas, targeting providers who were interested in one or more of the following opportunities: (1) opening new BHC or new CMHC sites in underserved areas of the State and (2) existing CMHC or BHC sites that want to expand the Medicaid community-based behavioral services. The initiative included $25 million of total available funding and will significantly help continue to expand the service provision among current BHCs and continue to expand the number of BHCs within Illinois.[5]

Pathways to Success: HFS has implemented the Pathways to Success program, which is an enhanced service delivery model comprised of intensive supports for Medicaid customers under the age of 21 who have complex behavioral health needs. Pathways to Success is comprised of two tiers of care coordination, high-fidelity wraparound and intensive care coordination, that are founded upon the philosophies and values of wraparound. The program also offers an array of home- and community-based services of intensive family peer support, therapeutic mentoring, respite, individual support, and therapeutic support services. Together, these services offer a coordinated system of care for customers engaged in the program. Referrals to Pathways to Success began in December 2022 and, to date, nearly 5,500 youth have been referred to the program, with 1,500 actively receiving services.[6]

Healthcare Transformation Collaboratives (HTCs)

Healthcare Transformation Collaboratives (HTCs)[7] are designed to build a healthcare system that achieves and maintains equity and encourages collaborations of healthcare providers and community partners to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities throughout Illinois. HTCs focus on HRSN and seek to address disparities by increasing access to preventive, primary care, and specialty care services through their collaborations with healthcare systems and community-based organizations. Each HTC has its own transformation focus. The following is a list of focus areas among the Round 1 HTCs:

- Increase access to specialty care and services that address HRSNs.
- Increase access to community-based behavioral health care with focus on those with chronic mental illness or substance use disorder (SUD).
- Deploy community health workers to connect people with holistic services, develop a culturally competent workforce, deflect people with behavioral health conditions from the criminal justice system, and increase access to culturally responsive care.

[5] Illinois Department of Healthcare and Family Services. *Illinois CCBHC FAQs and Webinars*. Available at: Illinois CCBHC FAQs and Webinars (illinois.gov). Accessed on: May 15, 2024.

[6] Illinois Department of Healthcare and Family Services. *Behavioral Health Providers.* Available at: Pathways to Success (illinois.gov). Accessed on May 15, 2024.

[7] Illinois Department of Healthcare and Family Services. *Healthcare Transformation Collaboratives*. Available at: https://hfs.illinois.gov/healthcaretransformation.html. Accessed on: June 10, 2024.

- Deploy integrated services coordinators to screen and engage people to holistic medical, behavioral health and social services; leverage telehealth to increase access in rural communities.
- Increase access to dental care, use telehealth to increase access to specialty care, and build HRSN service capacity.
- Assist people who are released from carceral settings with access to housing, employment, behavioral health services, and other supports to help reentry into communities.
- Increase access to specialty care and services that address HRSNs, develop a culturally competent workforce, and address primary care service gaps.
- Increase access to specialty care and advanced diagnostic services.

Healthcare Transformation (1115) Waiver Revisions

In June 2023, Illinois submitted a request to extend and amend its current Behavioral Health Transformation Section 1115 Demonstration waiver (Project No: 11-W-00316/5). The renamed Illinois Healthcare Transformation Section 1115 Demonstration request, approved in July 2024, includes the following additional services and supports to address HRSNs:[8]

- Housing Supports including pre-tenancy and tenancy sustaining services for individuals and families experiencing or at risk of homelessness.
- Medical Respite for those experiencing or at risk of homelessness to avoid or step down from higher levels of care.
- Justice-Involved Community Reintegration to connect adults and youth with vital services and supports in the months preceding release from incarceration.
- Community Reintegration for individuals transitioning to the community from institutional settings such as nursing facilities.
- Violence Prevention and Intervention services including home visiting and dyadic therapy for individuals and families impacted by violence as well as those at risk of experiencing violence.
- Employment Assistance for adults with disabilities, behavioral health conditions, and/or very low income.
- Food and Nutrition Services such as case management, nutrition education, and medically tailored meals for people who are food insecure.
- Non-Medical Transportation to empower individuals to engage with resources and supports in their communities.
- SUD Case Management for individuals with SUD who qualify for diversion into treatment from the criminal justice system.
- SUD Services in Institutions for Mental Diseases for short-term residential and inpatient treatment.

Maternal Health

Expanded Coverage for Reproductive Healthcare: Additionally, the Department and Administration have worked to maintain and expand coverage for reproductive healthcare. In November 2022, the Department implemented a new partial benefit Medicaid eligibility group for broad coverage of family planning and family planning-related services. The Department is working closely with the Illinois Department of Public Health (IDPH) to maximize coverage of family planning services between the HFS Family Planning Program and the IDPH Title X Illinois Family Planning Program. The Department also now allows pharmacists to be reimbursed for contraceptive counseling under the medical assistance program. Additionally, HFS increased provider rates for abortion care and is collaborating with IDPH, Rush University Medical Center, and the University of Illinois at Chicago on the Complex Abortion Regional Line for Access (CARLA), a first in the nation program with provider-led nurse navigation services for medically complex pregnant people needing abortion care in hospitals. The Department also has submitted a 1115 waiver concept paper to the Centers for Medicare & Medicaid Services (CMS) proposing infrastructure grants for reproductive health providers and community-based organizations which, if approved, would infuse funding into Illinois' reproductive health system with a federal Medicaid match.

[8] Illinois Department of Healthcare and Family Services. *Illinois Healthcare Transformation: Section 1115 Demonstration Extension Overview.* Available at: 1115demonstrationoverview05122023.pdf (illinois.gov). Accessed on: May 15, 2024.

Expanded Postpartum Medicaid Coverage: Improving maternal health outcomes and reducing health disparities are priorities for HFS and the Administration. In 2021, Illinois became the first state in the nation to extend full benefit Medicaid coverage with continuous eligibility through 12 months postpartum, regardless of how the pregnancy ends. In addition, Illinois also became the first state to offer 12 months of full benefit Medicaid coverage with continuous eligibility regardless of immigration status. To build on those efforts, HFS has added two additional preventive postpartum visits (between 0–3 weeks and 4–12 weeks) in alignment with the American College of Obstetricians and Gynecologists (ACOG) recommendation. HFS also has increased obstetric (OB) reimbursement rates and funded HTCs focused on improving maternal health.

New Maternal Services and Providers: The Department is also working to add new provider types and covered services, including doulas, home visitors, lactation consultants, and certified professional midwives, and has been meeting with providers and stakeholders to inform implementation. HFS believes that adding doulas and other new provider types on a statewide level can improve outcomes by providing quality prenatal and postpartum care to HFS' customers and advancing health equity.

Money Follows the Person

To support the Department's LTSS initiatives and rebalancing efforts to transition Medicaid customers out of institutional settings, the Department applied the Money Follows the Person (MFP) Demonstration.

The purpose of the MFP Demonstration is to increase the use of home- and community-based services (HCBS) rather than institutional services and supports. The MFP Demonstration enables Medicaid-eligible customers to receive long term supports necessary to reside in settings of their choice. This means more customers will have the opportunity to transition from an institution to a community setting or to remain in the community longer avoiding/delaying an institutional admission.[9]

In March 2022, CMS announced a NOFO to expand the MFP Demonstration. States that were not currently participating in the MFP Demonstration were invited to apply for the NOFO. In May 2022, the Department applied for this opportunity. Approved applicants were eligible to receive a funding grant of up to $5 million to support the efforts of a 16-month Planning Phase.

In September 2022, CMS announced that Illinois was one of five states selected to receive a funding grant, and that Illinois received an award exceeding $4 million. In addition, certain expenditures are eligible for an enhanced Federal Medicaid Assistance Percentage (FMAP) match under the MFP Demonstration.

The purpose of the 16-month Planning Phase is to assess LTSS currently available, what and where need exists, and the ability to provide those services to eligible customers. HFS, in collaboration with the Illinois Department of Human Services (DHS), Illinois Department on Aging (DOA), the Illinois Department of Housing Development Authority (IHDA), advocates, potential participants, stakeholders, and other interested parties are currently in the process of analyzing the needs and resources that will be necessary for implementation. Furthermore, during this Planning Phase, the Department will seek to enhance quality improvement systems, develop a service provider network, expand workforce recruitment and retention strategies, and further refine transition services.

Also, during the Planning Phase, HFS will seek CMS approval of an operational protocol to carry out the objectives of the MFP Demonstration. Approval of this protocol will allow the Department to move into

[9] Illinois Department of Healthcare and Family Services. *MFP Home: Pathways to Community Living*. Available at: MFP Home | HFS (illinois.gov). Accessed on: May 16, 2024.

an Implementation Phase. The Implementation Phase will be the beginning of transitioning eligible customers and providing LTSS under the MFP Demonstration. In April 2024, CMS released HCBS Quality Measure Set reporting requirements for MFP Demonstration grant recipients. For the initial reporting period, MFP grant recipients are expected to report on a subset of mandatory measures. MFP grant recipients must report on the mandatory measures beginning in the fall of 2026 for the 2025 performance period, and bi-annually thereafter. To help support future efforts, the Department is eligible to receive additional grant funding of up to $5 million per year for the next four years to meet the objectives of the MFP Demonstration, which has received federal funding through 2027.

Nursing Facility Rate Reform

Each year, HFS spends billions of dollars on nursing facility care for approximately 45,000 Medicaid customers. Medicaid pays for approximately 60 percent of all nursing facility days in Illinois and is the largest payor of days in both this State and across the nation. Starting in 2020, HFS led an effort to reform the nursing facility rate methodology used by the Medicaid program to pay for these services. Guiding principles were developed at the beginning of the process, which included:

- A transparent data-driven approach with a sustained focus on completing the transition to Medicare's Patient-Driven Payment Model (PDPM) nursing component.
- Linking payment to performance and staffing levels.
- The need to incorporate lessons from the coronavirus disease 2019 (COVID-19) pandemic.

Adopting the PDPM to Improve Payment Accuracy

The nursing component of the PDPM case mix classification system was adopted as the basis for calculation of the direct care rate, replacing use of the Resource Utilization Group (RUG) methodology.[10] The PDPM will improve payment accuracy and appropriateness by focusing on the resident, rather than the volume of services provided. In addition, implementation of PDPM will stop the shift of unnecessary Medicaid payment for rehabilitation services, which are already funded separately by Medicare in most instances, toward residents with genuine Medicaid-financed needs.

Payment Incentives for Increased Staffing in Illinois Nursing Facilities

Based on data reviewed during the reform process, Illinois has consistently ranked last among states in staffing as measured using the national Staff Time and Resource Intensity Verification (STRIVE) Project target staffing levels. Medicaid days are concentrated in facilities with high levels of Medicaid-enrolled residents as well as facilities with low staffing. Indeed, the higher the level of Medicaid utilization in a facility, the greater the likelihood that the facility is staffed below STRIVE target staffing levels—often far below that target.[11]

[10] Department of Health and Human Services. Centers for Medicare & Medicaid Services. *CMCS Informational Bulletin: Nursing Facility Case-Mix Payment Changes.* Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib120618_170.pdf. Accessed on: May 16, 2024.

[11] Illinois Department of Healthcare and Family Services. *A Comprehensive Review of Nursing Home Payment with Recommendations for Reform: Report to the Illinois General Assembly in Accordance with Requirement in 305 ILCS 5/5-2.10*. Available at: https://www.ilga.gov/reports/ReportsSubmitted/2953RSGAEmail5599RSGAAttachHFS%20NF%20Final%20Report%20on%20Nursing%20Home%20Payment.pdf. Accessed on: May 16, 2024.

Certified nursing assistant (CNA) shortages are the greatest factor in staffing shortages in Illinois nursing homes and explain Illinois' last-place ranking on staffing nationally. Reducing CNA turnover is key to turning around staffing shortages, and this is most important in nursing homes with a high number of Medicaid patients.[12]

The reformed reimbursement system allocates the majority of new funding for provider incentives intended to increase staffing levels. Over $300 million annually is paid through a tiered per diem add-on rate that starts at $9 per day for providers at 70 percent of the STRIVE staffing target, with a top-level add-on of $38.68 for those at 125 percent of the STRIVE target.

Additionally, Illinois implemented a unique payment program that reimburses providers for the Medicaid portion of retention and promotion-based wage increments. Providers must establish wage scales paying at least an additional $1.50/hour during a CNA's second year and another $1/hour for each additional year of experience up to a maximum of +$6.50/hour. Promotion-based increases will be reimbursed at $1.50/hour and may be stacked on top of the experience wage.

Quality and Performance in Illinois Skilled Nursing Facilities (SNFs)—Rewarding Providers for Quality Care

An analysis of the federally published Care Compare website's 22 long- and short-stay quality measures showed that Illinois ranked in the bottom 20 states for nearly two-thirds of the measures, in the bottom 10 states for nine of the measures, and last for three.

Increased staffing is expected to improve quality, but to further incentivize nursing facilities providing safe and high-quality care, Illinois established a Quality Incentive Payment program that annually distributes $70 million based upon federally published Medicare Star ratings. Providers must receive at least a 2-Star rating to receive funding. As provider Long Stay Star ratings increase, they receive a higher proportion of the pooled funding.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is designed to offer comprehensive health services for seniors living in the community who would otherwise qualify to live in a nursing facility. PACE creates a new model of community-based, comprehensive care in Illinois that will give seniors an additional choice in how they access health care as needs change with age, allowing more seniors to continue living at home safely, for longer. PACE will put in place an integrated model of care that is specific to each senior, and this level of customization will improve health outcomes not just for the seniors who enroll, but for the overall community. Based on a market analysis, HFS developed five service regions for PACE: West Chicago, South Chicago, Southern Cook County, Peoria, and East St. Louis. Through a request for application process, three PACE organizations were operational as of July 2024 and two additional PACE organizations plan to become operational in 2025.[13]

[12] Eiselt R. Nursing staff shortages ongoing. Jacksonville Journal-Courier. October 21, 2021. Available at: https://www.myjournalcourier.com/insider/article/Nursing-staff-shortages-ongoing-16550002.php. Accessed on: June 10, 2024.

[13] Illinois Department of Healthcare and Family Services. Program of All-Inclusive Care for the Elderly (PACE). Available at: Program of All-Inclusive Care for the Elderly (PACE) | HFS (illinois.gov). Accessed on: May 17, 2024.

Strengthening the State's Commitment to Ending the HIV Epidemic

Executive Order 2019-08 outlined expectations for state agencies to work with stakeholders to address opportunities to end human immunodeficiency (HIV) and address health disparities. In response, an intergovernmental agreement between HFS and the IDPH was enacted to share HIV data. A new workgroup was formed to address HIV quality measure data sharing. The workgroup members include representatives from the two State agencies as well as advocate organizations and other stakeholders. The workgroup identified three HIV quality measures (*HIV Viral Load Suppression*, *Gap in HIV Medical Visits*, and *Prescription of HIV Antiretroviral Therapy*) to validate and monitor. The HIV workgroup has been integral to the identification and improvement of managed care HIV data collection and validation processes.

Managed Care in Illinois

Statewide Managed Care

HFS has worked to expand managed care statewide to deliver integrated and quality managed care to nearly 4 million[14] enrollees, supporting seniors, persons with a disability, families and children, special needs children, and adults qualifying for the HFS Medical Program under the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA or short) (ACA Adults).

Managed Care Programs

HFS medical programs pay for a wide range of health services, provided by thousands of medical providers throughout Illinois. HFS operates three distinct medical programs:

- HealthChoice Illinois
- Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)
- YouthCare Specialty Plan (YouthCare)

HealthChoice Illinois is the statewide Medicaid managed care program, covering all counties in Illinois. HealthChoice offers most Medicaid customers enhanced healthcare coordination and quality services, including the following populations:[15]

- Families and children
- Adults eligible for Medicaid under the ACA
- Seniors and adults with disabilities who are not eligible for Medicare
- Dual Medicare-Medicaid eligible adults receiving certain LTSS, referred to as the Managed Long-Term Services and Supports (MLTSS) population
- Special needs children, which includes Former Youth in Care (FYiC) and Youth in Care (YiC)
- Health Benefits for Immigrant Seniors [HBIS] program[16]

HealthChoice Illinois health plans provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. Most people who enroll are covered for comprehensive services, including but not limited to doctor visits and dental care, well-child care, immunizations for children, mental health and substance abuse services, hospital care, emergency services, prescription drugs, and medical equipment and supplies.

Some enrollees who qualify for HCBS waiver programs receive additional benefits to assist with maintaining independence at home and in the community. These waivers have specific eligibility requirements, including but not limited to residency, financial, level of care and service needs, and age

[14] HFS publishes detailed managed care enrollment figures on its website at https://hfs.illinois.gov/info/factsfigures/detailedmanagedcareenrollment.html.

[15] Participants who are American Indian or Alaska Native are excluded from the program, unless they voluntarily enroll in a health plan.

[16] State-funded program only.

or diagnoses. The State identifies these enrollees based on the eligibility requirements; health plans can also refer enrollees to the State to be assessed for eligibility.

Some programs, like MLTSS, cover a limited set of services. The State identifies enrollees who are eligible for MLTSS if they are dually eligible for Medicaid and Medicare, receive institutional (nursing home and other long-term facility) care, or receive HCBS waiver benefits.

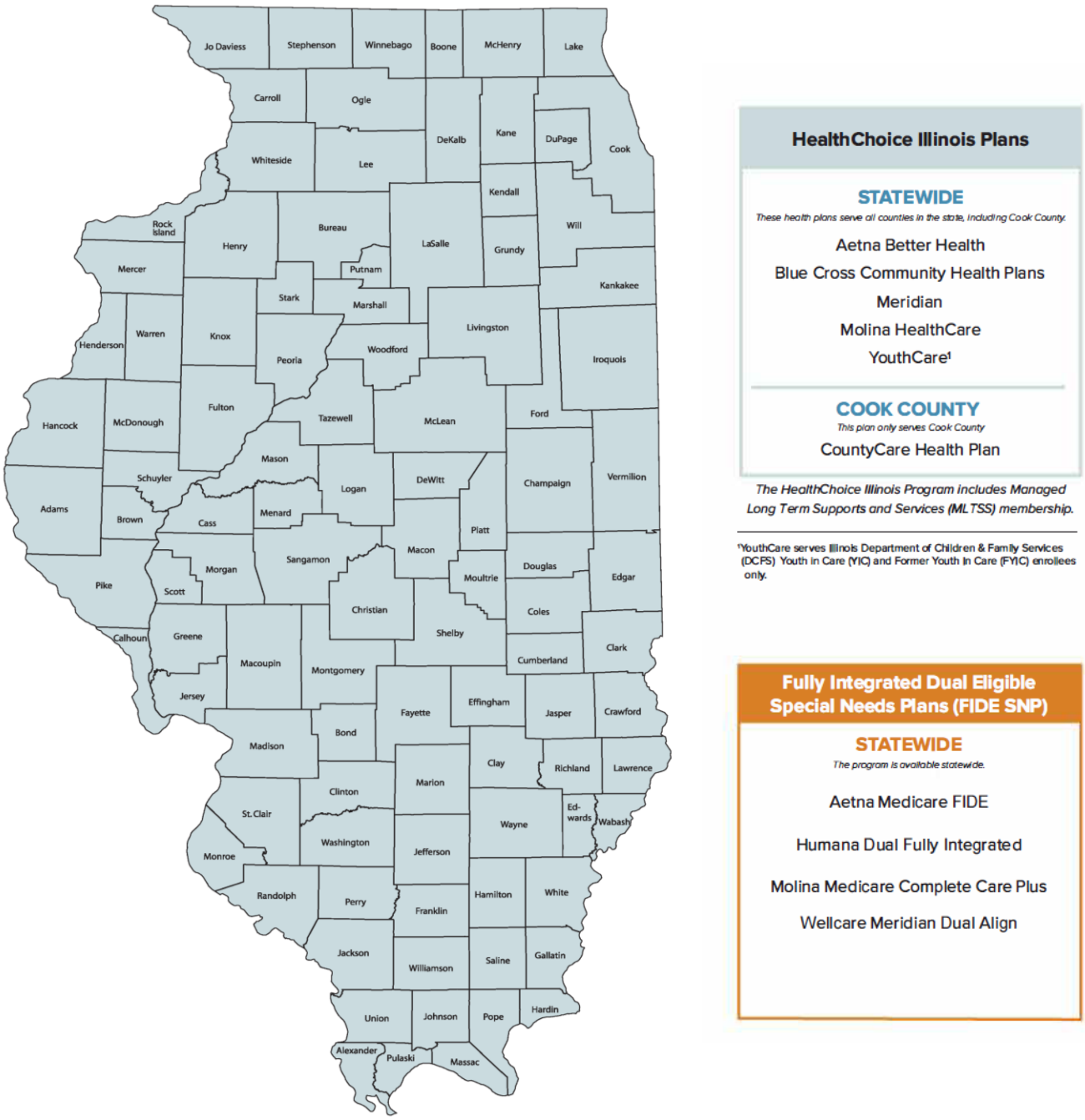
The statewide specialized HealthChoice health plan, YouthCare, was implemented in 2020 and administers benefits for Department of Children and Family Services (DCFS) Youth, DCFS YiC, and FYiC. Working with the youth's caseworker, YouthCare offers additional benefits and is designed to improve access to care through active coordination and a more robust provider network. With YouthCare, DCFS youth receive additional benefits, such as trauma-informed care coordination for behavioral health needs. YouthCare provides specialized programming for adoptive families, including an adoption-competent network of therapists to support the different phases of adoption and child development.

In accordance with CMS' Medicare Advantage and Part D Final Rule (CMS-4192-F), Illinois transitioned the previous Medicare-Medicaid Alignment Initiative to FIDE SNPs on January 1, 2026. FIDE SNP is a federal subcategory of Dual Eligible Special Needs Plan (D-SNP). More information can be found here: FIDE SNPs.

Managed Care Map

This map graphically displays the Illinois managed care map as of June 2026.

Figure 2-1—Managed Care Program Map



Health Plans

HealthChoice Illinois is served by six health plans, which includes one specialty plan. Five of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only, as shown below. HFS contracted with four health plans to deliver services to dually eligible members through a FIDE SNP, as shown in Table 2-1.

Table 2-1—Illinois Health Plans

Health Plan Name	Abbreviation	Health Plan Type	Managed Care Authority	Populations Served
HealthChoice Illinois				
Aetna Better Health	Aetna	Health Maintenance Organization (HMO)	Federal State Plan and Waiver Authority–Sec. 1932. [42 U.S.C. 1396u–2] (a), 1915(b), and 1915(c); State Authority–215 Illinois Compiled Statutes (ILCS) 125/1-1, et seq	• Families and children • Adults eligible for Medicaid under the ACA • Seniors and adults with disabilities who are not eligible for Medicare • Dual Medicare-Medicaid eligible adults receiving certain LTSS, referred to as the MLTSS population • Special needs children, which includes FYiC and YiC
Blue Cross Community Health Plans	BCBSIL	HMO		
CountyCare (serves Cook County only)	CountyCare	Managed Care Community Network (MCCN)	Federal State Plan and Waiver Authority–Sec. 1932. [42 U.S.C. 1396u–2] (a), 1915(b), and 1915(c); State Authority–89 Ill. Admin. Code Part 143	
Meridian	Meridian	HMO	Federal State Plan and Waiver Authority–Sec. 1932. [42 U.S.C. 1396u–2] (a), 1915(b), and 1915(c);	
Molina Healthcare of Illinois	Molina	HMO		

Health Plan Name	Abbreviation	Health Plan Type	Managed Care Authority	Populations Served
YouthCare Specialty Plan	YouthCare	HMO	State Authority–215 ILCS 125/1-1, et seq	• DCFS YiC • DCFS FYiC
FIDE SNP				
Aetna Medicare FIDE	Aetna D-SNP	HMO	Social Security Act §§ 1851–1859; 42 C.F.R. Part 422 (including §§ 422.2 and 422.107); State Authority–215 ILCS 125/1-1, et seq; 305 ILCS 5/5-30 et seq	• Members receiving full Illinois Medicaid benefits and enrolled in either the Medicaid Aid to the Aged, Blind, and Disabled (AABD) or the FamilyCare category of assistance • Ages 21 and older at the time of enrollment • Have Medicare Part A (hospital insurance) and Part B (medical insurance)
Humana Dual Fully Integrated	Humana D-SNP	HMO		
Wellcare Meridian Dual Align	Meridian D-SNP	HMO		
Molina Medicare Complete Care Plus	Molina D-SNP	HMO		

Quality Management Structure

HFS' Quality Management Structure aligns with its vision to improve lives, empower customers to maximize their health and well-being, and make equity the foundation of everything it does. HFS recognizes the importance of having specific and measurable goals and analytics to improve outcomes. HFS also places priority in ensuring all staff and systems work together.

The **Bureau of Quality Management**, purposed to improve healthcare quality for HFS customers in Illinois, serves as a centralized hub for HFS Medical Program quality assurance, performance improvement and evaluation activities. The **Bureau of Managed Care** administers and monitors HFS' managed care/care coordination programs. Together and in partnership with other support services, these bureaus work to administer initiatives and programs to drive improvements established by the clear goals and objectives in the Quality Strategy.

The bureaus evaluate the quality and effectiveness of Medicaid-funded programs by systematically monitoring and evaluating the quality of care and services; overseeing the design, implementation, monitoring, and evaluation of the quality management activities statewide; and developing and implementing a quality management workplan that identifies specific activities, measures, indicators, and health equity that are the focus of the Quality Management program. The bureaus are also responsible for oversight, monitoring, and evaluation of quality assurance to ensure health plans are in compliance with State standards, federal regulations, and contract requirements.

HFS is committed to the delivery of equitable access of its programs and services, removing disparate impact on its customers by ensuring each population gets what they need to thrive. Stakeholder engagement plays a key role in an equitable Quality Management program. HFS routinely meets with health plans to discuss operational topics and quality improvement progress/outcomes, facilitate staff education, promote equity initiatives, and promote quality-related information specific to health plan performance. In addition, the Medicaid Advisory Committee (MAC) advises HFS with respect to policy and planning related to the health and medical services provided under HFS' medical programs pursuant to federal Medicaid requirements established at 42 CFR §431.12. The MAC consists of up to 15 members, at least five of whom must be consumers or advocates. The MAC meets at least quarterly and currently has four subcommittees: Community Integration, NB (N.B. Consent Decree) Stakeholder, Public Education, and Health Equity and Quality Care. The subcommittees are supported by workgroups. In particular, the Health Equity and Quality Care Subcommittee meetings include managed care equity and quality improvement discussions.

Table 2-2 details HFS' operational quality activities and responsibilities.

Table 2-2—Operational Quality Activities and Responsibilities

Activity	HFS	Health Plans
Quality Performance and Improvement	Oversee development and monitoring of outcome measurements Oversee implementation of performance/quality improvement projects (PIPs/QIPs) Meet independently with health plans each quarter to improve health outcomes for customers; meetings include data-driven discussions related to quality performance and health equity Meet with health plans as a group to discuss quality-related activities, provide best practice, education, and technical assistance in collaboration with HFS' external quality review organization (EQRO) Work with health plans related to quality corrective action plans (CAPs) and/or sanctions	Develop and implement PIPs/QIPs as directed by HFS Engage with HFS, EQRO, providers, customers, and other stakeholders for continuous quality improvement Monitor performance measures at least quarterly Develop CAP to address and resolve deficiencies
Quality Performance Incentive	Develop Quality Withhold performance and reporting metrics Monitor and evaluate withhold metric performance quarterly Develop and monitor quality-driven managed care enrollment assignments Monitor health plan value-based provider payment plans	Comply with required performance measure validation (PMV) activities Implement and oversee value-based provider payment plan

Activity	HFS	Health Plans
Quality Assurance and Monitoring	Set clinical standards for program Oversee compliance of health plan related to State and federal regulations Monitor and evaluate health plan contract compliance and compliance with the goals and objectives identified in the Quality Strategy Conduct compliance reviews at least once every three years including an assessment of health plan quality improvement structure via HFS' EQRO. Work with health plans related to contract compliance CAPs and/or sanctions Meet independently with each health plan for monthly operations meetings and quarterly business reviews (QBRs) to monitor plan performance Meet with health plans as a group to discuss operational activities and provide policy guidance, technical assistance, and education in collaboration with subject matter experts (SMEs); meetings are most often weekly	Monitor adherence to State and federal regulations Monitor adherence to contractual requirements As directed by HFS, provide presentations and discuss operational activities in meetings including but not limited to QBRs Address findings from internal and external audit/monitoring Develop CAP to address and resolve deficiencies
Reporting	Define reporting standards and oversee quality- and compliance-related reports Provide transparency related to quality and compliance reporting	Complete reporting requirements in accordance with contract requirements or as directed by HFS, including but not limited to both operational and quality metrics

Activity	HFS	Health Plans
External Quality Review	Direct and monitor contracted activities of EQRO to ensure alignment with State and federal regulations and the Quality Strategy Routinely meet with EQRO to discuss contracted activities; meetings are at least weekly Utilize EQRO recommendations for continuous quality improvement	Review EQRO reports as part of health plan quality improvement and work to implement recommendations Participate in external quality review (EQR) compliance activities as directed by HFS including but not limited to on-site and webinar-based reviews
Health Equity	Define health equity and identify disproportionally impacted areas in Illinois Work collaboratively with health plans and community organizations to reduce disparity Monitor and discuss health plans' quality performance related to marginalized populations Incorporate discussion of health-related social needs into quality improvement framework	As directed by HFS, stratify performance metrics to include race, ethnicity, gender, and disproportionally impacted ZIP Codes Complete ongoing analytics to identify and address health disparities Incorporate health-related social needs into quality framework

Contracting for Managed Care

Right Care, Right Time, Right Place

Effective managed care expansion has been central to the Department's planning as it offers a way to deliver enhanced health coordination and quality services with the promise of reduced and predictable costs. Robust data collection, transparency and accountability, and clear performance targets are necessary to achieve true cost-effectiveness while also improving quality. HFS is working closely with key stakeholders to improve efficiencies around billing, payment, administration, and other systems. HFS believes managed care enhances HFS' ability to offer the right care, at the right time, in the right place. The graphic below outlines the primary potential benefits of implementing statewide managed care.

Paying for Value

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

Care Coordination

Public Act 96-1501 required that at least 50 percent of all Medicaid recipients eligible for full benefits would be enrolled in care coordination, which means the deliberate organization of patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.[17]

1915(b) Waiver Programs

To extend the benefits of managed care, HFS obtained 1915(b) or 1915(c) Waivers to include the following populations in HealthChoice Illinois:

1. Managed Long Term Services and Supports.
2. Home- and Community-Based Services.
3. Special Needs Children, including children from the Division of Specialized Care for Children (DSCC) Core Program and DCFS Youth.

Tech Integration

HFS uses advanced technology to manage Medicaid and human services functions to reduce costs, improve outcomes, and help implement structural changes for the healthcare program that provides health benefits to millions of Illinois residents. See the "Health Information Technology" section of this report for more details.

[17] McDonald KM, Sundaram V, Bravata DM, et al. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination*. Publication No. 04(07)-0051-7, June 2007. Agency for Healthcare Research and Quality, Rockville, MD. Available at: https://www.ncbi.nlm.nih.gov/books/NBK44015/. Accessed on: May 13, 2024.

What Care Coordination Looks Like

The six HealthChoice Illinois health plans are responsible for offering care management to enrollees who accept or request it through an Interdisciplinary Care Team (ICT). Enrollees are assigned a care coordinator who participates in the ICT and works directly with the enrollee to address care needs.

Each health plan is responsible for informing the enrollee of the contact information of the health plan's primary point of contact, as required by 42 CFR §438.208(b). Plans are further responsible for coordinating services between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays. If a member changes enrollment across managed care health plans or to the Medicaid State agency, the health plans are required to coordinate transition of services to ensure continuity of care and non-duplication of services (42 CFR §438.208[b][4]).

To identify members with care coordination needs, the health plans are required to assess risk for their enrolled population, including use of predictive modeling and surveillance data, and completion of a health risk screening to all new enrollees within 60 days after enrollment to collect information about the enrollee's physical, psychological, and social health. Based on analysis of the data gathered through the risk assessment processes, the enrollee is assigned to one of three risk levels as appropriate for level of care need.

- Level 1 (low risk): Requires minimum prevention or condition-specific education.
- Level 2 (moderate risk): Requires problem-solving intervention.
- Level 3 (high risk): Requires intensive care coordination to address acute and chronic health needs, behavioral/mental health, and lack of social support.

For enrollees who are stratified as high-risk, including those who have special health care needs (SHCN), receive HCBS waiver services, or reside in a nursing facility, the health plans are required, in compliance with the parameters set forth in 42 CFR §438.208(c), to conduct a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Based on the comprehensive assessment, the State requires the health plans to develop a person-centered care plan within 90 days after enrollment for all high-risk and HCBS enrollees. The care plan must be developed by a qualified care coordinator trained in person-centered planning processes. The planning process must be enrollee driven and reflect the enrollee's choice of needs, services and providers, service setting, personal goals, and preferences. The health plan is responsible for review of the care plan at required intervals. Additionally, the health plan is required to update the care plan when an enrollee's condition or needs change, or at the enrollee's request.

Development and Review of the Quality Strategy

HFS meets the requirements for development, evaluation, revision, and availability of the Quality Strategy as described in 42 CFR §438.340(c) and (d).

Developing a Quality Strategy

To draft the Quality Strategy, HFS convenes an interdisciplinary team, reviews federal regulations, and gathers information and resources.

Public Comment

HFS obtains input from customers and stakeholders as well as the MAC and the American Indian Health Services of Chicago in drafting and revising the Quality Strategy when it is shared with stakeholders for public comment.[18]

CMS Feedback

HFS considers and incorporates CMS feedback to revise the Quality Strategy.

Posting

HFS submits the Quality Strategy to CMS as required and makes the strategy available on its website required by 42 CFR §438.10(c)(3).

Updates

HFS reviews and updates the Quality Strategy as needed, but no less than every three years. Reviews include evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. Updates are made as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the Medicaid program. HFS considers statewide expansion or the addition of new programs/delivery systems as significant changes that necessitate updates to the Quality Strategy.

Figure 2-2—Quality Strategy Development Steps[19]

[18] Illinois seeks advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service, Tribes, or Tribal organizations under the *Indian Self-Determination and Education Assistance Act*, or Urban Indian Organizations under the *Indian Health Care Improvement Act*. There is a single qualifying entity in Illinois, the American Indian Health Services of Chicago, with which HFS has established a notification and feedback process.

[19] Medicaid.gov. *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit*. June 2021. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf. Accessed on: June 10, 2024.

Additional Information

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

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

Section 3. Quality of Care

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

- QA/UR/PR plan with overview of goal areas
- Major initiatives to comply with the State Quality Strategy
- Quality improvement and workplan monitoring
- Contractor network access and availability and service improvements, including access and utilization of dental services
- Cultural competency
- Fraud, waste, and abuse (FWA) monitoring
- Population profile
- Improvements in care management/care coordination (CM/CC) and clinical services/programs
- Effectiveness of care coordination model of care
- Effectiveness of quality program structure
- Summary of monitoring conducted including issues or barriers addressed or pending remediation
- Comprehensive quality improvement workplans
- Chronic health conditions
- Behavioral health (includes mental health and substance use disorder services)
- Dental care
- Discussion of the health education program
- Member satisfaction
- Enrollee safety
- FWA and privacy and security
- Delegation

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

Quality Metrics and Performance Targets

HFS requires health plans to submit results for a variety of quality measures in order to assess performance. In accordance with regulations—including 42 CFR §438.340(b)(3)(i) and 42 CFR §457.1240(e), cross-referencing 42 CFR §438.330(c)—the state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity with which it contracts. To drive progress in the Quality Strategy five pillars of improvement, HFS selected specific measures as program objectives with specified goals, as listed under "Objectives" in Section 1 of this report.

In addition to the Quality Strategy objectives, HFS has designated performance targets for select measures, such as those in its pay-for-performance (P4P) program, which direct focused efforts on initiatives. Performance targets for P4P measures can be found in HFS' report center. HFS also identified a portion of the P4P withhold to incentivize the reporting of the following measures identified as Quality Strategy program objectives. The pay-for-reporting (P4R) measures were chosen to expand the measures included in the P4P program to better align with HFS' five pillars of improvement. The reporting measures include HEDIS, CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), CMS Medicaid MLTSS, and HFS custom measures. The totality of quality metrics collected and reported provide HFS with quantifiable information to evaluate successes and identify opportunities for improvement. Table 3-1 lists quality measures collected for Illinois' Medicaid program.

★ This is a P4P measure. ★ This is a P4R measure. ★ This measure is stratified by ethnicity. ★ This is a YouthCare measure.

Table 3-1—Illinois Medicaid Quality Metrics

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Adults' Access to Preventive/Ambulatory Health Services ★	HEDIS[21]	✓	
Annual Dental Visit ★	HEDIS	✓	

[20] Centers for Medicare & Medicaid Services. Medicaid and CHIP Core Set Measures. *Child and Adult Health Care Quality Measures*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html. Accessed on: May 13, 2024.

[21] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the NCQA.

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Ambulatory Care	HEDIS	✓	
Ambulatory Care: Emergency Department Visits[22] ★	HEDIS	✓	
Asthma Medication Ratio ★★	HEDIS	✓	
Blood Pressure Control for Patients With Diabetes	HEDIS	✓	
Breast Cancer Screening ★★	HEDIS	✓	
Disparities Focus ★	HEDIS		
Cervical Cancer Screening ★★	HEDIS	✓	
Childhood and Adolescent Well-Care Visits	HEDIS	✓	✓
3–11 Years	HEDIS		
12–17 Years	HEDIS		
18–21 Years	HEDIS		
Total	HEDIS		
Childhood Immunization Status ★	HEDIS	✓	✓
Combination 3	HEDIS		
Combination 7	HEDIS		
Combination 10[23] ★	HEDIS		

[22] This measure is only reported for YouthCare.

[23] Combination 10 includes four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZW); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines. Health plans are expected to conduct root cause analysis for individual vaccine rates that perform poorly.

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Chlamydia Screening in Women—Total	HEDIS	✓	✓
Clinical Depression Screening and Follow-Up ★	HEDIS	✓	
Colorectal Cancer Screening ★	HEDIS	✓	
Controlling High Blood Pressure ★	HEDIS	✓	
Diagnosed Mental Health Disorders	HEDIS	✓	
Emergency Department Visits that Result in an Inpatient Admission for Children and Adolescents[24] ★	HFS Custom	✓	
Eye Exam for Patients With Diabetes	HEDIS	✓	
Contraceptive Care ★	CMS	✓	✓
Most or Moderately Effective Method of Contraception	CMS		
Long-Acting Reversible Method of Contraception	CMS		
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up	HEDIS	✓	✓
6–17 Years ★★	HEDIS		
18–64 Years	HEDIS		
65+ Years	HEDIS		
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	HEDIS	✓	✓
6–17 Years ★★	HEDIS		
18–64 Years	HEDIS		
65+ Years	HEDIS		

[24] This measure is only reported for YouthCare.

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Follow-Up After Emergency Department Visit for Substance Abuse—7-Day Follow-Up ★	HEDIS	✓	✓
13–17 Years ★	HEDIS		
18+ Years	HEDIS		
Follow-Up After Emergency Department Visit for Substance Abuse—30-Day Follow-Up ★	HEDIS	✓	✓
13–17 Years ★	HEDIS		
18+ Years	HEDIS		
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up	HEDIS	✓	
13–17 Years	HEDIS		
18–64 Years ★	HEDIS		
65+ Years ★	HEDIS		
Follow-Up After High Intensity Care for Substance Use Disorder—30-Day Follow-Up	HEDIS	✓	
13–17 Years	HEDIS		
18+ Years ★	HEDIS		
65+ Years ★	HEDIS		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up ★	HEDIS	✓	✓
6–17 Years ★	HEDIS		
18–64 Years	HEDIS		
65+ Years	HEDIS		

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up ★	HEDIS	✓	✓
6–17 Years ★	HEDIS		
18–64 Years	HEDIS		
65+ Years	HEDIS		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication ★★	HEDIS	✓	✓
Initiation Phase	HEDIS		
Continuation and Maintenance Phase	HEDIS		
Follow-Up After Mobile Crisis Response ★	HFS Custom	✓	
HbA1c Control for Patients with Diabetes	HEDIS	✓	
HbA1c Control (<8.0%)	HEDIS		
HbA1c Poor Control (>9.0%)[25]	HEDIS		
Human Immunodeficiency Virus (HIV) Viral Load Suppression	HRSA	✓	
Immunizations for Adolescents ★	HEDIS	✓	✓
Combination 1	HEDIS		
Combination 2	HEDIS		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Initiation of Alcohol and Other Drug (AOD) Treatment	HEDIS	✓	✓
13–17 Years ★★	HEDIS		
18–64 Years	HEDIS		
65+ Years	HEDIS		

[25] A lower rate indicates better performance for this indicator.

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Engagement of AOD Treatment	HEDIS	✓	✓
13–17 Years ★★	HEDIS		
18–64 Years	HEDIS		
65+ Years	HEDIS		
Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents[26] ★	HFS Custom	✓	
Lead Screening in Children	HEDIS	✓	✓
LTSS Minimizing Facility Length of Stay ★	CMS		
LTSS Successful Transition after Long-Term Facility Stay[27] ★	CMS		
Metabolic Monitoring for Children and Adolescents on Antipsychotics ★	HEDIS	✓	✓
Mental Health Utilization[28] ★	HEDIS		
Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents ★	HFS Custom	✓	✓
Oral Evaluation, Dental Services ★	Dental Quality Alliance (DQA)	✓	✓
Pharmacotherapy for OUD ★	HEDIS	✓	✓
Prenatal Depression Screening ★	HEDIS	✓	
Postpartum Depression Screening ★	HEDIS	✓	

[26] This measure is only reported for YouthCare.
[27] This measure is included in HFS' Quality Goals (Goal 5).
[28] This measure is only reported for YouthCare.

Metric Name	Metric Specification	Program	
		Medicaid	CHIP[20]
Prenatal and Postpartum Care ★	HEDIS	✓	✓
Timeliness of Prenatal Care	HEDIS		
Postpartum Care	HEDIS		
Repeat Behavioral Health Hospitalizations for Children and Adolescents[29] ★	HFS Custom	✓	
Screening for Clinical Depression and Follow-Up Plan	CMS	✓	✓
12–17 Years	CMS		
18+ Years	CMS		
Statin Therapy for Patients With Diabetes	HEDIS	✓	
Unexpected Complications in Term Newborns ★	National Quality Forum (NQF)	✓	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[30] ★	HEDIS	✓	✓
Well-Child Visits ★ ★	HEDIS	✓	✓
Well-Child Visits in the First 15 Months of Life—Six or More Visits	HEDIS		
Well-Child Visits in the First 30 Months of Life—Ages 15 Months–30 Months—Two or More Visits	HEDIS		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents ★	HEDIS	✓	✓
Body Mass Index (BMI) Percentile Documentation—Total	HEDIS		
Counseling for Nutrition	HEDIS		
Counseling for Physical Activity	HEDIS		

[29] Ibid.
[30] Ibid.

State-directed payments are a special type of payment arrangement regulated by CMS, which advance goals and objectives identified in the Quality Strategy and allow a state to direct expenditures to providers under the health plan contracts in certain situations. State-directed payments assist states in achieving their overall objectives for delivery system and payment reform, including efforts to ensure access to an adequate provider network and to increase the use of value-based payment methods. HFS' state-directed payments are detailed in Appendix C.

LTSS Performance Measures

HealthChoice Illinois plans also serve seniors and people with disabilities who receive full Medicare and Medicaid benefits and live in a nursing home or long-term care facility, or who receive HCBS waiver services. HFS has identified performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. These measures are included in the overall quality metrics displayed in Table 3-1 and displayed in Table 3-2.

Table 3-2—LTSS Quality Metrics[31]

Measure Name	Measure Specification
LTSS Minimizing Facility Length of Stay	CMS MLTSS
LTSS Successful Transition after Long-Term Facility Stay[32]	CMS MLTSS

National Performance Measures

Core Measure Sets

CMS publishes sets of core measures programs to aid in the assessment of the quality of care and health outcomes for adults participating in Medicaid and children enrolled in Medicaid and CHIP. The core sets are for voluntary use by state Medicaid and CHIP and include a

[31] LTSS quality metrics are included in the P4R program.
[32] This measure is included in HFS' Quality Goals (Goal 5).

range of quality measures encompassing both physical and mental health. HFS includes a number of core set measures in its quality monitoring program and requires health plans to report results, as listed below.

Adult Core Set

- *Asthma Medication Ratio*
- *Breast Cancer Screening*
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H—Adult Version*[33]
- *Cervical Cancer Screening*
- *Chlamydia Screening: Ages 21 to 24*
- *Colorectal Cancer Screening*
- *Controlling High Blood Pressure*
- *Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older*
- *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older*
- *Hemoglobin A1c Control for Patients With Diabetes*
- *HIV Viral Load Suppression*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment*
- *LTSS Comprehensive Care Plan and Update*
- *Prenatal and Postpartum Care: Age 21 and Older*
- *Screening for Depression and Follow-Up Plan: Age 18 and Older*
- *Use of Pharmacotherapy for OUD*

Child Core Set

- *Asthma Medication Ratio: Ages 5 to 18*
- *CAHPS Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items*
- *Chlamydia Screening in Women: Ages 16 to 20*
- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status*

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

- *Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17*
- *Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17*
- *Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17*
- *Immunizations for Adolescents*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
- *Oral Evaluation, Dental Services*
- *Prenatal and Postpartum Care: Under Age 21*
- *Screening for Depression and Follow-Up Plan: Ages 12 to 17*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 30 Months of Life*

Public Posting of Quality Measures and Performance Outcomes

To comply with reporting requirements described in 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed care programs in accordance with 42 CFR §457.1240(e), the state must identify which quality measures and performance outcomes it will publish at least annually on its website.

HFS tasked its EQRO with developing a report card to evaluate the performance of Illinois' health plans serving the Medicaid population. The report card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers. The EQRO analyzed HEDIS results, including CAHPS data.

Two report cards were created to evaluate health plan performance, one for consumers living in Cook County and one for consumers statewide (i.e., outside Cook County). The Cook County report card included an analysis of the five plans available to Medicaid beneficiaries in Cook County. The statewide report card included an analysis of the four plans available statewide to Medicaid beneficiaries.

The report cards support HFS' public reporting of health plan performance information and are posted to HFS' website. The most recent versions are available at https://enrollhfs.illinois.gov/en/healthchoice-illinois.

Performance Improvement Projects (PIPs) and PIP Interventions

As part of its QAPI program, HFS requires health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). HFS required the health plans to submit two new state-mandated PIPs for validation: Improving Timeliness of Prenatal Care and Improving Transportation Services. As one of the mandatory EQR activities, HFS' EQRO validates PIPs through an independent review process. The topics addressed CMS' requirements related to quality outcomes, specifically the timeliness of and access to care and services. The PIP aims and interventions are listed in Table 3-3.

Table 3-3—PIP Aims and Interventions

Health Plan	PIP Aim	Performance Indicator	PIP Intervention
Improving Timeliness of Prenatal Care			
Aetna	By the end of remeasurement period 2 (ending October 7, 2023), targeted interventions will improve *Timeliness of Prenatal Care* HEDIS measure for the entire eligible population. Compliance will increase from 78.5% to at least the 50th percentile benchmark performance of 89.05%.	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	In accordance with *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1),[34] HFS' EQRO assesses whether there is evidence that the selected interventions were appropriate to achieve the PIP's aim. HFS requires the health plans to focus at least one intervention on addressing health inequities that they identified within the eligible population for each PIP. Interventions are modified each year depending on results. HFS publishes details about PIP interventions in its annual technical report, available at HFS' Report Center.
BCBSIL	Does performing targeted outreach to pregnant women within the first trimester or within 42 days of enrollment with BCBSIL increase the HEDIS *Timeliness of Prenatal Care* annual results?	The percentage of deliveries that deliver a live birth and received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the BCBSIL organization.	
CountyCare	Improved care coordination processes, increased outreach earlier in pregnancy by care management staff, and improved linkage to prenatal provider groups will result in improved linkage to timely prenatal care in the first trimester among pregnant members.	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	

[34] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: May 14, 2024.

Health Plan	PIP Aim	Performance Indicator	PIP Intervention
Meridian	By 12/31/2023, Meridian aims to increase the percentage of prenatal care visits among women in their first trimester of pregnancy (within 280–176 days of delivery or estimated date of delivery), from 80.08% to 82.08% in CY2022 and to 84.08% in CY2023 (2.00% increase each year) through targeted interventions including, but not limited to, member and provider engagement and community partnerships to support the needs of this population.	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	In accordance with CMS Protocol 1, HFS' EQRO assesses whether there is evidence that the selected interventions were appropriate to achieve the PIP's aim. HFS requires the health plans to focus at least one intervention on addressing health inequities that they identified within the eligible population for each PIP. Interventions are modified each year depending on results. HFS publishes details about PIP interventions in its annual technical report, available at HFS' Report Center.
Molina	Do targeted interventions increase HEDIS PPC prenatal rates for Molina Medicaid members who deliver a live birth during the measurement year?	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	
Improving Transportation Services			
Aetna	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	
BCBSIL	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	

Health Plan	PIP Aim	Performance Indicator	PIP Intervention
CountyCare	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	In accordance with CMS Protocol 1, HFS' EQRO assesses whether there is evidence that the selected interventions were appropriate to achieve the PIP's aim. HFS requires the health plans to focus at least one intervention on addressing health inequities that they identified within the eligible population for each PIP. Interventions are modified each year depending on results. HFS publishes details about PIP interventions in its annual technical report, available at HFS' Report Center.
Meridian	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	
Molina	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the enrollee arriving to their scheduled appointment on time during the measurement period.	

Transition of Care Policy

As required in 42 CFR §§438.340(b)(5), 438.340(b)(5), and 438.62(b)(3), this section describes the HFS Bureau of Managed Care's (BMC's) policies that its Medicaid managed care health plans followed to transition members' care. Illinois' Managed Care Reform and Patient Rights Act (215 ILCS 134/25) provides the Department's policy on transition of care and services, which is described in BMC's Transition of Care policy In addition, all BMC policies are maintained and publicly available on the HFS BMC website, including its Community Transitions Initiative policy, which describes the processes for transitioning members living in nursing facilities and specialized mental health rehabilitation facilities into the community.

HFS requires health plans to submit a transition of care (TOC) plan for approval. The TOC plan must comply with the Managed Care Reform and Patient Rights Act and include policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to an enrollee's care.

Health plans manage TOC for new enrollees and for enrollees moving from an institutional setting to a community setting. As part of the enrollee's plan of care, health plans use interdisciplinary TOC teams to design and implement a TOC plan and provide oversight and management of all TOC processes. The teams consist of skilled personnel with extensive knowledge and experience transitioning enrollees with SHCN. The health plans' processes for facilitating continuity of care include:

- Identification of enrollees deemed critical for continuity of care.
- Communication with entities involved in enrollees' transitions.
- Stabilization and provision of uninterrupted access to covered services.
- Assessment of enrollees' ongoing care needs.
- Monitoring of continuity and quality of care and services provided.
- Medication reconciliation.

Disparities Plan

HFS' vision to improve lives means that the Department aims to address HRSNs, empower customers to maximize their health and well-being, provide consistent and responsive service to colleagues and customers, and make equity the foundation of everything we do. With a foundation based on equity, HFS aims to provide every community and population what is needed to succeed, so everyone can reach their full potential. To achieve health equity and empower customers, HFS seeks to reduce health disparities.

Disparity factors include gender, age, race, ethnicity, primary language, disability status, and geography. HFS uses the Social Security Administration's (SSA's) definition of disability: "Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months."[35] This definition applies when determining eligibility for Aid to the Aged, Blind, or Disabled (AABD) Medical coverage based on disability. Either the SSA or the Client Assessment Unit (CAU) housed at Illinois DHS can make a disability finding.

[35] United States Social Security Administration. *Compilation of the Social Security Laws: Other Definitions*. Available at: Social Security Act §216 (ssa.gov). Accessed on: Dec 9, 2024.

HRSNs and social determinants of health (SDOH) have changed the way HFS looks at healthcare. CMS defines HRSNs as "an individual's unmet, adverse social conditions that contribute to poor health outcomes."[36] It is estimated that up to 50 percent of health statuses can be attributed to HRSN. When HRSN needs are unmet, they can lead to gaps in access to care, higher medical costs, worse health outcomes, and continuation of health inequities, particularly for children and adults as risk for poor health outcomes and individuals in historically underserved communities. The federal Office of Disease Prevention and Health Promotion defines SDOH as "conditions and environments in which people are born, live, learn, work, play, worship, and age" that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[37]

Although SDOH and HRSN are sometimes used interchangeably, they are distinct concepts that impact health and well-being. HRSNs are more immediate individual or family needs, such as housing insecurity and lack of transportation; whereas SDOHs are community-level factors, like socioeconomic status and neighborhood.

To identify, evaluate, and reduce disparities, HFS contractually mandates that HealthChoice IL plans employ an equity director as well as develop and implement a Social and Structural Determinants of Health (SSDOH) Work Plan, which is submitted annually to the Department. The equity directors are responsible for the strategic design, implementation, and evaluation of health equity efforts; plan practices related to disparity reductions, including the provision of health equity and SDOH; and ensuring the plan collects and meaningfully uses race, ethnicity, and language data to identify and reduce disparities. The SSDOH Work Plans are required to identify, evaluate, and reduce, to the extent practicable, health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. The SSDOH Work Plans include:

- A strategy that adopts a whole person care approach through the provision of SSDOH resources at the customer and community levels.
- A Cultural Competence plan with targeted efforts to address and mitigate disparities and cultural gaps.
- Analytic methods to identify, monitor, and address unmet social needs.
- A plan to increase awareness of and access to community-based SSDOH supports and resources.

[36] Centers for Medicare & Medicaid Services. *Framework of Coverage of HRSN Services in Medicaid and CHIP*. Available at: https://www.medicaid.gov/media/166291. Accessed on: May 14, 2024.

[37] U.S. Department of Health and Human Services. *Healthy People 2030 Social Determinants of Health Workgroup*. Available at: https://health.gov/healthypeople/about/workgroups/social-determinants-health-workgroup#:~:text=The%20social%20determinants%20of%20health%20are%20the%20conditions%20and%20environments,play%2C%20worship%2C%20and%20age. Accessed on: May 14, 2024.

- Development of targeted strategies to address the SSDOH needs of special populations disproportionately impacted by SSDOH and at high risk for adverse health outcomes.
- Promotion of statewide collaboration with other health plans, the Department, other State agencies, and community partners in implementing SSDOH strategies.
- Reporting of performance measure data against a set of stratification criteria that includes, but is not limited to race, ethnicity, geography, eligibility category, age, and gender.

Health plans meet regularly with HFS to provide and discuss comparative data analysis of performance measures by geographic region, to identify disproportionately impacted areas, race, ethnicity, gender, and age.

Care coordination and many of HFS' Medicaid waivers allow the Department to offer more than typical medical services. Additional programs will offer "wraparound" care coordination to some of the more vulnerable populations and will include benefits to address health-related social needs, such as support with jobs, housing, food/nutrition services, nonmedical transportation, and other services. The Department has also launched the Healthcare Transformation Collaboratives (HTCs). This innovative program provides $150 million annually to partner healthcare providers with community-based organizations and offer more whole person supports, particularly in underserved communities.[38] Both the waiver changes related to health-related care needs and the HTCs are discussed in the "Transforming Medicaid in Illinois" section above.

HFS' Disparities Plan also looks inward. Department policy emphasizes that the HRSN framework is about more than medical issues. HFS staff are educated annually and have access to HRSN and unconscious bias resources internally. As part of the Department's Strategic Planning process, it has also activated a SDOH/HRSN working group. HFS also developed a Diversity, Equity, Inclusion, and Accessibility (DEIA) Action Plan as part of a Governor's Office of Equity Initiative: *Illinois Towards Equity.*[39] This plan outlines HFS' goals and strategies to address DEIA and identify needed resources.

[38] Illinois Department of Healthcare and Family Services. About HTC. Available at: https://hfs.illinois.gov/healthcaretransformation/htcabout.html#:~:text=The%20Healthcare%20Transformation%20Collaboratives%20program%20makes%20available%20as,entities%20that%20address%20the%20social%20determinants%20of%20health. Accessed on: May 17, 2024.

[39] State of Illinois Office of Equity. Illinois Toward Equity (ITE). Available at: Illinois Toward Equity. Accessed on: May 17, 2024.

Assessing and Improving the Quality of HealthCare and Services

As required in 42 CFR §438.340, this section describes HFS' strategies for assessing and improving the quality of healthcare and services furnished by its Medicaid managed care health plans. Table 3-7 summarizes HFS' assessment strategies for each federal regulation designated in CMS' Medicaid and CHIP Managed Care Final Rule (Final Rule) as requirements of HFS' Quality Strategy.[40]

Table 3-4—HFS Strategies to Assess and Improve the Quality of Healthcare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.334	Adopt a Medicaid managed care quality rating system in accordance with CMS requirements.	HFS implemented the HealthChoice Illinois Plan Report Card. This **quality rating system (QRS)** helps customers pick the health plan that is best for them by showing each plan's performance in providing care and services to its customers for specific measures in key performance areas. HFS produces a statewide report card and a Cook County report card, both of which are available online.
§438.340(b)(1)	State-defined quantitative network adequacy standard and availability of services standards. Validation of health plan network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and §438.206.	**Provider Network Capacity Reviews** conducted by the EQRO include the types of providers specified in §438.68 as well as LTSS providers. Quarterly monitoring is conducted for HealthChoice Illinois and LTSS. As specified in §438.68(b)(iv), HFS defines specialists in whatever way is deemed most appropriate for their programs. **Network Capacity Readiness Reviews** to monitor the capacity of each health plan's provider network in the expansion counties, including LTSS providers. **Annual Time and Distance Analysis** implemented by HFS and conducted by the EQRO to evaluate the degree to which health plans are complying with the time and distance network standards as outlined in the model Medicaid contract. **Geographic Distribution Tables and Maps** must be generated by health plans to plot enrollee and network provider locations by ZIP Code and analyze the information, considering the prevalent modes of transportation available to enrollees, enrollees' ability to travel, and enrollees' ability to be in an office setting. The results must be reported to HFS as requested. **Access and Availability Surveys** implemented by HFS and conducted by the EQRO to evaluate appointment availability and after-hours access among the health plans'

[40] Medicaid.gov. *Medicaid and CHIP Managed Care Final Rule*. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Accessed on: May 14, 2024.

Table 3-4—HFS Strategies to Assess and Improve the Quality of Healthcare and Services

42 CFR	Summary of Requirement	HFS Strategy
		networks by utilizing secret shopper telephone surveys for primary care providers (PCPs), obstetricians/gynecologists (OB/GYNs), and dental and specialty providers. Health plans are also required to monitor appointment availability as part of their access and availability plan. **Monitoring of Other Network Adequacy Indicators** is contractually required by health plans, including enrollee and provider complaints related to access; call center requests from enrollees, providers, advocates, and external organizations for help with access; and the percentage of completely open PCP panels versus the percentage open only to existing patients.
§438.340(b)(1)	Examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	HFS requires health plans to incorporate **practice guidelines** that meet nationally recognized standards and that: • Are based on valid, reliable clinical evidence. • Consider the needs of enrollees. • Are adopted in consultation with network providers. • Are reviewed and updated periodically as appropriate. All clinical practice guidelines will be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and adopted by the contractor's Quality Assessment Plan (QAP) Committee with sources referenced and guidelines documented in the contractor's QAP.
§438.340(b)(3)(i)	Description of the quality metrics and performance targets to measure the performance and improvement of each health plan.	HFS collects quarterly Managed Care Organization Performance Reporting (MPR) data from all health plans. QBR thresholds are set for a variety of metrics in the categories of New Enrollee Screening and Assessments, Enrollee Engagement: Risk Stratification, and Provider and Enrollee Service Call Center. A range of other metrics are collected quarterly, and HFS will continue to review and revise metrics as needed, and to set QBR thresholds for these metrics, including enrollee plans of care, enrollee grievances and appeals, claims, prior authorizations, and provider disputes.

Table 3-4—HFS Strategies to Assess and Improve the Quality of Healthcare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.340(b)(3)(i)(i)	Mandatory PIPs.	HFS implemented the Institute for Healthcare Improvement's (IHI's) rapid-cycle performance improvement approach for PIPs in 2019, which places a greater emphasis on improving outcomes using quality improvement science. HFS requires HealthChoice Illinois health plans to **conduct PIPs** and FIDE SNPs to **conduct QIPs**. HFS selects PIP topics based on its goals and areas identified for improvement. In the rapid-cycle process, each health plan is tasked with designing small tests of change (interventions) to implement in real-work settings and then studying the impact to determine which interventions may be effective and which may need to be modified, replaced, or eliminated. This results in a variety of health plan-specific interventions that are reported each year, when applicable, in HFS' External Quality Review Technical Report.
§438.340(b)(4)	Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered by the health plans.	HFS contracted with its EQRO to perform the EQR activities newly required by the Final Rule. See the "External Quality Review Arrangements" section of this report.
§438.340(b)(5)	A description of the State's Transition of Care (TOC) policy.	HFS requires health plans to **manage TOC** and continuity of care for new enrollees and for enrollees moving from an institutional setting to a community living arrangement. Health plans are required to submit a TOC Plan to HFS initially and when there are updates to the plan. HFS requires health plans to implement a quality improvement plan to address the EQR recommendations to improve the effectiveness of care transitions. To comply with §438.62, HFS account managers oversee the implementation of health plans' quality improvement plan for improving TOCs and monitor progress through weekly and quarterly meetings with the health plans. In addition, all health plans are required to participate in a TOC PIP. Under the new Community Transitions Initiative (CTI), HealthChoice Illinois plans may receive incentive payments for the successful transition of customers living in skilled nursing facilities and specialized mental health rehabilitation facilities.

§438.340(b)(6)	State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status.	HFS developed the following new goals for its Quality Strategy to focus improvement efforts on the reduction of health disparities: 1. Use data to identify and prioritize reducing health disparities, with ongoing reporting of quality measures stratified by social risk factors, including race, ethnicity, and geography. 2. Implement evidence-based interventions to reduce disparities. 3. Invest in the development and use of health equity performance measures. 4. Incentivize the reduction of health disparities and achievement of health equity. P4P measures have been selected to evaluate performance in the following categories: Male, Female, African American, and Hispanic. HFS identifies the **race, sex, age, ethnicity, disability status, primary language spoken**, and **waiver type** for each Medicaid beneficiary and provides this information to the health plans at the time of enrollment. The Illinois Client Enrollment Broker (CEB) transmits an enrollment file containing race/ethnicity and primary language of each enrollee to the health plans monthly. Health plans are required to develop and implement a **cultural competency plan**, offer appropriate foreign language versions of all beneficiary materials, and develop member materials which can be easily understood at a sixth-grade reading level. The plan is submitted to HFS for approval. Health plans are required to offer trainings to health plan staff and network providers. Health plans are required to monitor network provider compliance with **Americans with Disabilities Act** (**ADA) requirements**. The health plans also make ADA access information available in the online and hard copy provider directory. Health plans are required to proactively attempt to hire staff who reflect the diversity of enrollee demographics. Plan staff are required to complete linguistic and cultural competence training when hired and no less frequently than annually. Health plans are required to have a process to verify subcontractors' and the provider network's compliance with the health plans' Cultural Competency Plan. Health plans are required to collaborate with community-based organizations to address SDOH, assess beneficiary needs, formulate collaborative responses, and evaluate outcomes for community health improvement and eliminating health disparities.

Table 3-4—HFS Strategies to Assess and Improve the Quality of Healthcare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.340(b)(7)	Appropriate use of intermediate sanctions for health plans.	HFS sets forth the right to impose civil money penalties, late fees, performance penalties (collectively, "monetary sanctions"), and other sanctions on health plans for failure to substantially comply with the terms of the contract with HFS. Sanctionable events are included in the health plan contracts.
§438.340(b)(9)	State's mechanisms to identify persons who need LTSS or persons with SHCN and specify those mechanisms in the Quality Strategy.	HFS has had a mechanism in place since 2012 to identify persons who need LTSS services and children with SHCN using a program code in the enrollment file. HFS requires health plans to have specific mechanisms in place to identify individuals who need LTSS services or have SHCN. Health plans are required to have a full-time LTSS program manager who oversees the LTSS program and acts as a liaison among LTSS statewide agency liaisons. HFS requires health plans' qualified service coordinators to conduct comprehensive assessments for individuals in need of LTSS as well as those with SHCN. To assess satisfaction of customers with special needs, HFS added supplemental questions to the health plan CAHPS surveys that include the HCBS population as well as adults with mental health conditions. Questions covering children with SHCN were added to the HFS statewide CAHPS survey. HFS **defines SHCN** children as children under the age of 21 years who are eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 *et seq*) or Medicaid-eligible and eligible to receive benefits pursuant to Title XVI of the Social Security Act. Children with special health care needs (CSHCN) also include Medicaid-eligible children under the age of 21 years who receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 *et seq*) via the DSCC or other such entity that the Department may designate for providing such services and CSHCN as specified in Section 1932 (a)(2)(A) of the Social Security Act. HFS requires health plans to have a **SHCN plan** to conduct timely identification and screening, comprehensive assessments, and appropriate case management services. HFS' EQRO reviews compliance. HFS monitors quality and appropriateness of services for customers with LTSS and SHCN through compliance monitoring activities and regular review of health plan reporting.

Table 3-4—HFS Strategies to Assess and Improve the Quality of Healthcare and Services

42 CFR	Summary of Requirement	HFS Strategy
		Health plans are required to have a consumer advisory board. Health plans are required to identify a liaison who will be a consumer advocate for high-needs children. The individual is responsible for internal advocacy for these enrollees' interests, including input in policy development, planning, decision-making, and oversight.
§438.340(b)(10)	Nonduplication of mandatory activities with Medicare or accreditation review.	HFS requires all health plans to obtain National Committee for Quality Assurance (**NCQA) accreditation**. All six health plans have obtained NCQA accreditation. HFS will consider conducting a nonduplication review of mandatory activities now that all HealthChoice Illinois plans have achieved NCQA accreditation.

Section 4. Monitoring and Compliance

Network Adequacy and Availability of Services

Validation of network adequacy is a mandatory EQR activity according to CMS' *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023.[41] States must conduct this validation during the preceding 12 months to comply with requirements set forth in 42 CFR §438.68. This includes validating data to determine whether the network standards, as defined by the state, were met. Regulations regarding provider-specific network adequacy standards are set forth at 42 CFR §438.68(b).

HFS and its EQRO have established a process for health plans to submit provider network data. The process includes contracted providers within each health plan's service areas, including providers in contiguous counties that provide support to the health plan provider network. Each quarter, health plans are required to submit a provider file layout (PFL) that includes a range of provider types. The EQRO uses the provider network data submissions to conduct biannual analyses and monitoring of the provider network to ensure compliance with the Illinois HealthChoice contract, the FIDE SNP contract, and federal requirements.

HFS directed its EQRO to establish a process for health plans to submit provider network data quarterly for each of their service areas. The quarterly submission of MLTSS providers allows HFS to evaluate provider network capacity across the health plans using a multifaceted, iterative, standardized approach. These data are used to support ongoing monitoring, assessment, and reporting activities to evaluate provider network adequacy.

As part of its provider network adequacy monitoring activities, the EQRO conducts access and availability surveys to evaluate the accuracy of provider information and appointment availability for Illinois Medicaid enrollees. The EQRO also conducts an analysis of the travel time or distance between enrollees and providers in the health plans' networks. Time/distance analysis examines the geographical distribution of each health plan's provider network in relation to its enrollees. The study calculates the percentage of each health plan's enrollees who have a provider located within the required access standards.

HFS' network adequacy and availability of services standards are located here.

Clinical Practice Guidelines

Clinical practice guidelines (CPGs) provide health plan practitioners with "best practice" evidence-based resources and form a basis for health plan efforts to monitor the delivery of healthcare processes and outcomes. HFS mandates that all CPGs be either required by federal or State statutes (including IL Public Act 099-0433 relating to breast cancer diagnosis and care), CMS rules, guidance and conditions of federal match, or promulgated by the U.S. Preventive Services Task Force (USPSTF), the

[41] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: May 15, 2024.

Handbook for Providers of Healthy Kids Services issued by the Department, the Centers for Disease Control and Prevention (CDC) recommended immunizations, or leading academic and national clinical and specialty-based organizations. HFS, through its contracts with the health plans, requires adoption of CPGs to address conditions including the following:

- Asthma
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Adult preventive care
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for children from birth through age 20 years
- Smoking cessation
- Behavioral health (mental health and substance abuse) screening, assessment, and treatment, including medication management and PCP follow-up
- Psychotropic medication management
- Clinical pharmacy medication review
- Coordination of community support and services for enrollees in HCBS waivers
- Dental services
- Pharmacy services
- Community reintegration and support
- Long-term care residential coordination of services
- Prenatal, obstetrical, postpartum, and reproductive healthcare

The CPGs that are adopted by the health plans are based on guidelines developed by nationally recognized sources, including, but not limited to:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- ACOG
- American Diabetes Association
- American Heart Association
- American Psychiatric Association
- CDC
- Global Initiative for Chronic Obstructive Lung Disease
- National Heart, Lung and Blood Institute
- National Institutes of Mental Health
- National Kidney Foundation, Inc.
- American College of Cardiology Foundation
- HIV Medicine Association of the Infectious Diseases Society of America
- Substance Abuse and Mental Health Services Administration
- National Alliance for Tobacco Cessation
- Infectious Diseases Society of America
- U.S. Preventive Services Task Force

These organizations produce evidence-based guidelines using medical literature, professional standards, and/or expert opinions. CPGs are not a substitute for the professional judgment of physicians or other health professionals. CPGs are made available to health plan network providers through committee meetings, provider websites, newsletters and other communications, and they serve as informational resources for providers and members to assist in evidence-based clinical practice, setting member goals for health improvement, and other clinical purposes.

Intermediate Sanctions

In accordance with Section 7.16 of the health plan contract, HFS may impose civil money penalties, late fees, performance penalties such as monetary sanctions, and other sanctions on health plans for failure to substantially comply with the terms of the contract. Monetary sanctions may be imposed, as detailed in the contracts, with determination of the amount at the sole discretion of HFS, within the ranges set forth in the contracts. Self-reporting by a health plan is taken into consideration in determining the sanction amount. HFS may waive the imposition of sanctions for failures determined to be minor or insignificant. Upon determination of substantial noncompliance, HFS gives written notice to the health plan describing the noncompliance, the opportunity to cure the noncompliance where a cure is not otherwise disallowed under the contracts, and the sanction that HFS will impose. HFS may impose a performance penalty and/or suspend enrollment of potential customers. Areas subject to sanctions are included in the contract and include but are not limited to sanctions included in 42 CFR §438 Subpart I, such as the failure to submit required reports or performance results, misrepresentation of information, or failure to provide covered services.

During the past three calendar year reporting periods, the Department issued sanction notices as follows:

- Calendar Year 2022 (Jan 1, 2022, through Dec 31, 2022—18 HealthChoice Illinois (HCI) Sanction Notices:
    - Encounter Data Threshold Reporting Sanctions—seven monetary sanction notices issued
    - Provider Resolution Portal Untimely Ticker Resolution—two monetary sanction notices issued
    - Ad-Hoc and Other Reporting Sanctions—nine monetary sanction notices issued
- Calendar Year 2021 (Jan 1, 2021, through Dec 31, 2021)—11 HCI Sanction Notices:
    - Encounter Data Threshold Reporting Sanctions—10 monetary sanction notices issued
    - Ad-Hoc and Other Reporting Sanctions—one monetary sanction notice issued
- Calendar Year 2020 (Jan 1, 2020, through Dec 31, 2020)—seven HCI Sanction Notices:
    - Encounter Data Threshold Reporting Sanctions—six monetary sanction notices issued
    - Ad-Hoc and Other Reporting Sanctions—one monetary sanction notice issued

Corrective/Remedial Actions

In accordance with Section 7.16.9 of the health plan contract, if HFS determines a health plan has not made significant progress in monitoring or carrying out its required QAP, implementing its QAP, or demonstrating improvement in deficient areas, HFS shall provide notice that the health plan is required to develop a CAP. The CAP must specify the types of problems requiring remedial/corrective action; the type of corrective action to be taken; the goals of the corrective action; the timetable and workplan for action; the identified changes in processes, structure, and internal and external education; the type of follow-up monitoring, evaluation, and improvement; and the identified improvements and enhancements of existing outreach and care management activities, if applicable. Health plans are required to monitor and evaluate corrective actions to assure that appropriate changes have been made and to follow up on identified issues to ensure that actions for improvement have been effective and provide documentation on this process.

During calendar year 2022, the Department issued two HCI CAPs as follows:

- One CAP issued for noncompliance with 1915(c) waiver performance measures, as identified during quarterly HCBS reviews conducted by the EQRO.
- One CAP issued for noncompliance with 1915 (c) waiver case management requirements as identified during biannual staffing and training reviews conducted by the EQRO.

Monitoring System

As required in 42 CFR §438.66, this section describes HFS' monitoring system which addresses all aspects of the managed care program, including the performance of each health plan in the areas designated in the CFR, as summarized in Table 4-1. The table also indicates areas that are included as key indicators in health plan scorecards. Scorecards are a key component of HFS' monitoring system, developed to depict health plan performance on key metrics and performance indicators. The scorecards are reviewed quarterly and available online.

Table 4-1—HFS Monitoring System

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

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		resolution of disputes. HFS tracks and reports the volume of complaints received and resolved to each health plan as part of the QBR process and will be developing complaint trend reports to post on the portal home page beginning in 2021. Health plans are required to have a **provider complaint resolution process** which is linked to the HFS resolution portal for provider education efforts.	
§438.66(b)(3)	Claims management. 	Health plans are required to submit the following claims and encounter management reports: • Monthly encounter data report. • Monthly adjudicated claims inventory summary. • Monthly pharmacy claims monitoring report. • Quarterly report of percent of denied or rejected claims.	An enrollment and claims system review was conducted as part of the HealthChoice Illinois program readiness reviews. The EQRO performs an encounter data validation (EDV) activity once every three years.
§438.66(b)(4)	Enrollee materials and customer services, including the activities of the beneficiary support system. 	All enrollee materials must be approved by HFS initially and as revised. Enrollee service call center reporting metrics are monitored through the scorecard and quarterly health plan reporting in the MPR and QBR processes. HFS offers a variety of avenues for an individual to receive education and enrollment assistance under its beneficiary support system, including an enrollment call center that provides education and enrollment assistance, a secure online enrollment portal, program web pages, and the availability of	The readiness and administrative reviews include a review of enrollment materials and review of service level agreement (SLA) reporting for the member services for each health plan.

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		education and enrollment materials in other formats or languages (auxiliary aids) when requested.	
§438.66(b)(5)	Finance, including medical loss ratio (MLR) reporting.	Quarterly unaudited financial reports and annual audited financial reports. HFS defers review of the MLR reporting to the Department of Insurance (DOI). Annual submission of benefit expense claims for each MLR reporting year, including an attestation to the accuracy of all data and of the MLR calculation. Health plans are also required to collect all underlying data associated with MLR reporting from any third-party vendors and to calculate and validate the accuracy of MLR reporting. Each health plan must submit an annual cost report that provides a reconciliation of its audited financial statement to the annual cost report. The reconciliation must be reviewed and certified by an independent auditor or by an executive officer of the health plan.	The EQRO does not monitor this requirement.
§438.66(b)(6)	Information systems, including encounter data reporting.	Health plans submit a monthly encounter data report, and HFS conducts two levels of review. The review includes a check for completeness and accuracy of the data, and health plans are required to correct and resubmit the data if errors are identified.	An enrollment and claims system review was conducted for the HealthChoice Illinois program readiness reviews. The EQRO performs an EDV activity once every three years.
§438.66(b)(7)	Marketing.	All marketing materials, plans, and procedures must be approved initially and as revised.	The EQRO does not monitor this requirement.

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(8)	Medical management, including utilization management and case management. 	**Care Management** Care management and disease management program descriptions are submitted initially and as revised. Health plans are required to submit the following monthly and quarterly reports: • Monthly care coordination effectiveness summary report. • Annual care gap plan. • Quarterly outreach summary report. • Quarterly enrollee engagement metrics. • Transition of care plan, initially and as revised. • Care management metrics are also monitored through the scorecard. **Utilization Management** Health plans are required to submit the following monthly utilization management (UM) reports: • Monthly prior authorization report. • Monthly utilization management report, pharmacy utilization monitoring report, psychotropic review report, and drug utilization report. • Utilization metrics are also monitored through the scorecard.	The readiness and administrative reviews include utilization management and care management program requirements and case file reviews. The EQRO also conducts a CM/CC staffing, qualifications, and training review to review the educational qualifications, related experience, annual training hours, and caseloads of CM/CC staff serving the Medicaid managed care population against state-selected requirements.

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(9)	Program integrity.	Health plans are required to submit the following program integrity reports: • Quarterly fraud and abuse report. • Annual certification to confirm compliance of each contractor and its subcontractors. • Recipient verification procedure, initially, annually, and as revised. • FWA compliance plan.	Review of the FWA compliance plan, reporting, training, and mechanisms in place to detect FWA is conducted during readiness and administrative reviews.
§438.66(b)(10)	Provider network management, including provider directory standards. 	Monthly provider directory attestation reports. Quarterly review of health plan network capacity status. Provider metrics are also monitored through the scorecard.	Review of provider contracts for the following provider types: ancillary, facility, federally qualified health center (FQHC), hospital, physician hospital organization (PHO), and provider. The EQRO reviews a template contract to determine compliance with requirements. Compliance with provider directory standards is reviewed during the readiness and administrative reviews.

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(11)	Availability and accessibility of services, including network adequacy standards. 	Health plans are required to submit the following weekly and monthly provider network reports: • Weekly PCP, hospital, and affiliated specialist file (CEB Provider File). • Monthly provider network file (complete). • Provider site closures/terminations notification (as each occurs). • Network access metrics are also monitored through the scorecard.	Biannual provider network monitoring for HealthChoice Illinois and LTSS. Biannual network provider capacity reviews. Network capacity reviews as part of administrative and readiness reviews. Ad hoc network capacity analysis. Review of health plan provider access and appointment availability audit results to assess health plans' monitoring of provider compliance with appointment availability and after-hours access standards. Annual analysis of time/distance standards for specific network providers including PCPs, OB/GYNs, behavioral health, specialists, hospitals, pharmacy, and adult and pediatric dental.
§438.66(b)(12)	Quality improvement. 	Health plans are required to submit the following quarterly and annual reports: • A QAPI program description annually and evaluate the effectiveness of the QAPI program as indicated in the annual QA/UR/PR Report/Program Evaluation. • Adult and child CAHPS results are reported in each health plan's annual QAPI evaluation report. • Quarterly HEDIS measure rates report. • Submission of QA/UR/PR committee meeting minutes at the request of HFS.	Review of the QAPI program description and annual QAPI evaluation report. Administrative, readiness, and focused reviews. PIPs. The EQR report includes the results of the CAHPS surveys, quality measures, and all EQR mandatory and optional activities conducted during the preceding 12 months.

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(13)	Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program. 	Health plans are required to submit the following critical incident (CI) reports: • Health plans are required to submit policies and procedures for processing CIs, initially and as revised. • Monthly CI detail report and quarterly CI summary report. CI metrics are monitored through the scorecard. • The EQRO also submits the following reports as a result of monitoring of CIs and health, safety, and welfare (HSW). • EQR HSW reports identified during quarterly record reviews. • Quarterly summary of HSW reports.	Quarterly record review of plan compliance with the HCBS CMS performance measures. Review of HSW concerns during quarterly record reviews and review of health plan remediation actions. Quarterly CI monitoring through case file reviews and follow up on findings and remediation actions. Annual review of LTSS care management qualifications, training, and caseload requirements. Review of compliance with CI reporting during administrative reviews.
§438.66(b)(14)	All other provisions of the contract, as appropriate.	See the section on health plan reporting below.	See the "External Quality Review" section.
§438.66(d)	Assesses the readiness of each contracted health plan	HFS employs its EQRO to conduct readiness reviews: • Prior to the State implementing a managed care program, whether the program is voluntary or mandatory. • When the specific health plan entity has not previously contracted with the State. • When any health plan currently contracting with the State will provide or arrange for the provision of covered benefits to new eligibility groups. HFS ensures that readiness reviews are: • Initiated at least three months prior to the effective date of the events described above. • Completed in sufficient time to ensure smooth implementation of an event described above.	

Table 4-1—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		• Submitted to CMS for CMS to make a determination that the contract or contract amendment is approved. HFS also ensures that readiness reviews include both a desk review of documents and on-site reviews as required by federal regulations and assess the ability and capacity of the health plan to perform satisfactorily in all the applicable areas outlined in CFR §438.66(d)(4).	

Health Plan Reporting

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

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

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

Reporting is required monthly, quarterly, and annually as demonstrated in the reporting tables found in Attachment XIII (Required Deliverables, Submissions, and Reporting) of the HealthChoice contract and *Attachment 2 Required Deliverables, Submissions and Reporting* of the FIDE SNP contract.

Using Monitoring Data to Improve Performance

As required in 42 CFR §438.66(c), HFS uses data collected from its monitoring activities to improve the performance of its managed care program, including:

- Enrollment and disenrollment trends in each health plan.
- Member grievance and appeal logs.
- Provider complaint and appeal logs.
- Findings from the EQR process.
- Results from any enrollee or provider satisfaction survey conducted by HFS or the health plan.
- Performance on required quality measures.
- Medical management committee reports and minutes.
- Annual QAP for each health plan.
- Audited financial and encounter data submitted by each health plan.
- Medical loss ratio summary reports required by 42 CFR §438.8.
- Customer service performance data submitted by each health plan and performance data submitted by the beneficiary support system.
- Any other data related to the provision of LTSS not otherwise included in this section as applicable to the managed care program.

Section 5. External Quality Review Arrangements

HFS contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, the EQRO conducts the mandatory and optional EQR activities as set forth in 42 CFR §438.358. The EQRO performs services in accordance with 42 CFR and the Balanced Budget Act of 1997 (refer to *CMS External Quality Review (EQR) Protocols, February 2023*)[42] and provides biweekly status updates on all activities to HFS. Each year, the EQRO develops a detailed workplan to guide its activities with HFS.

Mandatory EQR Activities

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

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(i)	**Validates PIPs** in accordance with §438.330(b)(1) to determine if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and beneficiary satisfaction.
§438.358(b)(1)(ii)	**Validates performance measures**. Conducts NCQA HEDIS Compliance Audits™,[43] and PMV audits in accordance with §438.330(b)(2). A list of healthcare and quality of life measures is included in the HCI contract.

§438.358(b)(1)(iii)	**Conducts a review**, at least every three years, **to determine health plan compliance** with federal standards (subpart D) and the QAPI requirements described in §438.330. HFS' EQRO conducts a variety of types of compliance reviews including:
	• Administrative Reviews and Remediation
	  ○ To determine health plan compliance with various quality assessment/improvement standards in 18 areas of compliance. Results are published in the annual technical report which are located in HFS' report center.
	• Readiness Reviews and Remediation
	  ○ To evaluate, prior to client enrollment, whether a health plan's internal organizational structure, health information systems, staffing, and oversight are sufficient to enroll customers.
	• HCBS Record Reviews and Remediation
	  ○ In accordance with CMS requirements, quarterly on-site record reviews of a statistically valid sample, weighted by waiver type, are conducted by the EQRO. All record review findings and remediation of findings are tracked in the record review database. Annual reviews of HCBS staffing, experience, qualifications, FTEs, and caseload assignments are conducted on all health plans that provide

[42] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: May 15, 2024.

[43] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
	services to HCBS Waiver customers. A list of the CMS HCBS measures is included in the HCI contract. • Critical Incident/HSW Reviews and Remediation ○ To audit health plan processes for identifying and resolving Critical Incident/HSW concerns by conducting case file reviews.
§438.358(b)(1)(iv)	**Validates MCOs' and PIHPs' network adequacy** to comply with requirements set forth in §438.68. The EQRO conducts a biannual review of the provider network, annual time/distance analysis of selected providers to evaluate compliance with time/distance standards requirements, and appointment availability surveys to evaluation compliance with appointment standards and after-hours access for customers. HFS' EQRO also conducts an analysis of the health plans' provider networks as a key component of pre- and post-implementation readiness reviews to evaluate the progress of each health plan in contracting with a sufficient number of providers to establish network capacity in the expansion areas.
§438.364	**Produces an annual EQR technical report** and submits to the State in accordance with the CFR requirements. The EQRO works with HFS to follow up on EQR recommendations by building and monitoring EQR recommendations, QAPs, and corresponding implementation plans with each health plan.

Optional EQR Activities

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

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(c)(1)	**Validates encounter data** reported by health plans. Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates; however, these data must be valid, complete, and accurate.
§438.358(c)(2)	**Validates and administers consumer surveys of quality of care**. Each year, the health plans are required to independently administer a consumer satisfaction survey for both adults and children as applicable to the programs they cover. The EQRO administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. The EQRO summarizes the health plan and statewide data and includes the results of the CAHPS surveys in the annual EQR technical report.
§438.358(c)(3)	**Validates performance measures for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Program** using the CMS protocol. The primary objectives are to evaluate the processes used to collect the performance measure data by HFS and determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.
§438.358(c)(5)	**Conducts studies on quality** that focus on an aspect of clinical or nonclinical services at a point in time. The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of health plan customers.

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(c)(6)	**Assists** with the development and production of the **quality rating of health plans** report card consistent with §438.334.
§438.358(d)	**Provides technical assistance (TA)** to HFS and the health plans. The EQRO has provided a variety of TA to HFS that has led to quality outcomes, including TA in the following areas: PIPs, grievance and appeals process, CM/CC programs, CAHPS sampling and development of CAHPS supplemental questions, P4P program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS Waiver program requirements, and more.
§438.340(c)(2)(ii)	**Evaluation of Quality Strategy**. States are required to review the Quality Strategy including an evaluation of its effectiveness. This can be done by means of the annual EQR technical report by ensuring the report includes a section that addresses the effectiveness of the State's Quality Strategy and determines whether any updates to the strategy are necessary based on EQR results.

Section 6. Improvement and Interventions

Continuous Quality Improvement

HFS recognizes that having standards is a first step in promoting safe and effective healthcare. In order to ensure that standards are followed, HFS regularly monitors the health plans and managed care programs. HFS is also committed to ongoing assessment and identification of opportunities for improvement to ensure delivery of the highest-quality, most cost-effective services. Based on the results of the assessment and monitoring activities outlined in sections 4 and 5 of this report, Illinois has implemented comprehensive approaches for continuous quality improvement with the goal of improving healthcare outcomes to all customers enrolled in a Medicaid program. HFS' major, overarching strategies for improvement are described below.

Scorecards and Claims Analysis	Scorecards are developed to depict health plan performance on key metrics and performance indicators. Health plans use the scorecards to assist in developing action plans for improvement. In addition, MCO hospital claims processing and payment performance analysis is conducted twice a year.	HFS restructured management to add a new layer of Medicaid oversight. Each health plan is assigned an HFS account manager. Weekly meetings and monthly operations meetings are conducted to follow up on action plans. HFS also developed an Account Manager inbox so all requests and responses flow through one channel and are tracked across health plans.	**Account Managers**
Quarterly Business Reviews (QBRs)	QBRs are conducted with all health plans to review scorecards, discuss trends in performance, identify barriers, share best practices, and promote continuous improvement.	HFS account managers track the progress of health plan implementation of CAPs developed in response to administrative and readiness reviews, network monitoring, and HCBS record reviews.	**Corrective Action Plans (CAPs)**

Quarterly Quality Meetings	Two types of quality meetings are held each quarter. HFS meets with MCO quality teams as a group to facilitate discussion, best practices, and education, often adding SMEs to the discussion. HFS also meets individually with each MCO quarterly to discuss MCO QAPs. This often includes MCO analyses of quality performance measures, identification of any disparity or gaps in care, and targeted interventions to close specific gaps.	The goal of the PACE is to empower older adults with long-term care needs to maximize their health and well-being so they may live as freely as possible in their home as opposed to a long-term care facility. PACE will strive to improve the participants' quality of life by providing comprehensive health services in their home and community when possible. In addition to the CMS required quality data reporting, Illinois has established four additional sets of metrics: timely specialist referrals, reduction in the rate of fall incidents, participants not in long-term care, and nutritional status.	**All-Inclusive Care for the Elderly (PACE)**
EQR Recommendations	HFS has developed a process for the State and health plans to follow up on recommendations from the annual EQR process.	To provide feedback and analysis on the health plans' compliance with HSW and CI requirements, HFS' EQRO conducts quarterly reviews of HSW/CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Health plans are required to complete remediation of any findings.	**HSW and CIs**

Quality Improvement Interventions

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

Pillar	Initiatives
Maternal and Child Health	**Prenatal and Postpartum Care PIP**: In addition to establishing Maternal and Child Health and Equity as pillars of the HFS Quality Strategy and breaking out results by race, ethnicity, and geography, the Department selected the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure (a P4P measure) as the Medicaid managed care PIP, requiring all of the Medicaid MCOs to identify a health disparity within the prenatal and postpartum care period and close the gap. The Department's EQRO provides health plans with support and technical assistance. The HFS Illinois Moms & Babies Program[44] covers insurance for birthing persons during the course of their pregnancy and for up to 12 months after the baby is born. It provides screening and coverage for postpartum depression as well as any medical complications that can arise. Additionally, birthing persons can sign up for the "text4baby" program that provides them with advice on infant care and postpartum issues. Research indicates that infants and children with birthing persons who are insured are more likely to receive adequate medical care. Based on low rates of breast and cervical cancer screening according to electronic case reporting (eCR) reports, particularly in Black and Hispanic populations, HFS added P4P measures in the equity pillar for both topics. HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), developed a **statewide Bright Smiles from Birth Program** that uses web-based training to educate physicians, nurse practitioners, and FQHCs on how to perform oral health screenings, assessments, and fluoride and varnish applications in both the FFS and managed care delivery system. The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care, and studies confirm that fluoride varnish applications are effective in reducing early childhood caries in young children. See http://www.brightsmilesfrombirth.org for more information. **DCFS Youth** are now served by HealthChoice Illinois.

[44] Illinois Department of Healthcare and Family Services. *Moms and Babies Programs for Pregnant Women*. Available at: Moms and Babies | HFS (illinois.gov). Accessed on: June 10, 2024.

Pillar	Initiatives
Adult and Child Behavioral Health	**Violence Prevention—Community Support Team** is a new service designed to provide team-based services to individuals who have experienced trauma associated with community and gun violence. The team consists of mental health professionals and persons with lived experience with community and gun violence and is designed to reduce trauma symptoms and reduce community and gun violence.[45] **Directed payments and rate increases for targeted community behavioral health services** have been implemented totaling over $30 million. Additional work is being conducted to revise the payment strategies for Assertive Community Treatment, Community Support—Team and Mobile Crisis Response. To ensure follow-up after an acute care episode related to mental illness or substance abuse, some HTCs will work with the MCOs on stabilization, community-based supports, and ongoing care management.
Equity	The **MCO health equity director** oversees the MCO's strategic design, implementation, and evaluation of health equity efforts in the context of population health initiatives; informs decision-making around the provision of health equity and SDOH resources; and ensures the MCO collects and meaningfully uses race, ethnicity, and language data to identify disparities. **Quarterly equity discussions** are inclusive of MCO quality programs and their health equity directors. Each quarter focuses on different quality measures wherein MCO quality programs stratify measure data, such as by race, gender, ethnicity, and disproportionately impacted areas (DIAs). These analyses can help MCOs identify equity gaps, advance health equity efforts of their SSDOH Plans, further the work overseen by the health equity director, and incorporate customer feedback through their advisory committees. The **LTSS Disparities Workgroup** promotes and facilitates communication, coordination, and collaboration among relevant State agencies and communities of color, limited-English-speaking communities, and the private and public entities providing LTSS services to those communities. Many members of the LTSS Disparities Workgroup reflect the diversity in race, gender, age, and ethnicity served by the State. The workgroup explores trends and racial and ethnic profiles of customers who use LTSS services in facilities and in the home or community; family and/or informal caregivers for elders; and how the LTSS industry provides culturally sensitive, competent, and linguistically appropriate services. The workgroup submits their findings and recommendations in an annual report to the Governor and General Assembly. The State of Illinois' **Business Enterprise Program** is an integral part of addressing equity, and the goals of the program will be incorporated into how quality is measured.[46]

[45] Illinois Department of Healthcare and Family Services. *Violence Prevention Community Support Team.* Available at: Violence Prevention Community Support Team (illinois.gov). Accessed on: May 17, 2024.

Pillar	Initiatives
Community and Health Promotion	HFS has **updated the HCBS performance measures** to reflect CMS' recommendations. HFS made these updates with the goal of aligning measures across all Illinois waivers. Having consistency among the nine HCBS waiver programs will allow the Department to compare compliance among Operating Agencies (OAs), including the Illinois Department on Aging and the Illinois Department of Human Services' Division of Developmental Disabilities and Division of Rehabilitation Services. By comparing compliance, HFS and the various OAs can learn from each other and improve quality across all waiver programs for customers served. To promote access to care and support for ongoing needs, some HTCs and MCOs work in partnership to advance outcomes for eligible customers. On October 1, 2020, HFS operationalized the CTI. Under this initiative, HCI plans received incentive payments for the successful transition of customers living in skilled nursing facilities and specialized mental health rehabilitation facilities (SMHRFs).

[46] State of Illinois Commission on Equity & Inclusion. *Business Enterprise Program*. Available at: Business Enterprise Program (BEP) (illinois.gov). Accessed on: May 17, 2024.

Pillar	Initiatives
All Pillars	**Performance Management Initiative: Transition of Care Programs** (including CM/CC) • Increase HFS' performance management oversight of the MCOs. • MCOs identification of top hospitals with which they are working relative to transitions of care. • MCOs will submit weekly rosters to HFS account managers identifying behavioral health inpatient admissions. • HFS account managers will have weekly discussions with the MCOs to review the roster and to understand how the MCO is actively managing transition(s) of care. **Performance Management Initiative: Emergency Department Utilization** **Performance Management Initiative: Executive Scorecard Performance.** MedInsight metrics and MCO self-reported metrics. **Telemedicine task force** is charged with expanding the use of telemedicine within the Medicaid program. **Quality Withhold Program**. Health plans may earn payments based on performance with respect to select quality metrics that support the Quality Strategy goals. Collection of data and calculation of health plan performance against the quality withhold measures are in accordance with measure steward specifications and benchmarks. In calendar year 2023, Illinois adopted legislation regarding Medicaid managed care withhold program requirements. The Quality Withhold Program methodology incentivizes health plans to perform at a rate at or above the 90th percentile. Health plans can also earn a high-performance bonus for those who perform at a rate at or above the 75th percentile for two consecutive years. Finally, health plans can earn an improvement bonus if they demonstrated at or above a 25 percent degree of improvement with current year performance. HFS worked with its EQRO to research several states and resources to develop this comprehensive methodology. Medicaid managed care health plans are subject to a 2 percent withhold, with P4P making up 1 percent of the Quality Withhold Program and P4R making up the other 1 percent of the Quality Withhold Program. P4R helps provide insight and guidance regarding which measures could be moved to P4P in the future and reduce disparities, as measure stratification by race, disproportionally impacted areas, and ethnicity are required, allowing health plans to identify HRSNs. HFS is working to **engage customers in an advisory capacity** and to participate in the MAC. **Health Plan Accreditation.** Pursuant to 305 ILCS 5/5-30 (a) and (h), HFS requires that any health plan serving at least 5,000 seniors, or people with disabilities, or 15,000 customers in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one year are considered eligible for accreditation and will be accredited by the NCQA within two years after the date the health plan was eligible for accreditation. The health plans must achieve and/or maintain a status of "Excellent," "Commendable," or "Accredited."

Health Information Technology (HIT)

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

INTEGRATED ELIGIBILITY SYSTEM (IES)	• Eligibility system used to determine eligibility for medical programs: Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF); and cash assistance for Aged, Blind, or Disabled (ABD). • In collaboration with DHS and the Department of Innovation and Technology (DoIT). • Cost of development and installation largely defrayed by enhanced 90 percent match from federal government.
ILLINOIS MEDICAID PROGRAM ADVANCED CLOUD TECHNOLOGY (IMPACT)	The IMPACT initiative is a multi-agency effort that modernizes HFS' 30-year-old Medicaid Management Information System (MMIS) which was built to support a FFS Medicaid program. The MMIS supports claims processing for the HFS medical assistance programs.[47]
IMPACT'S FOUR PHASES	• **Electronic Health Records (EHRs) Medicaid Incentive Payment Program (eMIPP)**: Provides incentive payments to eligible providers (EPs), eligible hospitals (EHs), and critical access hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. • **Web Provider Enrollment**: Beginning in July 2015, providers have been required to enroll and revalidate their enrollment through the new IMPACT Web portal. • **Pharmacy Benefits Management System (PBMS)**: Internet-based application capable of interacting with providers, manufacturers, and other stakeholders to conduct the business processes of managing the Pharmacy Services and Drug Rebate program. • **Full Implementation/CoreSystem**: This phase is the largest and most complex. It encompasses numerous subsystems including claims/encounters, prior approval, eligibility/enrollment, business administration, and financials. The Full Implementation/CoreSystem is projected to be completed in 2026. Once completed, the Department will have a modern, single, cloud-enabled MMIS for all Medicaid claims processing.

[47] Illinois Department of Healthcare and Family Services. *About IMPACT*. Available at: About IMPACT | HFS (illinois.gov). Accessed on: May 16, 2024.

EHR PAYMENT INCENTIVE PROGRAM	Section 4210 of the Health Information Technology for Economic and Clinical Health (HITECH) Act established an EHR provider incentive payment program, which allows Medicaid to pay an incentive to eligible professionals who attested to adopt, implement, upgrade, or meaningfully use certified EHR technology. In September 2011, HFS launched Illinois' Medicaid EHR Incentive Payment Program, allowing attestations via a State Web application (now called the EHR Medicaid Incentive Payment Program [eMIPP]) from providers who had initiated the registration process on a CMS website. Since the program's inception through December 13, 2020, HFS has awarded over $656.2 million in incentive payments to 9,339 EPs and 174 EHs to encourage them to adopt, implement, or upgrade their local EHR system, with a later goal of engaging in the "meaningful use" of said technology. The State estimates that the 100 percent federally funded payments to eligible providers may exceed $700 million over the life of the program, which continued through 2021.
ADMISSION, DISCHARGE, TRANSFER (ADT) INITIATIVE	HFS began an Admission, Discharge, Transfer (ADT) initiative in spring 2021. ADT is a statewide data exchange platform that delivers vital information to Illinois Medicaid providers in a timely and secure manner. The platform sends real-time ADT notifications from the admitting or discharging facility, including emergency room visits, to a patient care coordinator or primary care provider. This real-time information improves care coordination opportunities by highlighting high utilizers of hospitals and emergency departments. The platform also provides higher quality care and produces more successful outcomes, decreases unnecessary hospital admissions and readmissions, decreases emergency room visits, as well as outlines the timeliness and type of care coordination response to notifications by end users. The platform is continuing to expand to other care providers including long-term care facilities, FQHCs, mental health centers, and others.[48]

[48] Illinois Department of Healthcare and Family Services. *HealthChoice Illinois ADT*. Available at: HealthChoice Illinois ADT | HFS. Accessed on: May 16, 2024.

Section 7. Conclusions

Evaluation of the Effectiveness of the Quality Strategy

The Department works closely with the EQRO throughout the year to support, oversee, and monitor quality activities and evaluate the HealthChoice Illinois Medicaid Managed Care Program's achievement of goals and objectives. The EQRO provides ongoing technical support to the Department in the development of monitoring strategies. The EQRO also works with the Department to ensure that the health plans stay informed about new State and federal requirements and evolving technologies for quality measurement and reporting. Additionally, the Department and the EQRO conduct a formal evaluation of the Quality Strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to recipients, providers, and integrated stakeholders was accomplished.

In accordance with federal regulations at 42 CFR §438.340(c)(2), HFS reviews its Quality Strategy, and that review includes an evaluation of the effectivities of the Quality Strategy using data from multiple sources. The evaluation includes:

- An analysis of each measure of the Quality Strategy's goals and objectives for improvement made over time against baseline data.
- An analysis of whether the State's managed care quality provisions, as detailed in its quality strategy, are aligned, and focus on consistent aims and goals.
- An analysis of whether the State's managed care quality provisions, as detailed in its quality strategy, address managed care plan performance on the Child and Adult Core Set measures.
- An analysis of how the State acted on EQR recommendations in its quality strategy.

HSAG used the above analyses to determine the following:

- Whether the State is making progress on its quality strategy goals and objectives.
- Whether the State is continuing with or revising its goals and objectives based on the evaluation.
- A description of how the State modified its approach in its revised quality strategy if it did not meet or make progress on its goals and objectives.

The Department uses several tools to evaluate the effectiveness and achievement of goals, including:

- The annual EQRO technical report.
- Validated healthcare and quality of life performance measure results.
- Validated PIP results.
- Plan compliance review results.
- Ongoing review of contractually required health plan deliverables.
- Recipient complaint and grievance information.
- Stakeholder feedback emailed to the Department via the Department website.

The most recent full evaluation assessed the Department's 2021–2024 Quality Strategy. The evaluation provided the following key findings:

- HFS' quality provisions for improvement, as detailed in its Quality Strategy pillars, were tied to a Quality Strategy program objective (performance measure).
- The Quality Strategy program objectives were assessed and reported annually.
- Performance improvements were realized in the following pillars: Improve Maternal and Infant Health Outcomes, Improve Behavioral Health Services and Supports for Children, Increase Preventive Care Screenings—Use Data to Identify Target Areas in Priority Regions where Disparities in Optimal Outcomes are the Highest, and Serve More People in the Settings of Their Choice.
- On P4P measures, the statewide rate met the national benchmark on four measures and demonstrated relative improvement on five measures. For P4R measures that were evaluated against national benchmarks, the statewide rate met or exceeded the 50th percentile when compared against national benchmarks for five of the six measures. For P4R measures that were evaluated against prior year performance only, the statewide rate demonstrated improvement for nine of the 10 measures.
- Although performance improvements were not realized in the Improve Behavioral Health Services and Supports for Adults pillar, the evaluation concluded that the Department had identified barriers and a viable strategy for continued improvement or overcoming those barriers.

The evaluation noted that the Department made this progress despite the COVID-19 public health emergency (PHE) that began in CY 2020.

The evaluation also reviewed the Department's responsiveness to EQRO recommendations and identified that the Department addressed recommendations and used performance results to inform revisions to the 2024–2027 Quality Strategy. Highlighted examples included:

EQRO Recommendation	Response and Impact to 2024–2027 Quality Strategy
Require health plans to conduct a root cause analysis or focus study to determine why child members are not receiving the recommended well-child visits or immunizations.	Health plans reported results of root cause analyses related to immunizations and well-child visits to the Department during the evaluation period, with information related to targeted areas for continued improvement. The analyses included identification of barriers, including disparities with linkages to demographic and geographic areas of focus. Health plans reported 2024 initiatives such as targeted value-based purchasing (VBP) programs and provider and member engagement events to address performance. The Department evaluated recommended immunizations for children and revised its measure to *CIS—Combination 10* (a P4R measure during the Evaluation period) in its 2024–2027 Quality Strategy to allow for capture of additional recommended immunizations. The Department also established a vaccine workgroup in 2024 to identify barriers and implement best practices.

EQRO Recommendation	Response and Impact to 2024–2027 Quality Strategy
	In addition, the Department established performance targets for well-child visit performance measures in its 2024–2027 Quality Strategy.
Improve follow-up after hospitalization for mental illness performance by requiring health plans to evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable; lead a program wide focus group that includes members of each health plan and key community stakeholders to identify barriers/facilitators to members accessing follow-up care; and/or encourage health plans to enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.	During the evaluation period, health plans conducted root cause analyses to determine observations and target areas for improvement related to follow-up after hospitalization for mental illness. Health plans identified barriers, including demographic and geographic areas of focus. Health plans reported initiatives such as targeted VBP programs in 2024 to address performance. The Department retained mental health performance measures in its P4P and P4R programs and its Quality Strategy priority goals. In its 2024-2027 Quality Strategy, the Department established performance targets for several behavioral health/mental health measures, including *Follow-Up After Hospitalization for Mental Illness (FUH)*.

Overall results of the Quality Strategy evaluation showed that, while the Department made considerable progress in addressing its Quality Strategy goals, opportunities for improvement remain available. The Department is committed to continuous improvement and is maintaining quality goals and associated measures in its 2024–2027 Quality Strategy, with modifications to reflect updates to statewide priorities and re-establish priority pillars. The Department further established performance targets for all quality measures in the 2024–2027 Quality Strategy, which will allow for more comprehensive evaluation of progress in meeting priority goals.

Next Steps

The Department will continue looking for innovative ways of improving the health of Illinoisans through service delivery in a managed care environment. For meaningful quality improvement, there must be improvement in equity; HFS will continue to collaborate with Medicaid managed care plans and other stakeholders using data analytics and disparity factors to identify care gaps and to implement interventions that reduce or remove barriers to care with the goal of improving equity.

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

AAP ..... Adults' Access to Preventative/Ambulatory Health Services

AABD ..... Aid to the Aged, Blind, or Disabled

ACA ..... Affordable Care Act

ADA ..... Americans with Disabilities Act

ADHD ..... Attention-deficit/hyperactivity Disorder

ADT ..... Admission, Discharge, Transfer

AOD ..... Alcohol and Other Drug

BMC ..... Bureau of Managed Care

BMI ..... Body Mass Index

CAHPS®[1] ..... Consumer Assessment of Healthcare Providers and Systems

CAD ..... Coronary Artery Disease

CAP ..... Corrective Action Plan

CAU ..... Client Assessment Unit

CCBHC ..... Certified Community Behavioral Health Clinics

CEB ..... Client Enrollment Broker

CFR ..... Code of Federal Regulations

CHF ..... Congestive Heart Failure

CHIP ..... Children's Health Insurance Program

CHIPRA ..... Children's Health Insurance Program Reauthorization Act

CI ..... Critical Incident

CM/CC ..... Care Management/Care Coordination

CMS ..... Centers for Medicare & Medicaid Services

CNA ..... Certified Nursing Assistant

COPD ..... Chronic Obstructive Pulmonary Disease

COVID-19 ..... Coronavirus Disease 2019

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

CPG ..... Clinical Practice Guidelines

CTI ..... Community Transitions Initiative

DCFS ..... Department of Children and Family Services

DHS ..... Department of Human Services

DOA ..... Department on Aging

DOI ..... Department of Insurance

DoIT ..... Department of Innovation and Technology

DSCC ..... Division of Specialized Care for Children

eCR ..... Electronic Case Reporting

EH ..... Eligible Hospital

EHR ..... Electronic Health Record

eMIPP ..... Electronic Health Records Medicaid Incentive Payment Program

EP ..... Eligible Provider

EQR ..... External Quality Review

EQRO ..... External Quality Review Organization

FFS ..... Fee-For-Service

FIDE-SNPs ..... Fully Integrated Dual Eligible Special Needs Plans

FMAP ..... Federal Medicaid Assistance Percentage

FQHC ..... Federally Qualified Health Center

FTE ..... Full-Time Equivalent

FUH ..... Follow-Up After Hospitalization for Mental Illness

FWA ..... Fraud, Waste, and Abuse

FYiC ..... Former Youth in Care

HbA1c ..... Hemoglobin A1c

HCBS ..... Home- and Community-Based Services

HCI ..... HealthChoice Illinois

HEDIS®[2] ..... Healthcare Effectiveness Data and Information Set

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

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

HIV ..... Human Immunodeficiency Virus

HMO ..... Health Maintenance Organization

HRSN ..... Health Related Social Needs

HSW ..... Health, Safety, and Welfare

HTC ..... Healthcare Transformation Collaboratives

ICT ..... Interdisciplinary Care Team

IHDA ..... Department of Housing Development Authority

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

IDHS ..... Illinois Department of Human Services

IDPH ..... Illinois Department of Public Health

IES ..... Integrated Eligibility System

IHI ..... Institute for Healthcare Improvement

ILCS ..... Illinois Compiled Statutes

IMPACT ..... Illinois Medicaid Program Advanced Cloud Technology

LTSS ..... Long-Term Services and Supports

MAC ..... Medical Advisory Committee

MCO ..... Managed Care Organization

MFP ..... Money Follows the Person

MLR ..... Medical Loss Ratio

MLTSS ..... Managed Long-Term Services and Supports

MMAI ..... Medicare-Medicaid Alignment Initiative

MMIS ..... Medicaid Management Information System

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

MPR ..... Managed Care Organization Performance Reporting

NCQA ..... National Committee for Quality Assurance

NOFO ..... Notice of Funding Opportunity

OB/GYN ..... Obstetrician/Gynecologist

OUD ..... Opioid Use Disorder

P4P ..... Pay-For-Performance

P4R ..... Pay-For-Reporting

PACE ..... Program of All-Inclusive Care for the Elderly

PAHP ..... Prepaid Ambulatory Health Plan

PBMS ..... Pharmacy Benefits Management System

PCCM ..... Primary Care Case Management

PCP ..... Primary Care Physician

PDPM ..... Patient Driven Payment Model

PHO ..... Physician Hospital Organization

PIHP ..... Prepaid Inpatient Health Plan

PIP ..... Performance Improvement Project

PMV ..... Performance Measure Validation

PPC ..... Prenatal and Postpartum Care

PR ..... Peer Review

QA ..... Quality Assurance

QAP ..... Quality Assessment Plan

QAPI ..... Quality Assessment and Performance Improvement

QBR ..... Quarterly Business Review

QIP ..... Quality Improvement Project

QRS ..... Quality Rating System

RUG ..... Resource Utilization Group

SLA ..... Service Level Agreement

SMART..... Specific, Measurable, Attainable, Relevant, and Time-Bound

SMHRF ..... Specialized Mental Health Rehabilitation Facility

SNAP ..... Supplemental Nutrition Assistance Program

SNF ..... Skilled Nursing Facility

SLA ..... Service Level Agreement

SSA ..... Social Security Administration

SSDOH ..... Social and Structural Determinants of Health

STRIVE ..... Staff Time and Resource Intensity Verification

SUD ..... Substance Use Disorder

TA..... Technical Assistance

TANF ..... Temporary Assistance for Needy Families

TOC ..... Transition of Care

UM ..... Utilization Management

UR ..... Utilization Review

USPSTF ..... United States Preventive Services Task Force

W30..... Well-Child Visits in the First 30 Months of Life

WCV ..... Child and Adolescent Well-Care Visits

YiC ..... Youth in Care

HealthChoice Illinois Enrollment

As of January 2024, six health plans participated in HealthChoice Illinois: Aetna Better Health (Aetna), Blue Cross Community Health Plans (BCBSIL), CountyCare, Meridian, Molina HealthCare of Illinois (Molina), and YouthCare Specialty Plan (YouthCare).

Enrollment figures for HealthChoice Illinois are displayed in the tables below. Table 1-2 presents overall enrollment. Table 1-3 and Table 1-4 display the gender and age bands of Medicaid/non-CHIP and CHIP enrollment, respectively, as of January 1, 2024. Table 1-5 presents non-match figures (non-match refers to State funding with no federal matching dollars), and Table 1-6 presents the race/ethnicity composition of beneficiaries.

Table 1-1—HealthChoice Illinois Enrollment

HEALTH PLANS	JAN 2024 ENROLLMENT
Aetna	396,878
BCBSIL	759,040
CountyCare (Cook County Only)	431,794
Meridian	828,504
Molina	331,069
YouthCare	36,482
Total HealthChoice Illinois Enrollment	**2,783,767**

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

GENDER/AGE BAND	JAN 2024 ENROLLMENT
<1 year	57,919
1–2 years	121,885
3–14 years	848,016
Males 15-18	145,725
Females 15-18	141,958
Males 19-34	257,801
Females 19-34	356,978
Males 35+	362,471
Females 35+	461,900
Total non-CHIP	**2,754,653**

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

GENDER/AGE BAND	JAN 2024 ENROLLMENT
<1 year	NA*
1 - 2 years	NA*
3 - 14 years	2
Males 15-18	2
Females 15-18	8
Males 19-34	NA*
Females 19-34	18,542
Females 35+	9,631
Males 35+	NA*
Total CHIP	**28,185**

*NA indicates there was no enrollment for that Gender/Age category.

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

GENDER/AGE BAND	JAN 2024 ENROLLMENT
<1 year	116
1 - 2 years	2,407
3 - 14 years	33,830
Males 15-18	5,546
Females 15-18	5,107
Males 19-34	2,750
Females 19-34	2,549
Males 35+	6,946
Females 35+	9,759
Total Non-Match	**69,010**

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

	COOK COUNTY			DOWNSTATE			
Race	**Ethnicity-Unknown**	**Hispanic-Latino**	**Not-Hispanic-Latino**	**Ethnicity-Unknown**	**Hispanic-Latino**	**Not-Hispanic-Latino**	**TOTAL**
American Indian/Alaska Native	877	1,355	1,842	1,347	454	1,447	7,322
Asian	48,264	4,022	11,209	31,068	2,355	8,761	105,679
Black	370,854	5,314	35,710	224,236	3,113	24,591	663,818
Did Not Answer/ Unknown	14,898	44,201	373,908	12,101	23,688	379,803	848,599
Hawaiian Native/ Other Pacific Islander	283	170	114	346	118	141	1,172
Multi-Race	NA*	NA*	NA*	NA*	NA*	NA*	NA*
White	151,675	118,785	132,547	531,302	75,051	146,888	1,156,248
Total	**586,851**	**173,847**	**555,330**	**800,400**	**104,779**	**561,631**	**2,782,838**

*NA indicates there was no enrollment for that Race/Ethnicity category.

Managed Long Term Care Services and Supports (MLTSS) Enrollment

Effective July 1, 2019, the Managed Long Term Services and Supports (MLTSS) program was expanded statewide when MLTSS and waiver services were incorporated into HealthChoice Illinois. HFS submitted to CMS a 1915(b) waiver application to implement the MLTSS waiver. Under the waiver, in specified geographies, dual eligible beneficiaries who receive institutional (except those receiving developmental disability institutional services) or community-based long-term services and supports (through five of the State's 1915(c) waiver programs) are required to enroll in managed care, unless they meet another exclusion. Current eligibility determination guidelines for institutional or hand community based (HCBS) services will not change under the waiver unless modified by the State. Under the waiver, beneficiaries receive the Medicaid institutional and community-based long-term services and supports (LTSS), transportation, and behavioral health services through a HealthChoice Illinois plan. Table 1-7 presents MLTSS enrollment.

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

HEALTH PLANS	JAN 2024 ENROLLMENT
Aetna	13,138
BCBSIL	19,708
CountyCare (Cook County Only)	9,199
Meridian	12,514
Molina	5,839
Total	**60,398**

Medicare-Medicaid Alignment Initiative (MMAI) Enrollment

Five health plans provide services in the MMAI program: Aetna Better Health Premier Plan (Aetna), Blue Cross Community MMAI (BCBSIL), Humana Gold Plan Integrated (Humana), Meridian, and Molina Dual Options Medicare-Medicaid Plan (Molina). Overall MMAI enrollment figures are displayed in Table 1-8.

Table 1-8—Medicare-Medicaid Alignment Initiative Enrollment

HEALTH PLANS	JAN 2024 ENROLLMENT
Aetna	16,836
Blue Cross	22,383
Humana	16,792
Meridian	16,082
Molina	17,611
Total	**89,704**

QUALITY STRATEGY GOAL	QUALITY STRATEGY OBJECTIVE	STATE DIRECTED PAYMENT OBJECTIVE	QUALITY MEASURE
Cook County Health and Hospital System Clinics			
Promote whole person wellness, preventive care, and management of chronic conditions	Adults with diabetes receive Hemoglobin A1c (HbA1c) Testing every year	Increase the rate of adults with diabetes who receive Hemoglobin A1c (HbA1c) testing every year	Comprehensive Diabetes Care (HbA1c Testing)
	Adults receive an ambulatory or preventive care visit at least once per year	Increase the rate of adults who receive an ambulatory or preventive care visit at least once per year	Comprehensive Diabetes Care (Retinal Eye Exam)
Egyptian Health Department Integrated Care for Kids			
Improve the health outcomes and management of behavioral health services and supports for children	Children receiving hospital services for select mental illnesses receive follow-up visit within 30 days	Increase the rate of children with follow-up care after a hospitalization for mental illness	Follow-Up After Hospitalization for Mental Illness – 6-17 years of age (FUH)
Improve the health outcomes of mothers, babies, and children	Children receive two or more primary care visits between 15-30 months of age	Increase the rate of children with well-child visits in the first 30 months of life	Well-Child Visits in the First 30 Months of Life (W30)
Improve the health outcomes of mothers, babies, and children	Children and adolescents receive a well-care visit at least once per year	Increase the rate of children and adolescents with well-care visits	Child and Adolescent Well-Care Visits (WCV)
Hospital Transformation Payments			
Improve the health outcomes and management of behavioral health services and supports for adults and children	Adults receiving hospital services for select mental illnesses receive follow-up visit within 30 days	Increase the rate of adults and children who receive timely follow- up care after a hospitalization for mental illness	Follow-Up After Hospitalization for Mental Illness (FUH)
	Children receiving hospital services for select mental illnesses receive follow-up visit within 30 days		

QUALITY STRATEGY GOAL	QUALITY STRATEGY OBJECTIVE	STATE DIRECTED PAYMENT OBJECTIVE	QUALITY MEASURE
	Adults receiving hospital services for select mental illnesses receive follow-up visit within 30 days	Increase the rate of adults who receive timely follow-up care after an emergency department visit for alcohol and other drug abuse	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Promote whole person wellness, preventive care, and management of chronic conditions	Adults receive an ambulatory or preventive care visit at least once per year	Increase the rate adults who receive an ambulatory or preventive care visit at least once per year	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Large Non-State Government Hospitals			
Promote whole person wellness, preventive care, and management of chronic conditions	Adults with diabetes receive Hemoglobin A1c (HbA1c) Testing every year	Increase the rate of adults with diabetes who receive Hemoglobin A1c (HbA1c) testing every year	Comprehensive Diabetes Care (HbA1c Testing)
	Adults receive an ambulatory or preventive care visit at least once per year.	Increase the rate of adults who receive an ambulatory or preventive care visit at least once per year	Comprehensive Diabetes Care (Retinal Eye Exam)
	Adults receive an ambulatory or preventive care visit at least once per year.	Increase rate of annual preventive care visits for chronic conditions	Asthma in Young Adults' Admission Rate (PQI 15)
			COPD or Asthma in Older Adults' Admission Rate (PQI 05)
			Heart Failure Admission Rate (PQI 08)
			Diabetes Short-Term Complications Admission Rate (PQI 01)

QUALITY STRATEGY GOAL	QUALITY STRATEGY OBJECTIVE	STATE DIRECTED PAYMENT OBJECTIVE	QUALITY MEASURE
Lurie Children's Hospital Integrated Care for Kids			
Improve the health outcomes of mothers, babies, and children	Children receive two or more primary care visits between 15-30 months of age.	Increase the rate of children with well-child visits in the first 30 months of life	Child and Adolescent Well-Care Visits (W30)
	Children and adolescents receive a well-care visit at least once per year	Increase the rate of children and adolescents with well-care visits	Child and Adolescent Well-Care Visits (WCV)
MCAP			
Promote whole person wellness, preventive care, and management of chronic conditions	Adults receive an ambulatory or preventive care visit at least once per year.	Increase rate of annual preventive care visits for chronic conditions	Asthma in Young Adults' Admission Rate (PQI 15)
			COPD or Asthma in Older Adults' Admission Rate (PQI 05)
			Heart Failure Admission Rate (PQI 08)
			Diabetes Short-Term Complications Admission Rate (PQI 01)
Nursing Facility Quality Star Ratings			
Provide person-centered services and supports to ensure care is delivered in the least restrictive care setting	After a long-term stay in a facility, residents are successfully transitioned to a community residence.	After a long-term stay in a facility, increase the rate of residents who are successfully transitioned to a community residence.	Long-Term Services and Supports (LTSS) Successful Transition after Long-Term Facility Stay (LTSS-TRAN)
State-Owned Medical Schools Average Commercial Rate			
Improve the health outcomes of mothers, babies, and children	Women have a prenatal care visit in the first trimester.	Improve the timeliness of initial prenatal care	Timeliness of Prenatal Care (PPC)
	Women have a postpartum care visit within 12 weeks of delivery	Improve the timeliness of postpartum care visits	Timeliness of Postpartum Care (PPC)

Pay-for-Performance (P4P) Measures

Measure	Specification
Pillar: Adult Behavioral Health	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	HEDIS
18–64 Years	
65+ Years	
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	HEDIS
18–64 Years	
65+ Years	
Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up	HEDIS
18+ Years	
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up	HEDIS
18+ Years	
Pharmacotherapy for Opioid Use Disorder—Total	HEDIS
Pillar: Child Behavioral Health	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	HEDIS
6–17 Years	
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	HEDIS
6–17 Years	
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up	HEDIS
6–17 Years	
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	HEDIS
6–17 Years	
Pillar: Maternal and Child Health	
Prenatal and Postpartum Care—Timeliness of Prenatal Care	HEDIS
Prenatal and Postpartum Care—Postpartum Care	HEDIS
Childhood Immunization Status—Combination 10	HEDIS
Pillar: Equity	
Breast Cancer Screening	HEDIS
Cervical Cancer Screening	HEDIS
Controlling High Blood Pressure	HEDIS
Pillar: Community and Health Promotion	
Adults' Access to Preventive/Ambulatory Health Services—Total	HEDIS

Pay-for-Reporting (P4R) Measures

Measure	Specifications
Pillar: Adult Behavioral Health	
Follow-Up After High-Intensity Care for Substance Use Disorder (SUD)—7-Day Follow-Up	HEDIS
18–64 Years	
65+ Years	
Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up	HEDIS
18–64 Years	
65+ Years	
Screening for Depression and Follow-Up Plan	CMS Adult Core Set
18–64 Years	
65+ Years	
Pillar: Child Behavioral Health	
Follow-Up After Mobile Crisis Response Services	HFS Custom
0–5 Years	
6–11 Years	
12–17 Years	
18–20 Years	
Screening for Depression and Follow-Up Plan	CMS Child Core Set
12–17 Years	
Initiation and Engagement of SUD Treatment	HEDIS
Initiation of SUD Treatment—13–17 Years	
Engagement of SUD Treatment—13–17 Years	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	HEDIS
Initiation Phase	
Continuation and Maintenance Phase	
Pillar: Maternal and Child Health	
Prenatal Depression Screening and Follow-Up	HEDIS
Depression Screening	
Follow-Up on Positive Screen	
Postpartum Depression Screening and Follow-Up	HEDIS
Depression Screening	
Follow-Up on Positive Screen	

Measure	Specifications
Child and Adolescent Well-Care Visits	HEDIS
3–11 Years	
12–17 Years	
18–21 Years	
Contraceptive Care—All Women—21–44 Years	CMS Adult Core Set
Most or Moderately Effective Method of Contraception	
Long-Acting Reversible Method of Contraception	
Unexpected Complications in Term Newborns	Joint Commission National Quality Measures
Severe Complications	
Moderate Complications	
Oral Evaluation, Dental Services	HEDIS
0–2 Years	
3–5 Years	
6–14 Years	
15–20 Years	
Pillar: Equity	
Breast Cancer Screening—Disparities Focus	HEDIS
Asthma Medication Ratio	HEDIS
5–11 Years	
12–18 Years	
19–50 Years	
51–64 Years	
Colorectal Cancer Screening	HEDIS
46–49 Years	
50–75 Years	
Pillar: Improving Community Placement	
Long-Term Services and Supports (LTSS) Successful Transition after Long-Term Facility Stay	CMS MLTSS
LTSS Minimizing Facility Length of Stay	CMS MLTSS