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ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Division of Medical Programs

COMPREHENSIVE MEDICAL PROGRAMS QUALITY STRATEGY

2014-2016

3. State Standards

4. Improvement and Interventions

5. Delivery System Reforms

6. Conclusions

Appendices

Quality Framework

The Illinois Department of Healthcare and Family Services (HFS or Department) developed this Medicaid Comprehensive Medical Programs Quality Strategy (Quality Strategy) in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.200 et seq. 5 and with a goal to accomplish HFS' mission. HFS' Quality Strategy provides a mechanism for assessing and improving the quality of the Medicaid program and a roadmap for improvement to ensure quality healthcare coverage at sustainable costs. The Quality Strategy was developed with input from provider groups, advocates, health plans, and HFS staff and was reviewed by the Centers for Medicare & Medicaid Services (CMS).

Illinois Medicaid is in the process of implementing a redesign of the Medicaid healthcare delivery system. This ambitious redesign will move Illinois from a fundamentally fee-for-service system to a system that aggressively promotes *care coordination, payment reform, technology,* and *transparency* to improve health outcomes. The new system incentivizes providers, community-based organizations, and traditional managed care organizations to work together to coordinate care and improve the experience and quality of care received by Illinois Medicaid beneficiaries.

Since 2011, HFS has embarked upon strategic planning which guides the State of Illinois' efforts to transform the way in which physical and behavioral health will be provided to its beneficiaries. HFS has established key initiatives that will result in the implementation of the State's vision of quality care for its residents. The diagram on page xiii denotes key areas of our future plan. As the comprehensive Quality Strategy reports on our past achievements, this Quality Framework provides a snapshot of where we are today and what our path forward will encompass.
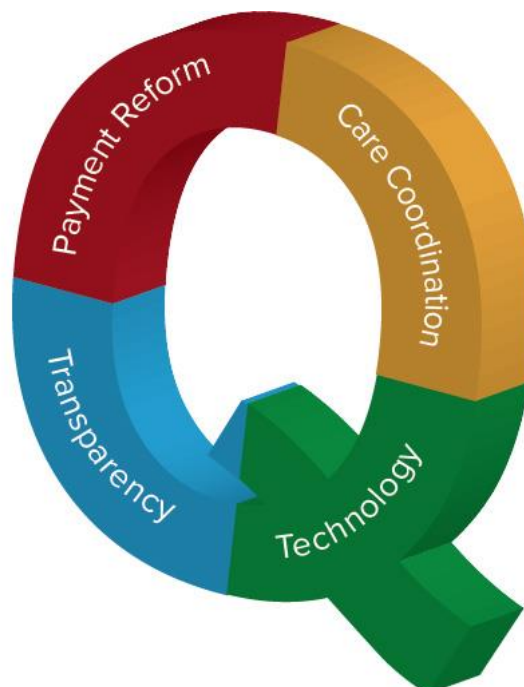
HFS' Mission

HFS is committed to ensuring quality healthcare coverage at sustainable costs, empowering people to make sound decisions about their well-being, and maintaining the highest standards of program integrity on behalf of the citizens of Illinois. The agency is establishing and enforcing child support obligations to make sure children and their families have the opportunities they deserve.

Strategic Planning

Mission Statement

Transformation Initiatives:
Care Coordination, Payment Reform,
Technology, Transparency

Impacts

Strategic
Initiatives

Progress
Indicators

Improved Health Outcomes

Medicaid Past to Present

HFS Division of Medical Programs administers and, in conjunction with the federal government, funds medical services to approximately 25 percent of the State's population: about 3.2 million Illinois residents, including 1.5 million children, 195,102 seniors, 252,313 persons with disabilities, 635,972 federal Affordable Care Act (ACA) eligible adults, 631,126 nondisabled adults, and 16,440 beneficiaries with partial benefit packages.

Medicaid Program Expansion

The Public Aid Code was amended in 2011 to mandate that at least 50 percent of all full benefit beneficiaries be in some form of risk-based care coordination by January 1, 2015. Effective managed care expansion was central to HFS' planning as the Department began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148), with emphasis on:

- ◆ Service delivery reforms.
- ◆ Cost containment strategies.
- ◆ Program integrity enhancements.
- ◆ Agency efficiencies.

Significant enrollment shifts in various coverage groups of HFS' programs are due to expanded coverage resulting from ACA as shown in the graphs below.

MEDICAL ASSISTANCE ENROLLMENT

■ Fee-for-Service ■ Managed Care

- 2010: Managed Care 7%, Fee-for-Service 93%
- 2016: Managed Care 65%, Fee-for-Service 35%

MEDICAL ASSISTANCE ENROLLMENT

■ Children ■ Adults

- 2010: Adults 1,022,447, Children 1,630,077
- 2016: Adults 1,670,222, Children 1,477,672
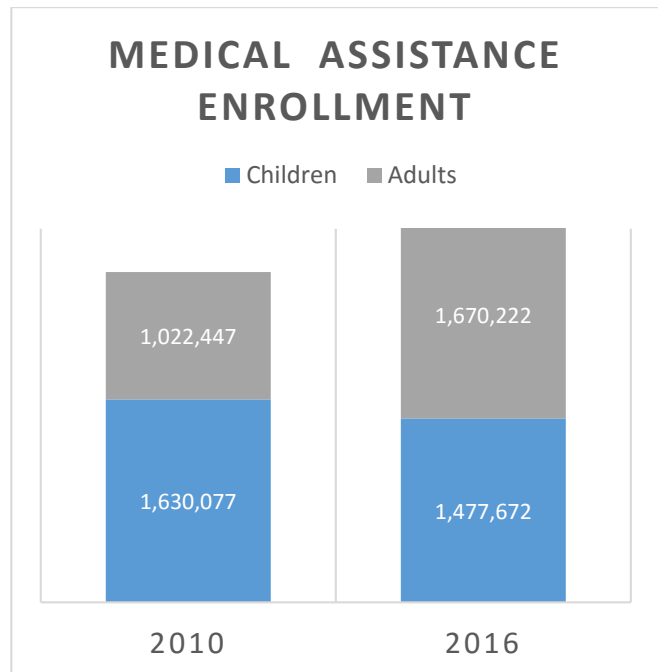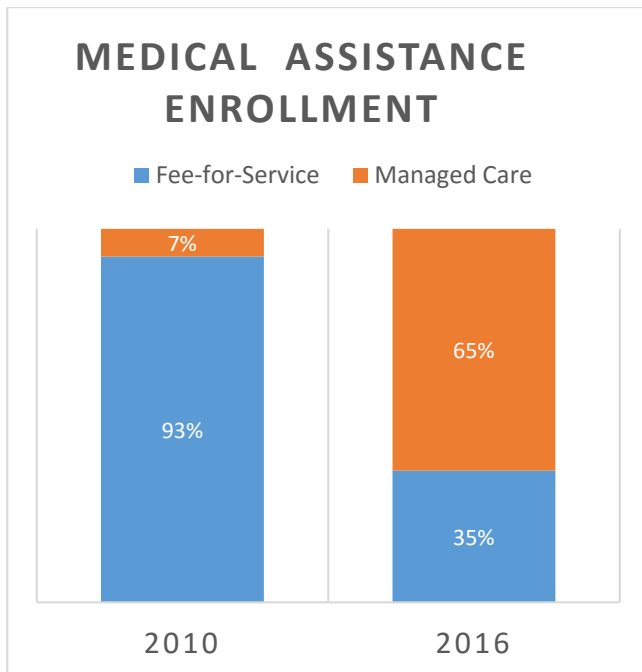
Legislative Mandated Goal: Enroll at least 50 percent of Medicaid beneficiaries into care coordination programs by 2015.

Result: Through expansion efforts, 65% of Illinois Medicaid beneficiaries enrolled in a care coordination program by June 1, 2015.
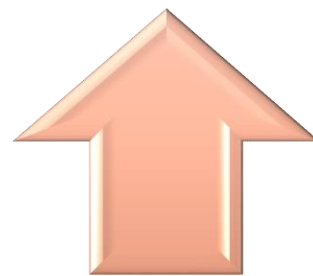
Medicaid Care Coordination Expansion Timeline

Care coordination was the centerpiece of Illinois' Medicaid reform. Initial expansion began with a focus on the most complex, expensive beneficiaries and was expanded with the development and implementation of additional managed care programs that offered the benefits of care coordination.

May 2011
- Integrated Care Program (ICP)

2012-2013
- Care Coordination Entities (CCEs)

2014
- Medicare-Medicaid Alignment Initiative (MMAI)
- County Care Waiver

2014
- Accountable Care Entities (ACEs)
- Family Health Plan (FHP)/ACA

2015-2016
- ACE/CCE Alignment with Managed Care Organizations (MCOs)
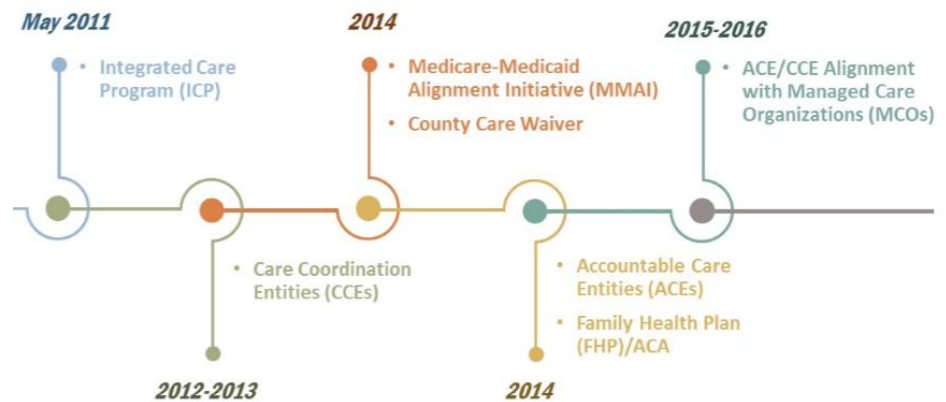
Medicaid Transformation

Managed Care and Care Coordination

Managed care offers a way to deliver better Medicaid services with the promise of reduced and predictable costs. Risk and performance must be tied to reimbursement in order to continue to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes. As one strategy to accomplish this objective, HFS began the implementation of the alignment of managed care organizations (MCOs) with accountable care entities (ACEs) and care coordination entities (CCEs). MCOs offer superior risk, quality management, and analytics. The resulting alignment will save taxpayers money while providing better care and fiscally sustainable entities that are better positioned to deliver quality, value, and outcomes.[1]

Care Coordination Programs

Current HFS programs serving mandatory managed care are the Integrated Care Program (ICP), Medicare-Medicaid Alignment Initiative (MMAI), and Family Health Program/Affordable Care Act (FHP/ACA). These managed care models allow HFS to meet its goal of testing innovative care coordination models. HFS maintains the Primary Care Case Management (PCCM) program in the nonmandatory counties of the State. For more information about Illinois' managed care programs, visit http://www.hfs.illinois.gov/managedcare/.

Program	Description	Enrollment[2]
FAMILY HEALTH PROGRAM (FHP)/AFFORDABLE CARE ACT (ACA)	In July 2014, voluntary managed care was transitioned to FHP/ACA within mandatory managed care regions. HFS contracts with health plans to manage the provision of healthcare for children and their families as well as newly eligible ACA adults through care coordination.	1,908,789
PRIMARY CARE CASE MANAGEMENT (PCCM)	PCCM, called Illinois Health Connect (IHC), became fully operational in November 2007. This program creates medical homes to make sure that primary and preventive care are provided in the best setting.	378,925
INTEGRATED CARE PROGRAM (ICP)	The ICP serves the Seniors and Persons with Disabilities (SPD) population previously referred to as Aid to the Aged, Blind and Disabled (AABD). The ICP provides integration of all of an individual's physical, behavioral, and social services needs to improve beneficiaries' health outcomes and enhance their quality of life by providing beneficiaries the support necessary to live more independently in the community.	121,622
MEDICARE-MEDICAID ALIGNMENT INITIATIVE (MMAI)	The MMAI is a joint federal-state demonstration program that enrolls beneficiaries who are eligible for both federal Medicare and state Medicaid programs (dual eligibles) into managed care plans. The plans are responsible for providing coordinated care under a three-way contract between HFS, federal CMS, and the health plans.	47,340

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[1] The *HFS Annual Report Medical Assistance Program Fiscal Years 2013, 2014, and 2015* was used in reference. Available at: https://www.illinois.gov/hfs/sitecollectiondocuments/fy2015_annual_report_3-31-16_final.pdf. Accessed on: Dec 6, 2016.
[2] Enrollment numbers as of June 2016 do not include nonmanaged care Medicaid beneficiaries served by HFS.

Technology

Technology initiatives are also an essential part of HFS' Medicaid transformation agenda. Systems changes will allow HFS to achieve the programmatic and financial objectives of the Medicaid program.

Integrated Eligibility System (IES)	• In collaboration with the Department of Human Services (DHS). • In Phase II of its implementation. • New eligibility system will determine eligibility for medical programs, Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps and cash assistance. • Replace the 30+-year-old COBOL mainframe application that was built before there was a functional Internet or relational databases were widely used.
Medicaid Management Information System (MMIS)	• Current MMIS supports management of beneficiary eligibility, provider enrollment, and medical claim processing and was built to support a fee-for-service Medicaid program. • A new system will be implemented to support the demands of the new Medicaid program with the transition to managed care. • Core MMIS: Called IMPACT, this project is developing a cloud-enabled MMIS that delivers a system (e-MIPP) to support the Electronic Health Record/Provider Incentive Payment (EHR/PIP) program and a system to support provider enrollment.
New Pharmacy Benefits Management System	• The new system will provide HFS with an 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.

Payment Reform (Paying for Quality)

To achieve optimal outcomes and measure performance across programs, HFS selected a uniform set of priority measures for FHP/ACA, ICP, and MMAI that support the Quality Strategy goals. This alignment allows for efficiency in reporting as HFS significantly reduced the overall number of measures health plans are required to report and created consistency across programs. Priority measures were selected for each program to measure performance in service areas unique to each program population. HFS established benchmarks for each priority measure to hold health plans accountable to assess performance and strive to improve achievement.

The contracts for ICP and FHP/ACA health plans contain several performance measures that create an incentive for the health plans to devote resources to procedures and care that produce valued outcomes. The health plans can earn incentive pool payments based on their performance by meeting pre-established targets. The MMAI health plan contracts include a combination of core performance measures established by CMS that are included in all demonstrations across the nation as well as state-specified performance measures. Shared savings are built into the MMAI capitation rates in anticipation of improved care management and administrative efficiencies across Medicare and Medicaid.

Transparency to Support Consumer Choice

To facilitate consumer choice, HFS categorized its priority measures into the following service categories that resonate with consumer concerns. Then, HFS developed a star rating methodology that displays health plan performance for the below service categories in a format that is easy for consumers to understand. Consumers will be able to use the star rating results to make choices regarding health plan selection.

Getting Care

Includes measures such as access to preventive care, ease of getting care when needed, and getting quality customer service.

Living with Illness

Evaluates basic care given to beneficiaries with some chronic illnesses or taking long-term medications.

Doctor's Communication and Service

Based on survey responses by beneficiaries to questions about their doctor.

Women's Health and Maternity Care

Determines if women receive necessary screenings and get recommended maternity care.

Behavioral Health

Includes monitoring of antipsychotic use in children, follow-up after services, and access to alcohol and chemical dependency treatment.

Keeping Kids Healthy

Tracking if health plans provide basic child healthcare including vaccinations, weight monitoring, and nutrition and fitness counseling.

Medicaid Moving Forward

State fiscal years (SFYs) 2014–2016 represented a year of significant change in Illinois' Medicaid program as we moved from managed care migration to managed care transformation. HFS will continue to be vigilant to transform our healthcare delivery system for Medicaid beneficiaries and maintain a program that achieves the highest standards of program integrity for the taxpayers of Illinois.

HFS' ROADMAP FOR QUALITY FRAMEWORK

TRANSFORMATION INITIATIVES

Care Coordination	Payment Reform	Technology (MMIS)	Transparency

PRIORITIES

- Right care, at the right time, at the right cost
- Pay for quality outcomes
- Focus on evidence-based prevention and treatment
- Disease prevention and management—improve quality of life and reduce chronic care costs
- Evidence-based care—best quality at the lowest cost
- Holistic care—integrating physical and mental health needs
- Maintain seniors and people with disabilities in own home or community-based settings, instead of a higher-cost setting like a nursing home

IMPACTS

Adequate access to care and services for Illinois Medicaid beneficiaries that is appropriate, cost effective, safe, and timely	Improved quality of care and services delivered to Illinois Medicaid beneficiaries	Integrated Care Delivery—the right care, right time, right setting, right provider	Consumer safety, satisfaction, access to, and quality of care and services delivered to Illinois Medicaid beneficiaries in select Care Coordination and Managed Care Programs	Efficient and effective administration of Illinois Medicaid Managed Care Programs

STRATEGIC INITIATIVES

- Validate Medicaid provider networks
- Monitor provider network appointment availability and wait times
- Implement payment reform—pay for quality

- Focus quality improvement (QI) using performance priority measures with established benchmarks
- Implement quality assessment and collaborative performance improvement projects (PIPs)
- Improve CMS Home and Community-Based Services (HCBS) Waiver performance through measure monitoring and quality initiatives

- Integrate physical and mental health and person-centered care
- Integrate care for beneficiaries served by both Medicare and Medicaid
- Monitor MCO grievances/complaints/appeals
- Consumer dashboard available to Medicaid beneficiaries during open enrollment

- Improve encounter data integrity
- Review and remediate the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) quality satisfaction issues

PROGRESS INDICATORS

- Rate of access-related grievances and network deficiencies
- Accurate MCO online provider directory
- Rate of open and closed panel reports
- Performance on pay for performance (P4P) measures

- Trend analysis of annual performance on priority measures and comparison to performance benchmarks
- Trend analysis of CMS HCBS waiver measure performance
- Collaborative PIPs' indicator performance
- Conduct health, safety, and welfare reporting

- Monitor outliers for grievances, complaints, and appeals
- Rates on the National Committee for Quality Assurance (NCQA) CAHPS global and composite measures and rates on NCQA CAHPS Consumer Satisfaction Surveys (adult and child) and comparison to percentiles

- MCO compliance monitoring performance
- MCO performance dashboard
- Achievement of phased implementation of new Medicaid Management Information System (MMIS)

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Acronyms

AAAHC .... Accreditation Association for Ambulatory Health Care
AABD .... Aid to the Aged, Blind, and Disabled
ACA..Affordable Care Act
ACE ....Accountable Care Entity
ACOG .... American College of Obstetricians and Gynecologists
ADA ....Americans with Disabilities Act
ADL ....activity of daily living
ARRA... American Recovery and Reinvestment Act of 2009
BBA..Balanced Budget Act of 1997
BBO...Better Birth Outcomes
BIP ....Balancing Incentive Program
BMC...Bureau of Managed Care
BQM ....Bureau of Quality Management
CAHMI..Child and Adolescent Health Measurement Initiative
CAHPS.. Consumer Assessment of Healthcare Providers and Systems
CANS...Child and Adolescent Needs and Strengths
CAP .... corrective action plan
CARTS .... CHIP Annual Report Template System
CCC .... Children with Chronic Conditions
CCCD..Care Coordination Claims Data
CCE .... care coordination entity
CCHHS .... Cook County Health and Hospital System
CCM.. complex case management
CCMN ....Children with Complex Medical Needs
CCMS .... CareEnhance Clinical Management Software
CFR ....Code of Federal Regulations
CHF... congestive heart failure
CHIP..Children's Health Insurance Program
CHIPRA ....Children's Health Insurance Program Reauthorization Act
CMPQS ....Comprehensive Medical Programs Quality Strategy
CMS .... Centers for Medicare & Medicaid Services
CoIIN... Collaborative Improvement and Innovation Network
COPD ....chronic obstructive pulmonary disease
CPT .... Current Procedural Terminology
CQI.. continuous quality improvement

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

HIT ....health information technology
HITECH Act .... Health Information Technology for Economic and Clinical Health Act
HMO ....health maintenance organization
HPL ....high performance level
HRSA... Health Resources and Services Administration
IADL ....instrumental activity of daily living
ICAAP..Illinois Chapter, American Academy of Pediatrics
ICF..intermediate care facility
ICP .... Integrated Care Program
IDPH ....Illinois Department of Public Health
IHC... Illinois Health Connect
ILCS... Illinois Compiled Statutes
ILHIE ....Illinois Health Information Exchange
ILPQC...Illinois Perinatal Quality Collaborative
IMHP..Illinois Medical Home Project
IQAP .... internal quality assessment program
IT... information technology
JCAHO..Joint Commission on Accreditation of Healthcare Organizations
KPI ....key performance indicator
LARC .... long-acting reversible contraceptive
LTSS .... long-term services and supports
MAC...Medical Advisory Committee
MCCN .... Managed Care Community Network
MCH ....Maternal and Child Health
MCHB .... Maternal and Child Health Bureau
MCHIP ....Maternal and Child Health Integrated Program
MCO .... managed care organization
MCS .... managed care system
MEDI..Medical Electronic Data Interchange
MFP .... Money Follows the Person
MLTSS.. Managed Long-Term Services and Supports
MMAI ....Medicare-Medicaid Alignment Initiative
MMIS..Medicaid Management Information System
MPL .... minimum performance level
NCPDP ....National Council for Prescription Drug Programs
NCQA...National Committee for Quality Assurance
P4P .... pay-for-performance

Prologue

Comprehensive Medical Programs Quality Strategy (Quality Strategy)

The Illinois Department of Healthcare and Family Services (HFS) developed this Medicaid Comprehensive Medical Programs Quality Strategy (Quality Strategy) in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.200 et seq.

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

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

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

The Quality Strategy's goals and objectives, scope, assessment of performance, improvement interventions, plan for periodic evaluation, and accomplishments are detailed in this Quality Strategy.

Scope

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

- All Medicaid beneficiaries in all demographic groups and in all service areas which receive Medicaid managed care services.
- All entities that provide Medicaid services for HFS.

- All aspects of care, including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by managed care entities.

- All aspects of managed care entities' performance related to access to care, quality of care, and quality of services, including:
    - Provider networks, contracting, and credentialing.
    - Medical recordkeeping practices.
    - Environmental safety and health.
    - Health and disease management.
    - Health promotion.

- Some aspects of care and performance related to services provided to Medicaid fee-for-service (FFS) beneficiaries through programs operated by managed care entities.

- All services covered, including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, and prescription drugs.

- All professional and institutional care in all settings, including inpatient, outpatient, and home settings that serve managed care beneficiaries.

- All providers and any other delegated or subcontracted provider types that contract with managed care entities.

- All aspects of managed care entities' internal administrative processes related to service and quality of care, including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.

Section 1. Introduction

Illinois Medicaid Overview

HFS is responsible for providing healthcare coverage for adults and children who qualify for Medicaid through its Division of Medical Programs. In conjunction with the federal government, the State of Illinois (State) provides funding for medical services to about 25 percent of its population.

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

In Illinois, coordinated care is provided to most Medicaid beneficiaries by health plans and PCCM entities. Health plans are managed care organizations that include health maintenance organizations (HMOs) and managed care community networks (MCCNs). HMOs are licensed by the Department of Insurance, and MCCNs are provider-owned, governed entities that operate like HMOs, but are certified by HFS rather than the Department of Insurance.[1-1]

In 2011, HFS began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148), with emphasis on service delivery reforms (access to care), cost containment strategies (structure and operations), program integrity enhancements, and agency efficiencies (quality measurement improvement). PA96-1501 (also known as "Medicaid Reform" or "the SMART Act") required the Department to enroll at least 50 percent of its Medicaid beneficiaries into care coordination

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[1-1] A MCCN is owned, operated, or governed by providers of healthcare services within Illinois and provides or arranges primary, secondary, and tertiary managed healthcare services under contract with HFS exclusively to persons participating in programs administered by HFS. The MCCN contract is very similar to other MCO contracts, the only variance being the financial requirements of the MCCN. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements.

programs by 2015. Through expansion efforts, the Department exceeded this requirement with over 65 percent of its Medicaid beneficiaries enrolled in a care coordination program.

HFS enrolls Illinois Medicaid beneficiaries into care coordination in five mandatory managed care regions: Rockford, Central Illinois, Metro East, Quad Cities, and the greater Chicago area. In the mandatory regions, Medicaid beneficiaries receive services through the following care coordination programs:

- Family Health Plan/Affordable Care Act (FHP/ACA)—Serve adults and children, and programs for children with special healthcare needs.

- Integrated Care Program (ICP)—Serve seniors and adults with disabilities.

- Medicare-Medicaid Alignment Initiative (MMAI)—Serve the dual eligible population (beneficiaries eligible for both federal Medicare and state Medicaid programs).

In the nonmandatory managed care regions, most beneficiaries will continue to be required to participate in the PCCM Program called Illinois Health Connect (IHC) for care coordination services. This program creates medical homes for its beneficiaries to make sure that primary and preventive care are provided in the best setting. IHC was the Department's first step toward implementing managed care throughout the State. In some counties, beneficiaries can choose to receive their care coordination services through the voluntary managed care (VMC) program.

Medical Program Eligibility

HFS medical programs pay for a wide range of health services, provided by thousands of medical providers throughout Illinois, to more than 3 million Illinoisans each year. The primary medical programs are as follows:

- *Medical Assistance*, as authorized under the Illinois Public Aid Code (305 ILCS 5/5 et seq.), and Title XIX of the Social Security Act, Medicaid.

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

Necessary medical benefits, as well as preventive care for children, are covered for eligible persons when provided by a healthcare provider enrolled with HFS. Eligibility requirements vary by program. Most people who enroll are covered for comprehensive services, including doctor visits, well-child care, immunizations for children, mental health and substance abuse services, hospital care, emergency services, prescription drugs, and medical equipment and supplies. Some programs, however, cover a limited set of services.

To be eligible for medical benefits, a person must meet certain eligibility requirements. Broadly, the categories are (1) families, children, or pregnant women, (2) aged, blind, or disabled persons, and (3) ACA adults. Medical coverage is provided to children, parents (or relatives caring for children), pregnant women, veterans, seniors, persons who are blind, persons with disabilities, and adults who qualify under ACA. To be eligible, adults must be a U.S. citizen or a qualified immigrant residing in Illinois. Noncitizens, ages 19 or over, who do not meet citizenship/immigration criteria may qualify for emergency medical services. Children and pregnant women are eligible regardless of immigration status. Different income limits apply for children, pregnant women, seniors, and persons with disabilities. If the household meets all the nonfinancial requirements but has excess income and/or resources, then it may qualify for medical assistance under the spend-down program to pay for some medical care.

Managed Care Coordination Delivery Systems

Care coordination continues to be the centerpiece of Illinois' Medicaid reform. It is aligned with Illinois' Medicaid reform law and the federal Affordable Care Act. The State's overall goal in utilizing managed care and other care coordination services is to improve the lives of participants by purchasing quality health services through an integrated and coordinated delivery system that promotes and focuses on health outcomes, medical necessity, accessibility to providers, accountability, and beneficiary satisfaction. As such, the goal of the Department's Quality Strategy is to continue to measure quality and health outcomes while working closely with stakeholders and sister agencies on the most effective ways under the expanded healthcare delivery systems in Illinois.

The State's initial expansion began with a focus on the most complex, expensive beneficiaries through the implementation of the **Integrated Care Program (ICP)** on May 1, 2011. This was Illinois' first integrated healthcare program for seniors and persons with disabilities. The ICP provides integration of all of an individual's physical, behavioral, and social needs to improve beneficiaries' health outcomes and enhance their quality of life by providing beneficiaries the support necessary to live more independently in the community. The integrated approach to care brings together local primary care providers (PCPs), specialists, hospitals, nursing homes, behavioral health, and other providers to organize care around a patient's needs.

The ICP initially began delivering services in two service packages. Service Package I was implemented May 1, 2011, and covered all standard Medicaid medical services, such as physician and specialist care, emergency care, laboratory, x-rays, pharmacy, mental health, and substance abuse services. Service Package II, implemented February 1, 2013, included nursing

facility services and the care provided through some of the HCBS waivers operating in Illinois (excluding developmental disabilities waivers).

Also in 2011, HFS launched the **Care Coordination Innovations Project** to test innovative models that offer risk-based care coordination through provider-organized networks structured as care coordination entities (CCEs) or accountable care entities (ACEs). This project worked to form alternative models of delivering care to Medicaid beneficiaries through provider-organized networks, ordered around the needs of the most complex beneficiaries, including serving seniors and persons with disabilities and children with special needs. Pursuant to P.A. 98-104, the ACEs and CCEs were required to take steps to become a licensed HMO or MCCN within 18 months of being approved and accepting enrollment as an ACE/CCE. Due to State budget changes, the timeline was accelerated for ACEs and CCEs to become a capitated health plan or partner with an existing health plan to continue care coordination services to beneficiaries.

In July 2014, Illinois transitioned from voluntary managed care in select counties to the **Family Health Program/Affordable Care Act (FHP/ACA)** with mandatory managed care regions that cover most of the State**.** The FHP/ACA is a mandatory program for children and their families as well as the newly eligible ACA adults. Under FHP/ACA the State contracts with health plans to manage the provision of healthcare for FHP/ACA beneficiaries through care coordination. Voluntary managed care, however, continues to be an option for beneficiaries for care coordination services within many nonmandatory counties.

The Department also began participating in a joint federal-state demonstration program, the **Medicare-Medicaid Alignment Initiative (MMAI),** that enrolls beneficiaries who are eligible for both the federal Medicare and State Medicaid programs (dual eligibles) into managed care plans. MMAI health plans are responsible for providing coordinated care for beneficiaries who are dually eligible for full Medicare and Medicaid benefits under a three-way contract between HFS, CMS, and the health plans. Enrollment into MMAI began in March 2014.

The **Choices Demonstration Project** was established in July 2014 to serve children in select counties through a tiered model of intensive care coordination, providing coordination of behavioral health services and management of the local children's mobile crisis response system. The State seeks to improve outcomes for children with behavioral health needs and their families through enhancement of the community services array in the Demonstration areas of Champaign, Ford, Iroquois, and Vermillion counties.

Illinois completed its expansion of care coordination in 2015. During this expansion period, upwards of 1.5 million people covered by Medicaid and the All Kids program in the five

mandatory managed care regions, including those beneficiaries enrolled in IHC, transitioned to some form of care coordination with a health plan. This means the majority of the beneficiaries currently enrolled in the Medicaid programs will receive care coordination services via managed care programs implemented under the expansion period.

Enrollment

In SFY 2016, Medicaid programs provided comprehensive healthcare coverage to more than 3 million Illinoisans. Enrollment figures are displayed in Table 1-1 below.

Table 1-1—Illinois Medicaid Enrollment

PROGRAM TYPE	JUNE 2016 ENROLLMENT
IHC (Illinois PCCM)	378,925
FHP/ACA	1,908,789
ICP	121,622
MMAI	47,340
All Other*	749,843
Total Beneficiaries	**3,206,519**

*   "All Other" category includes beneficiaries enrolled in fee-for-service programs that are not eligible to enroll in one of the programs above. These "carved out" populations include DCFS wards, beneficiaries with spend-down eligibility (met or unmet), beneficiaries with partial benefits, and many other small populations. This also includes dual eligibles who opted out of MMAI.

Family Health Program/Affordable Care Act (FHP/ACA) Enrollment

As of June 30, 2016, there were 10 FHP/ACA health plans that participated in Illinois: Aetna Better Health (Aetna), Blue Cross Blue Shield of Illinois (BCBSIL), County Care Health Plan (CountyCare), Family Health Network, Inc. (FHN), Harmony Health Plan of Illinois, Inc. (Harmony), Health Alliance Connect, Inc. (Health Alliance), IlliniCare Health Plan, Inc. (IlliniCare), Meridian Health Plan, Inc. (Meridian), Molina HealthCare of Illinois, Inc. (Molina), and NextLevel Health Partners, LLC (NextLevel).

Enrollment figures for the FHP/ACA program 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 FHP/ACA Medicaid/non-CHIP and CHIP enrollment, respectively, as of June 30, 2016. 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 1-2—Family Health Plan/Affordable Care Act (FHP/ACA) Enrollment

MANAGED CARE ORGANIZATIONS	JUNE 2016 ENROLLMENT
Aetna Better Health	167,278
Blue Cross Blue Shield of Illinois	285,260
CountyCare Health Plan	150,058
Family Health Network	240,825
Harmony Health Plan of Illinois, Inc.	167,141
Health Alliance Connect, Inc.	123,053
IlliniCare Health Plan, Inc.	170,496
Meridian Health Plan, Inc.	347,981
Molina Healthcare of Illinois, Inc.	190,467
NextLevel Health Partners, LLC	22,308
Total FHP/ACA Enrollment	**1,864,867**

* This total does not reflect 43,927 SmartPlan Choice beneficiaries. This ACE will transition all beneficiaries to an MCO.

Table 1-3—Family Health Plan/Affordable Care Act by Gender and Age (Non-CHIP)

GENDER/AGE BAND	SFY16 BENEFICIARY MONTHS	JUNE 2016 ENROLLMENT
<1 year	315,411	48,476
1–2 years	646,467	108,277
3–14 years	3,675,089	609,526
Females 15–18	436,227	78,320
Males 15–18	415,983	76,480
Females 19–34	1,626,750	255,620
Males 19–34	667,548	133,423
Females 35+	1,566,964	253,648
Males 35+	1,055,570	187,653
Total non-CHIP	**10,406,008**	**1,751,423**[†]

[†] Represents the total FHP/ACA enrollment of 1,864,862.

**Table 1-4—Family Health Plan/Affordable Care Act by Gender and Age
(Enrolled in CHIP)**

GENDER/AGE BAND	SFY16 BENEFICIARY MONTHS	JUNE 2016 ENROLLMENT
<1 year	58,226	11,367
1–2 years	46,404	10,895
3–14 years	181,336	48,110
Females 15–18	26,945	7,450
Males 15–18	27,545	7,683
Females 19–34	20,965	4,720
Males 19–34	297	124
Females 35+	5,777	1,550
Males 35+	6	1
Total CHIP	**367,500**	**91,900[†]**

[†] Note that Table 1-4 and Table 1-5 represent the total FHP/ACA enrollment of 1,864,862.

Table 1-5—Family Health Plan/Affordable Care Act by Gender and Age (Non-Match)

GENDER/AGE BAND	SFY16 BENEFICIARY MONTHS	JUNE 2016 ENROLLMENT
<1 year non-match	462	49
1–2 years non-match	2,137	516
3–14 years non-match	53,655	10,344
Females 15–18 non-match	25,362	5,150
Males 15–18 non-match	25,801	5,166
Females 19–34 non-match	1,299	184
Males 19–34 non-match	409	94
Females 35+ non-match	249	31
Males 35+ non-match	23	5
Total Non-Match	**109,396**	**21,539[†]**

Table 1-6—Family Health Plan/Affordable Care Act—Race/Ethnicity Composition

RACE	COOK COUNTY			DOWNSTATE			TOTAL
	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	
American Indian/Alaska Native	37	69	45	42	73	39	305
Asian	4,425	34,391	1,287	3,102	20,304	526	64,035
Black	27,254	377,278	7,765	13,396	179,259	2,581	607,533
Did Not Answer/ Unknown	59,975	30,433	166,547	32,909	19,689	92,077	401,630
Hawaiian Native/ Other Pacific Islander	374	1,271	836	197	575	295	3,548
Multi-Race	1,365	5,572	2,023	1,066	9,429	1,395	20,850
White	23,021	130,743	141,204	43,710	338,631	89,652	766,961
Total	**116,451**	**579,757**	**319,707**	**94,422**	**567,960**	**186,565**	**1,864,862**

Illinois Health Connect (IHC) Enrollment

With the transition of IHC beneficiaries to managed care, membership was decreased from roughly 2 million beneficiaries prior to June 2014, to less than 400,000 beneficiaries in the nonmandatory counties as of June 2015. Although IHC is no longer a statewide program, it continues to be the medical home program for beneficiaries in the nonmandatory counties. In addition, it is the primary access to care resource for beneficiaries who are currently not included in mandatory participation in a managed care program (Third Party Liability (TPL)/Private Insurance, Supplemental Security Income (SSI), Division of Specialized Care for Children (DSCC), etc.). Medicaid beneficiaries who are not mandatorily required to participate in a managed care program are directed to the IHC helpline for assistance in locating providers in their area of service and for scheduling appointments.

Table 1-7 and Table 1-8 display the gender and age bands of IHC/CHIPRA and IHC/MCHIP enrollment as of June 30, 2016. Table 1-9 presents non-match figures (non-match refers to State funding with no federal matching dollars), and Table 1-10 presents the race/ethnicity composition of IHC beneficiaries.

**Table 1-7—Illinois Health Connect
by Gender and Age—CHIPRA**

GENDER/AGE BAND	JUNE 2016 BENEFICIARIES
<1 year	548
1–2 years	1,843
3–14 years	13,329
Females 15–18	2,112
Males 15–18	2,142
Females 19–34	209
Males 19–34	35
Females 35+	55
Total IHC CHIPRA	**20,273▲**

**Table 1-8—Illinois Health Connect
by Gender and Age—MCHIP**

GENDER/AGE BAND	JUNE 2016 BENEFICIARIES
<1 year	8,554
1–2 years	20,396
3–14 years	112,657
Females 15–18	14,720
Males 15–18	14,860
Females 19–34	55,085
Males 19–34	30,658
Females 35+	57,477
Males 35+	41,983
Total IHC MCHIP	**356,390▲**

**Table 1-9—Illinois Health Connect
by Gender and Age—Non-Match**

GENDER/AGE BAND	JUNE 2016 BENEFICIARIES
<1 year	8
1–2 years	105
3–14 years	1,183
Females 15–18	428
Males 15–18	482
Females 19–34	25
Males 19–34	10
Females 35+	4
Males 35+	17
Total IHC MCHIP	**2,262▲**

▲ Note that Table 1-7, Table 1-8, and Table 1-9 represent the total IHC enrollment of 378,925.

Table 1-10—Illinois Health Connect—Race/Ethnicity Composition

RACE	COOK COUNTY			DOWNSTATE			
	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	TOTAL
American Indian/ Alaska Native	2	2	2	8	12	4	30
Asian	154	1,127	40	328	1,829	125	3,603
Black	322	4,982	191	1,740	23,258	431	30,924
No Answer/Unknown	1,834	1,061	9,803	7,466	4,278	9,640	34,082
Hawaiian Native/ Other Pacific Islander	14	54	47	36	111	26	2,88
Multi-Race	45	169	74	354	3,081	199	3,922
White	989	5,016	6,433	23,645	256,470	13,523	306,076
Total	**3,360**	**12,411**	**16,590**	**33,577**	**289,039**	**23,948**	**378,925**

Integrated Care Program (ICP) Enrollment

As of June 30, 2016, there were 11 ICP health plans that participated in Illinois: Aetna, BCBSIL, Cigna-HealthSpring of Illinois (Cigna), Community Care Alliance of Illinois (CCAI), CountyCare, Health Alliance, Humana Health Plan, Inc. (Humana), IlliniCare, Meridian, Molina, and NextLevel. Enrollment figures for the ICP are displayed in the tables below. Table 1-11 presents overall enrollment, Table 1-12 presents the gender and age bands of ICP beneficiaries as of June 30, 2016, and Table 1-13 presents the race/ethnicity composition of ICP beneficiaries.

Table 1-11—Integrated Care Program Enrollment

MANAGED CARE ORGANIZATIONS	JUNE 2016 ENROLLMENT
Aetna Better Health	29,171
Blue Cross Blue Shield of Illinois	11,064
Cigna-HealthSpring of Illinois	9,138
Community Care Alliance of Illinois	4,491
CountyCare Health Plan	7,950
Health Alliance Connect, Inc.	5,808
Humana Health Plan, Inc.	4,907
IlliniCare Health Plan, Inc.	27,458
Meridian Health Plan, Inc.	11,694
Molina Healthcare of Illinois, Inc.	5,939
NextLevel Health Partners, LLC	4,002
Total ICP Enrollment	**121,622**

Table 1-12—Integrated Care Program Enrollment by Gender and Age

GENDER/AGE BAND	SFY16 BENEFICIARY MONTHS	JUNE 2016 ENROLLMENT
Females 19–34	105,542	10,087
Males 19–34	147,089	14,756
Females 35+	548,564	52,129
Males 35+	448,869	44,650
Total	**1,250,063**	**121,622**

Table 1-13—Integrated Care Program—Race/Ethnicity Composition

	COOK COUNTY			DOWNSTATE			
RACE	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	ETHNICITY UNKNOWN	NOT HISPANIC-LATINO	HISPANIC-LATINO	TOTAL
American Indian/ Alaska Native	8	9	2	2	4	1	26
Asian	347	3,019	76	163	2,314	21	5,940
Black	4,739	40,409	629	1,179	11,192	114	58,262
Did Not Answer/ Unknown	3,685	1,993	7,042	1,431	807	1,858	16,816
Hawaiian Native/ Other Pacific Islander	13	137	39	2	35	6	232
Multi-Race	3	75	21	6	110	11	226
White	2,175	10,802	4,375	2,274	15,718	1,436	36,780
Total	**10,970**	**56,444**	**12,184**	**5,057**	**30,180**	**3,447**	**118,282**

Medicare-Medicaid Alignment Initiative (MMAI) Enrollment

As of June 30, 2016, there were seven MMAI health plans that participated in Illinois: Aetna, BCBSIL, Cigna, Humana, IlliniCare, Meridian, and Molina.

Enrollment figures for the MMAI are displayed in the tables below. Table 1-14 presents overall enrollment.

Table 1-14—Medicare-Medicaid Alignment Initiative Enrollment

HEALTH PLANS	JUNE 2016 ENROLLMENT
Aetna Better Health	6,424
Blue Cross Blue Shield of Illinois	13,610
Cigna-HealthSpring of Illinois	6,460
Humana Health Plan, Inc.	6,517
IlliniCare Health Plan, Inc.	4,644
Meridian Health Plan, Inc.	5,588
Molina Healthcare of Illinois, Inc.	4,098
Total	**47,341**

Additional Information

More detailed descriptions of Illinois' Medicaid managed care delivery systems are provided in the "Improvement and Interventions" section of this report. For more information about Illinois' managed care programs, visit https://www.illinois.gov/hfs/MedicalClients/ManagedCare/Pages/default.aspx.

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

Goals

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

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

    1.1   Validation and Monitoring of the Provider Network

    1.2   Appointment Availability Monitoring

    1.3   24/7 Nurse Advice Line Access

    1.4   Healthcare Effectiveness Data and Information Set (HEDIS), HEDIS-like Performance Measures, and State-defined Measures

    1.5   Cultural Considerations

    1.6   Americans with Disabilities Act (ADA) Accessibility

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

    2.1   Clinical Quality Focused Studies

    2.2   Age-Appropriate Preventive Care

    2.2   Clinical Practice and Preventive Care Guidelines (Evidenced-Based Care)

    2.4   Care Coordination and Behavioral Health Collaborative Performance Improvement Projects

    2.5   Preconception and Interconception Care

    2.6   Incentive Programs

    2.7   HEDIS, HEDIS-like, and State-defined Performance Measures

Goal 3: Integrated Care Delivery—the right care, right time, right setting, right provider.

3.1   Care Management/Care Coordination Program—
           a. Intensive Case Management for Chronically Ill Beneficiaries

3.2   Medical/Behavioral Care Coordination

3.3   Disease Management Program

3.4   Special Health Care Needs (SHCNs)

Goal 4: Ensure beneficiary safety, satisfaction, access to, and quality of care and services delivered to Illinois Medicaid beneficiaries in select Care Coordination and Managed Care Programs.

4.1   NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS) Consumer Satisfaction Survey—Adult, Child, and Children with Chronic Conditions

4.2   Participant Outcomes and Status Measures (POSM) Survey for the Elderly

4.3   Member Grievances/Complaints and Appeals

4.4   State Fair Hearings

4.5   Health and Safety Monitoring for Waiver Participants

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

5.1   Quality Assessment and Performance Improvement (QAPI) Program

5.2   Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs)

5.3   Monitoring of Performance Measures

5.4   Comprehensive Administrative Review/Readiness Review

5.5   State Oversight and Monitoring

5.6   Over- and Underutilization

5.7   Program Integrity—Fraud and Abuse

5.8   Practice Guidelines

5.9   Health Information Systems

5.10   Complete, Accurate, and Timely Encounter Data

Target Objectives

CMS recommends that states establish quantifiable, performance-driven objectives as part of their Quality Strategy to demonstrate success or challenges in meeting intended goals. These objectives should reflect the State's priorities and areas of concern for the population covered by managed care. To ensure consistent focus on the accomplishment of Quality Strategy goals, HFS has identified priority pay-for-performance (P4P) measures with specific, performance-driven target objectives that correlate to each goal of the Quality Strategy. P4P measures create an incentive for health plans to spend money on care that produces valued outcomes. These measures help health plans focus their quality improvement efforts. It is HFS' expectation that by targeting specific priorities, more consistent improvement in these areas can be achieved. Table 1-15, Table 1-16, Table 1-17, and Table 1-18 list the priority measures for the FHP/ACA, IHC, ICP, and MMAI programs for the HEDIS data collection year 2015 (reported in 2016), and their alignment to the Quality Strategy goals.

Table 1-15—Priority Measures for FHP/ACA

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	GOAL ALIGNMENT
Access/Utilization of Care	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*	1, 2, 5
	Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge (All Ages) (IAPI)	1, 2
	Well-Child Visits (WCV)	
	1) *Well-Child Visits in the First 15 Months of Life (W15)*	1, 2
	2) *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	1, 2
Maternity Care	Prenatal and Postpartum Care (PPC)	
	1) *Timeliness of Prenatal Care*	1, 2
	2) *Postpartum Care*	
Preventive/Screening Services	*Childhood Immunization Status (CIS) (Combo 3 Only)*	1, 2
	Developmental Screening in the First Three Years of Life (SDEV)	

For IHC, "bonus" measures are listed below in Table 1-16. These are measures for which a set bonus is paid to individual PCPs for each patient receiving that service and when a certain percentage of all patients on a PCP's panel roster are in the denominator for receiving services for that measure.

Table 1-16—Priority Measures for Illinois Health Connect (IHC)

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	GOAL ALIGNMENT
Appropriate Care	*Use of Appropriate Medications for People with Asthma*	1, 2, 3, 5
	Comprehensive Diabetes Care (HbA1c testing)	
Preventive/Screening Services	*Breast Cancer Screening*	1, 2, 5
	Childhood Immunization Status (Combo 3)	
	Lead Screening in Children	
	Developmental Screening in the First Three Years of Life	

Table 1-17—Priority Measures for Integrated Care Program (ICP)

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	GOAL ALIGNMENT
Access/Utilization of Care	*Adult's Access to Preventive/Ambulatory Health Services (AAP)*	1, 2, 5
	Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge	
Appropriate Care	Comprehensive Diabetes Care (CDC)	1, 2, 3, 5
	1) *Hemoglobin A1c (HbA1c) testing*	
	2) *Eye exam (retinal) performed*	
	3) *Medical attention for nephropathy*	
Behavioral Health	*Follow-up after Hospitalization for Mental Illness—30 Days*	2, 3
	Antidepressant Medication Management (Acute Phase)	
	Antidepressant Medication Management (Continuation Phase)	

Table 1-18—Priority Measures for Medicare-Medicaid Alignment Initiative (MMAI) Demonstration Years 2, 3, 4, and 5

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	GOAL ALIGNMENT
Long Term Care	*Care for Older Adults (including advance care planning, medication review, functional status assessment, and pain assessment)*	3, 4
	Movement of Members Within Service Populations	
Behavioral Health	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	1, 3

Future Measures Selection

HFS has selected a set of evidence-based measures (EBMs) for FHP/ACA, ICP, and MMAI health plans. The purpose was to look for opportunities for streamlining and aligning measures across programs to create a more efficient data collection process for the health plans and allow HFS to more effectively monitor and evaluate performance. HFS requested that Health Services Advisory Group, Inc. (HSAG), which serves as its External Quality Review Organization (EQRO), develop a recommended list of EBMs which HFS could use to achieve optimal outcomes. HSAG recommended EBMs by Illinois Medicaid program type and both uniformity across and uniqueness within health plan types. In addition, proposed measures that are included in the Child Core Set and Adult Core Set (or both) were identified.

HSAG included an analysis of measures used in other states, as well as measures based on national standards, to develop its recommendations. Although state Medicaid programs are vastly different, comparisons were made to other states to determine how the selected measures align with measures reported in those states. Given the distinct populations of the various programs, measure sets were developed. HFS evaluated these recommendations, including a review of the priority measures, to select a final set of EBMs for which health plans will begin data collection in contract year (CY) 2016 and report in 2017. Overall, the final recommended measure sets consist of 10 HEDIS measures that are shared across all three programs. An additional four measures are shared between FHP/ACA and ICP (for a total of 14 shared measures between those two populations). The 10 measures in common cut across major populations and evaluate medical and/or behavioral health areas. Some measures target preventive services, while others are closely tied to management of chronic conditions. All measures are aligned with CMS' Quality, Timeliness, and Access Framework, with the majority of the 10 measures being in the quality domain, two in the timeliness domain, and three in the access domain. HFS evaluated these recommendations and selected a final set of EBMs, shown in Table 1-19.

Table 1-19—Evidence-Based Measures

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	HFS PROGRAM	GOAL ALIGNMENT
Access/Utilization of Care	*Adults' Access to Preventive/Ambulatory Health Services*	FHP/ACA, ICP, MMAI	1,2,5
	Ambulatory Care	FHP/ACA, ICP, MMAI	
	Well-Child Visits in the First 15 Months of Life	FHP/ACA	
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	FHP/ACA	
Preventive/ Screening Services	*Childhood Immunization Status (All Combos)*	FHP/ACA	1,2,5
	Breast Cancer Screening	FHP/ACA, ICP, MMAI	
	Cervical Cancer Screening	FHP/ACA, ICP	
	Chlamydia Screening in Women	FHP/ACA, ICP	
Maternity Care	*Timeliness of Prenatal Care*	FHP/ACA, ICP	1,2,5
	Timeliness of Postpartum Care	FHP/ACA, ICP	
Appropriate Care	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*	FHP/ACA	1,2,5
	Human Papillomavirus Vaccine for Female Adolescents	FHP/ACA	
	Controlling High Blood Pressure	FHP/ACA, ICP, MMAI	
	Comprehensive Diabetes Care	FHP/ACA, ICP, MMAI	
	Statin Therapy for Patients with Diabetes	FHP/ACA, ICP, MMAI	
	Adult BMI Assessment	FHP/ACA, ICP, MMAI	
	Medication Management for People with Asthma	FHP/ACA, ICP	
Behavioral Health	*Follow-Up After Hospitalization for Mental Illness*	FHP/ACA, ICP, MMAI	1,2,5
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	FHP/ACA	
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FHP/ACA, ICP, MMAI	
Long Term Care	*Care for Older Adults*	MMAI	1,2,5
	Annual Monitoring for Patients on Persistent Medications	FHP/ACA, ICP, MMAI	
	Use of High-Risk Medications in the Elderly	MMAI	1,2,5

Quality Management Structure

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

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

The bureaus are also responsible for oversight, monitoring, and evaluation of quality assurance to ensure health plans are in compliance with state standards, federal regulations, and contract requirements. HFS monitors each health plan's compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via its internal quality management program and on-site reviews of compliance with various quality assessment/improvement standards. HFS' EQRO conducts compliance reviews at least once every three years. The purpose of the reviews is to determine a health plan's understanding and application of federal regulations and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during an on-site evaluation. The reviews include an assessment of each plan's quality improvement structure. This structure is necessary in facilitating quality improvement of performance measures and PIPs, which measure each health plan's performance in achieving quality goals and objectives identified in the Quality Strategy. The report enables the health plans to implement improvement interventions to correct any areas of deficiency. The report also helps HFS determine each health plan's compliance with the contract and identify contractual areas that need to be modified or strengthened to ensure that a health plan complies with the standards and can achieve the goals and objectives identified in the Quality Strategy.

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

HFS meets with the health plans independently for on-site quarterly operations meetings to monitor plan performance. Each plan is asked to provide HFS with a presentation on its recent activities and developments. These meetings serve as an interactive environment for open communication between health plans and HFS. This time also provides the opportunity for the health plans to ask any operational questions or receive assistance from HFS. HFS is interested in seeing what works well for the plans, what needs improvement, any developments that plans have on the horizon, and what HFS can do to provide assistance. On-site visits enhance the ability of HFS to oversee the health plans and build relationships with plan leadership. As the quarterly operations meetings progress, HFS is looking for an overall presentation of each health plan's latest data, achievements, and issues/concerns with regard to the above.

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. MAC consists of up to 15 beneficiaries and meets six times per year. It has two subcommittees: Quality and Public Education.

Figure 1-1—Illinois HFS Quality Strategy Organizational Structure
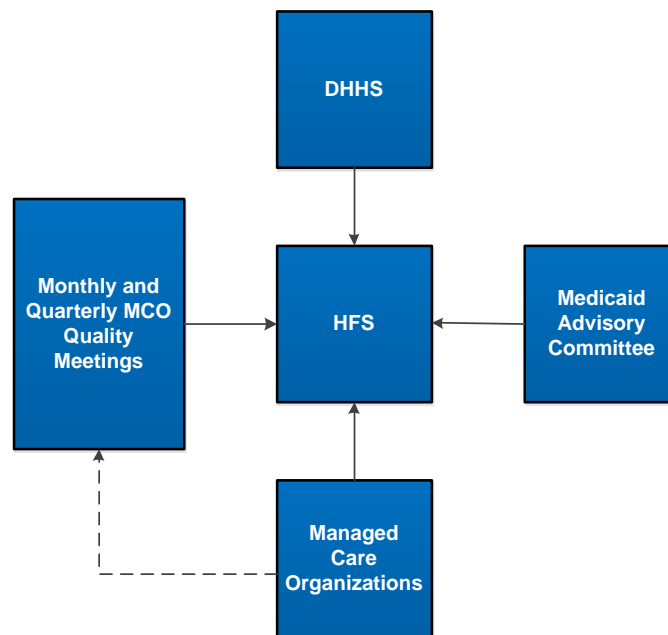
Development and Review of the Quality Strategy

In furtherance of HFS' mission to improve the health of Illinois Medicaid beneficiaries by providing access to quality healthcare, in consideration of the health needs of the participants served, and in compliance with federal and State regulations, HFS originally developed a strategy for the quality assurance component of the managed care program in 2006. After drafting the Quality Strategy with health plan involvement, it was reviewed by a diverse set of stakeholders, including providers and advocates; and their input was incorporated.

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

The process HFS uses to refine the Quality Strategy includes stakeholder involvement, such as collaboration between the health plans and HFS through ongoing monthly telephonic and quarterly face-to-face meetings. The MAC is the primary vehicle for involving stakeholders. HFS uses feedback from MAC beneficiaries and other stakeholders to make necessary revisions to

the Quality Strategy. The purpose of the Quality Strategy, to be achieved through consistent application, is to ensure the following:

- That quality healthcare services are delivered with timely access to appropriate covered services.
- Coordination and continuity of care.
- Prevention and early intervention, including risk assessment and health education.
- Improved health outcomes.
- Ongoing quality improvement.

HFS' goal is to measure both quality and health outcomes while continuing to work closely with stakeholders and sister agencies to ensure a comprehensive Quality Strategy that spans across all managed care/care coordination programs.

Strategy Updates

HFS updates the Quality Strategy as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program. To ensure the effectiveness of the Quality Strategy, at a minimum of every three years HFS will coordinate a comprehensive review and update its Quality Strategy. The purpose of this review is to determine if improvement in the quality of services provided to beneficiaries was accomplished; determine the need for revision; and ensure that health plans are in contract compliance and commit adequate resources to perform internal monitoring and ongoing quality improvement toward the Quality Strategy goals.

The comprehensive review of the Quality Strategy includes an assessment of the following:

- Access to care and network adequacy
- Organizational structure and operations of the managed care organizations
- Annual HEDIS, HEDIS-like, and state-defined performance measures scores
- CAHPS survey results
- Audit reports
- Quality assurance processes, including peer review and utilization review
- Beneficiary complaints, grievances, and appeals, as well as provider complaints and issues
- Preventing, detecting, and remediating critical incidents, at a minimum, according to the requirements of the State for home and community-based programs

- Collaborative performance improvement project findings

- Success in improving health outcomes for the priority performance measures

- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvement in care and services) and trending indicator data

- Identification of program barriers and limitations

- Feedback obtained from HFS leadership, health plans, the provider community, advocacy groups, Medicaid beneficiaries, and other internal and external stakeholders that can impact beneficiary access to high-quality and timely care and services

- Recommendations for the upcoming year

- Other relevant documentation

Prior to each update, HFS solicits stakeholder input on the goals and objectives of the Quality Strategy. Stakeholders include consumers, other State agencies and organizations that provide services, health plans, statewide associations, and the MAC.

In advance of stakeholder meetings, participants are invited to review a draft of the updated Quality Strategy. Participants can ask questions during the stakeholder meeting as time allows, and all questions are recorded and responded to in writing after the conclusion of the meeting. In addition, all stakeholders can submit their suggested changes in writing to HFS. HFS reviews all suggestions and determines the appropriateness of each in order to revise the Quality Strategy. In this manner, stakeholder input is incorporated into the Quality Strategy before it is published as a final document.

The revised Quality Strategy is shared with all pertinent stakeholders and posted on the HFS website for public view, as well as forwarded to CMS.

Strategy for Meeting Goals and Objectives

The methods employed by HFS to achieve these goals and objectives are detailed below.

- Developing and maintaining collaborative strategies among State agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk beneficiaries, and improve access to services for Illinois Medicaid and CHIP beneficiaries.

- Using additional performance measures, performance improvement projects, contract compliance monitoring, and emerging practice activities to drive improvement in beneficiary healthcare outcomes.

- Implementing mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using long-term services and supports (LTSS).

- Developing strategies to assess the quality of life of beneficiaries and the outcomes of health plans' community integration activities for beneficiaries receiving LTSS.

- Conducting collaborative performance improvement projects which are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.

- Strengthening evidence-based prevention, wellness, and health management initiatives to improve beneficiaries' health status and achievement of personal health goals.

- Enhancing beneficiary services and beneficiary satisfaction with services.

- Strengthening the health plans' provider network capacity reporting and validation processes to ensure timely access to care and services for beneficiaries.

- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.

- Working collaboratively with other federal and State agencies as well as community organizations to improve access to and quality of care and health outcomes of the populations served by Medicaid.

A timeline for assessing the effectiveness of the Quality Strategy is included in Appendix A.

Documenting Challenges, Successes, and Quality Strategy Changes

HFS has faced the many challenges that come with rapid expansion. To meet this challenge, HFS contracted its EQRO to conduct pre- and post-implementation operational readiness reviews for additional health plans contracted to implement HFS' programs. The purpose of the reviews was to determine the health plan's capacity to participate in the new Illinois Medicaid programs. The operational readiness reviews were designed to consist of four phases: pre-implementation activities, on-site readiness review, post-readiness review activities, and post-implementation monitoring. HFS supported readiness throughout the review process by providing ongoing technical assistance to allow the health plans to address all noncompliant areas. Technical assistance was provided in the development and implementation of corrective actions plans which were reviewed periodically for progress toward full compliance. The

corrective actions were validated through document review and will continue to be evaluated through on-site review in subsequent years.

This Quality Strategy reflects many new programs that have been initiated or are planned for implementation. HFS will continue to update the Quality Strategy to assure the quality of services being delivered to Medicaid managed care beneficiaries through new and expanded programs.

Section 2. Assessment

Quality and Appropriateness of Care and Services Delivered to Beneficiaries

As required by CFR §438.202(d), this section describes how the State assesses how well the managed care program is meeting the objectives outlined in the introduction. HFS has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure health plan compliance with contract requirements and to evaluate performance. Monthly, quarterly, and annual reporting is required. HFS holds monthly conference calls and quarterly face-to-face meetings with health plans to review performance. HFS contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, HFS' 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, parts §430, §433, §434, and §438, and the Balanced Budget Act (BBA) of 1997, which will hereafter be referred to as federal regulations.

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

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

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

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

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

- Implementing mechanisms to identify CSHCNs who are in need of a follow-up assessment, including PCP referrals, outreach, and contacting newly enrolled children.

- Assessing beneficiaries identified as CSHCN beneficiaries, including, but not limited to the following: use of a CSHCN standard assessment tool and completion of the assessment by a physician (or other allowable medical professional).

- Providing all CSHCN beneficiaries with case management services, including the components required for case management and the elements listed in the case management requirements.

- Notifying all CSHCN beneficiaries with a positive assessment and determined to need case management of their right to directly access a specialist.

Definition of Special Health Care Needs

HFS identifies CSHCN using 3M clinical risk grouping (CRG) software. The CRG software uses data from Medicaid Management Information System (MMIS) claims, including age, sex, diagnosis, procedures, pharmaceuticals, site of service, and date of service to assign each beneficiary to a single CRG. CRGs are aggregated in succession of health statuses from Status 1 (Healthy) through Status 9 (Catastrophic), with beneficiaries in the lower statuses identified as having fewer healthcare needs. Each status is further adjusted for severity of illness. For example, Status 6 (Significant Chronic Disease in Multiple Organ Systems) includes six levels of increasing severity of illness from 6.1 through 6.6. Beneficiaries assigned to Status 6.1 through Status 6.6 as identified through the CRG software tend to have chronic conditions affecting multiple organ systems. Currently, approximately 70,000 children have been identified through this model. HFS reserves the right to amend its method for identifying and defining this population.

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

To comply with the regulatory requirement for State procedures for race, ethnicity, and primary language spoken (CFR §438.206–§438.210), HFS requires the health plans to participate in Illinois' efforts to promote the delivery of service in a culturally competent manner to all beneficiaries. This includes those with limited English proficiency and diverse cultural and ethnic backgrounds. HFS identifies the race, ethnicity, and primary language spoken for each Medicaid beneficiary and provides this information to the health plans at the

time of enrollment as Section 438.204 of federal regulations requires. This statute requires HFS to establish a methodology for identifying the race, ethnicity, and prevalent non-English languages for health plan enrollees. HFS has defined "prevalent non-English language" as one in which 5 percent or more of families within the low-income households in the relevant Department of Human Services local office area speak a language other than English (as determined by HFS according to published Census Bureau data).

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

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

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

Efforts to Reduce Disparities in Healthcare

In an ongoing effort to reduce disparities in healthcare, HFS conducts activities detailed below.

- Annual public reporting on the Child and Adult Core Sets of healthcare performance measures.
- Implementing the Illinois Family Planning Action Plan to assure access to all available methods of contraception and to ensure availability of quality standards of care.
- Partnering with DHS to improve birth outcomes by identifying women at risk of a poor birth outcome for DHS' Better Birth Outcomes intervention and for intensive case management/care coordination by health plans for managed care beneficiaries.

- Developing and testing quality improvement tools and approaches under the CHIPRA Quality Demonstration Grant to assist in improving birth outcomes.

- Partnering with the Illinois Department of Public Health (IDPH) on the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality.

- Partnering with the IDPH on the Title V Maternal and Child Health (MCH) Program objectives and the State Action Plan.

National Performance Measures (42 CFR §438.204[c])

Section 401(a) of the CHIPRA of 2009 (Pub. L.111-3) required the Secretary of the Department of Health and Human Services (HHS) to identify a core set of child healthcare quality measures for voluntary use by state programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs (Medicaid Child Core Set).

Section 1139B of the Affordable Care Act also required the HHS Secretary to identify and publish an initial core set of health quality measures for adult Medicaid beneficiaries (Medicaid Adult Core Set).

Additionally, the law required the development of a standardized reporting format for states that volunteer to report on the Core Set measures. The CHIP Annual Report Template System (CARTS) is used for standardized reporting on these measures. During December 2015, CMS deployed the Medicaid and CHIP Program (MACPro) online reporting tool. While the CARTS system will continue to be used to report state added objectives to the annual report, for federal fiscal year (FFY) 2015 the MACPro system replaces CARTS for reporting the Child Core Set measures.

HFS publishes the Child Core Set Data Book annually. The report includes each Child Core Set measure reported in CARTS and provides information for the entire covered population (i.e., Title XIX, Title XXI, state-only funded). The report is available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/2014CHIPRAChildCoreSetDatabook.pdf. HFS compares progress with national HEDIS benchmarks and includes these comparisons in the report.

As new measures are developed on a national level by NCQA and others, HFS will review those measures to determine whether they are relevant to the Illinois Medicaid population.

Voluntary Collection of CMS Core Performance Measures

Child Core Set

Public Law 111-3, CHIPRA, included direction to CMS to establish a demonstration grant program for states, with a focus on improving the quality of children's healthcare. Illinois (as the partner state) in collaboration with Florida (as the lead state) was awarded one of 10 grants in 2010. The grant requires Illinois to test and report to CMS on a core set of pediatric quality measures over the six-year grant period. States report the Child Core Set measures annually to CMS using CARTS. The rates reported in CARTS include the combined Title XIX (Medicaid) and Title XXI (CHIP) populations. The report submitted to CMS via CARTS is posted on HFS' website. HFS also publishes a trend report on the Child Core Set measures reported to CMS. The rates reported to CMS differ from the rates reported in the CHIPRA Child Core Set Data Book posted on the HFS website (previous link), since the Data Book also includes the population of children who are state-funded (neither Title XIX nor Title XXI).

The CHIPRA Quality Demonstration Grant has provided an opportunity to focus on improving the quality of children's healthcare by testing and implementing the core set of pediatric performance measures. Illinois has made substantial progress on reporting the core measures: from 10 measures in 2010 (the baseline year), to 17 measures in 2011, 20 measures in 2012, 25 measures in 2013, and 21 measures in 2014 (since CMS retired some measures). The CHIPRA funding allowed Illinois to focus on the core measures and the measurement process, leading to improvements in the integrity of the data and the measurement process for all state performance measures. In FFY 2016, HFS will report Child Core Set measures that align with the measures selected by HFS as evidence-based measures.

Adult Core Set

The ACA (Pub. L. 111-148) was signed into law on March 23, 2010. This Act required the secretary of HHS to develop and publish a core set of healthcare quality measures for adults enrolled in Medicaid (Adult Core Set). The HHS secretary is also responsible for annually updating the core set measures to reflect new measures or enhancements to existing measures. The HHS secretary issues an annual report on states' voluntary reporting of the adult core measures.

The data collected through these measures are to provide a clear understanding to states and to CMS of the quality of healthcare provided to Medicaid-eligible adults. The Adult Core Set also advances toward a national system of data collection, measurement, reporting, and quality improvement.

In January 2012, an initial core set of adult measures was published by the HHS secretary and included 26 measures. CMS partnered with the Agency for Healthcare Research and Quality (AHRQ) to identify the measures in the initial core set. The initial core set was published after the public comment period concluded, occurring from December 30, 2010, to March 1, 2011.

Similar to reporting conducted for the Child Core Set measures, HFS reports on the Adult Core Set measures annually to CMS using CARTS. The rates reported in CARTS include the combined Title XIX (Medicaid) and Title XXI (CHIP) populations. During December 2015, CMS deployed the Medicaid and CHIP Program (MACPro) online reporting tool. For FFY 2015, the MACPro system replaced CARTS for reporting the Adult Core Set measures.

HFS first reported the adult core measures for FFY 2013. Of 26 core set measures that year, HFS reported seven measures. For FFY 2014, HFS reported 13 of 26 core measures plus one developmental measure on contraceptive use, bringing the total number of measures reported to 14. In FFY 2016, HFS will report Adult Core Set measures that align with the measures selected by HFS as evidence-based measures.

In addition to state-level reporting, Medicaid managed care plans are required to report on select core measures.

Monitoring and Compliance

HFS monitors and evaluates compliance with access to care, structure and operations, and quality measurement and improvement. In addition to HFS' Bureau of Managed Care (BMC) and Bureau of Quality Management (BQM), the State's Division of Information Systems (DIS) maintains the Medicaid Management Information System (MMIS) which includes all functional areas (beneficiary information, eligibility, demographics, provider enrollment, health plan enrollment, claims and encounter data, payment information, third-party liability, and reporting). HFS' enterprise data warehouse (EDW) and its executive information system (EIS) track key indicators for comparison (state, county, fee-for-service, and health plan [specific and aggregate]) for tracking and trending of utilization and health outcomes. Data are imported from other State agencies' data systems to determine utilization (e.g., immunization tracking systems and lead poisoning prevention programs) on an ongoing basis. The child-specific beneficiary information is provided to the respective health plan, as well as aggregate findings. The information is used to improve health plan outreach, patient compliance, and encounter data submission.

The areas described below are reviewed on an ongoing basis.

- Assuring the health plan (health maintenance organization [HMO]) has a certificate of authority (license), an approved certificate of coverage from the Illinois Department of Insurance, and an approval from the Illinois Department of Public Health to provide managed care services to beneficiaries.

- Assuring the health plan (Managed Care Community Network [MCCN]) meets HFS' regulatory requirements.

- Coordinating the monitoring of the fiscal components of the contract.

- Performing the initial, comprehensive readiness review and prior approval of the health plan's products and plans to comply with each aspect of the contract.

- Providing prior approval on all beneficiary and potential beneficiary written materials, including marketing materials.

- Ensuring that an information management system exists with sufficient resources to support health plan operations.

- Reviewing and providing approval (or requiring revision) on the health plan's submission of required reports or documentation on the following schedule, as appropriate: initially, as each event occurs; as revised; and monthly, quarterly, and/or annually.

- Performing on-site compliance monitoring visits, such as attendance at health plan meetings for performance reviews of quality assurance, or compliance checks, such as calling to assess after-hours availability.

- Performing network adequacy reviews, including prior approval of primary care providers to assure that they are enrolled in, and in good standing with, the Medical Assistance Program in one of the five primary care specialties allowed in the contract.

- Monitoring physician terminations and site closures to assure appropriate transfers and network adequacy.

- Monitoring encounter data for data file format, error rate of claims processing, and completeness.

- Monitoring of utilization data.

- Maintaining ongoing dialogue with, and providing technical assistance to, each health plan by conducting monthly conference calls and quarterly, face-to-face meetings with the medical directors and quality assurance staff in a collaborative forum to coordinate quality assurance activities, identify/resolve issues and barriers, and share best practices.

- Assessing beneficiary satisfaction through health plan consumer satisfaction surveys, problem and complaint resolution through HFS' hotline, direct calls to the BMC, referrals from the CMS regional office, and interaction with the beneficiary and health plan's member services or key health plan administrative staff.

- Monitoring the health plan's progress toward achieving the performance goals detailed in the contract and its focus on improving health outcomes.

- Requiring quality improvement projects, corrective action plans, and sanctions for contract noncompliance when the "cure" does not occur sufficiently and/or in a timely manner, as defined by HFS.

- Monitoring the health plan's compliance with its operation of a grievance and appeals process.

- Communicating recommendations to the health plans.

- Providing oversight for the quality improvement plan.

- Contracting with and monitoring the EQRO for the provision of external oversight and monitoring of the quality assurance component of managed care.

State Monitoring and Evaluation of Health Plan Requirements (42 CFR §438.204[b][3])

HFS holds health plans accountable for effective and efficient administration of quality healthcare services to the Medicaid population. The State has developed a robust system to monitor, evaluate, and ensure compliance with standards to improve the quality of services Medicaid managed care beneficiaries receive. 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, where 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.

HFS' protocol for review of reports involves two different roles that HFS staff have in the process. The "gatekeepers" confirm receipt of reports, check reports for completeness, communicate with health plans regarding delinquent or incomplete reports, and assign reports to designated reviewers for a complete review and analysis.

The "reviewers" check reports using report analysis guidance in the standard operating procedures (SOPs) and enter observations in the SharePoint database, along with designating the report as *Approved* or *Discrepancies Found*. The SOPs standardize the review process, help reviewers identify both compliance and quality of care issues, and hold all health plans to the same requirements. Reviewers maintain personal notes and documentation of reviews; initiate follow-up with health plans as necessary to obtain complete data and understand the data; and, if discrepancies are found, add a narrative in the SharePoint database to reflect resolution of the issue(s). Depending on the type of issues identified, reviewers may need to follow up with the health plans through written communications or a scheduled meeting. Reviewers might follow up on issues such as confirmation of the accuracy of the data, clarification regarding reasons for observed data trends, inquiry regarding continued undesirable data trends, and complex questions regarding the health plans' policies and procedures contributing to undesirable performance. Reviewers also recognize health plans for outstanding or improved performance and share best practices with other health plans.

Reporting is required monthly, quarterly, and annually for both the FHP/ACA and ICP health plans as demonstrated in the reporting tables found in Appendix B (FHP/ACA) and Appendix C (ICPs). The MMAI program has specific federal reporting requirements that can be reviewed at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Illinois.html.

Compliance Review (42 CFR §438.204[g])

In addition to the aforementioned monitoring and compliance activities, HFS contracts with its EQRO to perform comprehensive, on-site review of health plan compliance. According to 42 CFR §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid health plan's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR §438.204(g), these

standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438, which address requirements related to access, structure and operations, and measurement and improvement. The compliance reviews are conducted to meet this requirement.

The purpose of the compliance review is to determine health plan compliance with various quality assessment/improvement standards in 16 areas of compliance. The 16 compliance standards are derived from requirements in the *Department of Human Resources Division of Health Care Financing and Policy Request for Proposal No. 04-02 for Managed Care* and all attachments effective July 1, 2003, as well as amendments as of June 30, 2011; and the federal regulations, with revisions effective June 14, 2002. The 16 compliance standards are:

- Availability of Services

- Assurance of Adequate Capacity and Services

- Coordination and Continuity of Care (Including Transition of Care)

- Coverage and Authorization of Services

- Credentialing and Recredentialing

- Subcontractual Relationships and Delegation

- Enrollee Information/Enrollee Rights

- Confidentiality

- Enrollment and Disenrollment

- Grievance and Appeal Process

- Practice Guidelines—This standard will be combined with Standard XII

- Quality Assessment and Performance Improvement Program

- Health Information Systems

- Required Minimum Standards of Care

- Critical Incidents

- Fraud and Abuse

- Children's Mental Health System

The EQRO also conducts a review of individual files for the areas of delegation, credentialing/recredentialing, grievances, appeals, denials, and continuity of care/case management to evaluate implementation of the standards. On-site evaluations adhere to guidelines detailed in the November 12, 2012, CMS final protocol.

The State and the health plans use the information and findings from the compliance reviews for the purposes listed below.

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

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

Performance Dashboard (42 CFR §438.204[f])

HFS is the primary State entity tasked to monitor and direct health plans in the area of performance and quality related to the contract provisions of ICP, MMAI and FHP/ACA health plans in the State of Illinois. To provide these invaluable services, a number of dedicated processes, IT systems, and procedures have been created and/or adapted since 2013. One of the first of these new systems is the BMC Reporting SharePoint site. The site, and the processes to support it, were developed to support the gathering of contractually required performance data from health plans and to provide a communication platform accessible to HFS and health plans. Over the first 18 months since the site was operational, all of the health plans have been providing contractually required monthly, quarterly, and annual performance data to HFS using common report templates. The templates have been designed for commonality, functionality, and ease of use. The data reported are then reviewed by HFS staff. Based on thorough analysis of the reported data, HFS staff communicates with health plans, highlighting areas where performance should be improved.

External Quality Review (42 CFR §438.204[d])

HFS contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, 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, parts §430, §433, §434, and §438, and the Balanced Budget Act of 1997. The EQRO is required to use the tools published by CMS for the development of its oversight and monitoring process, to the extent possible and applicable to HFS' managed care program. The EQRO updates its monitoring assessment tools, as necessary, to assess each health plan's compliance with its quality assurance program (QAP), as federally mandated.

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.

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

Validation of Performance Measures. The EQRO conducts NCQA HEDIS Compliance Audits™[2-1] and performance measure validation (PMV) audits for the FHP/ACA, ICP and MMAI. HEDIS measures are standardized, nationally accepted measures for specific health indicators. In accordance with 42 CFR §438.240(b)(2), HFS requires health plans to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. HFS uses performance measures to assess compliance with care standards and level of beneficiary satisfaction.

To comply with 42 CFR §438.240(b)(2), HFS' EQRO validates the performance measures through NCQA HEDIS Compliance Audits. These audits focus on the ability of the health plans to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or

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[2-1] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

beneficiary) data, and provider data. As part of the NCQA HEDIS Compliance Audits, the Department's EQRO also explores the issue of completeness of claims and encounter data to evaluate reported rates for the performance measures.

For HEDIS-like measures, PMV activities are conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[2-2]

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

This system described above was used through calendar year 2015 and the process is being revised to incorporate NCQA benchmarks and percentiles.

HFS also contracted its EQRO to conduct the validation of performance measures for the PCCM Program and the CHIP using the CHIPRA measures. Validation activities were conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012 (the CMS Performance Measure Validation Protocol) cited above, as well as the *National Committee for Quality Assurance (NCQA) manual, HEDIS 2015 Compliance Audit: Standards, Policies and Procedures, Volume 5*. The primary objectives of the performance measure validation process were to evaluate the processes used to collect the performance measure

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[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Nov 29, 2016.

data by HFS and determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.

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

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

NCQA Benchmarking. HFS uses HEDIS data whenever possible to measure health plan performance with specific indicators of quality, timeliness, and access to care. HFS is committed to working with CMS in the development of national performance measures. It is HFS' understanding that there have been no national performance measures for managed care developed by CMS and the healthcare industry for states to monitor at the current time. It is understood that the State will be consulted in each phase of the development process at the point CMS undertakes their development. HFS is currently monitoring the performance measures recognized by CMS as being important in other areas, such as EPSDT participation (CMS 416), childhood immunization rates, adequate prenatal care, adult preventive care, and behavioral health utilization.

Validation of Focused Quality Initiatives. For Medicaid managed care (FHP/ACA and ICP), these projects are referred to as performance improvement projects (PIPs) and for MMAI they are called quality improvement projects (QIPs). As described in 42 CFR §438.240(b)(1), HFS requires health plans to conduct these focused quality initiatives in accordance with 42 CFR §438.240(d). These must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and beneficiary satisfaction. In accordance with 42 CFR §438.358(b)(1), HFS' EQRO validates these focused quality initiatives required by the State to comply with the requirements of 42 CFR §438.240(b)(1). HFS' EQRO validation determines if PIPs/QIPs were designed to achieve improvement in clinical and nonclinical care, and if they would have a favorable effect on health outcomes and beneficiary satisfaction.

EQR Technical Report. Public Law 105-33 requires states to prepare an annual EQR technical report that focuses on contract compliance, validation of performance measures, and performance improvement projects, and includes the components listed below.

- The manner in which the data were aggregated and analyzed, and conclusions that were drawn as to the quality, timeliness, and access to the care furnished by health plans.

- An assessment of the health plans' strengths and weaknesses with respect to quality, timeliness, and access to healthcare services.

- Recommendations for improving the quality of healthcare services.

- An assessment of the degree to which the health plans implemented the previous year's EQR recommendations for quality improvement and the effectiveness of the recommendations.

HFS' EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed. The EQR technical report includes a review of beneficiaries' access to care and the quality of services received by beneficiaries of Title XIX, Medicaid. In accordance with 42 CFR §438.364, the report includes the following information for each mandatory activity conducted:

- Activity objectives

- Technical methods of data collection and analysis

- Description of data obtained

- Conclusions drawn from the data

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

Nonduplication of Mandatory External Quality Review Activity. The federal managed care regulations, at 42 CFR §438.360, provide an optional mechanism for states to use to prevent duplication of the mandatory compliance monitoring activities for its managed care plans when a plan has had a similar review performed by either Medicare or an approved national accrediting organization. Managed care organizations, therefore, can be considered to have "deemed" compliance. Standards reviewed by the accrediting organization must be duplicative of the state's standards for access, structure and operations, and measurement and

improvement. Two areas that may not be considered to be deemed compliant on the basis of this alternative review are conducting PIPs and the calculation of performance measures.

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.

Validation and Certification of Encounter Data. Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates. However, in order for encounter data to effectively serve these purposes, these data must be valid (i.e., complete and accurate). An encounter data validation study may be conducted to evaluate completeness and accuracy of encounter data. It also can assist in the improvement of the processes associated with the collection and submission of encounter data to state Medicaid agencies.

Assessment of Consumer Satisfaction Surveys. 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. As part of the EQR technical report, the EQRO evaluates the results of adult and child CAHPS surveys conducted by the health plans to identify trends, strengths, and opportunities for improvement.

In SFY 2013–2014, HFS completed its first statewide 5.0 CAHPS survey for Medicaid and CHIP children which included children enrolled in both the FFS and managed care delivery systems. The FFS population included beneficiaries enrolled in a PCCM health plan. A second statewide survey was completed in 2015. HFS oversamples for CHIP and Medicaid so that the data can be analyzed in the aggregate and separately for CHIP and Medicaid enrolled.

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

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

Provision of Technical Assistance. As requested by HFS, the EQRO has provided ongoing technical guidance to the health plans to assist them in conducting the mandatory EQR

activities—particularly to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). The EQRO also provided technical assistance training to the health plans in conducting root cause analyses and implementing meaningful interventions to address the findings outlined in the health plan annual program evaluations and the results of PIPs and performance measures. The EQRO may also conduct a reevaluation of the CAPs for progress toward compliance with expected performance levels.

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

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

Section 3. State Standards

Performance Standards

HFS holds health plans accountable for effective and efficient administration of quality healthcare services to the Medicaid population. The State has developed a robust system to monitor, evaluate, and ensure compliance with standards to improve the quality of services Medicaid beneficiaries receive. HFS has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure compliance with contract requirements and evaluate performance. Reporting is required on a monthly, quarterly, and annual basis.

Access to Care Standards

The contracts between HFS and health plans detail Illinois Medicaid standards for access to care, as outlined in Subpart D of the Medicaid managed care rules and regulations. HFS' standards for access to care are as stringent as those in 42 CFR §438.206–438.210. Health plans are required to implement the following standards for access to care:

- Availability and accessibility of all covered services (42 CFR §438.206)
- Assurances of adequate capacity and services (42 CFR §438.207)
- Coordination and continuity of care (42 CFR §438.208)
- Coverage and authorization of services (42 CFR §438.210)
- Enrollment and disenrollment (FHP/ACA Contract 2015-24-002—Section 4.8)
- Credentialing and recredentialing (42 CFR §438.214)

For a detailed description of Illinois' access to care standards and health plan contractual requirements, please see Appendix D.

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

Structure and Operations Standards

State standards for structure and operations are as stringent as those in 42 CFR §§438.214–438.230, as follows:

- Provider selection and retention (42 CFR §438.214)

- Enrollee information (42 CFR §438.218)

- Enrollee rights (42 CFR §438.100)

- Confidentiality (42 CFR §438.224)

- Enrollment and disenrollment (42 CFR §438.226)

- Grievance systems (42 CFR §438.228)

- Appeals process (42 CFR §438.406)

- Subcontractual relations and delegation (42 CFR §438.230)

- Health and safety monitoring (FHP/ACA Contract 2015-24-002—Section 5.20)

- Required minimum standards of care (FHP/ACA Contract 2015-24-002—Attachment XXI)

For a detailed description of the grievance system, see Appendix E. Illinois' structure and operations standards and health plan contractual requirements are detailed in Appendix D. Additional information related to the structure and operation standards regarding HFS' procedures for the review of records of health plan grievance and appeals can also be found in Appendix D.

Quality Measurement and Improvement Standards

Standards for quality measurement and improvement are as stringent as those in 42 CFR §§438.236–438.242, as follows:

- Practical/clinical guidelines (42 CFR §438.236)

- Quality assessment and performance improvement program (42 CFR §438.240)

- Health information system (42 CFR §438.242)

For a detailed description of Illinois' quality measurement and improvement standards and health plan contractual requirements, see Appendix D. Additional information related to the quality measurement and improvement standards, including how the State determines health plan compliance with contract requirements (performance goals), can be found in Appendix D.

Measurement of Beneficiary Satisfaction

HFS also uses consumer satisfaction surveys to monitor health plan and provider performance, measure beneficiary satisfaction with services and access to care, and evaluate program characteristics. Each year, the health plans are required to independently administer a consumer satisfaction survey. Health plans administer CAHPS Adult and Child (if applicable) 5.0

surveys. The primary objective of the CAHPS surveys is to obtain information effectively and efficiently, showing the level of satisfaction Medicaid Illinois beneficiaries have with their healthcare experiences. The surveys ask beneficiaries to report on and evaluate their experiences with healthcare and cover topics important to them, such as the communication skills of providers, the accessibility of services, and satisfaction with the health plan. Health plans survey two populations: adults and children.

Performance Measures

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

HFS organizes performance reporting by classifying performance measures into the categories listed below. Measures in these categories provide information on the quality, timeliness of, and access to healthcare services furnished to HFS beneficiaries as indicated in Table 3-1 through Table 3-4 in this section.

- Access/Utilization of Care
- Appropriate Care
- Behavioral Health
- Long Term Care
- Maternity Care
- Movement of Members Between Care Settings
- Preventive/Screening Services

Summary of FHP/ACA Requirements

Table 3-1 outlines the P4P performance measures for FHP/ACA for the 2016 reporting year (data collection 2015). Current and trended performance can be found in Appendix F (FHN, trended), Appendix G (Harmony, trended) and Appendix H (Meridian, trended), and the current results for HEDIS 2015 for the three FHP/ACA health plans can be found in Appendix I. See Appendix J and Appendix K for a comprehensive list of FHP/ACA performance measures for the 2016 and 2017 reporting years, respectively.

Table 3-1—Priority Measures for FHP/ACA

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	QUALITY	TIMELINESS	ACCESS
Access/Utilization of Care	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*		√	√
	Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge (All Ages) (IAPI)		√	√
	Well-Child Visits (WCV)			
	1) Well-Child Visits in the First 15 Months of Life (W15)		√	√
	2) Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)		√	√
Maternity Care	Prenatal and Postpartum Care (PPC)			
	1) Timeliness of Prenatal Care		√	√
	2) Postpartum Care		√	√
Preventive/Screening Services	*Childhood Immunization Status (CIS) (Combo 3 Only)*	√	√	√
	Developmental Screening in the First Three Years of Life (SDEV)		√	√

Summary of Primary Care Case Management (PCCM) Requirements

As of June 30, 2015, almost 6,000 medical homes, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) were enrolled as PCPs in Illinois Health Connect. Table 3-2 outlines the bonus performance measures for the IHC in calendar year 2016.

Table 3-2—Priority Measures for Illinois Health Connect (IHC)

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	QUALITY	TIMELINESS	ACCESS
Appropriate Care	*Use of Appropriate Medications for People with Asthma*	√		√
	Comprehensive Diabetes Care (HbA1c testing)	√		√
Preventive/ Screening Services	*Breast Cancer Screening*	√		√
	Childhood Immunization Status (Combo 3)	√		√
	Lead Screening in Children	√		√
	Developmental Screening in the First Three Years of Life		√	√

In addition to the six "bonus" measures, IHC monitors program and PCP quality performance on an additional seven quality measures (*Cervical Cancer Screening; Objective Vision Screening in the 3rd and 4th Years of Life; Adults' Access to Preventive/Ambulatory Health Services; Ambulatory Care [ED only]; Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well Care Visits*). All 13 quality of care measures are detailed in the IHC Provider Profile Report each year. The Provider Profile contains the following information for each measure: number of eligible beneficiaries, number of eligible events, current rate, prior rate, and IHC state rate comparison to all IHC PCPs.

Summary of ICP Requirements

The ICP contracts for reporting year 2015 contained eight P4P measures, as displayed in Table 3-3 below. Results for ICP and ICP expansion health plans can be found in Appendix L and Appendix M, respectively. See Appendix N and Appendix O for a comprehensive list of ICP performance measures for reporting years 2016 and 2017, respectively.

Table 3-3—Priority Measures for ICP

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	QUALITY	TIMELINESS	ACCESS
Access/ Utilization of Care	*Adult's Access to Preventive/Ambulatory Health Services (AAP)*			√
	Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge		√	√
Appropriate Care	Comprehensive Diabetes Care (CDC)			
	1) Hemoglobin A1c (HbA1c) testing	√		
	2) Eye exam (retinal) performed	√		
	3) Medical attention for nephropathy	√		
Behavioral Health	*Follow-up after Hospitalization for Mental Illness—30 Days*	√	√	√
	Antidepressant Medication Management (Acute Phase)	√		
	Antidepressant Medication Management (Continuation Phase)	√		

Summary of MMAI Requirements

Of the MMAI Demonstration Years 2, 3, 4, and 5 measures, three are withhold measures, as displayed in the Table 3-4 below.

Table 3-4—Priority Measures for Medicare-Medicaid Alignment Initiative Demonstration Years 2-5

MEASURE FOCUS	KEY MEASURE NAME/ DESCRIPTION	QUALITY	TIMELINESS	ACCESS
Long Term Care	*Care for Older Adults (including advance care planning, medication review, functional status assessment, and pain assessment)*	√	√	
	Movement of Members Within Service Populations		√	√
Behavioral Health	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	√	√	√

Encounter Data

Encounter data represent detailed information regarding the services provided to Medicaid beneficiaries enrolled in capitated managed care. Capitated health plans that contract with HFS to provide Medicaid services are required to maintain health information systems. These systems must be able to collect data on Medicaid beneficiaries, provider characteristics, and services using encounter data or other state-specified methods. Health plans are required to ensure that data received from Medicaid providers are accurate and complete.[3-1]

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted health plans in order to monitor and improve the quality of care, establish performance measure rates, generate accurate and reliable reports, obtain utilization and cost information, and report aggregate statistical information to the federal government. The completeness and accuracy of these data are essential to the overall management and oversight of the Medicaid managed care program and in demonstrating the State's responsibility and stewardship.

Capturing, sending, and receiving encounter data has historically been difficult and costly for health plans and states alike on a nationwide basis. The encounter data process is lengthy and has many steps where data can be lost or errors can be introduced into submitted data elements. HFS has developed a number of validation techniques to help ensure the completeness and accuracy of its encounter data.

During SFY 2014, HFS contracted with its EQRO to conduct an encounter data validation (EDV) study. The goal of the study was to assess the degree of data file completeness, accuracy, and timeliness across two health plans in order to provide insight into the quality of HFS' overall encounter data system. The findings from this assessment provided a series of baseline results and established a foundation for reporting and monitoring activities.

HFS implemented methods that analyze multiple variables, as detailed below.

- Encounter data volume—evaluates the completeness of encounter data submissions over time reported as the volume of encounter data per beneficiary per month.
- Percent of duplication encounters—evaluates the percentage of submitted encounters associated with a duplicate record.

[3-1] Department of Health and Human Services, OIG. *Medicaid Managed Care Encounter Data: Collection and Use.* May 2009.

- Timeliness of encounter data—measures the length of time between the date of service and submission to HFS.

- Provider data accuracy—measures the presence and accuracy of provider information on submitted encounters.

Encounter Data Requirements

HFS' contractual requirements for encounter data submission include the four components described below.

Submission. Health plans are required to submit encounter data that encompass all services received by beneficiaries, including services reimbursed by the contractor through a capitation arrangement. Encounter data reports must provide HFS with Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant transactions, including the National Council for Prescription Drug Programs (NCPDP), 837D File, 837I File and 837P File, prepared with claims-level detail, as required herein, for all institutional and noninstitutional provider services received by the beneficiary and paid by or on behalf of the contractor during a given month. The contractor must submit administrative denials in the format and medium designated by HFS. The report must include all institutional and HCBS Waiver services.

Health plans submit encounter data to be accepted by HFS within 120 days after the contractor's payment or final rejection of the claim or, for services paid through a capitation arrangement, within 120 days after the date of service. Any claims processed by the contractor for services provided subsequent to the submission of an encounter data file are reported on the next encounter data file.

Testing. Upon receipt of each submitted encounter data file, HFS performs two distinct levels of review.

The first level of review and edits performed by HFS checks the data file format. These edits include, but are not limited to the following: completeness of records, correct sort order of records, proper field length and composition, and correct file length. To be accepted by HFS, the format of the file must be correct.

Once the format is correct, HFS performs the second level of review, standard claims processing edits. These edits include, but are not limited to, the following: correct provider numbers, valid beneficiary numbers, valid procedure and diagnosis codes, and crosschecks to assure provider and beneficiary numbers match the name on file. The acceptable error rate of claims processing edits of the encounter data provided by the contractor will be determined by HFS. Once an

acceptable error rate has been achieved, as determined by HFS, the contractor is instructed that the testing phase is complete and those data can be put into production.

Production. Once the contractor's data testing is completed, the contractor will be certified for production. Once certified for production, the contractor continues to submit encounter data in accordance with these requirements. HFS continues to review the encounter data for correct format and quality. The contractor must submit as many files as necessary, in a time frame agreed upon by HFS and the contractor, to ensure all encounter data are current. At the sole discretion of HFS, HFS may pull the contractor out of production and back to the testing protocol if warranted due to poor quality.

Records that fail the edits described above are returned to the contractor for correction. The contractor must return corrected encounter data to HFS for reprocessing within 30 days after the date of the original rejection.

Electronic Data Certification. In a format determined by HFS, the contractor will certify by the fifth day of each month that all electronic data submitted during the previous calendar month are accurate, complete, and true.

Health Information Initiatives

To facilitate better data submission, HFS is implementing the following initiatives.

HFS Electronic Health Records (EHR) Payment Incentive Program

Section 4210 of the 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 eMIPP) from providers who had initiated the registration process on a CMS website. Since the program's inception through August 5, 2015, HFS has awarded over $487 million in incentive payments to 6,591 eligible Medicaid providers (EPs) and 174 eligible Medicaid hospitals (EHs) to encourage them to adopt, implement, or upgrade their local EHR system, with a later goal of engaging in the "meaningful use" of said technology. The State estimates that the 100 percent federally funded payments to eligible providers will exceed $800 million over the life of the program, which continues through 2021.

Section 4. Improvement and Interventions

Improvement Strategy

Care coordination is the foundation of Illinois' Medicaid improvement efforts. Aligned with Illinois' Medicaid reform law and the federal Affordable Care Act, the Department began expansion of care coordination with an initial focus on the most complex, expensive beneficiaries through the development of an integrated approach for the ICP population. From there, the Department expanded its managed care programs to include care coordination for the FHP populations and ACA adults. Under this expansion, Illinois has worked to develop comprehensive approaches that offer and provide the benefits of care coordination and improved healthcare outcomes for additional beneficiaries enrolled in a Medicaid program.

Quality Improvement Interventions and Strategies

Based on the results of the assessment activities outlined in Section 2 of this report, HFS is attempting to improve the quality of care delivered by the health plans through the following types of improvement interventions and strategies described in this section, including:

- Cross-state agency collaboratives/initiatives
- External quality review (EQR) technical report
- Evaluation of the effectiveness of the quality assessment and performance improvement (QAPI) program
- Validation of performance improvement projects (PIPs)
- Validation of performance measures
- Facilitation of statewide collaborative PIPs
- Network capacity review
- HCBS staff capacity review
- CMS HCBS Waiver performance measures record reviews
- Monitoring corrective action plans
- CAHPS surveys for the Children's Health Insurance Program (CHIP)
- Family planning requirements compliance
- Americans with Disabilities Act (ADA) program requirements

- Monthly and quarterly quality meetings

- Pay-for-performance (P4P) incentives

- Corrective/remedial actions

- Health plan sanctions

- EHR initiatives

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

- Assessment of consumer satisfaction surveys

- Conducting collaborative PIPs

- Validation and certification of encounter data reported by health plans

- Readiness review of new health plans

- Provision of technical assistance

- Consumer-focused quality studies and quality of life studies

- Access and availability surveys

Cross-State Agency Collaboratives/Initiatives

Illinois Project LAUNCH

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

As part of this effort, the health plans led the development of a beneficiary resource card that describes for the primary care provider, community workers, and the beneficiary how to determine which health plan a beneficiary is assigned to and how to contact the health plan for assistance, such as member services, medical transportation, and the on-call nurse advice line. In addition, the health plans developed a provider resource card that describes the concepts and responsibilities of the medical home provider. The health plans, Illinois Project LAUNCH, HFS, Illinois Health Connect, and the Illinois Chapter of the American Academy of Pediatrics provided subject matter expert input regarding the content of the resource cards. The resource

cards are available to Illinois Project LAUNCH staff beneficiaries and providers in the community in English and Spanish.

Bright Futures[4-1]

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

Bright Futures guidelines were incorporated into the revision of the Handbook for Providers of Healthy Kids Services published January 2015 and have influenced other HFS policies. The handbook is consistent with Bright Futures guidelines and best practices, thereby enabling HFS-enrolled providers to more easily implement the guidelines and to promote some key elements of Bright Futures, such as anticipatory guidance and care coordination. The current version of the handbook is available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf.

Medical Home Primer for Community Pediatricians and Family Physicians

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

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[4-1] Bright Futures is a national health promotion and disease prevention initiative developed by the Health Resources and Service Administration with the American Academy of Pediatrics.

continues to advance HFS' quality improvement efforts toward promoting the medical home model.

Pathways to Community Living Program

The Pathways to Community Living program in Illinois was developed under the Money Follows the Person (MFP) federal demonstration project. Authorized by the Deficit Reduction Act of 2006, and extended until September 2016 by the Affordable Care Act, MFP supports state long-term care rebalancing by assisting eligible individuals to move from long-term care facilities (nursing homes) and intermediate care facilities for persons with developmental disabilities to community settings. In Illinois, HFS is the lead agency in this initiative, working in partnership with the Department of Human Services, the Department on Aging, and the Illinois Housing Development Authority.

Under MFP guidelines, the Pathways to Community Living initiative seeks to increase the use of community services and rebalance the State's long-term care systems by providing appropriate, person-centered services for individuals interested in transitioning from institutional settings to qualified home and community-based settings.

The goal of MFP is to complete transitions to the community which are successful and permanent. Keys to reaching that goal and ensuring the quality of the experience for those who are transitioning are pre- and post-transition staffing and the thorough analysis and remediation of factors contributing to critical incidents which occur once the individual has moved to the community. A multidisciplinary team of professionals looks holistically at the participant, his/her diagnoses, strengths, and support systems. Risk factors which might jeopardize the participant's continued residence in the community are identified and addressed. Reviews of critical incidents focus not only on the participant's actions or physical/mental health factors which may have contributed to the critical incident, but also on the behavior of support staff and others working with the participant. Discussion includes identifying and minimizing risks and deciding on alternative approaches to be used in the future. Follow-up meetings are held as needed to review the outcomes of changes made to the person-centered care plans and to discuss the results of additional training provided to staff.

I-CARE

I-CARE is a robust, web-based application available through the Illinois Department of Public Health which allows providers to collect, store, analyze, and report immunization data at individual provider sites.

The main features include:

- Calculation of immunization due dates
- Automatic population and printing options for the school physical form and patient immunization history report
- Remind/recall feature to track and notify patients of due dates
- Vaccine inventory feature to track vaccine usage by lot number
- Ability to record patient contraindications, adverse reactions, or immunities
- Assessment of immunization coverage levels by practice
- Temperature log feature to track and report vaccine storage by appliance
- Vaccine Information Statement (VIS) module containing up-to-date VIS forms for printing, distribution, and tracking

In 2015, approved designees of HFS-contracted health plans were given access to the registry in order to coordinate the provision of medical care to beneficiaries of the medical assistance programs and to better serve the populations they have been entrusted with, including preventive services and immunizations. Health plans are expected to show improvements in the national HEDIS scores, some of which measure immunization rates.

Illinois Perinatal Quality Collaborative

The Illinois Perinatal Quality Collaborative (ILPQC) has been in existence since late 2013. The ILPQC is an independent, voluntary organization that focuses on improving health outcomes for Illinois women and infants statewide by engaging perinatal stakeholders in quality improvement initiatives using science, education, data, and evidence-based practice guidelines. HFS provided initial funding for the creation of the ILPQC through the CHIPRA Quality Demonstration Grant. With 112 birthing hospitals currently engaged in one or more quality improvement initiatives, ILPQC's quality improvement initiatives are having a direct positive impact on the health outcomes for Medicaid/CHIP patients. During 2014, ILPQC conducted quality improvement projects focused on reducing early elective deliveries less than 39 weeks, and on infant nutrition and feeding. During 2015, ILPQC implemented quality improvement initiatives that directly impact health outcomes and associated costs for HFS beneficiaries focused on birth certificate accuracy and the golden hour. In 2016, ILPQC launched the maternal hypertension initiative with 110 hospitals, its largest initiative to date, continued the golden hour initiative, and will begin planning for a Neonatal Abstinence Syndrome (NAS) initiative.

Managed Care Improvement Interventions and Strategies

Focused Quality Initiatives

HFS requires health plans (FHP/ACA and ICP) to conduct performance improvement projects (PIPs) and MMAI health plans to conduct quality improvement projects (QIPs) in accordance with 42 CFR §438.240(b)(1). The purpose of a PIP/QIP is to achieve, through ongoing measurements and intervention, significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving health plan processes can have a favorable effect on health outcomes and beneficiary satisfaction. In accordance with 42 CFR §438.358(b)(1), HFS' EQRO validates PIPs/QIPs required by the State to comply with the requirements of 42 CFR §438.240(b)(1). HFS' EQRO validation determines if they were designed to achieve improvement in clinical and nonclinical care, and if the PIPs/QIPs would have a favorable effect on health outcomes and beneficiary satisfaction.

Care Coordination PIP

Integral to care coordination is the linkage of the beneficiary to community resources. Research demonstrates that high-risk beneficiaries who have increased access to community resources that provide education, physician assessments, and pharmacological interventions will demonstrate improved health outcomes by lowering readmission rates.

HFS requires participation by all health plans serving FHP/ACA, ICP, and MMAI beneficiaries in the collaborative *Community-Based Care Coordination* PIP, which focuses on medically high-risk beneficiaries with a recent hospital discharge who are actively receiving care coordination with linkage to community resources.

The PIP is focused on the relationship between care coordination with community resources, timely ambulatory care services, and hospital readmission rates less than 30 days post discharge. The study population includes beneficiaries stratified as high and moderate risk and includes quality improvement interventions with the aims listed below.

- Decrease the rate of medical inpatient readmissions within 30 days of a previous admission with the same diagnoses for identified beneficiaries.
- Improve health outcomes, baseline level of functioning, and quality of life.
- Promote patient-centered care.

- Foster beneficiary engagement and accountability and improve the beneficiary's ability to manage their own health conditions effectively.

- Realize a sustained decrease in avoidable utilization, problematic symptoms, as well as a mitigation of risk factors.

- Demonstrate sustained improvement in health outcomes and status.

With technical assistance from the EQRO and through a collaborative effort, the ICPs developed the study questions and indicators, record abstraction tool, and instructions. SFY 2015 was the second remeasurement year for Aetna and IlliniCare. All FHP/ACA, ICP, and MMAI plans will be required to participate in the *Community-Based Care Coordination* PIP beginning in SFY 2016 and will report baseline data in SFY 2017.

Behavioral Health PIP

The *Follow-up After Hospitalization for Mental Illness* behavioral health PIP is a new collaborative PIP that requires participation by all health plans serving FHP/ACA, ICP, and MMAI beneficiaries. Baseline measurement will occur in SFY 2017.

The interventions were chosen as appropriate for health plans' target populations based on a collaborative effort with health plans in Illinois and on state-defined metrics.

The clinical significance of the PIP, according to national statistics, is that about one in four adults in the United States lives with a mental illness. Those who experience a mental illness are less likely to use medical care and follow treatment plans. Each year, on average, 60 percent of adults do not receive the mental health services they need. Without the proper care, those with mental illness can expect to see a decline in their overall health and well-being. With proper follow-up care, health outcomes are more likely to improve.

Evidence suggests that the rate of avoidable behavioral health-related rehospitalization can be reduced with various interventions.[4-2] Some of these interventions include improving hospital discharge planning and transition processes; bettering medication practices; improving transitions and care coordination between care settings; and promoting the recovery-oriented practice model which includes enhancing coaching, education, and support for patient self-management. Therefore, the HEDIS measure *Follow-up After Hospitalization Measure for Mental Illness (FUH)* was chosen as the study indicator for this PIP. This is an industry standard

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[4-2] American Hospital Association (2012). Trendwatch: Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes.

for measurement of transitions in care between inpatient and behavioral health outpatient levels of care.

Statewide Improvement Interventions and Strategies

Uniform Assessment Tool

Over the last several decades, the Social Security Act has been amended several times to help reduce the institutional bias in Medicaid long-term care. The ACA included the Balancing Incentive Program (BIP—Section 10202) as an incentive to improve access to community-based long-term services and supports (LTSS) through receipt of enhanced federal funds in exchange for structural changes to state LTSS system entry and assessment systems.

The Illinois BIP application was approved June 12, 2013. The Illinois goal is to advance better health, improve healthcare quality, and provide value throughout the LTSS system. Development of a Uniform Assessment Tool (UAT) is one approach, among many, that Illinois might take to improve services for older adults and persons with disabilities and increase home and community-based options.

A UAT is a standardized and uniform process used across community-based programs to determine eligibility, identify support needs, and inform person-centered planning. The UAT is a two-step assessment (screening and assessment) which includes a core set of data containing five domains: activities of daily living (ADLs), instrumental activities of daily living (IADLs), medical conditions/diagnoses, cognitive functioning/memory, and behavior concerns.

High-Risk Pregnant Women

Better Birth Outcomes Project is a DHS/HFS collaboration focusing on improving birth outcomes. DHS and HFS are collaborating to share data related to women identified as high-risk for a poor birth outcome. HFS identifies women as potentially pregnant by culling through claims for data indicative of pregnancy (e.g., pharmacy claims for prenatal vitamins). Once identified as potentially pregnant, Phase I of the algorithm determines whether the women had a previous high-cost birth. Phase II of the algorithm was implemented after testing of Phase I was complete and identifies women with conditions identified as highly associated with a poor birth outcome. The conditions are identified based on an odds ratio analysis of HFS claims data and based on research information. Women who have a Phase I or Phase II risk are "flagged" in a file that is transferred to DHS. A high-risk pregnancy flag also is shared via the Care Coordination Claims Data (CCCD) files with the health plans for case management and risk adjustment purposes.

Behavioral Health

In 2016, Illinois announced the Health and Human Services Transformation. The focuses of this initiative are:

- Prevention and public health.

- Paying for value and outcomes rather than volume and services.

- Making evidence-based and data-driven decisions.

- Moving individuals from institutions to community care to keep them more closely connected with their families and communities.[4-3]

For this transformation effort, HFS has been collaborating with the Governor's office and 11 other State agencies, including health, human services, education, and criminal justice representatives as well as a broad stakeholder community. The initial area of focus for this effort is behavioral health (mental health and substance use), specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to both the urgency of the issue and the potential financial and human impact. Illinois conducted quantitative and qualitative analyses and sought extensive stakeholder input to understand what drives high costs and variable outcomes in the behavioral health system. As a result, the State has developed a comprehensive strategy that puts beneficiaries at the center, integrates behavioral and physical health, and transforms a fragmented and unsustainable system with new payment and delivery models, increased managed care, enhanced workforce capacity, and greater accountability. This strategy consists of four central approaches and 10 initiatives to support them.

In October 2016, Illinois submitted an application for a Section 1115 Medicaid demonstration waiver.[4-4] This proposal to CMS is one component the behavioral health transformation. Goals of the demonstration waiver are detailed below.

1. Rebalance the behavioral health ecosystem, reducing over-reliance on institutional care and shifting to community-based care.

[4-3] HHS Transformation. Overview. Available at: https://www.illinois.gov/sites/hhstransformation/overview/Pages/default.aspx. Accessed on: Dec 7, 2016.

[4-4] Illinois Department of Healthcare and Family Services. Illinois' Behavioral Health Transformation: Section 1115 Demonstration Waiver. Available at: https://www.illinois.gov/sites/hhstransformation/overview/Documents/1115WaiverPublicComment.pdf. Accessed on: Dec 7, 2016.

2. Promote integrated delivery of behavioral and physical healthcare for behavioral health beneficiaries with high needs.

3. Promote integration of behavioral health and primary care for behavioral health beneficiaries with lower needs.

4. Support development of robust and sustainable behavioral health services that provide both core and preventive care to ensure that beneficiaries receive the full complement of high-quality treatment they need.

5. Invest in support services to address the larger needs of behavioral health beneficiaries, such as housing and employment services.

6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments.

Upon CMS approval, Illinois will implement a priority set of benefits and initiatives, many of which will be conducted in pilot form. The behavioral health transformation will have a significant impact over the next five years. It will touch all regions of the state, improving care for approximately 800,000 Medicaid beneficiaries with behavioral health conditions. It will build a delivery system focused on integrated physical and behavioral healthcare impacting all Medicaid beneficiaries (and lay the foundation for a more integrated system for all Illinoisans).

Evaluation of the Effectiveness of the QAPI Program

HFS requires health plans to have an ongoing QAPI program that assesses the quality of care and adjusts processes and operations to improve the quality of care provided to beneficiaries. The QAPI programs consist of monthly and quarterly face-to-face meetings, adoption and monitoring of health plans' results using industry standards such as HEDIS measures and benchmarks, contract compliance, and performance improvement projects. Additionally, HFS contracts with an EQRO to provide the following services: oversight and monitoring of quality assurance components of the health plan contract, identifying areas needing improvement with the health plans, technical assistance to HFS and the health plans, identifying best practice findings, and improving healthcare outcomes of health plan enrollees. The EQR technical report also addresses the effectiveness of a health plan's QAPI program.

As a part of the QAPI program, health plans are required to develop a quality assessment plan (QAP). To ensure continuous quality improvement, HFS requires health plans to conduct regular (annually at a minimum) examinations of the scope and content of the QAP to ensure that it covers all types of services, including behavioral health services in all settings, as required. At

the end of each year, health plans are required to submit a written report on the QAP. This report must include, at a minimum, the following information:

- Executive summary (high-level discussion/analysis of each area of the annual report of findings, accomplishments, barriers, and continued need for quality improvement)

- Quality assurance (QA)/utilization review (UR)/peer review (PR) plan

- Major initiatives to comply with the State Quality Strategy, quality improvement, and work plan monitoring

- Provider network access and availability

- Cultural competency

- Fraud, waste, and abuse; and privacy and security

- Population profile

- Improvements in care coordination/care management and clinical services/programs

- Effectiveness of care coordination model of care

- Findings on initiatives and quality reviews

- Effectiveness of quality program structure

- Chronic conditions

- Behavioral health

- Delegation of services

- Discussion of health education programs

- Beneficiary satisfaction

- Beneficiary safety

- Patient-centered medical homes

CMS HCBS Waiver Performance Measures Record Reviews

CMS requires that states have processes in place to monitor performance in each of the HCBS Waiver assurances, as well as to demonstrate adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis. All discovery information must be in the form of performance measures. A list of the CMS HCBS Waiver performance measures can be found in Appendix P. HFS has implemented the following quality improvement and monitoring activities to monitor performance of the plans delivering services to HCBS Waiver beneficiaries.

Quarterly Record Reviews. Quarterly, on-site record reviews of a statistically valid sample, weighted by waiver type, are conducted by the EQRO. Using a web-based record review and reporting database, HFS reviews and approves all quarterly review findings. Documentation to complete the record reviews is abstracted from the case management/care coordination software systems. Following HFS approval, results of record reviews can be accessed in the reporting database.

Remediation. All record review findings are tracked in the remediation tracking database. Timeliness standards for completion of remediation actions (60 and 90 days) are reviewed by HFS and tracked for completion and timeliness by the EQRO. Remediation validation was implemented in SFY 2016. Remediation validation will occur through selecting a sample of remediated records. These records are validated by the EQRO during the quarterly, on-site record reviews.

Staffing Reviews. Reviews of staffing, qualifications, experience, training, and FTEs assigned to the HCBS program were conducted as a component of the readiness review prior to program implementation. Annual reviews of HCBS staffing, experience, qualifications, FTE, and caseload assignments are conducted on all health plans that provide services to HCBS Waiver beneficiaries.

Health and Safety Monitoring. Quarterly reporting is provided to HFS of all critical incidents and reports of abuse, neglect, and exploitation. During program implementation the readiness review included review of health and safety policies and procedures; the system and process used to document incidents; remediation; and reporting, oversight, and monitoring of trends related to health and safety monitoring. Health and safety monitoring is included as part of the administrative reviews.

Quality of Care Complaints/Concerns. On-site investigation and review of quality of care complaints are conducted. A corrective action plan is required if findings are identified during the review.

HFS Policy Guidance. HFS uses this guidance to clarify waiver requirements for both existing and new policies and allows for ongoing communication with the health plans. Examples of policy guidance include:

- Guidance related to completion of personal goals.
- Guidance related to completion of the Participant Outcomes and Status Measures (POSM).

- Guidance related to completion of the personal assistant (PA) evaluation.

HCBS Network Capacity Validation and Monitoring. Assessment of the HCBS provider network was conducted prior to program implementation. Quarterly review of the HCBS provider network is conducted to ensure ongoing oversight of this network. All gaps are identified and the EQRO monitors the network until it is determined adequate based on contract requirements.

HCBS Quality Oversight and Ongoing Monitoring. HFS has a robust oversight process for the HCBS Waiver program which includes:

- Development of policies and procedures to establish oversight of the program.
- Quarterly review of record review findings.
  - Review of trends in noncompliance as a result of the record reviews.
  - Identification of systematic improvement efforts as a result of the record review findings.
  - Identification of areas for ongoing training as a result of the findings of the record reviews and remediation validation.
  - The 2015 MMAI and ICP HCBS Waiver performance measures record review findings can be found in Appendix Q and Appendix R, respectively.
- Quarterly quality improvement, face-to-face meetings.
  - Each meeting includes an agenda item to address quality improvement activities for the HCBS Waiver program.
- Investigation of quality of care complaints and development of corrective action plans implemented based on findings, if applicable.
- HFS policy notifications to clarify existing and new waiver policies.
- The EQR technical report will contain an evaluation of the HCBS Waiver monitoring activities.

Corrective/Remedial Actions

HFS contractually requires each health plan to include written procedures in its QAPI program for taking appropriate, remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished (including behavioral health), or if services that should have been furnished were not. Quality assurance actions that result in remedial or corrective actions must be forwarded by the health plan to the State on a timely basis.

Written remedial/corrective action procedures are detailed below.

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

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. Health plans are also required to provide documentation on this process.

Pay-for-Performance (P4P) or Value-Based Purchasing Initiatives

Managed Care Organizations' P4P

HFS has a P4P program by which health plans may earn payments based on performance with respect to select quality metrics. Each month HFS withholds a portion of the contractual capitation rate. Annually, as specified in plans' contracts, a designated percentage of their total contract amount is withheld to be used for P4P payments. An equal portion of a plan's withheld amounts will be allocated to each P4P measure and paid (or not paid) based on the plan's calendar year performance data. If a health plan reaches the target goal on a P4P measure, it will earn the percentage of the withheld amount assigned to that P4P measure.

Collection of data and calculation of health plan performance against the P4P measures will be in accordance with national HEDIS timelines and specifications. If any P4P measures are not HEDIS measures but are distinct measures established by HFS ("HEDIS-like"), then the methodology for calculating such measures is detailed. Health plans must obtain an independent validation of their HEDIS and HEDIS-like results by an NCQA certified auditor, with such results submitted to HFS within 30 days after the health plan's receipt of its audited

results. Upon receipt of certified results, HFS compares health plan performance against the P4P measures and encounter data received and accepted. If HFS approves the submitted results and an incentive payment is due, then payment is made within 60 days after such approval. If there is a discrepancy, HFS notifies the health plan in writing within 30 days after receiving the results. Any significant discrepancies between the health plan's audited results and the encounter data received by HFS, or any audit of the measures by HFS, will be resolved in a manner mutually agreeable to the parties following good faith negotiations before HFS will distribute any incentive pool payments. Health plan audited results will be used to determine eligibility for incentive pool payments unless it is determined through the process outlined above that other data are more accurate.

P4P measures' baselines and goals will be negotiated and established through countersigned letters. If any coding or data specifications are modified and a party has a reasonable basis to believe that the modification will have an impact on P4P payment, then the parties will negotiate, and the resolution will be established through countersigned letters.

Primary Care Case Management—Illinois Health Connect (IHC) P4P

Under the IHC Bonus Payment for High Performance Program, qualifying IHC PCPs are eligible to receive annual bonus payments for each qualifying service under a bonus measurement. Payments issued under the bonus program are based on services provided for all beneficiaries on the PCP's panel on December 1 of the program year who have met the criteria of the indicated P4P measure.

HFS calculates the PCP's P4P measure rates using administrative claims data. A two-tier bonus is used with the HEDIS 50th and 75th percentiles as the benchmarks, with the exception of non-HEDIS measures for which the benchmark is established by the Department. If a PCP meets or exceeds the benchmark for a particular measured service, a bonus payment will be made for each patient on the PCP's panel that received the measured service. A PCP can receive a bonus for only one of the two tiers. The payment rate for meeting the 75th percentile is higher than for the 50th percentile.

Use of Medicare or Private Accreditation Reviews

Federal regulations provide an optional mechanism that states may use to prevent duplication of the comprehensive administrative review of health plans. This option allows states to use information from a similar review performed by either Medicare or an approved national accrediting organization to determine health plan compliance with federal managed care regulations. Standards reviewed by the accrediting organization must be equivalent to the

state's standards for evaluating health plan compliance with access, structure and operations, and measurement and improvement CFRs. Health plans that have completed a review with either Medicare or a national accrediting body may be eligible for deemed status for certain portions of the comprehensive administrative review.

CMS received and approved deeming applications from the NCQA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC). CMS also approved URAC as an accrediting organization with deeming authority. Both NCQA and URAC have published crosswalks of their standards with the CMS Medicaid regulations, and HFS is aware that these crosswalks are published on the NCQA and URAC websites.

Accreditation Requirements

Pursuant to 305 ILCS 5/5-30 (a) and (h), HFS requires that any health plan serving at least 5,000 seniors, or people with disabilities, or 15,000 beneficiaries in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one year are considered eligible for accreditation and shall 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." If the health plan receives a "Provisional" accreditation status, the health plan will be required to complete a "re-survey" within 12 months after the accreditation determination. During this provisionary period, enrollment may be limited. If the subsequent "re-survey" results in a "Provisional" or "Denied" status, the Department will regard this finding as a breach of contract. In such an event, the health plan's failure to achieve accreditation may result in the termination for the contract. Upon completion of the accreditation survey, the contractor must submit to HFS a copy of the "Final Decision Letter" no later than 10 calendar days upon receipt from NCQA. Thereafter, and annually between accreditation surveys, the health plan must submit a copy of the Accreditation Summary Report issued as a result of the HEDIS update no later than 10 calendar days upon receipt from NCQA. Upon HFS' request, the health plan must provide any and all documents related to achieving accreditation. Compliance will be assessed annually based on the health plan's accreditation status as of September 15 of each subsequent year.

Health Plan Sanctions

In accordance with Section 7.2 of the FHP/ACA contract and Section 7.2 of the ICP contract, HFS may impose monetary sanctions when a health plan fails to substantially comply with the terms

of the contract. Sanctions may be imposed, as detailed in the contracts, with the determination of the amount of any sanction 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. At its sole discretion, HFS may waive the imposition of sanctions for failures that are determined to be minor or insignificant.

Upon determination of substantial noncompliance, HFS gives written notice to the health plan describing the noncompliance, the opportunity to cure the noncompliance where a cure is not otherwise disallowed under the contracts, and the sanction that HFS will impose. HFS may impose a performance penalty and/or suspend enrollment of potential beneficiaries. The following areas are subject to sanction:

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

Health Information Technology (HIT)

HIT Initiatives

HFS Electronic Health Record (EHR) Payment Incentive Program

As described in Section 3 of this report, an EHR provider incentive payment program was established in 2011. Through August 5, 2015, HFS has awarded over $487 million in incentive payments to encourage providers and hospitals to implement or upgrade their local EHR. The eventual goal is for providers to engage in "meaningful use" of said technology. This program will continue through 2021.

IMPACT

HFS currently manages and operates the Illinois legacy Medicaid Management Information System (MMIS). The Illinois legacy MMIS was fully implemented in 1982 and was primarily built to support a fee-for-service Medicaid Program. Throughout the years, HFS has made many enhancements and modifications to the current MMIS. However, it is an older legacy system that is becoming increasingly difficult to maintain and modify. HFS is working toward the implementation of a new, state-of-the-art MMIS which will be versatile enough in its architecture, structure, and code to support current and evolving HFS business needs. It will meet the seven conditions and standards set forth in the April 19, 2011, CMS Directive and will be designed to meet the requirements set forth by the CMS Medicaid Information Technology Architecture (MITA) initiative.

HFS has partnered with Michigan to replace its 30-year-old MMIS with a system that meets Illinois' needs. Rather than developing a new system, Illinois is obtaining a fully operational, federally certified MMIS though this partnership. The Illinois Michigan Program Alliance for Core Technology (IMPACT) was formed to oversee the sharing of Michigan's MMIS.

Two components of the IMPACT project have been implemented. The first phase of IMPACT was implemented in November 2013. It included the launch of the EHR Medicaid Incentive Payment Program (eMIPP), which provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals to adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. The second phase of IMPACT, implemented in July 2015, requires providers seeking to serve Medicaid beneficiaries to enroll and revalidate enrollment through the new IMPACT Web portal. Finally, it is anticipated that the full implementation of the cloud-enabled MMIS will occur by the end of the project.

HIT Quality Strategy Support

The State's Division of Information Systems (DIS) maintains the MMIS which includes all functional areas (beneficiary information, eligibility, demographics, provider enrollment, health plan enrollment, claims and encounter data, payment information, third-party liability, and reporting). HFS' enterprise data warehouse (EDW) and its executive information system (EIS) track key indicators for comparison (state, county, fee-for-service, and health plan [specific and aggregate]) for tracking and trending of utilization and health outcomes. Data are imported from other State agencies' data systems to determine utilization and report findings to health plans to drive improvement. The State's robust information system is key to monitoring the goals and objectives of the Quality Strategy and provides essential information for the ongoing operation and review of the Quality Strategy.

Section 5. Delivery System Reforms

Expansion and Reforms

As described in this report, during SFY 2014–2016, HFS expanded it managed care programs and implemented delivery system reforms to meet the goal of PA 96-1501 (also known as "Medicaid Reform" or "the SMART Act") which required that 50 percent of Medicaid beneficiaries be enrolled in care coordination programs. The State's overall goal in utilizing managed care and other care coordination services is to improve the lives of participants by purchasing quality health services through an integrated and coordinated delivery system that promotes and focuses on health outcomes, cost controls, accessibility to providers, accountability, and beneficiary satisfaction. The map on the following page graphically displays the Medicaid Reform Care Coordination Expansion in Illinois.

Figure 5-1 illustrates the expansion efforts as of August 22, 2014.

Figure 5-1—Medicaid Reform Care Coordination Expansion—August 2014
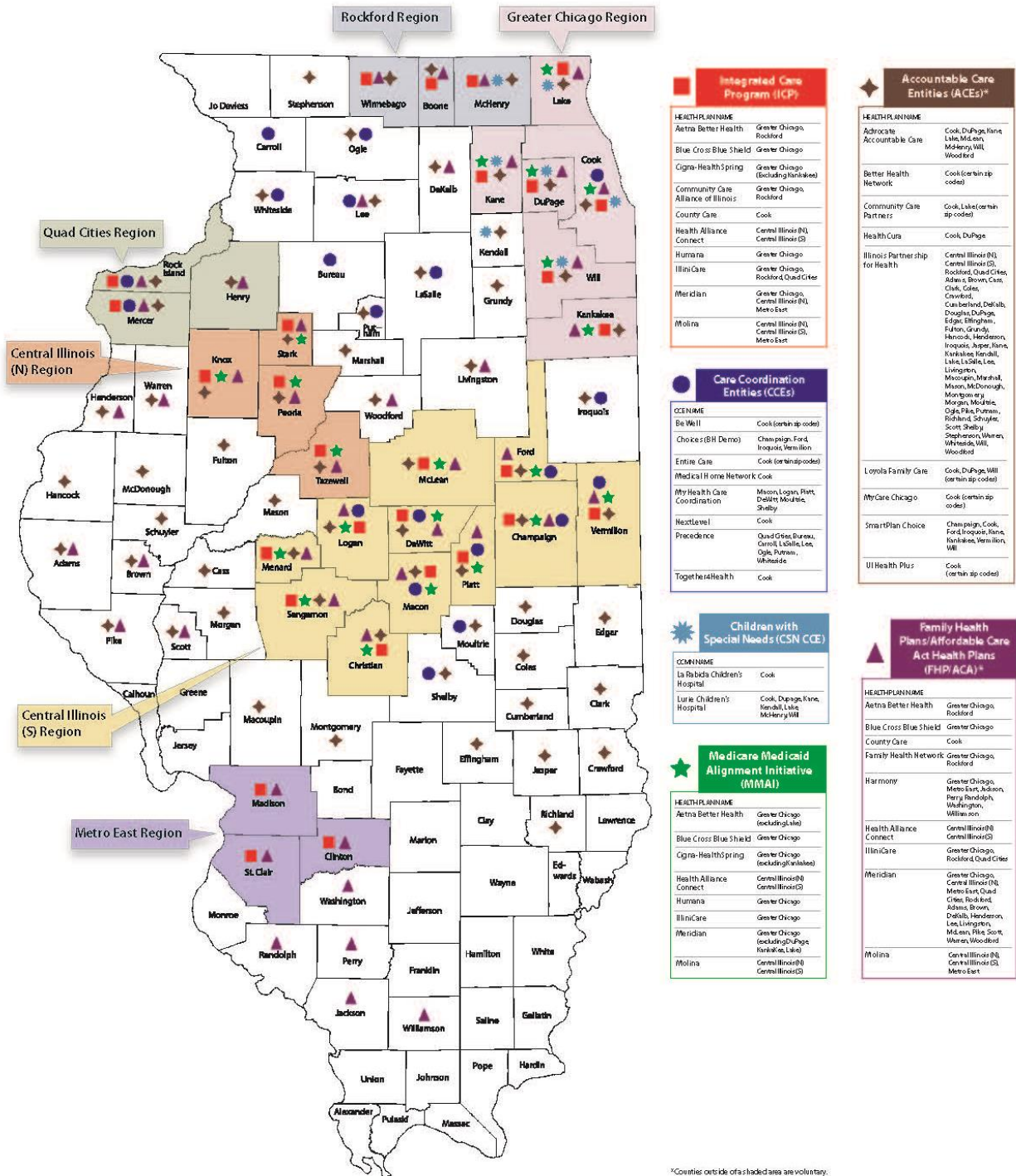
Expansion continued to evolve in Illinois as new service delivery models were tested and implemented to coordinate care for Medicaid beneficiaries. The map below displays expansion status as of February 2016.

Figure 5-2—Medicaid Reform Care Coordination Expansion—February 2016
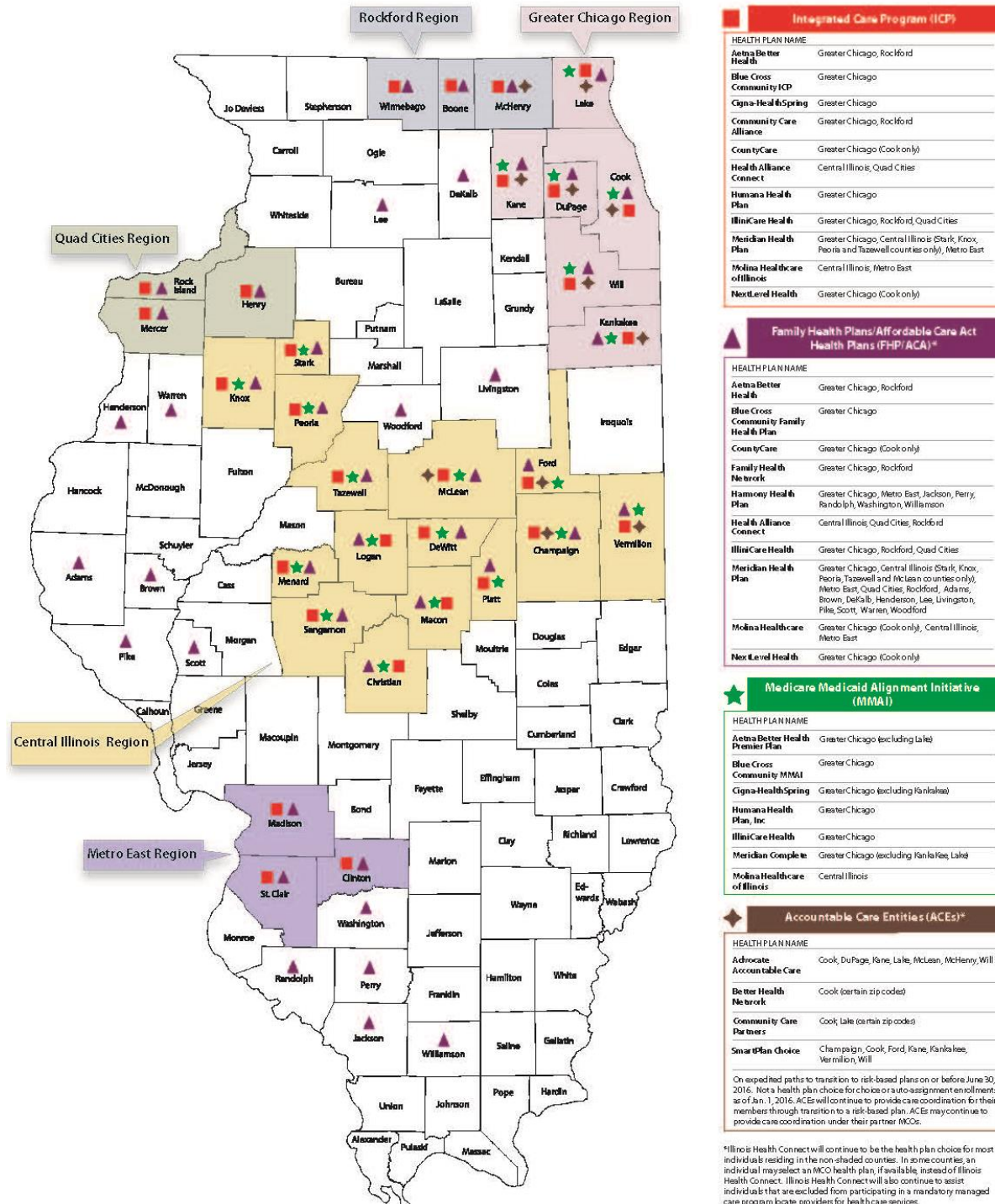
Care Coordination Roll-Out

To ensure coordinated implementation of the above detailed expansion, HFS issued a roll-out schedule identifying implementation dates for various care coordination programs by health plan. The following chart displays the Medicaid Reform Care Coordination Roll-out in Illinois as of March 2015.

Figure 5-3—Medicaid Reform Care Coordination Roll-Out
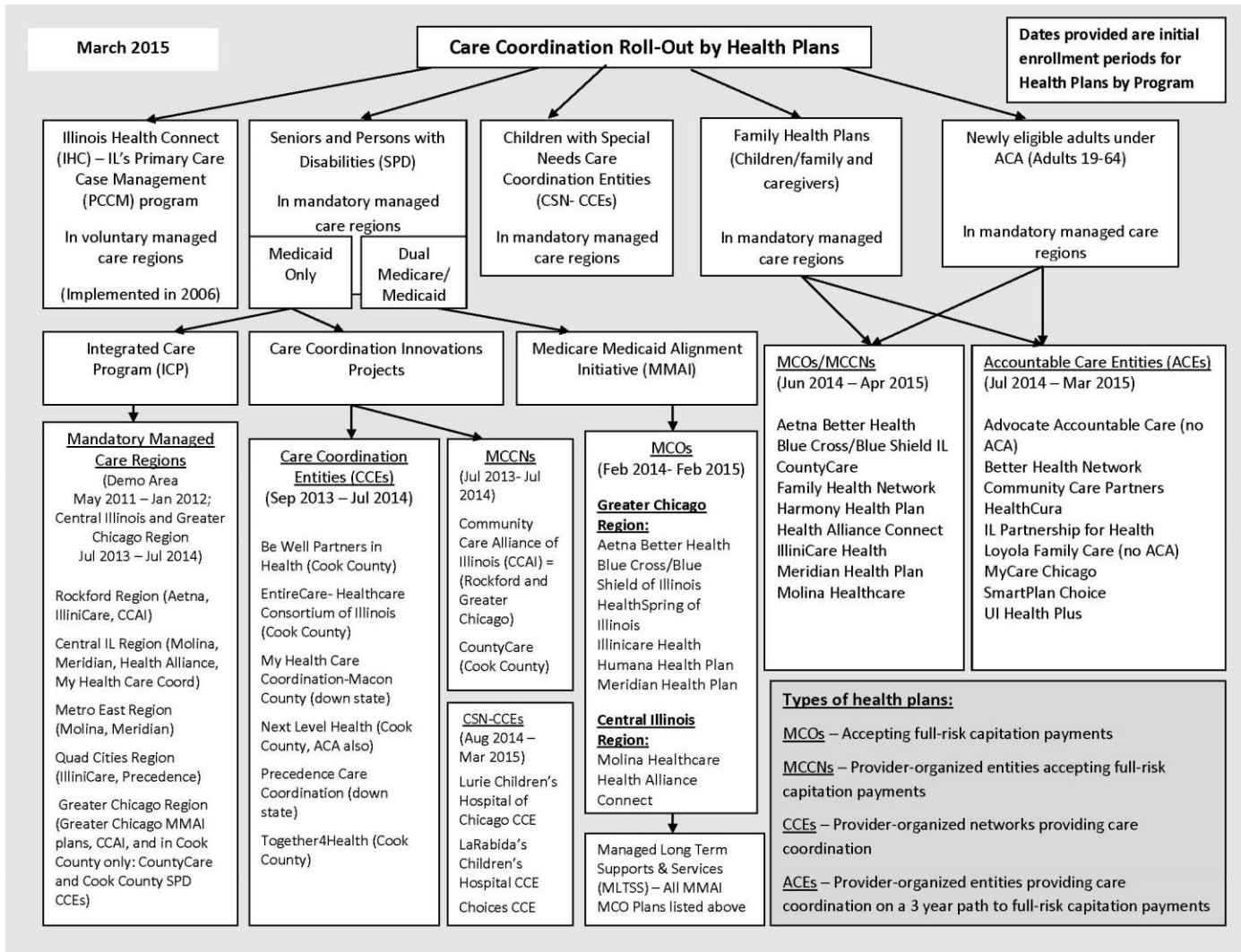
New Programs

HFS continues to develop programs to meet the goal of PA 96-1501. HFS implemented the Managed Long-Term Services and Supports (MLTSS) program on July 1, 2016. MLTSS is a mandatory program for full dual eligible beneficiary in the Greater Chicago area who opt out of MMAI and live in a nursing facility or receive services through one of the following HCBS waivers: Supportive Living Facilities, Persons with Disabilities, Persons with HIV or AIDS, Persons with Brain Injury, and Persons who are Elderly. MLTSS health plans cover LTSS, non-Medicare behavioral health, and nonemergency transportation benefits. All MLTSS health plans also participate in MMAI. After a 90-day switch period, MLTSS beneficiaries are "locked in" to their MLTSS health plan for one year and cannot switch MLTSS health plans until their anniversary month. However, beneficiaries enrolled in MLTSS may choose to opt in to the MMAI program at any time.

Future of Quality Improvement in Illinois

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

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

Core concepts of CQI are listed below.

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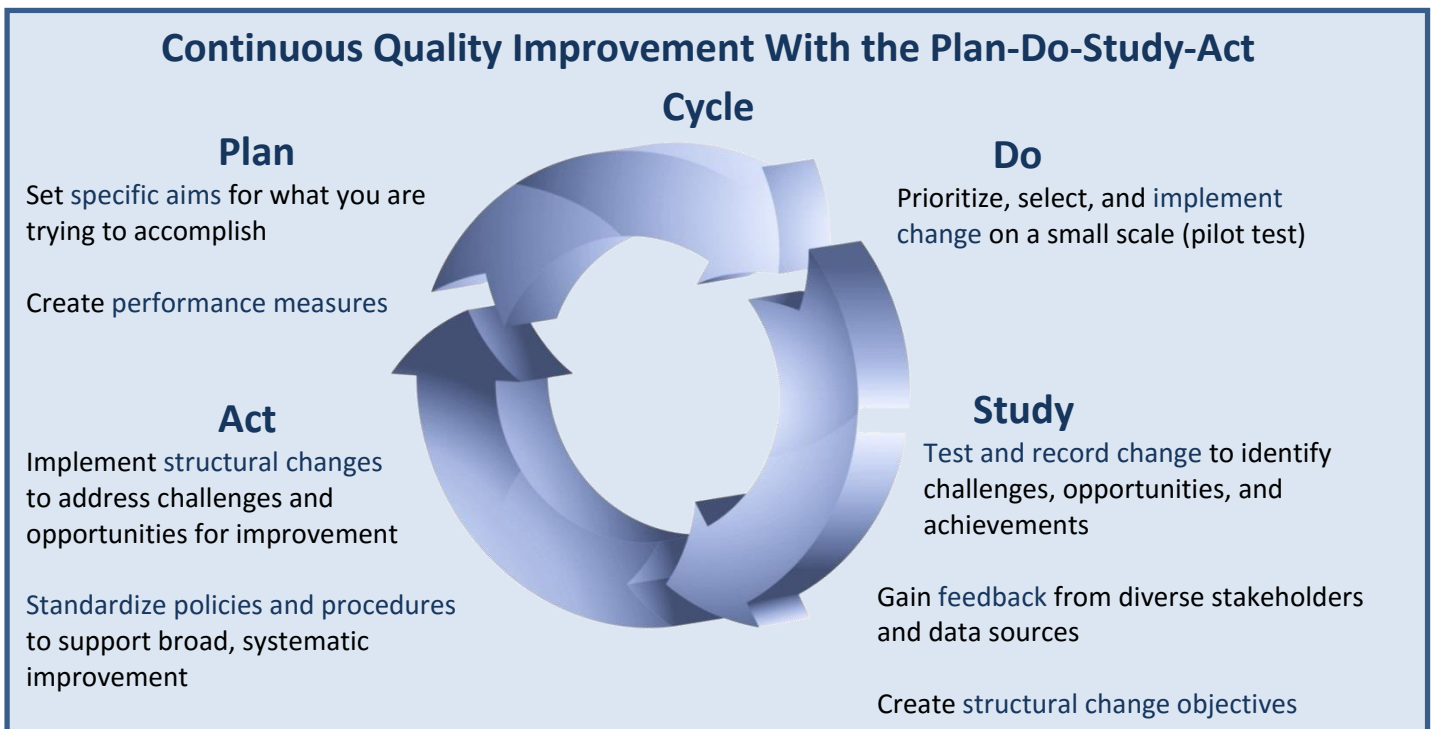
Core steps of CQI are listed below.

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

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

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

Figure 5-4—Steps Used in the PDSA Cycle

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

Plan
Set specific aims for what you are trying to accomplish

Create performance measures

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

Act
Implement structural changes to address challenges and opportunities for improvement

Standardize policies and procedures to support broad, systematic improvement

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

Gain feedback from diverse stakeholders and data sources

Create structural change objectives

Section 6. Conclusions

Successes, Best/Promising Practices, and Challenges

Ongoing assessment of the State's managed care Quality Strategy provides the opportunity for HFS to understand its successes and share what has been found effective in improving healthcare quality and/or service. Additionally, since it is expected that all strategy objectives may not be met, assessment of the Quality Strategy allows HFS to share challenges it encountered and whether the responses to those challenges were effective.

Successes

Child CAHPS Surveys

In 2013, HFS contracted HSAG to conduct a CAHPS 5.0 Child Medicaid Health Plan Survey and a general Child and Children with Chronic Conditions (CCC) CAHPS Survey for the All Kids and general Medicaid populations. Several findings from that survey represented a success for HFS.

The statewide aggregate general Child Medicaid and All Kids results for three CAHPS composite measures were above the 85 percent top box rate. The rate for *How Well Doctors Communicate* was the highest top box rate, at 93.5 percent. The rates for *Getting Care Quickly* and *Customer Service* were 92.8 percent and 86.0 percent, respectively. Results for Children with Chronic Conditions (CCC) demonstrated successes for the same measures, reaching 95.0 for *How Well Doctors Communicate*, 92.1 percent for *Getting Care Quickly*, and 80.9 percent for *Customer Service*. The Child CAHPS Survey was again implemented in SFY 2015 and SFY 2016 for reporting via CARTS.

Best/Promising Practices

Locating and Engaging Hard-to-Reach Beneficiaries

A key ingredient of effective care coordination is the ability to communicate with beneficiaries. As a part of ongoing expansion efforts, HFS has identified the following list of best practices that health plans might use to locate and engage hard-to-reach beneficiaries and complete timely health risk screenings/assessments.

Improving Staffing

1. Hire additional staff and/or restructure their staffing models to increase capacity and efficiency. Some examples are listed below.

   - Reducing caseloads per care coordinator.

   - Using nonlicensed staff (e.g., high school or associate's degree) or health navigators to increase capacity to communicate and connect with hard-to-locate beneficiaries without utilizing more expensive staff resources.

   - Assigning the task of engaging hard-to-reach beneficiaries to one person to create a centralized point of accountability within the organization.

2. Increase staff training. This could include both retraining staff on existing policies and procedures, as well as developing new trainings of additional techniques to encourage beneficiary participation in assessments. For example, one training technique is motivational interviewing for beneficiary engagement.

Connecting Systems

1. Enhance the accuracy of reporting by reevaluating the care management system/modules health plans use to track contacts with beneficiaries and completed assessments.

   - Remove disenrolled beneficiaries from the denominator when reporting percent of screenings or assessments completed.

   - Flag hard-to-reach beneficiaries across all plan systems so that if the beneficiary makes contact with the plan through any point of access, the appropriate staff will be alerted in real-time to engage the beneficiary in an assessment.

2. Implement continuous monitoring after the three required contact attempts are made. A continuous monitoring and outreach effort ensures that the organization does not stop trying to locate a beneficiary prematurely. This monitoring effort involves tracking who has attempted to find the beneficiary and the result of the attempt. The tracking is ongoing and should be updated frequently.

Increasing Outreach

1. Implement more aggressive community outreach by sending staff into the community to places hard-to-reach beneficiaries are likely to visit, including community centers,

senior centers, soup kitchens, food pantries, homeless shelters, grocery or liquor stores, etc.

2. Enhance contact methods.

- Call beneficiaries at convenient times, such as evenings or weekends or at the beginning of the month when it is more likely beneficiaries have minutes on their cellular phone plan.

- Call family beneficiaries or visit the last known address for unscheduled visits.

- Make the minimum number of required calls before trying a different contact method, such as sending a "please contact us" letter or mailing a health risk screening form along with a self-addressed, stamped envelope for the beneficiary to complete and return.

- Send a "please contact us" note to new beneficiaries with the welcome letters, welcome packets, and ID cards. This is a best practice to limit the number of potential, unreachable beneficiaries with a prospective initial mailing effort.

- Send a "PCP not assigned" letter or a "PCP assigned" letter to generate a callback.

Procuring Vendors

1. Procure outside vendors to assist. Examples include:

- Hiring vendors with technology to retrieve correct contact information, provide enhanced demographic data, or utilize location databases.

- Using vendors to engage outside nurse practitioners to conduct face-to-face health risk assessments on-site at skilled nursing facilities and/or inpatient hospitals.

Engaging Providers

1. Use claims history, where available, to outreach providers, including pharmacy, medical, and behavioral health providers.

- With pharmacies, health plans can use prescription data to locate hard-to-reach beneficiaries. They can first check with the pharmacy to determine the most recent contact information, and if not reliable, leave a "please contact us" card for the beneficiary to receive at the time of next script pick-up.

- Health plans can also use medical transportation vendor data to locate beneficiaries who use this service.

2. Work in collaboration with contracted provider networks, including behavioral health providers and caseworkers, adult foster care providers, and home health providers, to locate hard-to-find beneficiaries. Cultivating these relationships may assist with the ongoing communications and the frequent updates needed to stay in contact with a hard-to-reach beneficiary. These practitioners and entities develop unique relationships around beneficiaries with behavioral health conditions.

3. Request a monthly list of new beneficiaries receiving services from contracted behavioral health providers so they may work in collaboration to perform an assessment. This list is useful because it may be more current than claims, and the providers may have more current contact information.

Other Incentives to Engage Beneficiaries

1. For health plans that use a lengthy health risk screening tool, there may be opportunities for reducing the number of screening questions to increase beneficiary engagement.

   - Use an initial, brief health risk screening tool instead of the comprehensive assessment tool to initially engage beneficiaries.

2. Prioritize when completing the comprehensive health risk assessment by first addressing domains regarding the most urgent needs of the beneficiary, as determined at the time of initial screening.

3. Research allowable incentive programs to build beneficiary participation.

Challenges

HFS rose to the challenge of Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148) by undergoing expansion of care coordination programs to serve the increasing managed care population. By 2015, HFS had contracts with up to 33 new managed care entities. Contracting with so many new organizations presented challenges with ensuring each entity was prepared and capable of delivering services in compliance with HFS policies and standards. It was also a challenge for beneficiaries to understand and navigate through all of the options. HFS worked to reduce the number of managed care entities to eliminate some of the confusions beneficiaries faced. In addition, HFS implemented new oversight activities, including contracting its EQRO to conduct pre- and post-implementation operational readiness reviews for additional plans contracted to implement HFS' programs. HFS will continue to seek out innovative and efficient strategies to meet the demands of Medicaid reform.

Data Collection System Challenges and Opportunities

HFS Electronic Health Record (EHR) Payment Incentive Program

Since there is considerable and growing evidence of the value to patients and the cost savings resulting from the implementation of EHRs and HIEs, HFS considers these technological solutions a key opportunity for improvement. However, there are many barriers which slow the rate of adoption of HIE by providers including time and cost of implementation, lack of necessary computer skills and/or resistance to learning, lack of infrastructure and technical support, and lack of incentives.[6-1]

The Medicaid EHR Incentive Program provides incentive payments for certain Medicaid healthcare providers to adopt and use EHR technology in ways that can positively affect patient care. The Medicaid EHR Incentive Program will provide incentive payments to eligible professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. Meaningful use signifies that providers are showing (by meeting thresholds for a number of objectives) that they are using their EHRs in ways that can positively affect the care of their patients.[6-2]

Encounter Data Completeness

Encounter data represent detailed information regarding the services provided to Medicaid beneficiaries enrolled in capitated managed care. Any health plan that contracts with HFS to provide Medicaid services is required to maintain health information systems. These systems must be able to collect data on Medicaid beneficiaries, provider characteristics, and services using encounter data or other State-specified methods. Health plans are also required to ensure that data received from Medicaid providers are accurate and complete.[6-3]

Capturing, sending, and receiving encounter data has historically been difficult and costly for health plans and states alike. The encounter data process is lengthy and has many steps where

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[6-1] Ajami S, Bagheri-Tadi T. Barriers for Adopting Electronic Health Records (EHRs) by Physicians. Acta Inform Med. 2013;21(2):129–134. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3766548/. Accessed on: Dec 8, 2016.
[6-2] An Introduction to the Medicaid EHR Incentive Program for Eligible Professionals. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Medicaid_Guide_Remediated_2012.pdf. Accessed on: Dec 8, 2016.
[6-3] Department of Health and Human Services. Office of Inspector General. *Medicaid Managed Care Encounter Data: Collection and Use.* Available at: https://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf. Accessed on: Dec 8, 2016.

data can be lost or errors can be introduced into submitted data elements.[6-4] HFS has developed a number of validation techniques to help ensure the completeness and accuracy of its encounter data.

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's measurement year 2012 data. The State contracted with HSAG to audit its health plans. The audits were conducted in a manner consistent with the *2015 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. That audit found that some health plans have difficulty obtaining complete encounter data and recommended continued efforts to improve encounter data submission.

Conclusion

HFS provides a process to cooperatively work with health plans and other stakeholders to improve care. Goals, objectives, strategies, and initiatives identified throughout this Quality Strategy are continually implemented. This is accomplished by an emphasis on ensuring quality healthcare services are provided to managed care beneficiaries and that health plans are in compliance with federal and State requirements as well as contractual mandates. HFS expects that health plans will improve in care coordination with the integration of primary care and behavioral health services.

HFS is focused on continuous quality improvement by collaborating with its partners and stakeholders in support of the mission of HFS. HFS is committed to ensuring quality healthcare coverage at sustainable costs, empowering people to make sound decisions about their well-being, and maintaining the highest standards of program integrity on behalf of the citizens of Illinois.

[6-4] The Lewin Group. General Dynamics Information Technology. *Evaluating Encounter Data Completeness: For Researchers using the Centers for Medicare & Medicaid Services Chronic Condition Data Warehouse (CCW)*. Available at: https://www.ccwdata.org/cs/groups/public/documents/training/ccw_max_research_example_enctr.pdf. Accessed on: Dec 8, 2016.