ILLINOIS DEPARTMENT OF
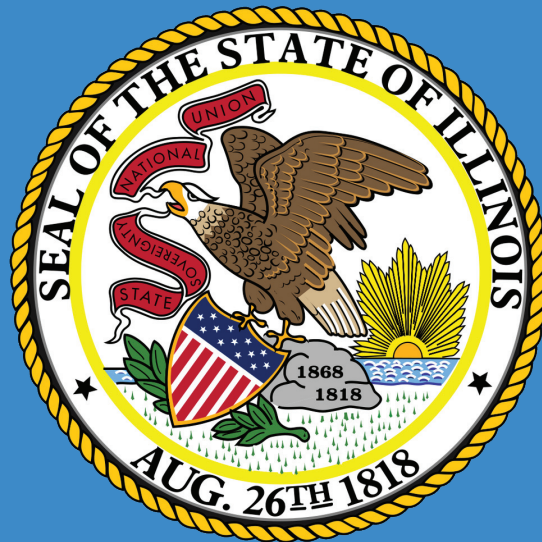## Healthcare and Family Services

Illinois Department of Healthcare and Family Services
Division of Medical Programs

External Quality Review
Annual Report

State Fiscal Year 2011-2012

Introduction

Since June 2002, Health Services Advisory Group, Inc. (HSAG), has served as the external quality review organization (EQRO) for the Illinois Department of Healthcare and Family Services (HFS), formerly known as the Illinois Department of Public Aid (IDPA). The State fiscal year (SFY) 2011–2012 Illinois External Quality Review (EQR) Technical Report describes the manner in which data from EQR activities conducted in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.358, were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to participants of the Illinois Medical Assistance Program. These beneficiaries were enrolled in Illinois' one managed care community network (MCCN), **Family Health Network, Inc.** (**FHN**), or in one of four contracted managed care organizations (MCOs): **Harmony Health Plan of Illinois, Inc.** (**Harmony**); **Meridian Health Plan, Inc.** (**Meridian**); **Aetna Better Health** (**Aetna**); and **IlliniCare Health Plan** (**IlliniCare**). Medicaid managed care is currently delivered through three models: Voluntary Managed Care (VMC), Primary Care Case Management (PCCM) and the Integrated Care Program. This executive summary outlines the mandatory and optional EQR activities performed by HSAG in SFY 2011–2012.

Purpose of Report

The SFY 2011–2012 EQR Technical Report provides an evaluation of the data sources reviewed by HSAG. As the EQRO, HSAG assessed the progress made in fulfilling HFS' goals for the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients for HFS-contracted MCOs for the SFY 2011–2012 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the BBA and State requirements.

The BBA requires that states contract with an EQRO to conduct an annual evaluation of MCOs that serve Medicaid recipients. The purpose of this annual evaluation is to determine each MCO's compliance with federal quality assessment and performance improvement standards. The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO.

Pursuant to the Balanced Budget Act (BBA), 42 CFR 438.364 calls for the production by each state of a detailed technical report on EQR results. In accordance with 42 CFR 438.358, the EQR technical report describes the manner in which the data from EQR activities were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients by Department-

contracted MCOs. Information released in this technical report does not disclose the identity of any recipient, in accordance with 438.350(f) and 438.364(a)(b). This report specifically addresses the following for each EQR activity conducted:

- Objectives

- Technical methods of data collection and analysis

- Description of data obtained

- Conclusions drawn from the data

In addition, this report includes an assessment of each MCO's strengths and weaknesses with respect to the quality and timeliness of, and access to, health care services furnished to HFS beneficiaries. The report also offers recommendations for improving the quality of health care services furnished by each MCO, makes comparisons of MCO performance, and describes performance improvement efforts.

Overview of the SFY 2011–2012 External Quality Review

Mandatory EQR Activities

The SFY 2011–2012 EQR Technical Report focuses on the three federally-mandated EQR activities that HSAG performed for the MCOs over a 12-month period (June 1, 2011, to May 31, 2012). As set forth in 42 CFR 438.352, these mandatory activities were:

- Review, within the previous three-year period, to determine MCO compliance with State standards for access to care, structure and operations, and quality measurement and improvement. During SFY 2011–2012, HSAG conducted a focused review of the Voluntary Managed Care MCOs (VMCOs) to review standards not met during the SFY 2011–2012 compliance review (VMCO compliance with the Quality Assurance Plan standards). An additional focus was a review of each MCO's case management and care coordination systems and programs. In addition, HSAG conducted readiness reviews for the health plans participating in the new Integrated Care Program.

- Validation of performance measures. The State contracted with HSAG to conduct a HEDIS® [1-1] (Healthcare Effectiveness Data and Information Set) compliance audit of 2012 data for the MCOs. The process of validating performance measures includes two elements: (1) validation of an MCO's data collection process, and (2) a review of performance measure results compared with other MCOs and national benchmarks. This report presents the performance

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

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measure results for the VMCOs. The ICPs did not begin accepting membership until May 2011; therefore, performance measure rates will not be reported by the ICPs until 2013.

◆ Validation of performance improvement projects (PIPs). As part of the SFY 2011–2012 review, HSAG validated PIPs conducted by the MCOs regarding compliance with requirements set forth in 42 CFR 438.240(b)(1). In SFY 2011–2012, the MCOs continued their PIPs on the topics of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening, perinatal care and depression screening, and improving ambulatory follow-up and primary care physician (PCP) communication. In addition, the Integrated Care Plans (ICPs) began development of the Community Based Care Coordination PIP.

Optional EQR Activities

Other EQR activities conducted by HSAG included:

◆ Assessment of consumer satisfaction surveys. Each year, the MCOs are required to independently administer a consumer satisfaction survey. As part of its SFY 2011–2012 review, HSAG evaluated the results of adult and child CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys conducted in 2011 by The Meyers Group to identify trends, strengths, and opportunities for improvement. **Meridian** was allowed to conduct its own survey due to insufficient enrollment to meet the CAHPS eligibility criteria.

◆ 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. HSAG provides support and assistance to the MCOs in developing, implementing, and evaluating each of the improvement initiatives.

◆ Provision of technical assistance. HSAG has provided ongoing technical assistance to the MCOs at the request of HFS.

Findings, Conclusions, and Recommendations

As set forth in 42 CFR 438.364(a)(3), this section of the technical report includes recommendations for improving quality of health care services furnished by each MCO.

The Centers for Medicare & Medicaid Services (CMS) chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid managed care plans. HSAG provides overall findings, conclusions, and recommendations regarding the health plans serving Illinois Medicaid beneficiaries during the review period for each domain of care and presents them in the annual EQR technical report.

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The findings, conclusions, and recommendations presented in this section are gathered from a variety of assessment sources, including:

◆ Performance measure audits using NCQA's standardized audit methodology (as described in Section 6 of this report).

◆ Performance improvement project (PIPs) results (as described in Section 7 of this report).

◆ Member satisfaction survey results (as described in Section 8 of this report).

◆ Focused administrative review and readiness review findings (as described in Section 5 of this report).

◆ Technical assistance to HFS and MCO (as described in Section 10 of this report).

Voluntary Managed Care

Performance Measures

For ease of review, this report organizes performance reporting by classifying performance measures into the following categories. These categories align with those included in the State Quality Strategy. Measures in these categories provide information on the quality, timeliness of, and access to health care services furnished to HFS beneficiaries.

◆ Child and Adolescent Care

◆ Access to Care

◆ Maternity-Related Care

◆ Preventive Screening for Women

◆ Chronic Conditions/Disease Management

◆ Behavioral Health

Child and Adolescent Care

The Child and Adolescent Care measures identified below fall into the Effectiveness of Care, Access/Availability of Care, and Utilization and Relative Resource HEDIS domains. Measures in the Effectiveness of Care domain provide information about the quality of clinical care, use of preventive practices, and recommended screening for common diseases. The Access/Availability measures provide information about member services, ease of members' access to health care providers, and timeliness of care. Utilization and Relative Resource measures provide information on resource management and how the MCO uses available health services and resources to manage chronic diseases. The following table presents HEDIS measures regarding care for children and adolescents.

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Table 1.1—HEDIS Measures for Child and Adolescent Care

Category	HEDIS Measure
Child and Adolescent Care	*Childhood Immunization Status (Combinations 2 and 3)*
	Lead Screening in Children
	Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
	Adolescent Well-Care Visits
	Immunizations for Adolescents (Combined Rate)

Of the eight measures in the Child and Adolescent Care category, **FHN**'s rates exceeded the 2011 HEDIS Medicaid 50th percentiles on two measures—*Lead Screening in Children* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*—improving 12.5 percentage points for *Lead Screening in Children* since HEDIS 2008.

Harmony reported one measure with rates at or above the Medicaid 2011 HEDIS 50th percentiles. For *Lead Screening in Children,* **Harmony** improved 13.2 percentage points.

Of the eight measures in the Child and Adolescent Care category, **Meridian** reported on six of the measures and achieved rates at or above the Medicaid 2011 HEDIS 50th percentiles on all six of those measures. However, given that this is only the second year of reporting for relatively low populations for many of the measures, caution should be used when comparing **Meridian** to the other MCOs.

Though neither plan met the National HEDIS 2011 Medicaid 50th percentile for the *Well-Child Visits During the First 15 Months of Life—Zero Visits* measure, both **FHN** and **Harmony** have demonstrated an overall trend of improvement since HEDIS 2008. The results for this measure indicate that approximately 95.0 percent of the eligible children receive at least one well-child visit in their first 15 months of life.

Though demonstrating trended improvement, the rates for both **FHN** and **Harmony** were well below the National Medicaid HEDIS 2011 50th percentile for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*.

Access to Care

The Access to Care measures identified below fall into the HEDIS Access/Availability of Care domain. These measures look at how members access health care services offered by the MCO. The measures look at preventive and ambulatory services for adult, children, and adolescent members. The following table presents HEDIS measures regarding access to care.

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Table 1.2—HEDIS Measures for Access to Care

Category	HEDIS Measure
Access to Care	*Children's and Adolescents' Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years)*
	Adults' Access to Preventive/Ambulatory Care (Ages 20–44 and Ages 45–64)

The low rates for *Children's Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Care* services indicate that both **FHN** and **Harmony** need to improve access to care. The rates continued to improve but still remain low and well below the national 50th percentiles. Both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education. The MCOs and the State should also consider conducting a PIP around these measures.

For most measures in this category, when looking at trended performance since the HEDIS 2008 baseline rate, **Harmony** has consistently outperformed **FHN** each year.

For HEDIS 2012, **Meridian** had 118 eligible cases and reported a rate of 100.0 percent for the *Children's and Adolescents' Access to Primary Care Practitioners (12–24 Months)* measure. **Meridian** also achieved rates at or above the Medicaid 2011 HEDIS 50th percentiles for four other measures in this category.

Maternity-Related Care

The Maternity-Related Care measures fall into the Access/Availability of Care and Utilization and Relative Resource Use HEDIS domains. The measures look at how well the MCO provides timely prenatal care and care provided to women following delivery. In addition, measuring the frequency of prenatal care provides information about how the stage of a woman's pregnancy when she enrolls in the MCO impacts the MCO's ability to provide effective pregnancy-related care. The following table presents HEDIS measures related to maternity care.

Table 1.3—HEDIS Measures for Maternity Care

Category	HEDIS Measure
Maternity-Related Care	*Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*
	Timeliness of Prenatal Care
	Postpartum Care

Both **FHN** and **Harmony** continue to report rates well below the HEDIS Medicaid 50th percentile for maternity-related measures. In response to these low rates, the State and the MCOs began a collaborative perinatal depression screening PIP in 2006–2007.

The interventions **FHN** and **Harmony** have implemented were expected to result in higher rates for these HEDIS measures. For most of these measures, the rates improved. **FHN** improved on all measures. However, **Harmony** had only limited success, improving by 7.1 percentage points for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)* but showing a small decline for HEDIS 2011*Timeliness of Prenatal Care*.

Meridian exceeded the HEDIS 2011 National Medicaid 50th percentile for all measures in this category, but again, the rates were based on small case sizes.

In prior years, there were several potential issues identified as probable causes for the poor rates for these measures: the encounter data may be incomplete, **FHN** and **Harmony** may have had difficulty identifying pregnant members, there may be a network adequacy issue, there may be issues with member compliance, or any combination of these factors. **FHN** and **Harmony** should include additional encounter data as a way to improve data completeness; conduct a root-cause analysis to determine the reason for low compliance; and assess interventions to improve the rates for maternity-related measures, particularly in regards to those measures that assess access to care. Both plans have implemented or expanded prenatal incentives and/or educational programs for women.

Preventive Screening for Women

The Preventive Screening for Women measures fall into the Effectiveness of Care HEDIS domain. The measures look at whether female members are screened for breast and cervical cancer and chlamydia. The following table presents HEDIS measures regarding preventive screenings for women.

Table 1.4—HEDIS Measures for Preventative Screening for Women

Category	HEDIS Measure
Preventive Screening for Women	*Breast Cancer Screening*
	Cervical Cancer Screening
	Chlamydia Screening in Women (Combined Rate)

Both **FHN** and **Harmony** rates for *Breast Cancer Screening* did not meet the National HEDIS Medicaid 50th percentile; however, **FHN**'s rate improved 21.1 percentage points since HEDIS 2008, and the current rate is less than 5 percentage points below the 50th percentile. **Harmony** showed a downward trend, with an overall decline of 1.1 percentage points since HEDIS 2008. **Meridian**'s rate of 60.8 percent was based on 74 cases. Given the relatively low population for this measure, caution should be used when comparing to the other MCOs.

The rates for both **FHN** and **Harmony** for *Cervical Cancer Screening* were identical, at 71.5 percent, and exceeded the National HEDIS 2011 Medicaid 50th percentile of 69.7 percent. **Meridian**'s

2011 rate of 87.5 percent was based on 99 eligible cases, while the HEDIS 2012 rate of 84.4 percent was based on 225 cases.

While **FHN**'s rate of 63.4 percent for *Chlamydia Screening in Women* exceeded the National Medicaid 50th percentile and demonstrated an improvement of 15.7 percentage points from HEDIS 2008, **Harmony**'s rate has remained fairly constant each year. Though this year showed the largest increase, **Harmony**'s rate remains below the 50th percentile.

Chronic Conditions/Disease Management

The Chronic Conditions/Disease Management measures fall into the Effectiveness of Care HEDIS domain. The measures look at how well care is delivered to members with chronic disease and how well the MCOs' health care delivery system helps members cope with their illness. The following table presents HEDIS measures regarding chronic conditions/disease management.

Meridian did not have more than 30 eligible cases for any of the measures in this section. In accordance with NCQA, the results for **Meridian** are NA and are not provided in this report.

Table 1.5—HEDIS Measures for Chronic Conditions/Disease Management

Category	HEDIS Measure
Chronic Conditions/Disease Management	*Controlling High Blood Pressure (Combined Rate)*
	Comprehensive Diabetes Care (HbA1c Testing, Good HbA1c Control, Poor HbA1c Control, Eye Exam, LDL-C Screening, LDL-C Level <100 mg/dL, Nephropathy Monitoring, Blood Pressure <140/90, and Blood Pressure <140/80)
	Use of Appropriate Medications for People With Asthma (Combined Rate)

FHN had one measure with rates that exceeded the 2011 HEDIS Medicaid 50th percentile in the Chronic Conditions/Disease Management category: *Comprehensive Diabetes Care (Nephropathy Monitoring)*.

Although **FHN**'s rates on many of the diabetes care measures have consistently improved, rates for all but one of those measures remained below the National Medicaid HEDIS 50th percentiles. Diabetes care measures were one of **Harmony**'s generally lowest-performing areas when comparing to the 50th percentiles and looking at improvement, though the plan did improve rates on some measures.

Both MCOs continue to struggle to improve performance for the *Diabetes Care—Eye Exam* measure. One barrier to consider is that Illinois law allows eye examinations for retinopathy to be performed by an optometrist. Optometry services are carved out of the MCO agreement as a covered service and therefore the MCO's do not receive the encounter data. However, **FHN** and **Harmony** need to conduct an analysis to determine the reason the rate continues to be so low. The MCOs and the State might also consider conducting a PIP around this measure.

The HEDIS 2012 compliance audit indicated that **Meridian**, **Harmony**, and **FHN** were in compliance with the *HEDIS 2012 Technical Specifications*. Membership data supported all necessary HEDIS calculations, medical data were fully or partially compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained a Report (R) designation.

Behavioral Health

The Behavioral Health measures fall into the Effectiveness of Care HEDIS domain. The measures look at continuity of care for mental illness. The following table presents HEDIS measures regarding behavioral health.

Table 1.6—HEDIS Measure for Behavioral Health

Category	HEDIS Measure
Behavioral Health	*Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)*

FHN had two measures with rates that exceeded the 2011 HEDIS Medicaid 50th in the Behavioral Health category: *Follow-up After Hospitalization for Mental Illness—7 Days* and *Follow-up After Hospitalization for Mental Illness—30 Days*.

The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7-day rate exceeding the 90th percentile and the 30-day rate improving 12.6 percentage points since HEDIS 2008. Though **Harmony**'s overall trend is still up from HEDIS 2008, this marked the second year of decline for **Harmony** in the *Follow-up After Hospitalization for Mental Illness—7 Days* measure and showed little to no real improvement in the 30-day measure.

Section 6 and Appendix A of this report provide detailed information on VMC performance for all of the performance measures.

Encounter Data Completeness

None of the encounter data were more than 90.0 percent complete for **FHN**. Although some encounter data completeness has improved, these results indicate that **FHN** continues to have difficulty obtaining complete encounter data for all the measures. **FHN** is strongly encouraged to continue its efforts on improving encounter data submission.

Harmony's encounter data submission rates were higher than **FHN**'s rates for every measure. **Harmony** had eight measures with more than a 90.0 percent encounter data completeness (compared to two measures for HEDIS 2011). Only two measures had less than a 50.0 percent data completeness level for HEDIS 2012. **Harmony** should continue to reinforce its efforts to improve submission of encounter data to maintain this level of encounter data submission.

A detailed analysis on encounter data completeness for **FHN** and **Harmony** can be found in Section 6 of this report.

Performance Improvement Projects (PIPs)

The purpose of performance improvement projects (PIPs) is to assess and improve processes to improve care outcomes. It typically consists of a baseline, intervention period(s), and remeasurement(s). The PIP process provides an opportunity to identify and measure a targeted area, analyze the results, and implement interventions for improvement. PIPs must be designed, conducted, and reported in a methodologically sound manner. In accordance with federal regulations, HFS' EQRO validates PIPs to determine if they are designed to achieve improvement in clinical and nonclinical care, and if the PIPs will have a favorable effect on health outcomes and member satisfaction. The EQRO validates the study's findings on the likely validity and reliability of the results.

HFS required each MCO delivering Voluntary Managed Care services to participate in a mandatory statewide PIP focused on the following three topics:

- ◆ Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

- ◆ Perinatal Care and Depression Screening

- ◆ Improving Ambulatory Follow-Up and PCP Communication

To conduct an effective PIP, study indicators are chosen for each topic. Indicators are quantitative or qualitative characteristics (variables) reflecting a discrete event that is to be measured. For example, one indicator for the *EPSDT* PIP is *Total number of members with a physical exam performed on every EPSDT visit.*

During SFY 2011–2012, HSAG conducted a validation and analysis of the three above-mentioned PIPs to evaluate the MCOs' performance on the PIP study indicators. The following summarizes the results of that analysis.

Ten study indicators were validated for the *EPSDT* PIP, which focused on improving performance related to EPSDT screenings and visits. **FHN** was not required to submit data to be validated during SFY 2011–2012. **Harmony** achieved improvement and sustained this improvement over comparable time periods for all 10 of its study indicators. **Meridian** progressed to reporting Remeasurement 1 data, with six of its 10 study indicators achieving improvement over the baseline rate.

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve PIP outcomes. For the *EPSDT* PIP, all three MCOs identified both member and provider barriers. The majority of the

barriers across all MCOs were lack of provider knowledge about EPSDT criteria and medical record review guidelines, and the need for standardized EPSDT documentation. Some of the interventions implemented to overcome these barriers were one-on-one provider education by provider representatives on the EPSDT audit tool, development of an educational EPSDT visit brochure for both providers and members, noncompliance lists mailed or faxed to providers quarterly, and a Provider Pay for Performance incentive program.

The primary purpose of the *Perinatal Care and Depression Screening* PIP was to determine if MCO interventions have helped to improve rates for the perinatal care and depression screening. **FHN** showed improvement for 11 of its 13 indicators; however, only six of the study indicators showed statistically significant improvement. **FHN** achieved sustained improvement for six indicators. **Harmony** demonstrated improvement for eight of its 16 indicators and declines in performance for eight indicators. Although there were eight declines, 11 of the study indicators achieved sustained improvement over comparable measurement periods without a statistically significant decline. **Meridian** achieved improvement for nine of its 16 indicators as it progressed to the first remeasurement. For six of these indicators, the improvement was statistically significant. For the four **Meridian** indicators that declined, one of these declines was statistically significant.

FHN, **Harmony**, and **Meridian** reported only Remeasurement 1 rates for the *Improving Ambulatory Follow-Up* and *PCP Communication* PIP and could not be assessed for sustained improvement. The goals of this PIP are to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral health care providers. **FHN** achieved improvement for two of its three indicators; however, none of this improvement was statistically significant. **Harmony** demonstrated declines in performance for all three of its study indicators, with two of the declines being statistically significant. **Meridian** had mixed performance as evidenced by one indicator improving, one indicator declining, and one indicator where the rate remained the same as baseline.

Overall recommendations for PIPs include:

- The MCOs should build on any existing momentum for study indicators demonstrating statistically significant improvement and implement new and/or enhanced quality improvement interventions for study indicators lacking the desired outcomes.

- The MCOs should implement a method to evaluate the effectiveness of each intervention implemented. The results of each intervention's evaluation should be included in the PIP documentation. If the interventions are not having the desired effect, the MCO should discuss how it will address these deficiencies by modifying or discontinuing current interventions or implementing new improvement strategies.

- The MCOs should continue to conduct and document an annual causal/barrier analysis and drill-down analysis in addition to periodic analyses of its most recent data. The results of this

analysis should be well documented in the PIP Summary Form. The MCOs should prioritize barriers and ensure that all interventions implemented are logically linked to the barriers and can directly impact study indicator outcomes.

Section 7 of this report details the validation process for PIPs and the results of the Voluntary Managed Care PIPs conducted during the report period.

Member Satisfaction Surveys

Member satisfaction surveys are designed to capture accurate and reliable information from consumers about their experiences with health care. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) and refers to collection of standardized healthcare-related surveys.

CAHPS measures fall into the Experience of Care HEDIS domain. The surveys ask adult Medicaid members and parents of Medicaid children to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The survey questions are categorized into nine measures, five composite scores of satisfaction and four global ratings. The composition scores reflect the satisfaction of adult members and parents with different aspects of care: getting needed care, getting care quickly, how well doctors communicate, and shared decision making. The global ratings reflect the overall satisfaction of adult members and parents of children with their personal doctor, specialist, health plan, and all health care.

The following tables present CAHPS measures regarding member satisfaction.

Table 1.7—CAHPS Measures for Member Satisfaction

Category	CAHPS 2011 Measure
Member Satisfaction—Composite Measures	*Getting Needed Care*
	Getting Care Quickly
	How Well Doctors Communicate
	Customer Service
	Shared Decision Making

Table 1.8—CAHPS Measures for Member Satisfaction

Category	CAHPS 2011 Measure
Member Satisfaction—Global Measures	*Rating of All Health Care*
	Rating of Personal Doctor
	Rating of Specialist Seen Most Often
	Rating of Health Plan

For the adult Medicaid surveys, a comparison of **FHN**'s 2011 results to its 2012 results revealed that **FHN**'s rates increased for six measures: *Getting Care Quickly, How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The increase in rates were substantial for *Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan*. However, a comparison of **FHN**'s 2011 to its 2012 results revealed that **FHN**'s rates decreased for four measures (*Getting Needed Care*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*), and the decrease in rates was substantial for all four measures. **FHN** scored more than 5 points below the 2012 NCQA CAHPS top-box national average on three measures: *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

For the child Medicaid surveys, a comparison of **FHN**'s 2011 results to its 2012 results revealed rates increased for five measures: *Getting Needed Care, Getting Care Quickly*, *Shared Decision Making, Rating of Specialist Seen Most Often,* and *Rating of Health Plan*. The increase for *Getting Needed Care* was substantial. Four measures decreased from 2011, including *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, and *Rating of Personal Doctor*. The decrease in rates was substantial for *Customer Service* and *Rating of All Health Care*. In comparison to NCQA national averages, **FHN** scored below the 2012 NCQA CAHPS top-box national average on all nine measures.

For the adult Medicaid surveys, **Harmony**'s rates showed an increase from 2011 to 2012 for eight of the nine measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service, Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often,* and *Rating of Health Plan*. One measure, *Rating of Specialist Seen Most Often*, displayed a substantial increase from 2011 to 2012. One measure, *Shared Decision Making,* showed a substantial decrease from 2011 to 2012. **Harmony** scored above the 2012 NCQA CAHPS top-box national averages on three measures: *How Well Doctors Communicate, Shared Decision Making*, and *Rating of Personal Doctor*. **Harmony** scored substantially below the 2012 NCQA CAHPS top-box national averages on five measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

For the child Medicaid surveys, a comparison of **Harmony**'s 2011 results to its 2012 results showed an increase in rates for four measures: *How Well Doctors Communicate*, *Customer Service, Shared Decision Making,* and *Rating of Specialist Seen Most Often*. One measure, *Rating of Specialist Seen Most Often,* displayed a substantial increase. **Harmony**'s rates decreased from 2011 to 2012 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Two measures showed a substantial decrease from 2011 to 2012: *Getting Needed Care* and *Rating of Health Plan*. **Harmony** did not score above the 2012 NCQA CAHPS top-box national averages on any measures. **Harmony** scored substantially below the 2012 NCQA CAHPS top-box national averages for seven measures: *Getting Needed Care*, *Getting Care Quickly*,

Customer Service, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Special Seen Most Often*, and *Rating of Health Plan*.

Overall recommendations for **FHN** and **Harmony** for improving CAHPS results include:

♦ Identify potential barriers for patients receiving appropriate access to care.

♦ Identify and eliminate patient challenges when receiving health care.

♦ Consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve.

♦ Encourage physician-patient communication to improve patient satisfaction and outcomes.

♦ Request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit.

♦ Consider establishing an online patient portal or integrating online tools and services into current Web-based systems that focus on patient-centered care.

♦ Create an environment that promotes quality improvement (QI) in all aspects of care to encourage organization-wide participation in QI efforts.

♦ Encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians.

♦ Revise existing and create new print materials that are easy to understand based on patients' needs and preferences, and provide training for health care workers on how to use these materials.

♦ Consider an open access scheduling model to match the demand for appointments with physician supply.

♦ Conduct a patient flow analysis.

♦ Establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s).

♦ Enhance provider directories.

♦ Ensure physicians are properly trained to facilitate the shared decision making process with patients.

Due to its size, **Meridian** was allowed to create and administer its own consumer satisfaction survey and therefore cannot be compared with the other health plans. A comparison of **Meridian**'s 2011 results to its 2012 results showed **Meridian** improved on six of the 13 measures. These measures include:

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- *Respondents getting in to see a doctor as soon as needed.*

- *Doctors who show respect for what patients say.*

- *Doctors who spend enough time with patients.*

- *Patients finding it easy to get an appointment with a specialist.*

- *Smokers stating their doctor recommended strategies other than medication to help them quit.*

- *Rating of doctor.*

- *Rating of **Meridian**.*

Rates decreased from 2011 to 2012 for four measures:

- *Doctor's office wait time.*

- *Office staff is courteous and helpful.*

- *Identified patients who found it was easy to get care, tests, or treatment with their health plan.*

- *Identified patients who found it easy to get behavioral health or substance abuse services.*

- *Identified smokers who say their doctor discussed smoking cessation medications.*

Overall recommendations for **Meridian** to improve member satisfaction include:

- Improve in the area of office wait time and encourage physicians to monitor patient flow by conducting a patient flow analysis.

- Encourage physicians to explore open access scheduling to improve in the area of patients getting a physician appointment as soon as needed.

Section 8 of this report presents the detailed results of the CAHPS surveys and other member satisfaction surveys conducted by the VMCOs during the report period.

Focused Reviews

In SFY 2011–2012, HSAG conducted focused on-site reviews of **FHN**, **Harmony**, and **Meridian**. The focused review areas included measurement and improvement standards for all areas related to quality assessment and process improvement; access standards for continuity of care and case management; and structure and operations standards for delegation oversight, credentialing, and recredentialing.

Review of **FHN**'s *Access* standards found that many of **FHN**'s policies and procedures for continuity of care and case management were deficient and not in compliance with federal Medicaid managed care regulations, State rules, and the associated Illinois contract requirements. In October 2010, **FHN** implemented new case management software and case management

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processes; therefore, its focused review was followed by additional corrective actions related to Case Management and Care Coordination requirements. In April 2011, a focused review of **FHN** resulted in a recommendation to continue to improve its case management and oversight and monitoring activities. **FHN** responded with a comprehensive plan implemented in May 2011 to build a robust care management program and boost QI improvements that were approved by HFS.

Review of **FHN**'s *Measurement and Improvement* standards included in the focused review identified that **FHN** did not have a system established for tracking and trending of health care utilization data for its delegated network providers. **FHN** will need to continue to evaluate the effectiveness of its quality improvement interventions and work with network providers to create, implement, and sustain quality improvement initiatives.

Review of the *Structure and Operations* standards included in the review identified that **FHN** failed to monitor the performance of its delegated entities through routine reporting and follow-up, ongoing monitoring, and evaluation to determine whether the delegated activities were being carried out according to BBA, HFS, and **FHN** requirements.

Review of *Access* standards included a review of **Harmony**'s progress toward strengthening its case management and care coordination program by evaluating the process for member referrals to case management through case and disease management claims/encounters algorithm. **Harmony** reported that as a result of this evaluation, the number of cases identified and referred to case management almost doubled between 2011 and 2012. Review of medical and behavioral case management files identified the need for continued focus on improved communication with members in case management.

Review of **Harmony**'s *Measurement and Improvement* standards included a review of the annual Quality Improvement Program (QIP) Evaluation, which revealed that **Harmony** needed to continue to strengthen its annual review process through continued evaluation of the barriers to quality improvement and the development of innovative interventions that will address the barriers identified.

Review of the *Structure and Operations* standards identified that **Harmony**'s behavioral health case management delegation oversight tool lacked all the required components necessary to ensure compliance with contract requirements. In addition, **Harmony** did not have a vendor oversight process in place to ensure coordination and continuity of care and involvement of the PCP in aftercare for members with behavioral health conditions. **Harmony** was in compliance with the credentialing and recredentialing policies and procedures and implemented changes to strengthen its grievance system reporting.

A review of the *Access* standards for **Meridian** identified that **Meridian** used the Managed Care Information System (MCS), its internally developed proprietary software system, for documentation of case management activities. A review of medical and behavioral case management files found that while the files provided documentation of timely development of care treatment plans, **Meridian** needed to ensure that the member and the member's primary care physician/specialist are consistently informed that the member has been enrolled into case management services and that the PCP receives a copy of the care treatment plan. **Meridian** must also continue its efforts to facilitate and coordinate communication between service providers and the member/member's family.

Review of **Meridian**'s *Measurement and Improvement* standards identified that **Meridian** will need to include an evaluation of the effectiveness of its cultural competency and case and disease management programs in the Quality Improvement Program Plan.

A review of *Structure and Operations* standards found **Meridian** in compliance with the delegation, and credentialing and recredentialing requirements.

Integrated Care Program

Performance Measures

The ICPs will collect baseline rates for performance measures in calendar year 2013, based on the data collection year 2012.

Performance Improvement Project (PIP)

The health plans participating in the ICP, through input from HFS, identified the PIP topic, Community Based Care Coordination, which will be designed to focus on medically high-risk members with a recent hospital discharge who are actively receiving care coordination with linkage to community resources. During the third quarter of 2011, the ICPs began developing the study question and indicators and identifying data sources. Development of the PIP will continue in SFY 2012, and the ICPs are scheduled to report baseline rates for the PIP in SFY 2013.

Both **Aetna** and **IlliniCare** demonstrated strong performance in the Design stage, meeting 100 percent of the evaluation elements in Activities I through V. Both plans had not progressed to the point of implementing interventions or reporting baseline data. The technical design of the PIPs was sufficient to measure and monitor PIP outcomes, and both ICPs have laid the foundation for the successful progression to the next stages of the PIP process.

Overall recommendations for the PIP include:

◆ As the ICPs progress to collecting and analyzing baseline data, each plan should be conducting its causal/barrier analysis, prioritizing the identified barriers from highest to lowest priority, implementing active interventions that are logically linked to the barriers and that will directly impact study indicator outcomes.

Member Satisfaction Surveys

It is important to note that 2012 represents the first year **Aetna** and **IlliniCare** participated in the CAHPS surveys. Therefore, the 2012 CAHPS survey results presented in this report for **Aetna** and **IlliniCare** represent a baseline of member satisfaction with these plans. For **Aetna**, because the first-year baseline measurement occurred after launch of a new program, the rates represent a period when the ICP plans were in the process of building networks and engaging providers to participate, and there was some reluctance on the part of providers to participate in the plan.

For the adult Medicaid surveys, **Aetna** scored below the 2012 NCQA CAHPS top-box national average for all nine measures. **Aetna** scored more than 5 percentage points below the 2012 NCQA CAHPS top-box national average for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

For the adult Medicaid survey, **IlliniCare** scored above the 2012 NCQA CAHPS top-box national average on four measures: *How Well Doctors Communicate, Customer Service*, *Shared Decision Making*, and *Rating of Personal Doctor*. **IlliniCare** scored below the 2012 NCQA CAHPS top-box average on the other five measures, and it scored more than 5 percentage points below the 2012 NCQA CAHPS top-box national average on three measures: *Getting Needed Care, Rating of Specialist Seen Most Often*, and *Rating of Health Plan.*

Overall recommendations for **Aetna** and **IlliniCare** for improving CAHPS results include:

◆ Identify potential barriers for patients receiving appropriate access to care.

◆ Identify and eliminate patient challenges when receiving health care.

◆ Consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve.

◆ Encourage physician-patient communication to improve patient satisfaction and outcomes.

◆ Request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit.

◆ Consider establishing an online patient portal or integrating online tools and services into current Web-based systems that focus on patient-centered care.

◆ Create an environment that promotes quality improvement (QI) in all aspects of care to encourage organization-wide participation in QI efforts.

◆ Encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians.

◆ Revise existing and create new print materials that are easy to understand based on patients' needs and preferences, and provide training for health care workers on how to use these materials.

◆ Consider an open access scheduling model to match the demand for appointments with physician supply.

◆ Conduct a patient flow analysis.

◆ Establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s).

◆ Enhance provider directories.

◆ Ensure physicians are properly trained to facilitate the shared decision making process with patients.

Readiness Reviews

HSAG was contracted by HFS to conduct a pre- and post-implementation operational readiness review for the health plans contracted to implement HFS' Integrated Care Program, **Aetna** and **IlliniCare**. The pre-implementation readiness review activities conducted in SFY 2010–2011 consisted of a comprehensive desk document review. The documents requiring review were determined based on HFS contractual and federal requirements. The ICPs were required to comply with all elements identified as mandatory or critical components prior to the May 1, 2011, program implementation date. HFS, with assistance from HSAG, reviewed and approved all mandatory documentation prior to implementation of the program. Both **Aetna** and **IlliniCare** met the State requirements for document approval prior to the implementation date.

Assessment of the ICPs' readiness and compliance continued throughout SFY 2012 as HSAG conducted an on-site review to further monitor compliance to ensure the ICPs are meeting the State's standards for program implementation.

Aetna Readiness Review

A review of the *Access* standards identified that **Aetna** did not meet the 30-mile distance requirement in Kane County for specialists, including orthopedics, endocrinologists, oncologists, and otolaryngologists. **Aetna** was required to pursue contracts in Kane County with specialist providers as well as home health agencies, physical therapists, and hospice providers. **Aetna** was required to continue strengthening the provider network by contracting with additional specialty

and subspecialty providers including optometrists, skilled nursing facility physicians (SNFists) as well as providers willing to provide services to homebound members.

The **Aetna** Medicaid Integrated Care Management (ICM) Program described that the purpose of the program was to identify the most vulnerable members who have complex or chronic clinical and/or social conditions, and assist them in using medical, behavioral, social, and community resources efficiently and effectively. **Aetna**'s case managers used CaseTrakker for documenting case management services. The CaseTrakker software supported case management activities by storing member assessments, claims data, authorizations and treatment plans and generating follow-up tasks for care coordinators. HSAG provided feedback on how the CaseTrakker software could be enhanced by customizing goals to more closely meet the specialized needs of individual members, and establishing benchmarks to evaluate progress and health outcomes for members receiving case management services. **Aetna** demonstrated a new case management software program scheduled for implementation in December 2011. This system, Dynamo, contains modules including case finding tools, outreach questionnaires, clinical assessments, integrated care plans, correspondence, condition-specific assessments, member satisfaction surveys, audit tools, and reporting.

HSAG also identified the need for improved coordination of follow-up care with the PCP and other health care providers for members with chronic conditions, and strengthening the care coordination process for SNFist providers in nursing facilities.

An additional recommendation included improving communication between case management and member services staff on the status of completion of the Health Risk Questionnaire (HRQ). A review of the *Measurement and Improvement* standards identified that **Aetna** was required to implement a process to develop, adopt, and implement practice guidelines for all the conditions/services as required by contract. In addition, the Clinical Practice and Preventive Services Guidelines policy, Quality Assessment and Performance Improvement (QAPI) program description, and Utilization Management (UM) plan needed revision to include an annual update of the practice guidelines as required by contract.

The QAPI program description defined the Member Advisory Council (MAC) as responsible for providing feedback to **Aetna** regarding strategies for improving member care and services, including health education and other member materials. At the time of the on-site review, the MAC had not yet convened its first meeting. HSAG recommended that **Aetna** initiate meetings of its quality committees and update the QAPI Work Plan to reflect the post-implementation committee meetings schedule.

A review of *Structure and Operations* standards found that the **Aetna** Delegation Subcommittee had not initiated the required quarterly meetings. In addition, the standard-delegated vendor contract did not contain language that subcontractors comply with **Aetna**'s Cultural Competency Plan. A

review of the **Aetna** grievance oversight and reporting system identified the need for increasing the frequency of oversight and monitoring of grievances from monthly to weekly during this early implementation phase of the integrated care program. HSAG recommended that increasing the frequency of grievance monitoring will assist **Aetna** with early identification and resolution of issues unique to the members of this program. **Aetna** was also required to ensure that its affiliated providers are advised of changes to the grievances and appeals policies and procedures.

The **Aetna Better Health** 2011 Compliance and Fraud Plan included the Waste, Fraud, and Abuse (WFA) Program, which described the prevention, detection, and reporting of fraud and abuse. The Compliance Committee Charter required revision to reflect the meeting frequency (monthly) as required by contract, and **Aetna** was also required to initiate the meeting schedule for the Compliance Committee to complete review and approval of the Compliance and Fraud Program and associated policies and procedures.

A review of the *Access* standards identified that **IlliniCare** identified deficiencies in the provider network; however, it was difficult to determine actual deficiencies for the rural areas as the accessibility analysis was evaluated using the 30 miles/30 minutes urban requirement rather than the 60 miles/60 minutes requirement for rural counties. Based on this accessibility analysis, the following deficiencies in the **IlliniCare** provider network were identified: (1) less than one provider was located within 30 miles in Kankakee County for home health care, hospitals, and speech, occupational and physical therapy; and (2) less than one provider was located within 30 miles for hospitals and specialists such as allergy and immunology, gastroenterology, nephrology, neurology, infectious disease, and surgeries (cardiothoracic, neurosurgery, and orthopedic). HSAG recommended that **IlliniCare** should revise the accessibility analysis using the requirement of 60 miles or 60 minutes for rural counties to evaluate the adequacy of the network based on established requirements. In addition, **IlliniCare** was required to identify providers who are willing to provide home visits to homebound members in the accessibility analysis.

IlliniCare Readiness Review

IlliniCare was also required to revise its policies to reflect quarterly GeoAccess reporting, and notification of HFS of changes in the MCO's network that impact members' access to care. Access policies must also include the requirements that providers offer hours of operation that are the same as other payer types and that the MCO has a process to ensure provider compliance with cultural competency requirements. In addition, **IlliniCare** must implement mechanisms to communicate the MCO's services offered to providers who support the medical home concept.

The findings of the review of the care coordination/case management program identified the need to improve the process for documentation of the medical, behavioral health, and social service needs identified as a result of the health risk assessment (HRA), and ensuring those needs are addressed in the member care plan. Recommendations also included improving care plan

documentation by establishing goals for moderate- and high-risk members, ensuring member involvement and agreement with the care plan, ensuring PCP involvement in the care plan, and referring members identified with chronic care conditions to the disease management program and/or having in place a chronic care management plan. Additional findings included revisions to the Care Coordination/Case Management Program and associated policies and procedures to include the care coordination process with SNFist providers, nursing facilities, and **IlliniCare** care coordination staff.

A review of *Structure and Operations* standards found that the **IlliniCare** Committee Charter described the Delegation Oversight Committee's responsibilities for conducting quarterly meetings to review delegation oversight activities; however, the requirements for quarterly delegation oversight audits, monthly joint operating meetings, and regular monitoring of member complaints were not included in policies or the QAPI program description. In addition, the template delegated contract did not contain language that subcontractors comply with **IlliniCare**'s Cultural Competency Plan.

Four findings were identified related to member rights and responsibilities. There was no evidence that **IlliniCare**'s policies contained reasons for members to request voluntary disenrollment from the plan or that **IlliniCare** will provide the member written notice of termination of a contracted provider. Additionally, there was no evidence that **IlliniCare**'s centralized database flagged or identified the special communication needs of all members (i.e., those with Limited English Proficiency [LEP], limited reading proficiency, visual impairment, or hearing impairment) and the provision of related services (i.e., MCO materials in alternate format, oral interpretation, oral translation services, written translations of MCO materials, and sign language services). Information omitted from the member handbook included the member's right to obtain family planning services from a Medicaid provider in or out of the **IlliniCare** network.

A review of *Measurement and Improvement* standards identified that **IlliniCare** will need to continue to develop, adopt, and implement guidelines for all the conditions/services as required by contract. In addition, the Preventive Health and Clinical Practice Guidelines policy should include provisions to annually update the practice guidelines as required by contract.

Review of the associated QAPI Program policies and procedures identified that the policies and or program description did not include provisions for including the member satisfaction analysis in the annual QA/UR/PR report, methods for monitoring provider compliance with the cultural competency plan, quarterly meeting frequency of the Member Advisory Committee, and State access to peer review files if requested. In addition, **IlliniCare** will need to implement a process to ensure providers are informed and trained on the signs of suspected abuse and neglect and how to report alleged abuse or neglect.

A review of the *Program Integrity* requirements identified that The **IlliniCare** Waste, Abuse, and Fraud (WAF) Program Description described the prevention, detection, and reporting of fraud and abuse. A toll-free Fraud and Abuse Hotline was available to employees, members, business partners, and business providers. Review of the program policies and procedures identified that the State's quarterly submission and certification requirements were not included in the policies.

Section 5 details the procedures and findings of the focused reviews and readiness reviews conducted in SFY 2011–2012.

Technical Assistance to HFS and MCOs

Throughout 2011–2012, HSAG provided ongoing technical assistance in the following areas: MCO compliance with administrative compliance standards and readiness review requirements, performance improvement projects, grievance and appeals process, care management/care coordination program implementation and monitoring, performance tracking tools, children's special health care needs, the Pay-for-Performance (P4P) program, identification and selection of program-specific performance measures, and developing and implementing new Medicaid programs.

As requested by HFS, HSAG has continued to provide technical guidance to the MCOs to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective corrective action plans (CAPs) to address and correct the findings from the focused reviews and readiness reviews. HSAG, at the request of HFS, provided technical assistance training to the MCOs in conducting root cause analyses and implementing meaningful interventions to address the findings outlined in the MCOs' annual program evaluations and the results of PIPs and performance measures. HSAG's technical assistance efforts are detailed in Section 10 of this report.

Report Organization

The EQR technical report is organized as follows:

- **Section 1—Executive Summary** describes the purpose of this report, the scope of the report (mandatory and optional EQR activities), and a summary of overall conclusions and recommendations.

- **Section 2—Introduction** outlines the organization of the report, Section 2 also provides the history of State Medicaid and describes its eligibility requirements, enrollment, and programs.

- **Section 3—HFS Managed Care Program Quality Strategy** describes the goals of the quality strategy, the State's monitoring and compliance efforts to assess progress toward meeting quality strategy goals, and describes HFS' process for updating its quality strategy.

- **Section 4—HFS Managed Care Program Initiatives** highlights initiatives that support the improvement of quality of care and services for Medicaid beneficiaries as well as activities that support plan improvement efforts.

- **Section 5—Annual Administrative Assessment** describes the EQR activities conducted for each MCO. For each of the activities, the report presents the objectives, technical methods of data collection and analysis, description of data obtained, findings for each plan, and conclusions drawn from the data.

- **Section 6—Performance Measures** describes the evaluation of the MCOs' ability to collect and accurately report on the performance measures and performance measure results for HEDIS 2012 and trended HEDIS measures from 2008–2012.

- **Section 7—Performance Improvement Projects** [PIPs] describes the validation process for PIPs and presents the results of the PIPs conducted by MCOs during the report period.

- **Section 8—Member Satisfaction Survey** presents the results of the CAHPS surveys and other member satisfaction surveys conducted by MCOs during the report period.

- **Section 9—Overall Findings, Conclusions, and Recommendations** provides overall findings, conclusions, and recommendations regarding the health plans serving Illinois Medicaid beneficiaries during the review period.

- **Section 10—Technical Assistance to HFS and the HFS Managed Care Plans** describes technical assistance provided by HSAG in SFY 2011–2012.

◆ **Appendix A**—displays the Illinois HEDIS 2012 Medicaid rates for Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Health Services measures, and Chronic Conditions and Disease Management measures for voluntary managed care.

Illinois Medicaid Overview

The Department of Healthcare and Family Services (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 provides medical services to about 20 percent of its population. HFS was formerly known as the Illinois Department of Public Aid.

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

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

PA96-1501 (also known as "Medicaid Reform") requires that 50 percent of Medicaid clients be enrolled in care coordination programs by 2015. In Illinois, care coordination will be provided to most Medicaid clients by a variety of "managed care entities," a general term that includes managed care organizations (MCOs), integrated care plans (ICPs), coordinated care entities (CCEs), managed care community networks (MCCNs), and accountable care entities (ACEs).

In the upcoming years, many of the above-mentioned care coordination efforts will be expanded or initiated. The status of each managed care entity is detailed in the sections below.

Medical Programs and Eligibility

HFS Medical Programs pay for a wide range of health services, provided by thousands of medical providers throughout Illinois, to about two million Illinoisans each year. The primary medical programs are:

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

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

Necessary medical benefits, as well as preventive care for children, are covered for eligible persons when provided by a health care provider enrolled with HFS. Eligibility requirements vary by program. Most people who enroll are covered for comprehensive services, including, but not limited to, doctor visits, well-child care, immunizations for children, mental health and substance abuse services, hospital care, emergency services, prescription drugs, and medical equipment and supplies. Some programs, however, cover a limited set of services.

Medical Assistance Programs

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

The following lists eligibility requirements for Medical Assistance Programs:

1. The *All Kids* and *FamilyCare* programs are composed of six plans: FamilyCare/All Kids Assist, All Kids Share, All Kids Premium Level 1, All Kids Premium Level 2, All Kids Rebate, and Moms and Babies. Children are eligible through 18 years of age. Adults must be either a parent or caretaker relative with a child under 19 years of age living in their home, or be a pregnant woman. For all plans, non-pregnant adults must live in Illinois and be U.S. citizens or legal permanent immigrants in the country for a minimum of five years. Children and pregnant women must live in Illinois and are eligible regardless of citizenship or immigration status.

2. *Aid to Aged Blind and Disabled (AABD)* covers seniors 65 or older, persons who are blind and persons with disabilities with income up to 100 percent of the federal poverty level (FPL) and no more than $2,000 of non-exempt resources (one person). Individuals who receive Supplemental Security Income (SSI) or are ineligible for SSI due to income or are ineligible for SSI due to expiration of federal time limit on assistance to certain immigrants who have not yet become U.S. citizens may be eligible.

State Children's Health Insurance Program (SCHIP)

HFS also operates the State Children's Health Insurance Program (SCHIP) designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. The following lists eligibility requirements for SCHIP:

1. *All Kids Share* provides a full range of health benefits to eligible children. To be eligible children must have countable family income over 133 percent and at or below 150 percent of the FPL.

2. *All Kids Premium Level 1* provides a full range of health benefits to eligible children. For children to be eligible, families must have countable income over 150 percent and at or below 200 percent of the FPL.

3. *All Kids Premium Level 2* provides a full range of health benefits to eligible children in families with income above 200 percent and at or below 300 percent of the FPL.

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

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

Illinois Medicaid Managed Care

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

Voluntary managed care (VMC) has been a health care option for medical assistance participants in Illinois since 1976 and continues to be a choice even with the implementation of newer managed care models. The State contracts with MCOs to manage the provision of health care for HFS beneficiaries. MCOs include health maintenance organizations (HMOs), managed care community networks (MCCNs), and integrated care plans (ICPs). The State's contracts require the MCOs to offer the same comprehensive set of services to HFS beneficiaries that are available to the fee-for-service population, except certain services which are carved out and available through fee-for-service.

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

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

Detailed descriptions of Illinois' Medicaid managed care delivery systems are provided below.

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Voluntary Managed Care

During the report period, HFS contracted with three MCOs—**FHN**, **Harmony**, and **Meridian**—to participate in VMC in Illinois and provide health care services to Medicaid managed care beneficiaries.

Harmony and **Meridian** are HMOs, and **FHN** is a not-for-profit, provider-sponsored organization that operates as an MCCN. All three health plans operated in Cook County in SFY 2011–2012. **Harmony** also operated in the southern counties of Madison, Perry, Randolph, St. Clair, Washington, Jackson, Williamson, and Kane (a collar county in northern Illinois) in SFY 2011–2012. **Meridian** also operated in Adams, Brown, DeKalb, Henry, Henderson, Knox, Lee, Livingston, McHenry, McLean, Mercer, Peoria, Pike, Rock Island, Scott, Tazewell, Warren, Winnebago, and Woodford counties in January 2009.[2-1] *All Kids, Moms & Babies, and FamilyCare* recipients living in certain counties can voluntarily enroll in an MCO. Recipients living in Illinois counties with a VMC option choose a primary care physician (PCP) in the MCO's network for their medical home. Recipients who enroll in an MCO receive most of their services from the doctors and hospitals that are in the VMC network unless they gain approval to obtain outside services. Recipients can receive their health care and may receive additional benefits by enrolling in an MCO.

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

Integrated Care Program

The Integrated Care Program is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of chronic health conditions and coordination and continuity of care. It is a program for older adults and adults with disabilities who are eligible for Medicaid but not Medicare. It is a mandatory program and operates in suburban Cook (zip codes that do not begin with "606"), DuPage, Kane, Kankakee, Lake, and Will counties.

The Integrated Care Program brings together local primary care physicians, specialists, hospitals, nursing homes and other providers to organize and coordinate care around a patient's needs. It

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[2-1] http://www.hfs.illinois.gov/managedcare/managedcare_enrollment.html

keeps members healthy through more coordinated and better medical care, helping prevent unnecessary healthcare costs.

With Integrated Care members have:

◆ Choices of doctors, specialists and hospitals

◆ Better coordination of care with a team of people working with members to help them live an independent and healthy life

◆ Control of managing their health care needs

◆ Additional programs and services to help them live a healthy life

Expansion of the Integrated Care Program was initiated in 2012 and will continue in 2013, with new health plans undergoing readiness and implementation reviews in anticipation of expanding the Integrated Care Program to additional counties.

The ICPs are responsible for all covered services currently funded by Medicaid through the State plan or waivers. However, covered services will be phased in as the following three service packages.

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

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

Service Package II: Effective February 1, 2013, Service Package II of the ICP will deliver care coordination and waiver services through a mandatory managed care delivery system for

participants in several 1915 c) HCBS waivers who are enrolled in the ICP. Service Package II includes all long-term care services and the care provided through HCBS waivers, excluding waivers designed for individuals with developmental disabilities, including skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

Service Package III: Service Package III, scheduled for implementation in 2015, includes long-term care services and/or HCBS wavier services for members with developmental disabilities.

During the report period, ICP participants in Illinois could choose between two health plans—**Aetna Better Health (Aetna)** and **IlliniCare Health Plan, Inc. (IlliniCare)**. HFS' contracts with **Aetna** and **Illinicare** contain 30 performance measures. These measures create an incentive for the health plans to direct money toward care that produces valued outcomes. The plans are rewarded for meeting pre-established targets for delivering quality health care services that result in:

◆ Better health for the member.

◆ Better quality of life for the member.

◆ Reduction in the cost of the service over time.

Primary Care Case Management

Illinois' PCCM Program, called Illinois Health Connect (IHC), is currently a statewide health plan that is available to most persons covered by an HFS medical program. IHC is based on the American Academy of Pediatrics' initiative to create medical homes to encourage delivery of health care services in the most appropriate setting and ensure access to preventive health care services. Under IHC, recipients can choose their own medical home/PCP while receiving the advantages of care coordination and case management. At this time, IHC has over 5,600 medical homes with a total available panel capacity to serve over 5.3 million HFS medical assistance program-eligible recipients statewide.

As Illinois expands its Care Coordination Program, beginning in July 2014, Illinois Health Connect members in the five mandatory managed care regions will join a managed care entity. This means that most children, families, and newly eligible ACA adults will receive care coordination services in the five mandatory managed care regions primarily from one of three types of managed care entities: managed care organizations (MCOs), accountable care entities (ACEs), or care coordination entities (CCEs). Counties not included in the five managed care regions will continue to include Illinois Health Connect as a plan choice for most individuals enrolled in the HFS Medical program.

Enrollment

In State Fiscal Year (SFY) 2012, Medicaid, and the means-tested medical programs associated with it, provided comprehensive health care coverage to approximately 2.74 million Illinoisans and partial benefits to over 300,000.

On average, each month HFS' programs cover nearly 1.7 million children; 179,000 seniors; 268,000 persons with disabilities; 648,000 non-disabled, non-senior adults; and approximately 269,000 additional members with partial benefit packages (such as Illinois Healthy Women). Enrollment figures for SFY 2012 are displayed in Table 2.1 below.

Table 2.1—Illinois Medicaid Enrollment SFY 2012

Type of Benefits	Enrollment
Comprehensive Benefits	
Children	1,697,319
Adults with Disabilities	267,807
Other Adults	647,877
Seniors	178,642
Total Comprehensive	2,791,645
Partial Benefits	
Members with Partial Benefits	269,030
Total Members	
Total Members	3,060,675

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

HFS Managed Care Program Quality Strategy

Federal regulations at 42 CFR §438.200 and §438.202 require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards the State and its contracted plans must meet. The State must conduct periodic reviews to examine the scope and content of its quality strategy, evaluate its effectiveness, and update this strategy as needed.

In furtherance of HFS' mission to improve the health of Illinois families by providing access to quality health care, in consideration of the health needs of the participants served, and in compliance with federal and State regulations, HFS updated the quality strategy in SFY 2012. After drafting the Quality Strategy with MCOs' involvement, it was reviewed by a diverse set of stakeholders, including providers and advocates; and their input was incorporated.

During the review period, HFS continued revisions to the original State Quality Strategy to incorporate the following comments and recommendations from the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS):

- The overall program goal could be enhanced by adding a short list of objectives that references baseline performance data, measureable targets, and planned initiatives.

- HFS should clarify what constitutes satisfactory progress for an MCO unable to meet each of the established goals, and the actions HFS will take if progress is not achieved.

- HFS should include targets the MCOs must meet for each HEDIS measure. This should include MCO outcomes and trends, baseline, benchmarks, and targets.

- HFS should identify successes that may be considered best practices.

- The State should identify ongoing challenges to improving the quality of care to beneficiaries.

- The State should recommend ongoing quality improvement activities—e.g., performance improvement projects, withholds/pay-for-performance incentives, value-based purchasing incentives or disincentives, telemedicine, and health information technology changes.

The Quality Strategy has evolved over time based on community concerns and feedback, participant health needs, federal and State law, industry standards, lessons learned, and best practices, and in collaboration with the MCOs to establish objectives, priorities, and achievable timelines. The Quality Strategy is viewed as a "work in progress" as the state of health care quality

(e.g., clinical practice and improved methods for quality measurement and monitoring accountability) is continuously evolving.

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

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

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

Throughout SFY 2011–2012, HFS continued to focus on measuring progress and outcomes, and establishing thresholds for improved performance. In addition, 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). Specific program changes and enhancements include continued enrollment in the Primary Care Case Management (PCCM) program to encourage delivery of health care services in the most appropriate setting and ensure access to preventive health care services and the creation of the Integrated Care Program, which aims to keep members healthy through more coordinated and better medical care while helping to prevent unnecessary health care costs. HFS is working on revisions to the State Quality Strategy to address these and other legislative and programmatic changes.

The fully revised State Quality Strategy was published in November 2012.

Quality Strategy Objectives

HFS worked with stakeholders to begin drafting the revised Quality Strategy and identified the following overarching goals for quality improvement.

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

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

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

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

Goal 5: Ensure efficient and effective administration of Illinois Medicaid managed care programs.

To focus continuous quality improvement efforts toward the aims of the Quality Strategy, HFS is identifying priority measures to align with the revised Quality Strategy goals. The measures will help MCOs focus their quality improvement efforts. It is HFS' expectation that by targeting specific priorities, more consistent improvement in these areas can be achieved. Minimum performance goals (benchmarks) for many of these measures will be established using the Quality Improvement System for Managed Care (QISMC) hybrid method. The hybrid 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.

Quality Performance Withhold—Voluntary Managed Care

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

Performance calculations are based on the hybrid Quality Improvement System for Managed Care (QISMC) methodology. The previous year's score is the baseline for each year. For measures that decline from the prior year, the original hybrid QISMC goal will remain the basis for the MCO in

meeting the goals. Rates that receive a Not Report (NR) designation for either a baseline year or a remeasurement year will result in the withhold amount for the measurement year being retained by HFS.

The HEDIS measures used to determine the quality performance payments for voluntary managed care were:

- *Childhood Immunization Status—Combo 3*

- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

- *Cervical Cancer Screening*

- *Timeliness of Prenatal Care*

- *Postpartum Care*

- *Use of Appropriate Medications for People With Asthma—Combined Rate*

- *Comprehensive Diabetes Care—HbA1C Testing*

Quality Performance Withhold—Integrated Care Program

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

ICPs are not eligible to receive any incentive payments if they fail to meet a minimum performance standard. The minimum performance standard will require ICPs' measurement year performance to be no lower than 1 percent below that year's baseline on all P4P measures, except that ICPs may regress more than 1 percent in three P4P measures in the first measurement year.

Calendar year 2010 is considered the initial baseline year, meaning 2010 baseline data will be used to set the baseline for 2012. In consultation with the ICPs, HFS will use the rates reported for members who were previously enrolled in the fee-for-service program but who are now enrolled in an ICP to derive a baseline rate. These rates represent the performance on these measures while these members were participating in the fee-for-service program. This baseline rate was then used to calculate a QISMC goal for 2013. By developing a QISMC goal via this method, the State was

able to establish a baseline for performance for the new program. For the first two years, the target goal will be set as a percentage above the baseline equal to 10 percent of the difference between the baseline score and 100 percent. For example, if the baseline is 50 percent, 10 percent of the difference between 50 percent and 100 percent is 5 percent; therefore, the goal will be set at 55 percent. When the ICPs report actual baseline rates in 2013, these will be used to calculate future QISMC target goals.

P4P metrics, baselines, and goals for future years will be negotiated and established through countersigned letters. If any coding or data specifications are modified, and HFS or ICP has a reasonable basis to believe that the modification will have an impact on an incentive pool payment, then the two entities will negotiate; and the resolution will be established through countersigned letters.

During SFY 2011–2012, HFS worked collaboratively with HSAG and the ICPs to identify and develop performance measures specific to ICP members. Through this collaboration, 30 performance measures were identified and technical specifications were developed for each of the HEDIS-like and State-defined performance measures. The 30 ICP performance measures that were developed by HFS and the ICPs are a mix of HEDIS, HEDIS-like, and State-defined measures. Of the performance measures, 12 P4P measures were identified and are displayed below.

Table 3.1—ICP P4P Measures

Dental
1. *Annual Dental Visits—DD Population*
Comprehensive Diabetes Care
1. *HbA1c Testing*
2. *Nephropathy Monitoring*
3. *LDL-C Screening*
4. *Statin Therapy (80% of Eligible Days)*
5. *ACE/ARB Therapy (80% of Eligible Days)*
Congestive Heart Failure (CHF)
1. *ACEI/ARB Therapy 80% of the Time*
2. *Beta Blockers 80% of the Time*
3. *Diuretics 80% of the Time*

Table 3.1—ICP P4P Measures

Coronary Artery Disease
1. *Cholesterol Testing*
2. *Statin Therapy 80% of the Time*
3. *ACEI/ARB Therapy 80% of the Time*
4. *Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)*
Pharmacotherapy Management of COPD Exacerbation
1. *Systemic Corticosteroid Dispensed Within 14 Days of the Event*
2. *Bronchodilator Dispensed Within 30 Days of the Event*
3. *Use of Spiromotry Testing in the Assessment and Diagnosis of COPD (SPR)*
Behavioral Health
1. *Follow-up After Hospitalization for Mental Illness (30 days)*
2. *Antidepressant Medication Management (AMM) Effective Acute Phase Treatment*
3. *Antidepressant Medication Management (AMM) Effective Continuation Phase Treatment*
Access/Utilization of Care
1. *Ambulatory Care Follow-up With a Provider Within 14 Days of Emergency Department Visit*
2. *Ambulatory Care Follow-up With a Provider Within 14 Days of Inpatient Discharge (FPID)*
3. *Ambulatory Care—ED Visits per 1000 Member Months*

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

HFS monitors and evaluates compliance with access to care, structure and operations, quality measurement and improvement, and consumer satisfaction to monitor progress toward the goals of the Quality Strategy. In addition to HFS' Bureau of Managed Care, the State's Bureau of Information Systems (Medicaid Management Information System [MMIS] and Client Information System (SIS) maintains functional areas, including without limitation: client information—eligibility, demographics, provider enrollment, MCO enrollment, claims and encounter data, payment information, third-party liability, and reporting. HFS' data warehouse and its executive information system (EIS) track key indicators for comparison (state, county, fee-for-service, and MCO [specific and aggregate]) for tracking and trending of utilization and health outcomes. Data matches with other data systems to determine utilization (e.g., immunization tracking systems and lead poisoning prevention programs) are performed on an ongoing basis, providing child-specific

member information to the respective MCO, as well as aggregate findings, for improvement in MCO outreach, patient compliance, and encounter data submission.

The areas described below are reviewed on an ongoing basis.

- Assuring the MCO (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 members.

- Assuring the MCO (MCCN) meets HFS' regulatory requirements.

- Coordinating monitoring of the fiscal components of the contract that are performed by HFS' Office of Health Finance.

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

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

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

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

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

- Maintaining a historical registry of marketing representatives, tracking marketing meeting schedules, handling marketing complaints, and addressing marketing concerns.

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

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

- Performing compliance reviews, including encounter data monitoring and utilization reporting to each MCO based on HFS' analyses of administrative data.

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

◆ Assessing customer satisfaction through MCO customer satisfaction surveys, problem and complaint resolution through HFS' hotline, and interaction with the member and the MCO's member services or key MCO administrative staff members.

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

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

◆ Monitoring the MCO's compliance with its operation of a grievance and appeals process.

◆ Communicating recommendations to the MCOs.

◆ Providing oversight for the quality improvement plan.

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

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

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

◆ Compliance monitoring activities, including areas for targeted improvement for the MCOs.

◆ Benchmarks for performance measures.

◆ HEDIS tables for MCOs to automatically trend, graph, determine HEDIS percentile rankings, and determine next goals.

◆ PIP summary tables to determine the validation status and improvements for individual PIP quality indicators.

◆ Chi-square and p value calculator to facilitate the VMCOs' ability to determine if changes are statistically significant.

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

Quality Strategy Review

To promote continuous quality improvement, HFS has developed a strategy to ensure that review of the Quality Strategy's objectives is ongoing throughout the year. HFS holds quarterly Quality Improvement Committee meetings with its EQRO, staff from the MCOs, and health plan medical directors and quality program staff. The meetings include discussion of compliance with the State's quality strategy, ongoing monitoring of performance of the MCO and ICP programs, program changes or additions, and future initiatives. As new programs and initiatives are implemented, such as the Integrated Care Program, HFS incorporates initiatives of those programs into the Quality Strategy to ensure continuous quality improvement.

HFS also conducts monthly Quality Assessment and Performance Improvement (QAPI) committee meetings to evaluate MCO performance and whether the goals and objectives of the Quality Strategy are being met, as well as to establish goals and objectives.

The monthly conference calls and quarterly face-to-face meetings ensure frequent review of the Quality Strategy objectives and regular evaluation of plan performance.

HFS implemented the performance tracking tool (PTT) which allows plans to track their performance and P4P measures and provides calculation of the performance goals using the QISMC methodology. Formulas for determining improvement in the measures are programmed in the PTT, allowing for immediate evaluation of statistical significance. Once the most current results are populated, the PTT will also calculate an MCO's QISMC goals for the following years.

The EQRO evaluates the MCOs' annual evaluation of their QAPI programs, and results of this evaluation are used to help develop the strategic direction for HFS and the MCOs. The results of this review are used in annual meetings between HFS and the MCOs to review the results of the EQR activities such as compliance reviews, validation of performance measures, and validation of non-collaborative and collaborative PIPs. In addition, HFS convenes an annual quality assurance meeting to review the Quality Strategy with stakeholders, providers, and MCOs.

Each year, HFS requires its EQRO to provide a written review of the State's Quality Strategy for compliance with the requirements of 42 CFR 438.204 and for its effectiveness for managed care. This review is to include specific recommendations regarding any compliance deficits that may exist, as well as any revisions that might help the MCOs improve the health outcomes of the State's Medicaid recipients. The results and recommendations of this review will be included in the annual EQR report. The Quality Strategy review process includes the following elements:

1. Review of annual results
2. Calculation of performance goals (QISMC)
3. Identification of compliance with strategic goals

4. Establishment of new/revise existing performance targets

5. Consultation with HFS on P4P measures

HFS will update the Quality Strategy as necessary based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program. HFS will update the Quality Strategy to ensure its effectiveness at least annually to incorporate new goals and objectives for the following year.

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

The annual evaluation includes an assessment of the following:

- Access to care and network adequacy.

- Organizational structure and operations.

- Quality assurance processes, including peer review and utilization review.

- Recipient complaints, grievances, and appeals, as well as provider complaints and issues.

- Nonclinical and clinical quality measure results.

- Performance improvement project findings.

- Success in improving health outcomes.

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

- Identification of program barriers and limitations.

- Feedback obtained from HFS leadership, MCOs, the provider community, advocacy groups, Medicaid recipients, and other internal and external stakeholders that can impact recipient access to high-quality and timely care and services.

- Recommendations for the upcoming year.

HFS will update the Quality Strategy as necessary based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program. Prior to each annual update, HFS solicits stakeholder input on the goals and objectives of the Quality Strategy. HFS will update the Quality Strategy to ensure its effectiveness and incorporate new goals and objectives for the following year. The revised Quality Strategy will be shared with all pertinent stakeholders, posted on the HFS Web site for public view, and forwarded to CMS.

HFS Managed Care Program Initiatives Driving Improvement

This section highlights initiatives that support the improvement of quality of care and services for Medicaid beneficiaries as well as activities that support plan improvement efforts. All initiatives and activities were in alignment with the State's quality strategy.

Statewide Collaboratives/Initiatives

Integrated Care Program

HFS implemented the State's first integrated health care program on May 1, 2011. Two health maintenance organizations (HMOs), **Aetna** and **IlliniCare**, were selected to administer the program. The ICP is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of chronic health conditions, and coordination and continuity of care. It is a program for older adults and adults with disabilities in the following counties who are eligible for Medicaid but not Medicare: Suburban Cook, DuPage, Kane, Lake, Kankakee, and Will.

The ICP brings together local PCPs, specialists, hospitals, nursing homes, and other providers to organize and coordinate care around a patient's needs. It aims to keep members healthy through more coordinated and better medical care while helping to prevent unnecessary health care costs. Under the program, members choose a health plan and a doctor or clinic as a primary care provider (PCP) for their medical home.

With integrated care, members will have:

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

The participants in the ICP previously received covered services through the Medicaid fee-for-service system. Most of these participants were enrolled in the PCCM program. The MCOs that participate in the ICP will be responsible for all covered services currently funded by Medicaid

through the State plan or waivers. However, covered services will be phased in as three service packages.

The savings/cost avoidance over the five-year contract period are estimated at nearly $200 million as a result of:

◆ Automatic savings every year due to rates set for the companies at 3.9 percent below what is otherwise estimated to be spent on care for these Medicaid recipients.

◆ Lower growth rates (or estimated cost inflation) over time because of requirements for enhanced coordination of services and focus on prevention, especially as more services are added in Service Package II and Service Package III.

During the reporting period, the ICPs, through input from HFS, identified the PIP topic of Community Based Care Coordination. The PIP will explore the relationship between care coordination, timely ambulatory care services, and readmission rates less than 30 days post discharge.

Performance Tracking Tool

The PTT initially was designed to be used by each VMCO as a mechanism for monitoring and trending the results of each performance measure identified in the tool. During SFY 2012 HSAG updated the PTT with the most recent HEDIS performance measure results. The tool was used to record the baseline and remeasurement results for each performance measure and identify how the MCO was performing in comparison to national benchmarks and the calculated goals for the subsequent reporting period.

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

◆ Incentive measures and calculation of the pay-for-performance bonus incentive.

◆ Benchmarks for performance measures.

◆ HEDIS tables for VMCOs to automatically trend, graph, determine HEDIS percentile rankings, and determine next goals.

◆ PIP summary tables to determine the validation status and improvements for individual PIP quality indicators.

◆ Chi-square and p value calculator to facilitate the VMCOs' ability to determine if changes are statistically significant.

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

Children's Health Insurance Program Reauthorization Act

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

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

MCO Collaboratives/Initiatives

EPSDT Screening Performance Improvement Project

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

- Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.

- Improve the quantity and quality of EPSDT examinations through a collaborative process.

- Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

The Statewide *EPSDT* performance improvement project (PIP) was redesigned in calendar year 2012. The number of indicators was decreased to simplify data collection and intervention development. The first three indicators are the HEDIS measures listed below:

- Well-Child Visits in the First 15 Months of Life—Six or More Visits

- Well-Child Visits in First 15 Months of Life—Zero Visits

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

The remaining indicators are included in the Developmental Screening measure that is part of the CHIPRA set of measures. The MCOs revised all parts of this PIP. The data collection tool and instructions for the CHIPRA measure were developed.

The *EPSDT* PIP will be continued until the indicators demonstrate sustained improvement. In addition, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs in an effort to improve EPSDT screening rates.

Family Health Network

Member Initiatives

- Mailings

  - Continued partnership with Wyeth/Pfizer to send immunization reminders. Each month, **FHN** sends Pfizer a list of members aged 8–9 months and 16–17 months who are missing encounters for Prevnar, the pneumococcal vaccine. Pfizer has partnered with Televox, who makes immunization reminder calls to **FHN**'s members on the list. **FHN**'s performance on the Combo 3 immunization rate has steadily increased over the last few years.

  - Continued Project LAUNCH to increase marketing of the importance of well-child visits to the targeted zip codes.

Provider Initiatives

- Offered provider education sessions to each medical group. Targeted information included documentation requirements, coding, EPSDT components, encounter data submission, and use of standardized charting forms emphasizing thorough and complete documentation. The sessions included analysis of submitted encounter data. Each group is required to submit a corrective action/quality improvement plan.

Harmony

Member Initiatives

- Telephonic Outreach

  - Continued the HEDIS Inbound Care Gap program. This intervention involves members who call inbound to Customer Service and are identified as having a HEDIS Care Gap. Customer service representatives educate the member on the importance of scheduling

and receiving preventive care services and offer to assist them in scheduling their doctor appointment via a three-way telephone call to the member's physician office.

- Continued centralized telephonic outreach to parents/caregivers of children regarding the importance of scheduling well-child visits and childhood immunizations, reaching nearly 6,500 members, leaving over 15,000 messages, and scheduling over 900 member appointments.

- Mailings

  - Provided newborn packets that contained information on the recommended well-child visits, immunizations, and lab testing schedule.

  - Sent over 50,000 preventive care booklets to new members which listed the recommended well-child visits and immunization schedule, and highlighted the importance of preventive health care services.

- Incentive Programs

  - Awarded 23 gift cards for completion of recommended well-child visits in the first 15 months of life (6+ visits). The card can be used at one of several retail stores.

Provider Initiatives

- Implemented outreach visits to medical groups and providers. During these visits, Provider Services representatives provided education and encouraged compliance with encounter submission of immunizations.

- Continued provider OB education regarding **Harmony** Hugs program and the utilization of the OB Notification form for providers to receive the $25 OB Incentive Program.

Meridian

Member Initiatives

- Mailings

  - Revised member outreach materials to include a clear reminder to parents/guardians on the necessary elements of well-child visits and immunizations, as well as continuation of incentive mailings for members who are in need of HEDIS services (well-child visits).

- Referral Program

  - Implemented a process to refer pregnant members to the State Family Case Management program to access their services. The goal of the Family Case Management program is to inform expectant women and new mothers of available services and then assist them with obtaining prenatal and well-child care. Infants and young children may obtain the

health care services and other assistance they need in order to have a healthy pregnancy and to promote the child's healthy development.

Provider Initiatives

- Provider Education

    - Created an EPSDT toolkit outlining EPSDT and developmental screenings for providers to have access to tools and to promote each aspect of the EPSDT program.

- Provider Tools

    - Created and provided EPSDT forms for all providers to use during well visits. The forms provide specific information for various age groups, ranging from 1 week to 17 years of age. They were provided in a toolkit and posted to the **Meridian** Web site.

Illinois Project LAUNCH

During this reporting period, the VMCOs participated in Project LAUNCH collaborative, which is a cross-agency initiative that supports the EPSDT PIP interventions. The focus of Illinois Project LAUNCH is to promote mental health wellness, to link families with community-based programs, and to encourage families and providers to regularly access and use services that promote family wellness. The VMCOs joined the partnership with Illinois Project LAUNCH to connect with hard-to-reach members who reside in a targeted low-income, high-violence geographic area in Chicago. The extraordinary social issues in this area cause significant barriers for members in prioritizing health care and accessing their medical home for preventive health care, including well-child screening services. Barriers to accessing health care identified for residents in this area included lack of transportation to medical appointments, lack of awareness of benefits available through the VMCOs, and lack of knowledge or relationship with their primary care provider or medical home.

Among the collaborative activities currently in process are the development of a member resource card and a provider resource card for use by Project LAUNCH outreach coordinators and community partners. The resource cards describe for the primary care provider, community workers, and the member what a medical home is, how to determine to which health plan a member is assigned, lists benefits available under the VMCOs and how to contact the VMCO for assistance regarding member services, medical transportation, and the on-call nurse advise line. In addition, the VMCOs plan to develop a provider resource card that describes the concepts and responsibilities of the medical home provider.

The VMCOs, Illinois Project LAUNCH, HFS, Illinois Health Connect, and the American Academy of Pediatrics (Illinois Chapter) provided subject matter expert input regarding the content of the resource cards.

The resource cards have been approved by all stakeholders and at the time of this report were ready to be translated, printed, and distributed. The resource cards will be available to Illinois Project LAUNCH staff members and providers in the community in both English and Spanish versions.

Perinatal Care and Depression Screening PIP

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

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

The *Perinatal Care and Depression Screening* PIP will be continued until the indicators demonstrate sustained improvement.

In addition, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs in an effort to improve perinatal care and depression screening rates.

Family Health Network

Member Initiatives

- Incentive Programs

    - Continued Brighter Beginnings, an incentive program for pregnant members and their babies, throughout the reporting period. Brighter Beginnings was a URAC Best Practice Awards Finalist in 2012. For calendar year 2011, 1,822 $10 gift cards and 178 $25 gift cards were mailed.

    - Continued the Baby Photo Program, in which a coupon for a free baby photo from Sears is mailed to members who meet the criteria for the $25 postpartum incentive.

- Continued the immunization incentive consisting of mailing a monthly coupon for one free package of Osco brand diapers to parents of children under 3 years of age who are enrolled in the program and whose immunizations are up to date.

- Member Education/Support

  - Continued partnership with "Text4Baby." Information about the program is included in member newsletters and in the prenatal information packet mailed to all known pregnant members.

  - **FHN** maternity care managers completed a telephonic screening tool as part of the comprehensive assessment for maternity case management and as part of the postpartum telephone calls. Same-day follow-up was provided by the behavioral health vendor for positive screenings.

Provider Initiatives

- Incentive Programs

  - Continued provider incentive for early notification of pregnant members in February 2011. Providers receive $25 for notifying **FHN** of members who were pregnant. Details of the incentive program were communicated to the providers through the provider newsletter and through office visits by the **FHN** maternity case manager.

Harmony

Member Initiatives

- **Harmony** Hugs Program

  - Continued the **Harmony** Hugs program. All members that are identified as pregnant receive a Hugs enrollment card. **Harmony** Hug team members perform the Edinburg Perinatal Depression Screening (EPDS) during the antenatal period if the member has a history or current symptomology of depression. Postpartum EPDS will be conducted for all members that **Harmony** Hugs contacts. Home visits are made by a plan filed based care manager to high risk members. Alere also care manages high risk maternity members telephonically.

- Mailings

  - Continued distribution of maternity booklets which provided prenatal, postpartum, and newborn care education to all known pregnant members whether they are enrolled in the **Harmony** Hugs program or not.

◆ Incentive Programs

- ▪ Maternity Education Reward Program—Members are rewarded with a stroller or diapers for completing six prenatal visits. The diaper reward is one package per month for 12 months. The member must be effective with the plan to receive the diapers.

- ▪ The Centralized Telephonic Outreach (CTO) team reaches out to members to educate the member on the importance of postpartum care, and assist with scheduling the appointment and transportation if needed. Members receive an IVR reminder 24 hours prior to the appointment.

Provider Initiatives

◆ Incentive Programs

- ▪ Continued the provider incentive program, which provides a monetary bonus for each compliant, first prenatal visit, as confirmed by submission of a notification form. This initiative focuses on lower-performing provider groups.

Meridian

Member Initiatives

◆ Maternity Program

- ▪ Transitioned to a Maternity Care Coordination program where a team manages all pregnant members throughout the prenatal and postpartum period.

◆ Screenings

- ▪ Completed 203 high-risk prenatal screenings for referral and intervention by high-risk prenatal nurses, and postpartum depression screening of 85 percent of the current eligible population using the Edinburgh Postnatal Depression Screening Tool.

◆ Mailings

- ▪ Distributed prenatal and postpartum educational materials to members.

◆ Telephonic Outreach

- ▪ Implemented the program option for prenatal and postpartum members to receive texts from Text4Baby, a program that offers education throughout the member's pregnancy and into the postpartum period.

- ▪ Created an outreach campaign using the automatic dialer software to reach more members in an efficient manner. All staff members working this campaign are trained to administer high risk prenatal assessments and EPDS screening tools.

Provider Initiatives

◆ Provider Communication

▪ Updated process flows for prenatal/postpartum member outreach to include faxing of all prenatal and postpartum EPDS to the OB provider and the PCP.

▪ Created and used provider fax templates to obtain timely prenatal authorization information.

Improving Ambulatory Follow-Up and PCP Communication PIP

HFS required that each MCO participate in a statewide PIP on improving ambulatory follow-up and PCP communication. This is a two-part collaborative study between the State, EQRO, and MCOs that began in 2009. This is the second year of this PIP and the goals are to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral health care providers.

For the *Improving Ambulatory Follow-up and PCP Communication* PIP, a collaborative meeting occurred between the State, EQRO, and MCOs to discuss barriers. Based on the outcomes of this meeting, the MCOs implemented the following interventions:

◆ Member outreach calls within two business days of discharge from an inpatient facility to confirm the treatment plan.

◆ Provider outreach call after an appointment within seven calendar days to confirm that follow-up occurred.

◆ If unable to confirm follow-up within seven days, a minimum of two additional outreach calls to the member are made to continue efforts to link the member with timely follow-up within 30 days.

◆ If unable to reach the member after a minimum of three telephone contacts, an outreach letter is sent to the member informing the member of the importance of continued care and available services.

In addition to these collaborative efforts, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs to improve ambulatory follow-up and PCP communication rates.

Family Health Network

◆ **FHN** and PsycHealth (**FHN**'s behavioral health provider) continued the Home Intervention Program (HIP) and Transitional Care Visits Program (TCVP) developed specifically to address linkage to aftercare post discharge from an inpatient setting. All members being discharged from an inpatient setting receive a comprehensive aftercare plan for continued care including,

at a minimum, an outpatient appointment within seven days of discharge and how to access 24-hour on-call services if needed at any time. An in-home Transitional Care Visit (TCV) is also offered to every member being discharged with the focuses of the visit to reinforce the importance of the aftercare plan and troubleshoot any potential barriers to the plan. If continued in-home services are recommended at that time, they are also available and will be authorized.

◆ In addition to the in-home TCV, PsycHealth, Ltd., offers a member incentive, Aftercare Rewards Program, in which the member is given a $20/$10 gift card on proof of visit within 7/30 days of discharge, respectively.

Harmony

◆ Hospital to Home (H2H) Initiative and Bridge Appointments—**Harmony** and Magellan (**Harmony**'s behavioral health provider) continued the H2H initiative to **Harmony** members, which is available to all members who are discharged from an inpatient level of care. This initiative offers members an opportunity to be evaluated in their home within seven days of discharge. This assessment may lead to certain members being eligible to receive ongoing services in the H2H program if determined to be clinically necessary to support their recovery. All members leaving an admitting facility without an aftercare appointment in place are worked for a minimum of three telephonic outreach and follow-up calls. If the member is unable to be contacted by telephone, a letter is mailed detailing the importance of continued care, and offering assistance and FAH services.

Meridian

◆ Worked in collaboration with the State of Illinois and HFS to inform and educate providers on Public Act 97-0515 which eliminates the need for the BH provider and MCO to collect a member-signed consent for "release of information." This is an amendment to the Mental Health and Developmental Disabilities Confidentiality Act to help improve continuous communication between medical health and behavioral health providers and the MCO.

◆ Provided specific education on the changes to the Mental Health and Developmental Disabilities Confidentiality Act within the **Meridian** Provider Newsletter. Additional information will be offered on behavioral health specialist communication with the PCP.

◆ Supported the consistent use of a "patient transition of care" tool to communicate the member's diagnosis, health status, medications, and follow-up appointments at the time of discharge.

◆ Clear communication of **Meridian**'s expectations of the HEDIS follow-up within seven days and 30 days among behavioral health providers at the time of admission. Increased collaboration with behavioral health partners to improve this metric.

 ◆ Promoted PCP and behavioral health specialist communication by the consistent use of the "continued outpatient treatment notification form" or other communication document.

 ◆ Adopted a coordination of care model that supports the **Meridian** BH case manager with a multidisciplinary team of health care professionals who can assist in addressing the behavioral, medical, and social needs of the member.

 ◆ Considered behavioral health provider incentives for follow-up within seven days of an inpatient behavioral health stay and communication of the treatment plan with the PCP.

Care Coordination PIP—Integrated Care Program

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

The ICPs, through input from HFS, identified the PIP topic (Community Based Care Coordination), the rationale, indicators, and measurement periods. The PIP is designed to focus on medically high-risk members with a recent hospital discharge who are actively receiving care coordination with linkage to community resources. The PIP will focus on reducing the readmission rates for members stratified as medically high to moderate risk by measuring the effectiveness of care coordination for medically high-risk members with a recent hospital discharge. These members are: clinically complex; at risk for readmission post discharge from a medical hospitalization; actively receiving care coordination; and require linkages to ambulatory care services. The goal of the PIP will be to increase access to community resources that provide education, physician assessments, and pharmacological interventions to decrease hospital readmissions and improve health outcomes.

The PIP will explore the relationship between care coordination, timely ambulatory care services, and readmission rates less than 30 days post discharge. The study focuses on member risk stratified as high and moderate risk to:

 ◆ Decrease the rate of medical inpatient readmissions within 30 days of a previous admission with the same diagnoses for identified members.

 ◆ Improve health outcomes, baseline level of functioning, and quality of life.

 ◆ Promote patient-centered care.

 ◆ Foster member engagement and accountability and improve the member's ability to effectively manage his or her own health conditions.

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

- Demonstrate sustained improvement in health outcomes and status.

The targeted population includes members who are:

- Stratified as high to moderate risk.

- Clinically complex.

- At risk for readmission post discharge from a medical hospitalization.

- Actively receiving care coordination/care management.

- Require linkages to ambulatory care and HCBS.

As both plans implement targeted care coordination efforts to facilitate the member's receipt of appropriate and timely care, the PIP will result in a positive impact on rates for the following mandated, reportable, state-defined performance measures:

- *Ambulatory Care Follow-up With a Provider Within 14 Days of Inpatient Discharge*

- *Inpatient Hospital Readmission Rate*

It is projected that baseline measurement data for this PIP will be collected in SFY 2013.

Expansion of Managed Care

Pursuant to P.A. 96-1501 ("Medicaid Reform") signed into law in January 2011, Illinois must enroll at least 50 percent of its Medicaid clients into some form of risk-based coordinated care by January 1, 2015. Under Medicaid reform, care coordination is defined broadly to include both traditional managed care organizations as well as provider-organized delivery systems that include risk-based payment methodologies.

HFS currently manages two capitated Medicaid managed care programs and an early expansion waiver program for adults residing in Cook County, which was extended through March 31, 2014. The first is a voluntary program for children and parents. The second program, known as the "Integrated Care Program" (ICP), is a mandatory program for non-dual seniors and persons with disabilities (SPDs). The program was launched in 2010 for adults residing in Chicago and collar counties surrounding Chicago. The ICP program will continue expansion into additional counties with the addition of new integrated care plans.

Coordinated Care Innovations Project

The Care Coordination Innovations Project works to form alternative models of delivering care to Medicaid clients through provider-organized networks, initially organized around the needs of the most complex clients. The project has two components serving seniors and adults with disabilities and children with complex health needs. These provider-based networks will be organized as care coordination entities (CCEs) and managed care community networks (MCCNs). Illinois' goal is a redesigned health care delivery system that is more patient-centered, with focus on improved health outcomes and evidence-based treatments, enhanced patient access, and patient safety. Care coordination is also the key strategy to contain the Medicaid budget. Under this project, Illinois will begin a shift toward moving at least 50 percent of its recipients into coordinated care programs that organize care around recipients' medical needs by 2015 as called for by the Medicaid reform law (PA 96-1501).

Introduction

HFS contracts with HSAG to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR 438.356, HFS contracts with an EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR 438.358.

As set forth in 42 CFR 438.352, a mandatory EQR activity is to conduct a review, within the previous three-year period, to determine MCO compliance with State standards for access to care, structure and operations, and quality measurement and improvement. HFS has an annual monitoring process in place to ensure the CFR and BBA requirements are met over a three year period. HSAG reviews MCO compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.

In SFY 2011–2012, HSAG conducted focused on-site reviews of the three voluntary managed care organizations (VMCOs): **FHN**, **Harmony**, and **Meridian**. The focused review areas included Measurement and Improvement standards for all areas related to quality assessment and process improvement; Access standards for continuity of care and case management; and Structure and Operations Standards for delegation oversight, credentialing, and recredentialing if the score received by the VMCO in the prior comprehensive review warranted re-review. In addition, HSAG completed a review of the VMCOs' annual quality improvement program (QIP) evaluation reports. The findings of the evaluation were discussed with each VMCO and included in a Focused Review Report prepared for HFS and the VMCO.

In SFY 2010–2011, the State of Illinois awarded Medicaid managed care contracts to **Aetna** and **IlliniCare** to administer services to Illinois Medicaid beneficiaries enrolled in the State's new Integrated Care Program (ICP) for seniors and adults with disabilities who are eligible for Medicaid but not Medicare. HSAG conducted pre-implementation readiness review activities with **Aetna** and **IlliniCare** and followed up in SFY 2011–2012 with a post-implementation on-site readiness review. The State and the MCOs used the information and findings from the focused administrative reviews and post-implementation readiness reviews to:

◆ Evaluate the quality and timeliness of, and access to, health care furnished by the MCO 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.

For each of the activities, this section of the report presents the objectives, technical methods of data collection and analysis, description of data obtained, findings for each plan, and conclusions drawn from the data. Additional details about the results of the EQR activities are included in the individual and aggregate MCO reports prepared by HSAG.

Focused Administrative Reviews—Voluntary Managed Care Organizations

Objective

The primary objective of HSAG's focused reviews were to provide meaningful information to HFS and the health plans regarding VMCO compliance with federal managed care regulations and contract requirements specified in the October 1, 2009, *State of Illinois Department of Healthcare and Family Services Contract for Furnishing Health Services by a Managed Care Organization and Amendment dated October/November 2011.* A particular focus of this review was to determine how each VMCO maintained compliance in the areas identified in the prior comprehensive review findings as warranting re-review. The focused review also emphasized review of the VMCOs' case management and care coordination systems and programs.

Procedure

Throughout preparation for the focused review and performance of the activities during the on-site review, HSAG worked closely with HFS and the VMCOs to ensure a coordinated and supportive approach. To complete the focused review, HSAG assembled a team to:

◆ Collaborate with HFS to determine the scope of the review and scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.

◆ Collect and review data and documents before and during the on-site review.

◆ Aggregate and analyze the data and information collected.

◆ Prepare a report of review findings.

HSAG followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations at 42 CFR, Parts 400, 430, et al.* The following list describes the focused review activities in chronological order.

- Established the review schedule.

- Prepared the data collection tool for reviewing the standards and submitted it to HFS for approval.

- Prepared and submitted the pre-assessment form and agenda to the VMCOs.

- Forwarded the focused review tool and file review tools to the VMCOs.

- Participated in pre-on-site conference calls with HFS and each VMCO.

- Responded to VMCOs' questions related to the review and provided additional information needed before the review.

- Received data files from the VMCOs, then selected and posted samples to HSAG's file transfer protocol (FTP) site prepared for each VMCO.

- Conducted a file review of selected sample files.

- Received VMCOs' documents for HSAG's desk review and evaluated the information before conducting the on-site review.

- Conducted the on-site portion of the review.

- Calculated the individual scores and determined the overall compliance score for performance.

- Prepared a report of findings and required corrective actions.

Data Collection and Analysis

HSAG developed the SFY 2011–2012 Focused Review Administrative Tool and file review tools consistent with State and federal requirements and protocols. To select standards for inclusion in the focused review tool, HSAG used the requirements specified in the *State of Illinois Contract for Furnishing Health Services by a Managed Care Organization, and Amendment dated October/November 2011*; the *Illinois Compiled Statutes*; and the Balanced Budget Act of 1997 (BBA), including revisions issued June 14, 2002, and effective August 13, 2002.

The focused review areas selected included Measurement and Improvement standards for all areas related to quality assessment and process improvement, Access standards for continuity of care and case management, and Structure and Operations standards for delegation oversight, credentialing, and recredentialing (if the score received by the VMCO in the prior comprehensive review warranted re-review).

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For the file review, HSAG generated unique record review samples based on data files supplied by the VMCOs and HFS. A random sample of 10 unduplicated records was selected from each of the data files, and an additional 5 unduplicated records were selected for the oversample. For case management, HSAG reviewed 5 additional cases with a medical diagnosis that were not shared with the MCO prior to the site visit (unannounced sample). In addition to the sample file reviews, HSAG conducted a delegation oversight file review of the VMCOs' delegated vendors.

During the on-site review, HSAG conducted interviews, reviewed systems demonstrations, and reviewed files designated for the file reviews with VMCO staff to obtain further information to determine the VMCO's compliance with contract requirements. Throughout the desk review and on-site review process, reviewers documented within the standardized monitoring tools.

HSAG analyzed the review information to determine the organization's performance for each of the elements within the standards. HSAG used the designations *Met*, *Partially Met*, and *Not Met* to document the degree to which the VMCOs complied with the requirements. HSAG used a designation of *Not Evaluated* if an individual element was not evaluated for the VMCO during the period covered by the review. HSAG also used the standardized monitoring tool to document follow-up on any elements that required corrective action.

VMCO Plan-Specific Findings

Family Health Network

Table 5.1 presents a summary of **FHN**'s focused review results.

Table 5.1—Summary of Scores for the Standards

Standard #	Standard	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# NA	Total Compliance Score
Access Standards								
III	Coordination and Continuity of Care	14	14	12	2	0	0	93%
IV	Coverage and Authorization of Services	12	12	8	3	1	0	79%
Structure and Operations Standards								
VII	Enrollee Information/Enrollee Rights	24	24	22	2	0	0	96%
VIII	Confidentiality	9	9	8	1	0	0	94%
IX	Enrollment and Disenrollment	6	6	6	0	0	0	100%
X	Grievance Process	29	29	20	8	1	0	83%
Measurement and Improvement Standards								
XIII	Health Information System	5	5	5	0	0	0	100%
Program Integrity								
XIV	Fraud and Abuse	9	9	9	0	0	0	100%
	Totals	**108**	**108**	**90**	**16**	**2**	**0**	**91%**

Access Standards

Case Management and Care Coordination Program—The Utilization Management (UM) Program Description included policies and procedures to evaluate medical necessity, the criteria used, information sources, the process used to review and approve the provision of medical services, and the annual evaluation of program effectiveness. **FHN** used nationally recognized standards and practice guidelines when reviewing and making decisions regarding provider and member requests for services. **FHN** used qualified staff to review and make authorization and denial of service decisions. Timely UM decisions were made, depending on the clinical urgency of the situation. Turnaround times for prior-authorization decisions were monitored and reported monthly. The review findings showed that **FHN** for the most part provided timely UM decisions on prior authorizations and had appeal procedures in place.

Review of the retrospective authorization process identified that **FHN** will need to evaluate its process to ensure efforts are made to obtain all necessary information, including appropriate

clinical information and consultation with the treating physician as appropriate, and that application of the review criteria is consistent.

Review of the appeals process identified that **FHN** will need to ensure that communication to the enrollee includes the right to have benefits continued pending resolution of an appeal, how to request those benefits, and circumstances under which the enrollee may be required to pay the cost of these services.

During the on-site administrative review, HSAG evaluated the implementation and effectiveness of the new case management software, CareEnhance, and the overall case management program. **FHN** hired additional staff for the medical management and member services departments to assist with outreach and engagement of members in case management services. This effort significantly increased the number of members actively engaged in case management services since the SFY 2011 review. In addition, **FHN** hired a perinatal case manager dedicated to perinatal case management.

The case management file review identified significant improvements in the case management program including documentation of member and provider participation in care planning, identification of special health care needs, timely completion of care plans, completion of health risk assessments for new enrollees, and completeness of comprehensive assessments.

Measurement and Improvement Standards

FHN had a health information system in place that collected, analyzed, integrated, and reported data on performance measures, utilization data, grievances and appeals, case and disease management, credentialing and recredentialing, and enrollee characteristics. **FHN** is in the process of implementing the TriZetto QNXT information system which is scheduled for "go live" in third quarter 2012.

Structure and Operations Standards

FHN had mechanisms in place through the member and provider handbooks to distribute member rights and responsibilities to its members and providers as required. Member information was written in language that was readable and easy to understand and was available, as needed, in language(s) of the major populations served. **FHN** completed annual training of all staff, which included information regarding member rights and responsibilities.

FHN had policies, procedures, and processes in place to protect member privacy and confidentiality.

FHN had a grievance system for members that included the registration of an oral or written grievance; acknowledgement, investigation, and notification of the disposition of the grievance

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within the required time frame; and a process to appeal the grievance decision and to access the State's fair hearing system. However, review of 10 grievance files identified noncompliance with acknowledgement to the member of receipt of grievances, resolution of grievances within the required time frames, resolution notification to the member, and notification to members of their right to a State fair hearing. Staff also appeared to be confused about the required documentation and processing of formal and informal grievances. Finally, it was identified that a formal grievance sent to the Medical Management department was not processed according to the requirements and was not reviewed by the Grievance Committee as required.

In addition, **FHN** had an established process for registering written or oral appeals that included documentation of the appeal, consent from the member if a provider is acting on his or her behalf, investigation, action taken, and notification of the disposition of the appeal within the required time frame.

Program Integrity

FHN's Corporate Compliance Plan outlines the responsibilities and procedures for prevention; investigation; reporting; correction; and deterrence of fraud, waste, and abuse (FWA). Suspected violations can be reported via a suggestion box, or via an e-mail or voicemail to the compliance officer. Annual training was conducted to maintain staff awareness of the need for detection and deterrence of fraud and abuse.

Harmony Health Plan

Table 5.2 presents a summary of **Harmony**'s focused review results.

Table 5.2—Summary of Scores for the Standards

Standard #	Standard	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# NA	Total Compliance Score
	Access Standards							
I	Availability of Services	12	12	10	2	0	0	92%
II	Assurance of Adequate Capacity and Services	5	5	4	1	0	0	90%
IV	Coverage and Authorization of Services	12	12	11	1	0	0	96%
	Measurement and Improvement Standards							
XIII	Health Information Systems	5	5	5	0	0	0	100%
	Structure and Operations Standards							
VIII	Confidentiality	9	9	9	0	0	0	100%
IX	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Program Integrity							
XIV	Fraud and Abuse	9	9	9	0	0	0	100%
	Totals	**58**	**58**	**54**	**4**	**0**	**0**	**97%**

Access Standards

The **Harmony** Provider Relations Department analyzes provider availability and geographic distribution annually to evaluate the accessibility of plan primary care providers (PCPs), behavioral health care, and high-volume specialists to eligible members. **Harmony** identified some GeoAccess deficiencies in the specialty areas of the Southern Illinois market, and members were directed to the closest provider. **Harmony** continued its recruitment efforts to address the deficient areas.

Harmony used a contracted vendor to complete the semiannual accessibility and availability audits to monitor provider compliance with appointment and after-hours standards. Providers are re-audited if found noncompliant with the audit and are required to take written corrective action if found noncompliant in the second audit.

The Utilization Management (UM) Program Description included policies and procedures to evaluate medical necessity, the criteria used, information sources, the process used to review and approve the provision of medical services, and the annual evaluation of program effectiveness.

Harmony used nationally recognized standards and practice guidelines when reviewing and making decisions on provider and member requests for services. The MCO used qualified staff to review and make authorization and denial of service decisions. Timely UM decisions were made, depending on the clinical urgency of the situation. Turnaround times for prior-authorization decisions were monitored and reported monthly. The review findings showed that **Harmony** for the most part provided timely UM decisions on prior authorizations and had appeal procedures in place. A review of 10 denial files found that one file was out of compliance with the timely processing of an expedited request for services.

Harmony used the Enterprise Medical Management Application (EMMA) system to process requests for services. The functionality of the system allowed for:

◆ Collecting data such as receipt date, decision date, standard vs. expedited appeals, request outcomes, reasons for the decision, and reviewer identification and credentials.

◆ Directing information to other utilization reviewers, medical directors, and mail service staff to work queues for service requests requiring attention.

◆ Storing supplemental scanned documentation.

◆ Tracking and facilitating communication received from or sent to requesting physicians including faxed documentation.

The data collected in the EMMA system also allowed utilization management staff tasked with generating reports to analyze and monitor utilization functions.

During the interview with plan staff, **Harmony** described the improvements implemented by the Appeals Department during the period under review including reviewing and improving the processing and reporting of appeals and grievances by combining the databases, improving work flow processes, and cross training between the Grievance and Appeals departments.

Measurement and Improvement Standards

Harmony had a health information system in place that collected, analyzed, integrated, and reported data on performance measures, utilization data, grievances and appeals, case and disease management, credentialing and recredentialing, and enrollee characteristics. Plan data were maintained within the Peradigm system. **Harmony** used CareEnhance Resource Management Software (CRMS) to integrate claims, member, and provider data into one data repository.

The 2011 HEDIS Audit Report provided documentation that the HEDIS audit findings confirmed the accuracy and completeness of **Harmony**'s primary databases, including claims, encounters, membership and enrollment, and provider credentialing, and the ability to synthesize the information and generate reports.

Structure and Operation Standards

Harmony had an information system capable of integrating incoming enrollment and disenrollment data files including all member demographic information. **Harmony** implemented an interdisciplinary Medicaid Membership Retention subgroup in May 2011 to evaluate reasons for disenrollment. The Customer Service Quality Improvement work group also reviewed reasons for disenrollment in conjunction with determining reasons for member dissatisfaction.

Harmony had policies, procedures, and processes in place to protect member privacy and confidentiality.

Program Integrity

Harmony created a special investigation unit (SIU) responsible for the detection, prevention, investigation, reporting, correction, and deterrence of fraud, waste, and abuse (FWA). The SIU reports to the vice president, compliance investigations, who reports to the chief compliance officer. The SIU is also overseen by the FWA Committee. A toll-free fraud and abuse hotline is available to employees, members, business partners, and business providers.

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Meridian Health Plan

Table 5.3 presents a summary of **Meridian**'s focused review results.

Table 5.3—Summary of Scores for the Standards

Standard #	Standard	Total # of Elements	Total # of Applicable Elements	# *Met*	# Partially Met	# *Not Met*	# *NA*	Total Compliance Score
			Access Standards					
IV	Coverage and Authorization of Services	12	12	10	1	1	0	88%
			Structure and Operations					
VII	Enrollee Information/Enrollee Rights	24	24	20	2	2	0	88%
VIII	Confidentiality	9	9	9	0	0	0	100%
IX	Enrollment and Disenrollment	6	6	6	0	0	0	100%
X	Grievance Process	28	28	25	0	3	0	89%
			Measurement and Improvement					
XIII	Health Information System	5	5	5	0	0	0	100%
			Program Integrity					
XIV	Fraud and Abuse	9	9	9	0	0	0	100%
	Totals	**97**	**97**	**84**	**3**	**6**	**0**	**88%**

Access Standards

The 2011 Utilization Management (UM) Program Description included policies and procedures to evaluate medical necessity, the criteria used, information sources, the process used to review and approve the provision of medical services, and the annual evaluation of program effectiveness. **Meridian** used nationally recognized standards and practice guidelines when reviewing and making decisions on provider and member requests for services. The MCO used qualified staff to review and make authorization and denial of service decisions. Timely UM decisions were made, depending on the clinical urgency of the situation. Turnaround times for prior-authorization decisions were monitored and reported monthly. **Meridian**'s medical director is responsible for oversight of the UM Program. Utilization data are reviewed by the Quality Improvement Committee (QIC) which meets quarterly. The effectiveness of the program is evaluated through annual enrollee and provider satisfaction, and quarterly collection of grievance and appeals data. The QIC is also responsible for approving the written evaluation, program description, policies and procedures, and suggested revisions annually.

The review findings showed that **Meridian** for the most part provided timely UM decisions on prior authorizations and had appeal procedures in place. A review of five denial files found that

denial decisions were made by appropriately qualified staff and complied with the notification requirements, and decisions were made within the required time frames. **Meridian** will need to review the Notice of Action letter and corresponding policies and procedures to ensure compliance with the requirements.

Measurement and Improvement Standards

Meridian's custom-developed Managed Care System (MCS) is an integrated enterprise-wide solution that integrates all aspects of its operations. The integrated MCS system is used to:

◆ Manage member and provider data.

◆ Submit, approve, deny, and appeal authorizations.

◆ Process claims.

◆ Process, track, and report on member grievances and member and provider appeals.

◆ Initiate, investigate, and route fraud, waste, and abuse cases.

Providers can submit authorizations by faxing the information directly to MCS or by entering an authorization request in the provider Web portal.[5-1] Network providers have the ability to submit claims via hard copy, electronically through an 837 file, using a secure FTP Web site, or directly to **Meridian** using the provider Web portal. Out-of-network providers have the ability to submit claims via hard copy or electronically through the submission of an 837 file through one of the national health care clearing houses operating in Illinois. **Meridian**'s data warehouse uses Oracle Business Intelligence Enterprise Edition 11g (OBIEE) for reporting.

The HEDIS 2012 Report of Initial Audit Review Findings identified that **Meridian** is expected to be fully compliant with Information System (IS) Standards 1.0 through 1.7. The audit report provided documentation that the HEDIS audit findings confirmed the accuracy and completeness of **Meridian**'s primary databases, including claims, encounters, membership and enrollment, and provider credentialing, and the ability to synthesize the information and generate reports.

Structure and Operation Standards

Meridian had established policies and procedures that addressed enrollee information/enrollee rights confidentiality, enrollment and disenrollment, and the grievance process. The policies and procedures were in compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements for structure and operations standards.

Meridian had mechanisms in place through the member and provider handbooks to distribute member rights and responsibilities to its members and providers as required. Member information

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[5-1] Meridian Managed Care Information System Overview, page 4 of 4.

was written in language that was readable and easy to understand and was available, as needed, in languages of the major populations served. Findings identified related to member rights and responsibilities included ensuring the provision of basic information to enrollees; prohibiting discrimination because of race, color, religion, sex, national origin, ancestry, age, or physical or mental disability; informing members that they are free to exercise their rights; and informing members that prior authorization is not required for emergency services.

Meridian completed annual training of all staff, which included information regarding member rights and responsibilities. **Meridian** had policies and procedures and processes in place to protect member privacy and confidentiality.

Meridian's Managed Care System (MCS) was capable of integrating incoming enrollment and disenrollment data files including all member demographic information.

Meridian had an established grievance system for members that included the registration of an oral or written grievance; acknowledgement, investigation, and notification of the disposition of the grievance within the required time frame; and a process to appeal the grievance decision and to access the State's fair hearing system. The MCS was used to store grievance information including reason codes. **Meridian** was logging disenrollment reasons as grievances; however, this presented an issue with follow-up with the member due to being disenrolled from the plan. Following consultation with HFS, **Meridian** was advised to track the reasons for disenrollment separately from grievances. In addition, **Meridian** had an established process for registering written or oral appeals that included documentation of the appeal, consent from the member if a provider is acting on his or her behalf, investigation, action taken, and notification of the disposition of the appeal within the required time frame. Findings from the review of grievances identified that **Meridian** will need to establish a process for grievances to be reviewed by a grievance committee; continuation of member benefits during an appeal; and notifying members of the circumstances where a member may be required to pay for costs of services.

Program Integrity

The Fraud, Waste and Abuse (FWA) Program is directed and managed by the chief compliance officer in conjunction with the Medicaid compliance officer and the MHP Compliance Department, including the FWA Committee. MHP's vice president and general counsel is the chief compliance officer and the chairperson of the Corporate Compliance Committee. The chief compliance officer reports to the Corporate Compliance Committee, CEO, and COO, and reports quarterly on the status of the FWA program implementation, identified instances of noncompliance, and monitoring and auditing activities. The FWA Committee has established a special investigation unit (SIU) responsible for the detection, prevention, investigation, reporting, correction, and deterrence of FWA. A toll-free fraud and abuse hotline is available to employees, members, business partners, and business providers.

Operational Readiness Reviews—Integrated Care Program

Objectives

HSAG was contracted by HFS to conduct a pre- and post-implementation operational readiness review for the health plans contracted to implement HFS' Integrated Care Program, **Aetna** and **IlliniCare**. The primary objectives of HSAG's pre-implementation reviews were, prior to member enrollment in the new Integrated Care Program, to provide information that would allow HFS and the ICPs to assess access and availability of services, facilitate revisions to policies and procedures, and ensure compliance with federal managed care regulations and contract requirements specified in the May 1, 2011, *State of Illinois Department of Healthcare and Family Services Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization.* The purpose of the review was to determine the ICPs' capacity to participate in the new Illinois Medicaid program. The operational readiness review was designed to consist of four phases: pre-implementation activities, an on-site readiness review, post-readiness review activities, and post-implementation monitoring. During SFY 2011–2012, HSAG conducted the pre-implementation activities. The on-site and post-readiness review activities occurred in SFY 2012 (Phase 2).

Procedure

During SFY 2011–2012, HSAG conducted the on-site readiness review which was the second phase of the operational readiness reviews.

The Code of Federal Regulations (CFR) at 42 CFR 438.358 describes activities related to required external quality reviews of an MCO's compliance with state and federal standards related to access, structure and operations, and measurement and improvement. HFS contracted with HSAG, as its EQRO, to:

◆ Conduct a comprehensive pre-implementation readiness review for each of its Integrated Care Program ICPs.

◆ Identify the ICPs' compliance related to Access, Structure and Operations, and Measurement and Improvement standards and State contract requirements.

The primary objective of HSAG's readiness reviews was to evaluate implementation by the ICPs of their integrated care programs and readiness to provide services to aged, blind, and disabled (ABD) adults enrolled in Service Package I which covers all non-long-term care services and mental health and substance abuse services.

To complete the readiness review HSAG assembled a team to:

♦ Collaborate with HFS to determine the scope of the review and scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.

♦ Collect and review data and documents before and during the on-site review.

♦ Aggregate and analyze the data and information collected.

♦ Prepare a report of its findings.

To accomplish its objective, and based on the results of collaborative planning with HFS, HSAG developed a standardized data collection tool and processes to access and document each ICP's compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements. The readiness review tool included requirements that addressed the following operational areas:

Data Collection and Analysis

Throughout preparation for the post-implementation readiness review and performance of the activities during the on-site review, HSAG worked closely with HFS and the ICPs to ensure a coordinated and informed approach to completing the required activities.

HSAG also followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations* (42 CFR, Parts 400, 430, et al.).

HSAG's findings of the SFY 2012 readiness reviews were determined from its:

♦ Desk review of the documents submitted to HSAG prior to the on-site portion of the readiness review.

♦ On-site activities, which included reviewing additional documents and records, observing systems demonstrations, and interviewing key Human administrative and program staff members.

Based on the results from the comprehensive post-implementation readiness review tool and conclusions from the review activities, HSAG identified any elements that were assigned a score of *Partially Met* or *Not Met* and identified the corrective action the ICP needed to take to bring the requirement into compliance. HSAG also used the standardized monitoring tool to document follow-up on any elements that required corrective action.

ICP Plan-Specific Findings

Aetna Better Health

Table 5.4 presents a summary of **Aetna**'s readiness review results.

Table 5.4—Summary of Scores for the Standards

Standard #	Standard	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# NA	Total Compliance Score
Access Standards								
I	Availability of Services	12	12	10	2	0	0	83%
II	Assurance of Adequate Capacity and Services	23	23	18	4	1	0	78%
III	Coordination and Continuity of Care (Including Transition of Care)	39	38	32	6	0	1	84%
IV	Coverage and Authorization of Services	17	17	16	1	0	0	94%
Structure and Operations Standards								
V	Credentialing and Recredentialing	42	42	41	1	0	0	98%
VI	Subcontractual Relationships and Delegation	19	19	16	3	0	0	84%
VII	Enrollee Information/Enrollee Rights	26	26	23	3	0	0	88%
VIII	Confidentiality	2	2	1	1	0	0	50%
IX	Enrollment and Disenrollment	9	9	8	1	0	0	89%
X	Grievance Process	35	35	35	0	0	0	100%
Measurement and Improvement Standards								
XI	Practice Guidelines	6	6	4	2	0	0	67%
XII	Quality Assessment and Performance Improvement Program	31	26	26	0	0	5	100%
XIII	Health Information System	6	6	6	0	0	0	100%
Program Integrity Requirements								
XIV	Fraud and Abuse	8	8	5	3	0	0	63%
	Totals	**275**	**269**	**241**	**27**	**1**	**6**	**90%**

Access Standards

The Quality Management and Provider Service Departments monitored the availability of providers and accessibility of medical and behavioral health services. The Provider Services

Department is responsible for monitoring the provider network to ensure that a sufficient number and types of primary care providers/medical homes and specialty physicians, dentists, behavioral health (including substance abuse), home and community-based providers (during Service Packages II and III), and other ancillary services are available to meet members' medical and behavioral health needs. The Web-based provider directory contained a list of about 2,300 providers and identified provider office handicap accessibility as well as those providers willing to see members with developmental and physical disabilities. After reviewing the GeoAccess report dated July 15, 2011, and interviewing **Aetna** staff, it was identified that **Aetna** did not meet the 30-mile distance requirement in Kane County for specialists, including orthopedics, endocrinologists, oncologists, and otolaryngologists. **Aetna** is continuing to pursue contracts in Kane County with specialist providers as well as home health agencies, physical therapists, and hospice providers. **Aetna** will need to continue strengthening the provider network by contracting with additional specialty and subspecialty providers including optometrists, skilled nursing facility physicians (SNFists), as well as providers willing to provide services to homebound enrollees. The results of quarterly access monitoring were presented to the Quality Management Oversight Committee and the Board of Directors.

Aetna provided ongoing network capacity reports to HFS both before, during, and post implementation of the ICP program.

During the on-site readiness review, HSAG evaluated the implementation and effectiveness of the **Aetna** Medicaid Integrated Care Management (ICM) Program. The evaluation also included a review of 10 case management files to determine compliance with requirements for identification, risk-stratification, assessment, treatment planning, care coordination and communication with the members and providers, access to specialists, and overall Integrated Care Team (ICT) functions.

The **Aetna** Integrated Care Management Teams consisted of care coordinators who are licensed staff with medical and behavioral health experience, care management associates who have medical or behavioral health experience, provider representatives, and a community liaison.

The **Aetna** Medicaid ICM Program described that the purpose of the program was to identify the most vulnerable members who have complex or chronic clinical and/or social conditions, and assist them in using medical, behavioral, social, and community resources efficiently and effectively. **Aetna** identifies members who are in need of case management services through the use of a Health Risk Questionnaire as well as through utilization data, community referrals, and provider and/or practitioner referrals. Based on risk factors, members are stratified into the appropriate levels of care management. **Aetna**'s case managers use CaseTrakker for documenting case management services. The CaseTrakker software supports case management activities by storing enrollee assessments, claims data, authorizations, and treatment plans, as well as generating follow-up tasks for care coordinators. HSAG provided feedback on how the CaseTrakker software could be enhanced by customizing goals to more closely meet the specialized needs of

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individual enrollees, and establishing benchmarks to evaluate progress and health outcomes for enrollees receiving case management services.

Aetna demonstrated a new case management software program scheduled for implementation in December 2011. This system, Dynamo, contains modules including case finding tools, outreach questionnaires, clinical assessments, integrated care plans, correspondence, condition-specific assessments, member satisfaction surveys, audit tools, and reporting.

The findings of the review identified that the plan was compliant with most of the components of the ICM Program, including identification of at-risk members and assignment of stratification levels, involvement of the member, providers, and other practitioners in the development of the care plan, health assessments and care treatment planning, and coordination and communication with PCPs and other health systems. Areas identified for improvement included improved coordination of follow-up care with the PCP and other health care providers for members with chronic conditions. The ICP Program could also be strengthened to include the care coordination process for SNFist providers and care coordination activities with nursing facilities. Improving communication between case management and member services staff on the status of completion of the Health Risk Questionnaire (HRQ) will allow member services staff to identify enrollees at the point of contact who need referral for a health risk assessment.

HSAG also evaluated the ability of the plan to transition members from one care setting to another. A review of a randomly selected transition of care file identified compliance with the transition of care requirements. The Transition of Care (TOC) Advisory Council meeting minutes documented that the TOC Council met weekly, reviewed individual case issues, and identified and pursued resolution to transition of care concerns.

The Utilization Management (UM) Plan included policies and procedures to evaluate medical necessity, the criteria used, information sources, the process used to review and approve the provision of medical and behavioral health services, and the annual evaluation of program effectiveness. The Quality Management Oversight Committee (QMOC) provides executive oversight of the utilization activities. The QM/UM Committee provides utilization review and monitoring of utilization management activities. Daily oversight of the program is the responsibility of the chief medical officer.

Aetna used nationally recognized standards and practice guidelines when reviewing and making decisions regarding provider and member requests for services. The MCO used qualified staff to review and make authorization and denial of service decisions. Timely UM decisions were made, depending on the clinical urgency of the situation. Turnaround time for prior-authorization decisions was monitored and reported. The review findings showed that **Aetna** provided timely UM decisions on prior authorizations and had appeal procedures in place. A review of 10 denial

files found that all files were compliant with the processing, timeliness, and notification requirements.

The prior authorization policy and procedures will require revision to include the reason for the extension of the time frame for authorization decisions, and the right of the enrollee to file a grievance if he or she disagrees with the decision.

Structure and Operations Standards

Aetna had established policies and procedures that addressed provider selection, subcontractual relationships and delegation, enrollee information, confidentiality, enrollment and disenrollment, and grievance systems. The policies and procedures were generally compliant with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements for Structure and Operations standards.

Aetna maintains corporate accreditation as an NCQA credentials verification organization (CVO). The Enterprise Provider Database was demonstrated as the database used to track the credentialing and recredentialing process, including tracking the credentialing dates to assure recredentialing occurs at least every three years as determined by the provider's social security number. A review of 10 credentialing files identified full compliance with the credentialing requirements. A recredentialing file review was not conducted as the provider network has not been in place long enough to meet the recredentialing requirements review. **Aetna** had not reviewed the HFS-excluded provider Web page for identifying sanctioned providers; therefore. **Aetna** will need to incorporate this step into its formal monitoring process. As a result of the review, **Aetna** corrected this procedure to include checking the State's excluded provider listing when credentialing new providers.

Aetna has policies, procedures, and processes in place for monitoring the performance of its affiliated providers and subcontractors. **Aetna** also had mechanisms in place for quarterly, semiannual, and annual oversight and monitoring of its affiliated providers and subcontractors. **Aetna** monitored the performance of its delegated entities through a pre-delegation audit as well as ongoing monitoring and evaluation to determine whether the delegated activities were being carried out according to federal and HFS contract requirements. A review of three delegation oversight files identified compliance with the delegation requirements.

The **Aetna** Delegation Subcommittee Charter described the committee's responsibilities for conducting quarterly meetings to review delegation oversight activities; however, this committee had not initiated meetings at the time of the on-site review. In addition, the standard delegated contract did not contain language that subcontractors comply with **Aetna**'s Cultural Competency Plan. **Aetna** will also be required to ensure that its affiliated providers are advised of substantive changes to the grievances and appeals policies and procedures.

Aetna had mechanisms in place through the member and provider handbooks to distribute member rights and responsibilities to its members and providers as required. Member information was written in language that was readable and easy to understand and was available, as needed, in languages of the major populations served. Four findings were identified related to member rights and responsibilities. There was no evidence that **Aetna**'s policies contained reasons for enrollees to request voluntary disenrollment from the plan, or that the **Aetna** will provide the enrollee written notice of termination of a contracted provider. Additionally, there was no evidence that **Aetna**'s centralized database flagged or identified the special communication needs of all members (i.e., those with Limited English Proficiency [LEP], limited reading proficiency, visual impairment, or hearing impairment) and the provision of related services (i.e., MCO materials in alternate format, oral interpretation, oral translation services, written translations of MCO materials, and sign language services).

Aetna completed annual training of all staff, which included information regarding member rights and responsibilities. **Aetna** had policies, procedures, and processes in place to protect member privacy and confidentiality; however, **Aetna** was required to revise its policies and procedures to include handling and reporting requirements if there is a breach of confidentiality.

Aetna had an information system capable of integrating incoming enrollment and disenrollment data files, including all member demographic information. The new member packet contained information on how to contact the MCO if members needed to change their PCP. **Aetna** had policies and procedures governing changes in PCPs and disenrollment procedures; however, **Aetna** will need to revise its policies and procedures to include the requirement that the member may disenroll for cause as described in 42 CFR 438.56–(d).

Aetna had established policies and procedures for registering written or oral appeals that included documentation of the appeal, consent from the member if a provider was acting on his or her behalf, investigation, action taken, and notification of the disposition of the appeal within the required time frame. **Aetna** had a grievance system for members that included the registration of an oral or written grievance; acknowledgment, investigation, and notification of the disposition of the grievance within the required time frame; and a process to appeal the grievance decision and to access the State's fair hearing system. HSAG recommended increasing the frequency of oversight and monitoring of grievances from monthly to weekly during this early implementation phase of the integrated care program. More frequent oversight could assist **Aetna** with early identification and resolution of issues unique to the enrollees of this program.

Measurement and Improvement Standards

Aetna had established mechanisms for dissemination of practice guidelines to providers and upon request to consumers. **Aetna** had a process in place to annually evaluate provider adherence to the practice guidelines through review of medical records and utilization management reports. **Aetna**

will need to continue to develop, then adopt and implement, guidelines for all the conditions/services as required by contract. In addition, the Clinical Practice and Preventive Services Guidelines policy, QAPI program description and UM plan was revised to include an annual update of the practice guidelines as required by contract.

Aetna's QAPI Program Description described the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the Quality Improvement (QI) program, purpose of the program, goals and objectives, scope of activities, committee structures and reporting, and responsibilities of the quality management department. The committee structure demonstrated participation by the plan's physicians.

The QAPI Program Description defined the Member Advisory Council (MAC) as responsible for providing feedback to **Aetna** regarding strategies for improving member care and services, including health education and other member materials. In addition, the composition of the MAC was described as including members, caregivers, stakeholders, and community advocates. At the time of the on-site review, the MAC had not yet convened its first meeting. **Aetna** was required to update the QAPI Work Plan to reflect the post-implementation committee meetings schedule.

Aetna had a cultural competency plan in place designed to assist providers, staff, and subcontractors with integrating cultural and linguistic competence with health literacy into the health plan operations. The cultural competency plan was described as a guide to actions **Aetna** will implement to promote an understanding of and respect for the diverse cultural backgrounds, attitudes, and beliefs of its service population.

Aetna had a health information system in place that collected analyzed, integrated, and reported data on performance measures, utilization data, grievances and appeals, care management, credentialing, and enrollee characteristics. Plan data were housed in the QNXT system which was used for collecting and reporting information for medical claims processing, member/provider services, prior authorization, benefit/contract coding, and electronic data interchange (EDI) processing. QNXT is the primary data source for Case Trakker, **Aetna**'s care coordination software application. AboveHealth is **Aetna**'s Health Insurance Portability and Accountability Act (HIPAA)-compliant Web portal for enrollees and providers.

Program Integrity Requirements

The **Aetna** 2011 Compliance and Fraud Plan included the Waste, Fraud, and Abuse (WFA) Program, which described the prevention, detection, and reporting of fraud and abuse. A toll-free Fraud and Abuse Hotline was available to employees, members, business partners, and business providers. Annual training was conducted through an online learning module to maintain staff awareness of the need for detection and deterrence of fraud and abuse. The **Aetna** corporate compliance officer was identified as responsible for implementation of the Compliance and Fraud

Plan. Revision of the Compliance and Fraud Plan was necessary to include (1) the State quarterly certification and submission requirements, (2) reporting any suspected fraud, abuse, or misconduct to the Office of Inspector General (OIG) within three days after receiving such report, and (3) affiliated providers or subcontractors reporting suspected fraud, abuse, or misconduct shall immediately make a report to the MCO's liaison. In addition, the Compliance Committee Charter will require revision to reflect the meeting frequency (monthly) as required by contract, and **Aetna** was required to initiate the meeting schedule for the Compliance Committee to complete review and approval of the Compliance and Fraud Program and associated policies and procedures.

IlliniCare Health Plan

Table 5.5 presents a summary of **IlliniCare** readiness review results.

Table 5.5—Summary of Scores for the Standards

Standard #	Standard	Total # of Elements	Total # of Applicable Elements	# Met	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
Access Standards								
I	Availability of Services	12	12	10	2	0	0	83%
II	Assurance of Adequate Capacity and Services	19	19	9	8	2	0	47%
III	Coordination and Continuity of Care (Including Transition of Care)	46	45	35	8	2	1	78%
IV	Coverage and Authorization of Services	17	17	14	2	1	0	82%
Structure and Operations Standards								
V	Credentialing and Recredentialing	42	42	40	2	0	0	95%
VI	Subcontractual Relationships and Delegation	19	19	16	3	0	0	84%
VII	Enrollee Information/Enrollee Rights	26	26	24	2	0	0	92%
VIII	Confidentiality	2	2	1	1	0	0	50%
IX	Enrollment and Disenrollment	9	9	7	2	0	0	78%
X	Grievance Process	35	35	31	4	0	0	89%
Measurement and Improvement Standards								
XI	Practice Guidelines	6	6	4	2	0	0	67%
XII	Quality Assessment and Performance Improvement Program	31	25	19	6	0	6	76%
XIII	Health Information System	6	6	6	0	0	0	100%
Program Integrity Requirements								
XIV	Fraud and Abuse	8	8	7	1	0	0	88%
	Totals	**278**	**271**	**223**	**43**	**5**	**7**	**82%**

Access Standards

The Access standards are established by federal and state requirements to ensure the availability of and access to all covered services for Illinois Medicaid HFS managed care members. The readiness review standards included in this assessment were assessment of network adequacy and availability of services, coordination and continuity of care including transition of care, and coverage and authorization of services.

IlliniCare had established policies and procedures that addressed network adequacy and availability of services, coordination and continuity of care, and coverage and authorization of services that were generally compliant with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements for Access standards.

The Quality Improvement Committee (QIC) is responsible for oversight of the provider network. Provider availability is monitored by the Provider Relations Department and Network Management Department on an ongoing basis. Results are reviewed and recommendations are made to the QIC to address any deficiencies in the number and distribution of primary care and high-volume specialists. A Primary Care Provider Ratio Report is submitted to HFS each quarter as required. **IlliniCare** provided ongoing network capacity reports to HFS both before and after implementation of the ICP.

IlliniCare has developed network adequacy standards based on the requirements described in its contract with HFS, which states that enrollees shall not be required to travel more than 30 minutes or 30 miles to receive primary health care services in urban areas, or 60 minutes or 60 miles to receive primary health care services in rural areas. Review of the **IlliniCare** GeoAccess reports identified deficiencies in the provider network; however, it was difficult to determine actual deficiencies for the rural areas as the accessibility analysis was evaluated using the 30 miles/30 minutes urban requirement rather than the 60 miles/60 minutes requirement for rural counties. Based on this accessibility analysis, the following deficiencies in the **IlliniCare** provider network were identified: (1) less than one provider was located within 30 miles in Kankakee County for home health care, hospitals, and speech, occupational and physical therapy, and (2) less than one provider was located within 30 miles for hospitals and specialists such as allergy and immunology, gastroenterology, nephrology, neurology, infectious disease, and surgeries (cardiothoracic, neurosurgery, and orthopedic). **IlliniCare** should consider running the accessibility analysis using the requirement of 60 miles or 60 minutes for rural counties to evaluate the adequacy of the network based on established requirements. In addition, **IlliniCare** must include the homebound enrollees in the accessibility analysis.

IlliniCare should continue its efforts to expand the provider network to ensure there are sufficient providers such as hospitals, specialists, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), high-volume providers who are willing to embrace the medical home model, and providers willing to provide skilled nursing facility physicians (SNFist) services, to ensure member access to all covered services under the contract.

IlliniCare will need to revise its policies to reflect quarterly GeoAccess reporting, and notification of HFS of changes in the MCO's network that impact members' access to care. Access policies must also include the requirements that providers offer hours of operation that are the same as other payer types and that the MCO has a process to ensure provider compliance with cultural

competency requirements. In addition, **IlliniCare** must implement mechanisms to communicate the MCO's services offered to providers who support the medical home concept.

During the on-site readiness review, HSAG evaluated the implementation and effectiveness of the **IlliniCare** Medicaid Integrated Care Management (ICM) Program. The evaluation also included a review of 10 case management files to determine compliance with requirements for identification, risk-stratification, assessment, treatment planning, care coordination and communication with the members and providers, access to specialists, and overall Integrated Care Team (ICT) functions as well as the software used by the ICT staff for management of members in case and disease management programs.

IlliniCare had a Health Plan Care Coordination/Case Management Program Description in place which described the purpose and scope of the program, staffing, software, member satisfaction, outcome measurement, authority, and committee oversight.

The **IlliniCare** Integrated Care Teams (ICTs) consisted of care coordinators and social workers, care coordinators, MemberConnections staff, and health coaches. The social workers are licensed staff with medical and behavioral health experience; the care coordinators are nonclinical staff with experience in health care or health insurance settings whose primary role is to assist members with their care coordination needs. MemberConnections representatives are nonclinical staff who support the care coordinator with activities such as home visits to assist the member in completing health risk assessments or with understanding the benefits of their health plan, and evaluation of the home setting. In addition, transition coordinators are Illinois-licensed LPNs, social workers, or nonclinical staff responsible for assisting the ICT in identifying members in HCBS waiver programs and assisting in the transition of those members to the health plan. Finally the health coaches are health professionals who may or may not be licensed. The health coaches' responsibilities include providing telephonic or in-home disease management services to members, assessing clinical risk, readiness to change, and health literacy of members enrolled in the disease management program.

IlliniCare uses Impact Pro, an episode-based predictive modeling and care management analytics tool integrated with Centene's Oracle-based Enterprise Data Warehouse (EDW). EDW regularly updates Impact Pro with data such as member demographics (including age, gender, and diagnoses); clinical and behavioral health claims data; lab test results; and, if made available, pharmacy utilization data. Impact Pro contains algorithms from several different industry standard predictive modeling approaches. It can stratify members according to risk and provide member profiles showing historical diagnoses, care episodes, and service utilization. Impact Pro also provides patterns of utilization by members with specified conditions at risk of over- or underutilization, such as asthma, cardiovascular disease, and chronic neuromuscular conditions.

IlliniCare uses CaseNet's TruCare (TC) application, integrated with McKesson's InterQual clinical decision criteria, to perform functions related to medical necessity review, discharge planning, and case management. Member and provider data including demographics and eligibility information are passed from **IlliniCare**'s claims processing system into TruCare.

Assessments, case management plans, and all medical management interactions with the member are documented in TruCare, a clinical management system which facilitates automatic documentation of the individual user name, along with date and time notations for all entries. TruCare allows the ICT to generate reminder prompts for follow-up activities according to the timelines established in the care plan.

The findings of the review identified that the plan was compliant with most of the components of the ICM program, including identification of at-risk members and assignment of stratification levels, health assessments, and care treatment planning. Areas identified for improvement included ensuring that needs identified in the health risk assessment (HRA) are included and addressed in the enrollee care plan, establishing goals for moderate- and high-risk enrollees, ensuring member involvement and agreement with the care plan, ensuring PCP involvement in the care plan, and referring enrollees identified with chronic care conditions to the disease management program and/or having in place a chronic care management plan.

Additional findings included revisions to the Care Coordination/Case Management Program and associated policies and procedures to include the care coordination process with SNFist providers, nursing facilities, and MCO care coordination staff. Finally, **IlliniCare** must have written procedures in place to include provision of coordination of care for prospective enrollees upon request.

HSAG also evaluated the ability of the plan to transition members from one care setting to another. A review of four randomly selected transition of care files identified compliance with the transition of care requirements.

The **IlliniCare** Medical Management Department maintains a Utilization Management (UM) Program Description, which encompasses the functions of pre-authorization, concurrent review, retrospective review, and discharge planning. The UM Program incorporates preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care, and ancillary care services. The **IlliniCare** Board of Directors (BOD) oversees development, implementation, and evaluation of the UM Program. The **IlliniCare** BOD delegates the oversight and operating authority of the UM activities to the UM Committee (UMC), including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMC is responsible for reviewing all utilization management issues and related information and making recommendations to **IlliniCare**'s Quality Improvement Committee (QIC), which reports to the BOD. The **IlliniCare** medical director has operational

responsibility for and provides support to the UM Program. A behavioral health practitioner and a dentist is involved in the implementation, monitoring, and directing of behavioral health and dental aspects of the UM Program.

IlliniCare used nationally recognized standards and practice guidelines when reviewing and making decisions regarding provider and member requests for services. The MCO used qualified staff to review and make authorization and denial of service decisions. A review of nine denial files found that denial decisions were made by a qualified clinician. File review also identified that timely standard authorization decisions were made; however, one file identified that an expedited request was not completed within the required time frame for expedited denials.

IlliniCare notified reviewers that during an internal audit of denials, staff had identified that member notification letters were erroneously addressed to the provider. Staff reported that a corrective action was initiated and that monitoring was in place to assure that member and provider notification letters are addressed to the appropriate recipients. **IlliniCare** must continue its oversight and monitoring of the denial process.

Structure and Operations Standards

IlliniCare had established policies and procedures that addressed provider selection, subcontractual relationships and delegation, enrollee information, confidentiality, enrollment and disenrollment, and grievance systems. The policies and procedures were generally compliant with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements for Structure and Operations standards.

The Centene Corporate Credentialing and Recredentialing Program Description described the credentialing and recredentialing process for evaluating, retraining, and recommending competent practitioners for participation in the provider network. Providers must meet the minimum qualifications outlined by State and NCQA regulations. The Credentialing Committee is responsible for administering the credentialing program.

A review of 10 credentialing files identified full compliance with the credentialing requirements. A recredentialing file review was not conducted as the provider network had not been in place long enough to meet the recredentialing requirements review. **IlliniCare** had not reviewed the HFS-excluded provider Web page for identifying sanctioned providers; therefore, **IlliniCare** will need to incorporate this step into its formal monitoring process. In addition, credentialing policies should include the process for confirmation of languages spoken by network providers.

IlliniCare has policies, procedures, and processes in place for monitoring the performance of its affiliated providers and subcontractors. **IlliniCare** also had mechanisms in place for quarterly, semiannual, and annual oversight and monitoring of its affiliated providers and subcontractors. **IlliniCare** monitored the performance of its delegated entities through a pre-delegation audit as

well as ongoing monitoring and evaluation to determine whether the delegated activities were being carried out according to federal and HFS contract requirements. A review of three delegation oversight files identified compliance with the delegation requirements.

The **IlliniCare** Committee Charter described the Delegation Oversight Committee's responsibilities for conducting quarterly meetings to review delegation oversight activities; however, the requirements for quarterly delegation oversight audits, monthly joint operating meetings, and regular monitoring of member complaints were not included in policies or the QAPI Program Description. In addition, the standard delegated contract did not contain language that subcontractors comply with **IlliniCare**'s Cultural Competency Plan. **IlliniCare** will also be required to ensure that its affiliated providers are advised of substantive changes to the grievances and appeals policies and procedures.

All **IlliniCare** plan members received a welcome packet and member handbook upon enrollment into the plan. The handbook contained and described member rights and responsibilities and met the specific State-required reading level. Member rights and responsibilities could also be found on the Web site www.illinicare.com. Member information was written in language that was readable, easy to understand, and available, as needed, in languages of the major populations served. **IlliniCare** had policies and procedures in place for registering and responding to oral and written grievances, appeals, and State fair hearings.

Four findings were identified related to member rights and responsibilities. There was no evidence that **IlliniCare**'s policies contained reasons for enrollees to request voluntary disenrollment from the plan, or that **IlliniCare** will provide the enrollee written notice of termination of a contracted provider. Additionally, there was no evidence that **IlliniCare**'s centralized database flagged or identified the special communication needs of all members (i.e., those with Limited English Proficiency [LEP], limited reading proficiency, visual impairment, or hearing impairment) and the provision of related services (i.e., MCO materials in alternate format, oral interpretation, oral translation services, written translations of MCO materials, and sign language services). Information omitted from the member handbook included the member's right to obtain family planning services from a Medicaid provider in or out of the **IlliniCare** network.

IlliniCare completed annual training of all staff, which included information regarding member rights and responsibilities. **IlliniCare** had policies, procedures, and processes in place to protect member privacy and confidentiality; however, **IlliniCare** will need to revise its policies and procedures to include handling and reporting requirements if there is a breach of confidentiality.

IlliniCare had an information system capable of integrating incoming enrollment and disenrollment data files, including all member demographic information. The new member packet contained information on how to contact the MCO if members needed to change their PCP; however, the right for the member to request and receive basic information annually was not

included in the new member packet. **IlliniCare** had policies and procedures in place governing changes in PCPs and disenrollment procedures; however, **IlliniCare** will need to revise its policies and procedures to include the requirement that the member may disenroll for cause as described in 42 CFR 438.56–(d)(2)(ii) through (iv).

IlliniCare had established policies and procedures for registering written or oral appeals that included documentation of the appeal, consent from the member if a provider was acting on his or her behalf, investigation, action taken, and notification of the disposition of the appeal within the required time frame. **IlliniCare** had a grievance system in place for members that included the registration of an oral or written grievance; acknowledgment, investigation, and notification of the disposition of the grievance within the required time frame; and a process to appeal the grievance decision and to access the State's fair hearing system. The member handbook did not contain information on the time frame for acknowledging the receipt of a grievance or that formal grievances must be resolved by **IlliniCare** within 90 days of receipt of the grievance.

Review of three grievance files identified compliance with acknowledgement of the receipt of the grievances (either oral or written), appropriate individuals involved in decisions, timely resolution in two of three files, and written notification of the resolution.

Review of five standard appeal files identified compliance with acknowledgement of the receipt of the appeal and timely written resolution of the appeal. Review of the files identified no documented written consent of the member when the appeal was submitted by a provider on behalf of the member. The review of one expedited appeal file included written notification of the expedited resolution; however, there was no evidence of efforts to provide verbal notice to the member as required.

Measurement and Improvement Standards

IlliniCare had established policies and procedures that addressed the Quality Assessment and Performance Improvement (QAPI) Program and health information systems compliant with federal Medicaid managed care regulations, State rules, and the associated Illinois contract requirements for QAPI Program standards.

IlliniCare had a process in place to annually evaluate provider adherence to the practice guidelines through review of the treatment rendered to members for a specific condition or diagnosis and/or review of practitioner records to evaluate compliance with the guidelines. Guidelines were being disseminated to providers through the new practitioner orientation materials, provider newsletters, and provider Website; and to members through the member handbook, member newsletters, and special educational mailings. Review of existing guidelines identified that **IlliniCare** will need to continue to develop, then adopt and implement, guidelines for all the conditions/services as required by contract. In addition, the Preventive Health and

Clinical Practice Guidelines policy should include provisions to annually update the practice guidelines as required by contract.

IlliniCare Better Health's QAPI Program Description described the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the Quality Improvement (QI) program, purpose of the program, goals and objectives, scope of activities, committee structures and reporting, and responsibilities of the quality management department. The committee structure demonstrated participation by the plan's physicians.

The **IlliniCare** Board of Directors (BOD) has the ultimate authority and accountability for quality of care and services provided to members. The BOD oversees development, implementation, and evaluation of the QAPI Program. The BOD approves the annual QAPI Program Description and QI Work Plan. The BOD monitors the program's effectiveness through review of committee meeting minutes and discussion of the annual program evaluation.

The Quality Improvement Committee (QIC) is **IlliniCare**'s senior-level committee accountable directly to the BOD. The purpose of the QIC is to promote a system-wide approach to QI, and to provide oversight and direction in assessing the availability, access, and appropriateness of care and services delivered and to continuously enhance and improve the quality of care and services provided to members.

Review of the associated QAPI Program policies and procedures identified that the policies and/or program description did not include provisions for including the member satisfaction analysis in the annual QA/UR/PR report, methods for monitoring provider compliance with the cultural competency plan, quarterly meeting frequency of the Member Advisory Committee, and State access to peer review files if requested. In addition, **IlliniCare** will need to implement a process to ensure providers are informed and trained on the signs of suspected abuse and neglect and how to report alleged abuse or neglect.

IlliniCare had a health information system in place that collected, analyzed, integrated, and reported data on performance measures, utilization data, grievances and appeals, care management, credentialing, and enrollee characteristics.

IlliniCare's Management Information System (MIS) uses an Oracle-based Enterprise Data Warehouse (EDW) that allows for the collection, integration, and reporting of clinical claim/encounter data (medical, laboratory, pharmacy, behavioral health, dental, and vision as included in **IlliniCare** benefits); financial information; medical management information (referrals, authorizations, case management, disease management); member services information (current and historical eligibility, demographics, primary care provider, member outreach); and provider information (participation status, specialty, demographics) as required by **IlliniCare**'s QAPI Program and other contractual requirements.

IlliniCare uses AMISYS, a claims payment system with built-in dataset structures that maintain a history of claims, members, providers, authorizations, and many other transactions.

IlliniCare uses Quality Spectrum Insight (QSI) a Catalyst Technologies/MedAssurant Solution, to support performance measurement and QI reporting. QSI is an NCQA-certified software system that produces results for HEDIS, state-specific measures, pay-for-performance measures, internally designed QI studies, and provider reporting studies. QSI enables **IlliniCare** to integrate claim, member, and provider data into a single repository. Additionally, the QSI database provides an integrated clinical and financial view of care delivery which allows **IlliniCare** to identify cost drivers and manage variances in its efforts to improve performance. The QSI server and database is maintained internally at the corporate level; and data are updated at least monthly by using an interface that extracts claims, member, provider, and financial data and maps these data to the QSI preferred data format. QSI also allows for import of external data such as immunization registry, lab value, vision, or dental encounter data.

Program Integrity Requirements

The **IlliniCare** Waste, Abuse, and Fraud (WAF) Program Description described the prevention, detection, and reporting of fraud and abuse. A toll-free Fraud and Abuse Hotline was available to employees, members, business partners, and business providers. Centene's Special Investigations Unit (SIU) had oversight of the WAF program. Annual training was being completed in conjunction with Centene's yearly ethics and compliance training. Review of the program policies and procedures identified that the State's quarterly submission and certification requirements were not included in the policies.

Validation of Performance Measures—HEDIS Compliance Audit—SFY 2011–2012

Objectives

This section describes the evaluation of the MCOs' ability to collect and accurately report on the performance measures. HEDIS performance measures are a nationally recognized set of performance measures developed by NCQA. Health care purchasers use these measures to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.

A key element of improving health care services is the ability to provide easily understood, comparable information on the performance of the MCOs. Systematically measuring performance provides a common language based on numeric values and allows the establishment of benchmarks, or points of reference, for performance. Performance measure results allow the MCO to make informed judgments about the effectiveness of existing processes and procedures, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives.

The Department requires the MCOs to monitor and evaluate the quality of care through the use of HEDIS and Department-defined performance measures. The MCOs must establish methods by which to determine if the administrative data are accurate for each measure. In addition, the MCOs are required by contract to track and monitor each performance measure and applicable performance goal on an ongoing basis, and to implement a quality improvement initiative addressing compliance until the MCOs meet the performance goal.

NCQA licenses organizations and certifies selected employees of licensed organizations to conduct performance measure audits using NCQA's standardized audit methodology. The NCQA HEDIS® Compliance Audit indicates the extent to which MCOs have adequate and sound capabilities for processing medical, member, and provider information for accurate and automated performance measurement, including HEDIS reporting. The validation addresses the technical aspects of producing HEDIS data, including:

- Information practices and control procedures

- Sampling methods and procedures

- Data integrity

- ◆ Compliance with HEDIS specifications

- ◆ Analytic file production

Technical Methods of Data Collection and Analysis

The Department required that an NCQA-licensed audit organization conduct an independent audit of each MCO's measurement year (MY) 2011 data. The State contracted with HSAG to audit **FHN**, **Harmony**, and **Meridian**. The audits were conducted in a manner consistent with the 2011 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. The audit incorporated two main components:

- ◆ A detailed assessment of the MCO's IS capabilities for collecting, analyzing, and reporting HEDIS information.

- ◆ A review of the specific reporting methods used for HEDIS measures, including computer programming and query logic used to access and manipulate data and to calculate measures; databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; and any manual processes employed for 2011 HEDIS data production and reporting. The audit extends to include any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

For each MCO, a specific set of performance measures was selected. This selection was based on factors such as Department-required measures, a full year of data, previously audited measures, and past performance. The measures selected for validation through the HEDIS compliance audits were the following:

- ◆ *Childhood Immunization Status*

- ◆ *Well-Child Visits in the First 15 Months of Life (0 Visits and 6 or More Visits)*

- ◆ *Prenatal and Postpartum Care*

The MCOs also reported on other HEDIS measures that were not validated during the audit, although the processes for collecting and calculating each measure were validated. The rates for these HEDIS measures are included in this report and consist of the following performance measures:

- ◆ *Lead Screening in Children*

- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*

- ◆ *Adolescent Well-Care Visits*

- ◆ *Immunizations for Adolescents (Combined Rate)*

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- *Children's and Adolescents' Access to Primary Care Practitioners (PCPs)*

- *Adults' Access to Preventive/Ambulatory Care*

- *Breast Cancer Screening*

- *Cervical Cancer Screening*

- *Chlamydia Screening in Women*

- *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*

- *Controlling High Blood Pressure*

- *Comprehensive Diabetes Care*

- *Use of Appropriate Medications for People With Asthma*

- *Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)*

HSAG used a number of different methods and information sources to conduct the audits, including:

- Teleconference calls with MCO personnel and vendor representatives, as necessary.

- Detailed review of each MCO's completed responses to the HEDIS Record of Administration, Data Management and Processes (HEDIS Roadmap) published by NCQA as Appendix 2 to HEDIS Volume 5, and updated information communicated by NCQA to the audit team directly.

- On-site meetings in the MCOs' offices, including: staff interviews, live system and procedure documentation, documentation review and requests for additional information, primary HEDIS data source verification, programming logic review and inspection of dated job logs, computer database and file structure review, and discussion and feedback sessions.

- Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.

- If the hybrid method was used, abstraction of a sample of medical records selected by the auditors, with a comparison of the results to the MCO's review determinations for the same records.

- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.

- Accuracy checks of the final HEDIS rates completed by the MCO.

- Interviews of a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, IS director, quality management director, enrollment and provider data manager, medical records

staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that provided or processed HEDIS 2012 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

Each of the audited measures reviewed by the audit team received a final audit result consistent with the NCQA categories listed below. Table 6.1 provides the audit finding results that are applicable to the HEDIS measures.

Table 6.1—HEDIS Measure Audit Findings

Rate/Result	Comment
0–XXX	Reportable rate or numeric result for HEDIS measures.
NR	Not Reported: 1. Plan chose not to report 2. Calculated rate was materially biased 3. Plan not required to report
NA	Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate
NB	No Benefit: The organization did not offer the health benefits required by the measure (e.g., mental health or chemical dependency)

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage.

For some measures, more than one rate is required for HEDIS reporting (for example, *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*). It is possible that the MCO prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the MCO would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive an "NR" result in the Interactive Data Submission System (IDSS), where appropriate.

Upon completion of the audit, HSAG prepared a final audit report for the MCOs that included a completed and signed final audit statement. The reports were forwarded to the Department for review.

For the discussions that follow regarding conclusions drawn from the data for each MCO, full compliance is defined as the lack of any findings that would significantly bias HEDIS reporting by more than 5 percentage points. Additionally, when discussing rates for *Well-Child Visits in the First 15 Months of Life,* assessments are made for *0 Visits* and *6 or More Visits*, as those measures are most indicative of the range of quality of health care. *Frequency of Ongoing Prenatal Care* is also assessed using the two categories of *0–21 Percent of Visits* and *81–100 Percent of Visits*.

To validate the medical record review (MRR) portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the MCO, including staff qualifications, training, data collection instruments/tools, interrater reliability (IRR) testing, and the method used for combining MRR data with administrative data; and (2) abstract and compare the audit team's results to the MCO's abstraction results for a selection of hybrid measures.

HSAG's audit team reviewed the processes in place at each MCO for performance of MRR for all measures reported using the hybrid method. The audit team reviewed data collection tools and training materials to verify that all key HEDIS data elements were captured. Feedback was provided to each MCO's staff if the data collection tools appeared to be missing necessary data elements.

HSAG's audit team also performed a re-abstraction of records selected for MRRs and compared the results to each MCO's findings for the same medical records. This process completed the medical record validation process and provided an assessment of actual reviewer accuracy. HSAG reviewed up to 30 records identified by each MCO as meeting numerator event requirements (determined through MRR) for measures selected for audit and MRR validation. Records were randomly selected from the entire population of MRR numerator positives identified by the MCO, as indicated on the MRR numerator listings submitted to the audit team. If fewer than 30 medical records were found to meet numerator requirements, all records were reviewed. Reported discrepancies only included "critical errors," defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa).

For each of the selected measures where the hybrid methodology was used, auditors determined the impact of the findings from the validation process on the MCO's audit designation. The goal of the MRR validation was to determine whether the MCO made abstraction errors that significantly biased its final reported rate. HSAG used the standardized protocol developed by NCQA to validate the integrity of the MRR processes of audited MCOs. The NCQA-endorsed *t*-test was employed to test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If the test revealed that the difference was greater than 5 percent, the MCO's estimate of the positive rate was rejected and the measure could not be reported using the hybrid methodology.

Plan Specific Findings

Family Health Network

The Medicaid HEDIS 2012 rates for **FHN** and the National Medicaid 2011 HEDIS 50th percentiles are presented below (Table 6.2). As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile. The measures highlighted in green are the incentive measures.

Table 6.2—FHN HEDIS 2012 Rates

	FHN Rates for HEDIS 2012	2011 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	72.0	75.1
Childhood Immunizations—Combo 3	69.9	71.0
Lead Screening in Children	82.9	72.2
Well-Child Visits in the First 15 Months (0 Visits)*	2.3	1.6
Well-Child Visits in the First 15 Months (6+ Visits)	50.1	61.3
Well-Child Visits (3–6 Years)	73.0	72.3
Adolescent Well-Care Visits	44.1	46.1
Immunizations for Adolescents**	44.8	49.8
Children's Access to PCPs (12–24 Months)	91.8	97.0
Children's Access to PCPs (25 Months–6 Years)	77.2	89.6
Children's Access to PCPs (7–11 Years)	53.1	91.3
Adolescent's Access to PCPs (12–19 Years)	54.6	89.7
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	69.2	83.2
45–64 Years of Age	74.1	87.4
Preventive Screening for Women		
Breast Cancer Screening	48.9	52.4
Cervical Cancer Screening	71.5	69.7
Chlamydia Screening (16–20 Years of Age)	59.0	53.6
Chlamydia Screening (21–24 Years of Age)	68.1	62.5
Chlamydia Screening (Combined Rate)	63.4	57.2

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	FHN Rates for HEDIS 2012	2011 HEDIS 50th Percentiles
Maternity-Related Measures		
Frequency of Ongoing Prenatal Care (<21% of Visits)*	15.9	7.7
Frequency of Ongoing Prenatal Care (81–100% of Visits)	43.0	64.4
Timeliness of Prenatal Care	69.8	86.0
Postpartum Care	45.0	64.6
Chronic Conditions/Disease Management		
Controlling High Blood Pressure	43.4	56.4
Diabetes Care (HbA1C Testing)	79.5	82.2
Diabetes Care (Poor HbA1c Control)*	63.6	42.6
Diabetes Care (Good HbA1c Control)	36.4	47.4
Diabetes Care (Eye Exam)	44.7	52.8
Diabetes Care (LDL-C Screening)	69.6	75.4
Diabetes Care (LDL-C Level <100 mg/dL)	27.7	35.2
Diabetes Care (Nephropathy Monitoring)	85.8	78.5
Diabetes Care (BP < 140/80)**	30.8	38.5
Diabetes Care (BP < 140/90)	52.6	61.2
Appropriate Medications for Asthma (Combined)	88.1	88.9
Follow-up After Hospitalization for Mental Illness—7 Days	69.2	45.1
Follow-up After Hospitalization for Mental Illness—30 Days	80.5	66.6

* Lower rates indicate better performance for these measures.
** This is a new or changed HEDIS measure; therefore, no benchmarks are available.

FHN had nine measures with rates that exceeded the 2011 HEDIS Medicaid 50th percentiles, including two measures in the Child and Adolescent Care category, four in the Preventive Screening for Women, and three measures in the Chronic Conditions/Disease Management category. Only two of the nine measures were incentive measures.

FHN performed the lowest compared to the 50th percentiles on measures related to maternity care and access to care, where none of the measures exceeded the 50th percentiles.

Encounter Data Completeness for FHN

Table 6.3 provides an estimate of the data completeness for **FHN**'s hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last column

indicates that the encounter data were complete for that HEDIS measure. Rates highlighted in red indicate a 50.0 percent or less encounter data completion rate.

Table 6.3—FHN Estimated Encounter Data Completeness for Hybrid Measures

Performance Measures	Final HEDIS 2012 Rate	Percent from Administrative Data
Childhood Immunizations—Combo 2	72.0	**6.4**
Childhood Immunizations—Combo 3	69.9	**6.0**
Lead Screening in Children	82.9	77.1
Well-Child Visits in the First 15 Months (6+ Visits)	50.1	**48.8**
Well-Child Visits (3–6 Years)	73.0	84.8
Adolescent Well-Care Visits	44.1	83.8
Immunizations for Adolescents (Combined Rate)	44.8	66.5
Cervical Cancer Screening	71.5	80.4
Frequency of Ongoing Prenatal Care (81–100%)	43.0	52.2
Timeliness of Prenatal Care	69.8	**34.1**
Postpartum Care	45.0	**28.2**
Diabetes Care (HbA1c Testing)	79.5	**8.5**
Diabetes Care (Good HbA1c Control)	36.4	**0.0**
Diabetes Care (Eye Exam)	44.7	62.8
Diabetes Care (LDL-C Screening)	69.6	**12.5**
Diabetes Care (LDL-C Level <100 mg/Dl)	27.7	**0.0**
Diabetes Care (Nephropathy Monitoring)	85.8	**34.6**

Overall, the results show that **FHN** has difficulty receiving all of its encounter data, although it has improved since 2011. Ten measures had less than a 50.0 percent encounter data completeness rate (compared to 12 measures in 2011). Seven of the HEDIS measures had more than a 50.0 percent encounter data completeness rate, but none of the measures had a data completion rate at or above 90.0 percent.

FHN continues to demonstrate difficulty in obtaining complete encounter data for childhood immunizations, timeliness of prenatal care, postpartum care, and the lab-related measures for diabetes care.

Compliance Audit Results for FHN

The HEDIS 2012 compliance audit indicated that **FHN** was in compliance with the *HEDIS 2012 Technical Specifications* (Table 6.4). Membership data supported all necessary HEDIS calculations, medical data were partially compliant with the audit standards, and measure calculations resulted

in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 6.4—FHN 2012 HEDIS Compliance Audit Results

Main Information Systems			Selected 2012 HEDIS Measures
Membership Data	**Medical Data**	**Measure Calculation**	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Partially Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

FHN was compliant with IS 1.0 for medical services data. **FHN** did not implement the system conversion as expected in 2011, but it will go live with using QNXT in April 2012. For calendar year 2011, claims and encounters were processed following the same method used in previous reporting years. Edit and validation checks for claims and encounters were sufficient. **FHN** saw an increase in claims and encounter data submission over the year due to the increase in membership, but it did not experience any delays in processing data. **FHN** continued its efforts to increase encounter data submission. **FHN** was instructed that the transition to QNXT would be the focus of the audit 2012 and that documentation should be included with the Roadmap submission showing how the implementation occurred and how issues were handled. **FHN** continued to have strong incentive programs targeted to many of the key HEDIS measures, including W15, CIS, and PPC. Since providers were given incentives to submit complete and accurate encounters, it was recommended that **FHN** complete an analysis of the data found during hybrid abstraction compared to encounter submissions, and determine the amount of money that providers could have received through the incentive program if all encounters had been submitted. This information could be an incentive to providers moving forward. **FHN** also provided each PHO a packet of information specific to its performance on all reported HEDIS measures.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

FHN was compliant with IS 2.0 for the processing of enrollment data standards. **FHN**'s processes for receiving, loading, and validating eligibility files from the State have not changed. **FHN** continued to see an increase in its Medicaid population, from 53,822 members at the end of 2010 to 69,256 members at the end of 2011. This large increase was due to **FHN**'s efforts to grow

its business and expand into additional markets. Enrollment data were received daily and monthly from Automated Health Systems (AHS), the State's enrollment broker. These data were processed, validated, and disseminated to the PHOs. Reconciliations were performed between the full roster file and the payment files to ensure the counts matched. There were no backlogs or delays with receiving enrollment data during the measurement year. The current enrollment database, Grandpa, will be retired as **FHN** converts to QNXT in 2012, but it will be archived and loaded into the data warehouse for historical reference. Enrollment files from the previous 18 months will be loaded into QNXT.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

FHN was fully compliant with IS 3.0 for practitioner data. **FHN** added providers to its network during 2011 to meet the growing demands of its population. The increase in providers did not cause any backlogs or delays in processing provider applications and information. For the measurement year, all provider data resided in the Access database but will be migrated to QNXT when it goes live later in 2012. **FHN** continued to work with the State on resolving the NPI and State provider ID issues to ensure that all data for providers were linked and matched. For the measures under the scope of this audit, **FHN** was able to identify rendering provider type. **FHN** will continue its efforts to ensure complete NPI data are submitted as QNXT goes live, and it will ensure rendering providers are always identified on submitted claims via QNXT edits.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

FHN was fully compliant with the IS 4.0 reporting requirements. Medical record pursuit and data collection were conducted by health plan staff using internally developed data abstraction tools. The tools contain all necessary edits to ensure consistent data collection practices. The data abstraction tools and corresponding instructions were reviewed and approved by HSAG. Reviewer qualifications, training, and oversight were appropriate. **FHN** passed the over-read requirements (Table 6.5) for the following two measures: *Timeliness of Prenatal Care* and *Childhood Immunization Status—Combo 3*.

Table 6.5—FHN Selected HEDIS 2012 Measures for Medical Record Validation

Measure	Product Line	Number of Records	*T*-test	Pass/Fail
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Medicaid	30	NA	**Pass**
Childhood Immunization Status—Combo 3	Medicaid	30	NA	**Pass**

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IS 5.0—Supplemental Data—Capture, Transfer, and Entry

FHN was compliant with IS 5.0 for supplemental data files. **FHN** used several sources of supplemental data for HEDIS reporting. This was the first year that **FHN** received QUEST lab data results for its members. While the impact was minimal to the measures under the scope of the audit, there could be lab results for the *Prenatal and Postpartum Care (PPC)* measure to identify the pregnant women. The processes in place to receive the data were discussed and met the requirements for external, standard supplemental data. **FHN** was instructed to complete Section 5 for these data in next year's Roadmap. **FHN** continued to use Cornerstone and HealthKids immunization data from the State; these data were received in standard formats. **FHN** was instructed to include Roadmap sections for these data sources next year as well. A few additional sources of supplemental data were discussed during the audit. **FHN** should develop a timeline for integrating supplemental data sources for HEDIS reporting in order to avoid future HEDIS reporting delays.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data were not applicable under the scope of the audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

FHN was substantially compliant with IS 7.0 for data integration. **FHN** continued to write its own source code for HEDIS reporting. All source code for the measures being reported (CIS, W15, and PPC) was approved. Primary source verification was performed on all three measures, and no issues were identified. **FHN** had adequate security and back-up procedures in place to ensure all data were secure and at minimal risk for loss. **FHN** encountered delays with reporting final HEDIS rates due to the conversion to QNXT in April 2012. Since data were not being reported to NCQA, an extension was given to report rates. **FHN** also had delays and challenges receiving and integrating State supplemental data. Moving forward, these should be scheduled and monitored or **FHN** could be at risk for not being able to include these data sources for reporting.

FHN Trended Results

Table 6.6 provides the results of **FHN**'s trended performance measures. Only HEDIS measures reported for at least the last two years are included in the table. The last column denotes the difference in the rates between the HEDIS 2008 rate, or the baseline rate, and HEDIS 2012 results. The measures highlighted in green are the incentive measures.

Table 6.6—FHN Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Family Health Network					Difference From Baseline
	2008	**2009**	**2010**	**2011**	**2012**	
Child and Adolescent Care						
Childhood Immunizations—Combo 2	68.9	72.0	75.5	75.7	72.0	3.1
Childhood Immunizations—Combo 3	53.0	65.8	69.7	70.4	69.9	16.9
Lead Screening in Children	70.4	69.5	82.2	81.9	82.9	12.5
*Well-Child Visits in the First 15 Months (0 Visits)**	10.0	7.7	5.1	3.5	2.3	-7.7
Well-Child Visits in the First 15 Months (6+ Visits)	29.0	43.5	48.4	53.8	50.1	21.1
Well-Child Visits (3–6 Years)	68.4	74.8	79.2	67.4	73.0	4.6
Adolescent Well-Care Visits	32.2	36.9	45.7	43.9	44.1	11.9
*Immunizations for Adolescents***	NA**	NA**	18.2	40.5	44.8	26.6
Children's Access to PCPs (12–24 Months)	77.3	81.8	84.1	82.2	91.8	14.5
Children's Access to PCPs (25 Months–6 Years)	65.2	68.9	70.6	69.9	77.2	12.0
Children's Access to PCPs (7–11 Years)	52.4	49.5	47.8	51.1	53.1	0.7
Adolescent's Access to PCPs (12–19 Years)	48.4	49.9	46.7	53.0	54.6	6.2
Adults' Access to Preventive/Ambulatory Care						
20–44 Years of Age	56.6	59.4	65.4	64.6	69.2	12.6
45–64 Years of Age	48.6	58.8	69.9	67.4	74.1	25.5
Preventive Screening for Women						
Breast Cancer Screening	27.8	33.9	44.9	47.7	48.9	21.1
Cervical Cancer Screening	68.0	55.4	63.9	69.4	71.5	3.5
Chlamydia Screening (16–20 Years of Age)	47.7	53.6	55.4	62.5	59.0	11.3
Chlamydia Screening (21–24 Years of Age)	47.7	53.8	57.5	70.7	68.1	20.4
Chlamydia Screening (Combined Rate)	47.7	53.7	56.4	66.3	63.4	15.7
Maternity-Related Measures						
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	29.4	39.3	16.9	18.2	15.9	-13.5
Frequency of Ongoing Prenatal Care (81–100% of Visits)	33.4	25.6	26.1	42.3	43.0	9.6
Timeliness of Prenatal Care	45.4	49.4	49.2	62.4	69.8	24.4
Postpartum Care	32.3	32.9	39.3	40.2	45.0	12.7
Chronic Conditions/Disease Management						
Controlling High Blood Pressure	45.3	54.6	27.0	45.6	43.4	-1.9
Diabetes Care (HbA1C Testing)	68.5	66.9	77.6	79.2	79.5	11.0
*Diabetes Care (Poor HbA1c Control)**	56.5	65.5	69.1	69.9	63.6	7.1
Diabetes Care (Good HbA1c Control)	12.0	27.0	30.9	31.7	36.4	24.4

HEDIS Measures	HEDIS Rates for Family Health Network					Difference From Baseline
	2008	2009	2010	2011	2012	
Diabetes Care (Eye Exam)	22.8	24.3	25.0	31.7	44.7	21.9
Diabetes Care (LDL-C Screening)	56.5	60.8	69.1	68.9	69.6	13.1
Diabetes Care (LDL-C Level <100 mg/dL)	15.2	19.6	27.0	29.5	27.7	12.5
Diabetes Care (Nephropathy Monitoring)	57.6	79.7	85.5	84.7	85.8	28.2
Diabetes Care (BP < 140/80)**	NA	NA	NA	NA	30.8	NA
Diabetes Care (BP < 140/90)	51.1	45.3	40.8	54.6	52.6	1.5
Appropriate Medications for Asthma (Combined)	79.3	85.0	93.0	90.3	88.1	8.8
Follow-up After Hospitalization for Mental Illness—7 Days	56.4	64.2	66.9	70.9	69.2	12.8
Follow-up After Hospitalization for Mental Illness—30 Days	67.9	76.5	79.8	80.2	80.5	12.6

* Lower rates indicate better performance for these measures.
** This is a new or changed HEDIS measure; therefore, no benchmarks are available.

The results show that 33 of the 35 trended measures improved since HEDIS 2008 (or the baseline rate), and 24 measures improved by more than 10.0 percentage points, including nine measures that improved by more than 20.0 percentage points.

Rates for two of the 35 measures declined. The rate for *Comprehensive Diabetes Care (Poor HbA1c Control)* has increased 7.1 percentage points since 2008. For this measure, a lower rate indicates better performance, and the 7.1 percentage point increase represents a continuing trend for this measure. The other measure with a rate decline was *Controlling High Blood Pressure*, which had an insignificant decline of 1.9 percentage points compared to HEDIS 2008. Nevertheless, the lack of improvement with this rate, along with the very low improvement in rate for the *Comprehensive Diabetes Care (BP<140/90)* measure, indicates a need to focus on improving blood pressure rates for **FHN**'s population.

Harmony Health Plan of Illinois, Inc.

The Medicaid HEDIS 2012 rates for **Harmony** and the national Medicaid 2011 HEDIS 50th percentiles are presented in Table 6.7. As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile. The measures highlighted in green are the incentive measures.

Table 6.7—Harmony health Plan HEDIS 2012 Rates

	Harmony Rates for HEDIS 2012	2011 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	68.9	75.1
Childhood Immunizations—Combo 3	64.0	71.0
Lead Screening in Children	79.1	72.2
Well-Child Visits in the First 15 Months (0 Visits)*	4.6	1.6
Well-Child Visits in the First 15 Months (6+ Visits)	51.3	61.3
Well-Child Visits (3–6 Years)	65.2	72.3
Adolescent Well-Care Visits	35.5	46.1
Immunizations for Adolescents**	38.7	49.8
Children's Access to PCPs (12–24 Months)	88.8	97.0
Children's Access to PCPs (25 Months–6 Years)	74.2	89.6
Children's Access to PCPs (7–11 Years)	71.0	91.3
Adolescent's Access to PCPs (12–19 Years)	72.3	89.7
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	70.8	83.2
45–64 Years of Age	71.3	87.4
Preventive Screening for Women		
Breast Cancer Screening	34.4	52.4
Cervical Cancer Screening	71.5	69.7
Chlamydia Screening (16–20 Years of Age)	50.1	53.6
Chlamydia Screening (21–24 Years of Age)	59.7	62.5
Chlamydia Screening (Combined Rate)	54.0	57.2
Maternity-Related Measures		
Frequency of Ongoing Prenatal Care (<21% of Visits)*	14.8	7.7
Frequency of Ongoing Prenatal Care (81–100% of Visits)	42.1	64.4
Timeliness of Prenatal Care	64.7	86.0
Postpartum Care	49.6	64.6

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	Harmony Rates for HEDIS 2012	2011 HEDIS 50th Percentiles
Chronic Conditions/Disease Management		
Controlling High Blood Pressure	37.2	56.4
Diabetes Care (HbA1C Testing)	71.1	82.2
Diabetes Care (Poor HbA1c Control)*	62.5	42.6
Diabetes Care (Good HbA1c Control)	29.4	47.4
Diabetes Care (Eye Exam)	27.5	52.8
Diabetes Care (LDL-C Screening)	59.9	75.4
Diabetes Care (LDL-C Level <100 mg/dL)	22.4	35.2
Diabetes Care (Nephropathy Monitoring)	67.6	78.5
Diabetes Care (BP < 140/80)**	31.1	38.5
Diabetes Care (BP < 140/90)	48.7	61.2
Appropriate Medications for Asthma (Combined)	79.9	88.9
Follow-up After Hospitalization for Mental Illness—7 Days	41.8	45.1
Follow-up After Hospitalization for Mental Illness—30 Days	57.1	66.6
* Lower rates indicate better performance for these measures. ** This is a new or changed HEDIS measure; therefore, no benchmarks are available.		

Harmony reported two measures with rates at or above the Medicaid 2011 HEDIS 50th percentiles: *Lead Screening in Children* and *Cervical Cancer Screening (CCS)*. The CCS measure was also an incentive measure.

Compared to the 50th percentiles, **Harmony** generally performed the lowest on maternity-related measures, diabetes care measures, and access measures.

Encounter Data Completeness for Harmony

Table 6.8 provides an estimate of the data completeness for **Harmony**'s hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last columns indicates that the encounter data were complete for that HEDIS measure. Rates highlighted in green indicate a 90.0 percent or more encounter data completion rate, while rates highlighted in red indicate a 50.0 percent or less encounter data completion rate.

Table 6.8–Harmony Estimated Encounter Data Completeness for Hybrid Measures

Performance Measures	Final HEDIS 2012 Rate	Percent from Administrative Data
Childhood Immunizations—Combo 2	68.9	78.3
Childhood Immunizations—Combo 3	64.0	69.6
Lead Screening in Children	79.1	**96.3**
Well-Child Visits in the First 15 Months (6+ Visits)	51.3	79.6
Well-Child Visits (3–6 Years)	65.2	**92.5**
Adolescent Well-Care Visits	35.5	**91.8**
Immunizations for Adolescents (Combined Rate)	38.7	83.0
Cervical Cancer Screening	71.5	**95.9**
Frequency of Ongoing Prenatal Care (81–100%)	42.1	82.1
Timeliness of Prenatal Care	64.7	54.5
Postpartum Care	49.6	67.6
Diabetes Care (HbA1c Testing)	71.1	**92.8**
Diabetes Care (Good HbA1c Control)	29.4	**22.3**
Diabetes Care (Eye Exam)	27.5	**90.3**
Diabetes Care (LDL-C Screening)	59.9	**90.2**
Diabetes Care (LDL-C Level <100 mg/Dl)	22.4	**37.0**
Diabetes Care (Nephropathy Monitoring)	67.6	**95.3**

The rates indicate **Harmony** has reasonably good encounter data completeness. Eight measures had more than a 90.0 percent data completion rate, two were above 80.0 percent, two were above 70.0 percent, and two measures were above 60.0 percent. However, two measures had data completeness rates less than 50.0 percent. Both were lab-related *Comprehensive Diabetes Care* measures. **Harmony** should concentrate its efforts toward obtaining complete lab data.

Compliance Audit Results for Harmony

The HEDIS 2012 compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2012 Technical Specifications* (Table 6.9). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 6.9—Harmony HEDIS 2012 Compliance Audit Results

Main Information Systems			Selected 2012 HEDIS Measures
Membership Data	**Medical Data**	**Measure Calculation**	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

Harmony was fully compliant with IS 1.0. Edit checks were appropriately employed throughout the claims and encounter systems. Industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) were used and all characters were captured; non-standard coding schemes were not employed at the time of the onsite visit. **Harmony** used standard submission forms and was able to capture all fields relevant to HEDIS reporting. There were no proprietary forms used to capture data, and electronic transmission procedures conformed to industry standards. **Harmony** met all data entry standards, and its processes were timely and accurate. Processes included sufficient edit checks to ensure accurate entry of submitted data in **Harmony**'s transaction files for HEDIS reporting. **Harmony** regularly monitored this vendor's performance against expected performance standards.

In prior years, **Harmony** had several provider groups that were submitting claims via flat files. For HEDIS 2011, this was reduced to only one provider group. This provider group began submitting through Emdeon, the clearinghouse vendor for encounters, during 2011. By mid-2011, **Harmony** had no providers who were submitting claims in non-standard formats. In 2011, all claims were submitted 100 percent electronically, which was a best practice. The auditor had no issues with **Harmony**'s capabilities to process claims accurately, completely, and within reasonable time frames.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

Harmony was fully compliant with IS 2.0 for enrollment data. There were no concerns with the processing of enrollment files received from the state. Monthly files were received and loaded into **Harmony**'s data system. Processing of membership information complied with standards. There were sufficient edits checks in place to ensure files loaded did not contain errors. Enrollment files were reconciled monthly against the capitation file as an additional validation check to ensure that all eligible members were being captured for service and payment. **Harmony** had no issues with

membership data during 2011. There were no backlogs of applications since the State provided the eligibility files. There were minimal retroactive enrollments during the year.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

Harmony was fully compliant with IS 3.0 for practitioner data. **Harmony** used Peradigm software to produce its provider directory. The Peradigm system was continuously reconciled against Visual Cactus, the credentialing system, to ensure data was synchronized and complete. Specialties and sub-specialties were accounted for in both systems. During the site visit, specialty mapping for nurse practitioners and physician assistants was reviewed, and no issues were found. No other significant changes to any specialty were noted. The auditor ensured there were sufficient provider identifiers in place to appropriately monitor and count providers.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

Harmony was fully compliant with IS 4.0 for the medical record review process. **Harmony** used CRMS NCQA-certified software. Medical record pursuit was conducted by **Harmony** staff and forwarded to the medical record review vendor, Outcomes Health, for abstraction. Medical record data were collected into the Outcomes hybrid tools. The Outcomes hybrid tools and corresponding instructions were reviewed and approved by HSAG. Reviewer qualifications, training, IRR process, and vendor oversight were appropriate. Due to changes in the medical record review process, a convenience sample was required and subsequently passed. **Harmony** passed the over-read requirement (Table 6.10) for the following measures: *Childhood Immunization Status—Combo 3*, *Timeliness of Prenatal Care* and *Postpartum Care*, and *Well-Child Visits in the First 15 Months of Life (6+ Visits)*. Four measures were over-read due to the small number of hybrid positives.

Table 6.10—Harmony Selected HEDIS 2012 Measures for Medical Record Validation

HEDIS Measure	Product Line	Number of Records	*T*-test	Pass/Fail
Well-Child Visits in the First 15 Months of Life (6+ Visits)	Medicaid	7	NA	**Pass**
Childhood Immunization Status—Combo 3	Medicaid	30	NA	**Pass**
Prenatal and Postpartum Care	Medicaid	15	NA	**Pass**

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

Harmony was fully compliant with IS 5.0 for supplemental data. **Harmony** used three supplemental data sources for reporting its Medicaid measures. One was non-standard while the other two were standard external data sources. No issues were identified during the measurement year. During the load process to the data warehouse, edit checks ensured that members in the

registry were actual members of the health plan. The edit checks also determined if standard codes were being submitted. In 2011, the data sources provided significant numerator positive hits for inclusion in the final rates. Primary source verification completed on-site indicated that several of the numerators were from the **Harmony** Kids, Cornerstone or Pseudo-claims data sources.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data were not applicable to the scope of the audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Harmony was fully compliant with IS 7.0 for data integration. **Harmony** consolidated data from several different data sources and platforms. **Harmony** maintained sufficient processes to integrate these data sources for HEDIS reporting. **Harmony** used CRMS, an NCQA-certified software provided through McKesson, to report its HEDIS measures. **Harmony** provided sufficient documentation ensuring that appropriate fields were mapped. Initial rates were available from McKesson and reviewed on-site. The preliminary rates appeared to be in sync with the previous year's data. There did not appear to be any outliers at the time of the on-site visit. The audit team conducted primary source verification on several members for each measure to ensure the software was working and to determine if the source records matched the target records. All primary source data verification was found to be compliant.

Harmony Trended Results

Table 6.11 provides the results of **Harmony**'s trended performance measures. Only HEDIS measures reported for at least the last two years are included. The last column denotes the difference in the rates between the HEDIS 2008 rate, or the baseline rate, and HEDIS 2011 results. The measures highlighted in green are the incentive measures.

Table 6.11—Harmony Health Plan Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Harmony Health Plan					Difference From Baseline
	2008	2009	2010	2011	2012	
Child and Adolescent Care						
Childhood Immunizations—Combo 2	53.8	62.5	67.4	65.9	68.9	15.1
Childhood Immunizations—Combo 3	42.8	51.6	60.6	61.6	64.0	21.2
Lead Screening in Children	65.9	69.8	74.7	78.1	79.1	13.2
Well-Child Visits in the First 15 Months (0 Visits)*	9.2	4.6	4.1	5.4	4.6	-4.6
Well-Child Visits in the First 15 Months (6+ Visits)	21.7	40.4	45.7	51.3	51.3	29.6
Well-Child Visits (3–6 Years)	57.4	65.9	69.8	71.8	65.2	7.8
Adolescent Well-Care Visits	37.7	37.7	37.2	38.9	35.5	-2.2

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HEDIS Measures	HEDIS Rates for Harmony Health Plan					Difference From Baseline
	2008	2009	2010	2011	2012	
Immunizations for Adolescents**	NA**	NA**	23.4	29.9	38.7	15.3
Children's Access to PCPs (12–24 Months)	82.5	83.3	82.2	86.5	88.8	6.3
Children's Access to PCPs (25 Months–6 Years)	65.7	70.1	73.1	73.3	74.2	8.5
Children's Access to PCPs (7–11 Years)	60.7	61.6	69.3	70.5	71.0	10.3
Adolescent's Access to PCPs (12–19 Years)	58.7	60.8	68.6	71.4	72.3	13.6
Adults' Access to Preventive/Ambulatory Care						
20–44 Years of Age	57.5	66.3	67.3	69.3	70.8	13.3
45–64 Years of Age	54.6	63.3	67.6	68.8	71.3	16.7
Preventive Screening for Women						
Breast Cancer Screening	35.5	32.5	31.5	30.7	34.4	-1.1
Cervical Cancer Screening	59.1	62.0	69.3	69.8	71.5	12.4
Chlamydia Screening (16–20 Years of Age)	45.1	44.5	45.6	46.1	50.1	5.0
Chlamydia Screening (21–24 Years of Age)	53.3	54.8	56.2	57.2	59.7	6.4
Chlamydia Screening (Combined Rate)	49.3	48.8	49.9	50.9	54.0	4.7
Maternity-Related Measures						
Frequency of Ongoing Prenatal Care (<21% of Visits)*	21.9	27.0	17.8	16.5	14.8	-7.1
Frequency of Ongoing Prenatal Care (81–100% of Visits)	31.4	33.6	39.4	39.9	42.1	10.7
Timeliness of Prenatal Care	56.4	56.4	65.2	64.7	64.7	8.3
Postpartum Care	35.0	40.1	49.6	48.7	49.6	14.6
Chronic Conditions/Disease Management						
Controlling High Blood Pressure	34.3	39.7	43.3	42.6	37.2	2.9
Diabetes Care (HbA1C Testing)	57.7	68.1	67.0	69.6	71.1	13.4
Diabetes Care (Poor HbA1c Control)*	72.7	67.3	64.2	65.9	62.5	-10.2
Diabetes Care (Good HbA1c Control)	15.6	24.6	28.8	29.4	29.4	13.8
Diabetes Care (Eye Exam)	9.0	13.3	15.0	18.2	27.5	18.5
Diabetes Care (LDL-C Screening)	52.3	58.0	58.2	63.7	59.9	7.6
Diabetes Care (LDL-C Level <100 mg/dL)	12.4	17.7	18.6	17.5	22.4	10.0
Diabetes Care (Nephropathy Monitoring)	59.9	69.9	68.4	67.4	67.6	7.7
Diabetes Care (BP < 140/80)**	NA	NA	NA	NA	31.1	NA
Diabetes Care (BP < 140/90)	45.0	54.0	51.3	49.6	48.7	3.7
Appropriate Medications for Asthma (Combined)	84.1	86.6	86.5	86.0	79.9	-4.2
Follow-up After Hospitalization for Mental Illness—7 Days	20.0	43.2	49.2	42.7	41.8	21.8
Follow-up After Hospitalization for Mental Illness—30 Days	32.3	55.6	58.7	56.1	57.1	24.8

* Lower rates indicate better performance for these measures.
** This is a new or changed HEDIS measure; therefore, no benchmarks are available.

The results show that 32 of the 35 trended measures improved since HEDIS 2008 or the baseline rate, and the rates for 19 measures improved by 10.0 or more percentage points. Four rates improved by more than 20.0 percentage points: *Childhood Immunization Status—Combo 3, Well-Child Visits in the First 15 Months of Life (6+ Visits), and Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days).*

Three rates have shown small declines of less than 5 percentage points; *Adolescent Well-Care Visits, Breast Cancer Screening in Women,* and *Use of Appropriate Medications for People with Asthma (Combined)* declined 2.2, 1.1, and 4.2 percentage points, respectively. Nevertheless, the lack of improvement in these rates and the fact that they tend to be low compared to national percentiles indicates a need for **Harmony** to explore the barriers to improving the rates for these measures.

Meridian Health Plan, Inc.

Due to **Meridian**'s low population size, **Meridian** did not have more than 30 eligible members for many of the reported HEDIS 2012 measures, and trending rates across years was not possible. In accordance with NCQA requirements, the rates for these measures are not applicable (NA). Since the enrollment for **Meridian** was expected to still be low for 2012, the audited measures required for **Meridian** consisted of the following measures:

- *Children's and Adolescents' Access to Primary Care Practitioners (PCPs)*
- *Adults' Access to Preventive/Ambulatory Care*
- *Prenatal and Postpartum Care*

The Medicaid HEDIS 2012 rates for **Meridian** and the National Medicaid 2011 HEDIS 50th percentiles are presented below (Table 6.12). As a visual aid for quick reference, rates highlighted in yellow indicate the rates that were at or above the 50th percentile. The measures highlighted in green are the incentive measures.

Table 6.12—Meridian Health Plan HEDIS 2012 Rates

	Meridian Rates for HEDIS 2012	2011 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	87.0	75.1
Childhood Immunizations—Combo 3	83.3	71.0
Lead Screening in Children	92.2	72.2
Well-Child Visits in the First 15 Months (0 Visits)*	0.0	1.6
Well-Child Visits in the First 15 Months (6+ Visits)	82.0	61.3
Well-Child Visits (3–6 Years)	84.9	72.3
Adolescent Well-Care Visits	66.7	46.1
Immunizations for Adolescents**	NA	49.8
Children's Access to PCPs (12 - 24 Months)	100.0	97.0
Children's Access to PCPs (25 Months–6 Years)	92.1	89.6
Children's Access to PCPs (7 – 11 Years)	81.3	91.3
Adolescent's Access to PCPs (12–19 Years)	90.0	89.7
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	89.1	83.2
45–64 Years of Age	91.1	87.4

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	Meridian Rates for HEDIS 2012	2011 HEDIS 50th Percentiles
Preventive Screening for Women		
Breast Cancer Screening**	NA	52.4
Cervical Cancer Screening	84.4	69.7
Chlamydia Screening (16–20 Years of Age)**	NA	53.6
Chlamydia Screening (21–24 Years of Age)	67.4	62.5
Chlamydia Screening (Combined Rate)	60.8	57.2
Maternity-Related Measures		
Frequency of Ongoing Prenatal Care (<21% of Visits)*	1.4	7.7
Frequency of Ongoing Prenatal Care (81–100% of Visits)	94.5	64.4
Timeliness of Prenatal Care	93.9	86.0
Postpartum Care	76.2	64.6
Chronic Conditions/Disease Management**		
Controlling High Blood Pressure	NA	56.4
Diabetes Care (HbA1C Testing)	NA	82.2
Diabetes Care (Poor HbA1c Control)*	NA	42.6
Diabetes Care (Good HbA1c Control)	NA	47.4
Diabetes Care (Eye Exam)	NA	52.8
Diabetes Care (LDL-C Screening)	NA	75.4
Diabetes Care (LDL-C Level <100 mg/dL)	NA	35.2
Diabetes Care (Nephropathy Monitoring)	NA	78.5
Diabetes Care (BP < 140/80)	NA	38.5
Diabetes Care (BP < 140/90)	NA	61.2
Appropriate Medications for Asthma (Combined)	NA	88.9
Follow-up After Hospitalization for Mental Illness—7 Days	NA	45.1
Follow-up After Hospitalization for Mental Illness—30 Days	NA	66.6
* Lower rates indicate better performance for these measures. ** Meridian Health Plan had fewer than 30 eligible cases, and these rates are reported as NA.		

Meridian reported 19 out of 20 measures with rates at or above the Medicaid 2011 HEDIS 50th percentiles. For an additional 16 measures, NA was recorded for the rate since **Meridian** had fewer than 30 eligible cases for those measures. Only *Children's Access to PCPs (7–11 Years)*, at 81.3 percent, was below the HEDIS 2011 Medicaid 50th percentile.

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Encounter Data Completeness for Meridian

Meridian reported all measures using the administrative method. Therefore, an encounter data completeness comparison (between medical record data versus administrative data) was not applicable and was not provided in this report.

Compliance Audit Results for Meridian

The HEDIS 2012 compliance audit indicated that **Meridian** was in full compliance with the *HEDIS 2012 Technical Specifications* (Table 6.13). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 6.13—Meridian HEDIS 2012 Compliance Audit Results

Main Information Systems			Selected 2012 HEDIS Measures
Membership Data	**Medical Data**	**Measure Calculation**	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

Meridian was fully compliant with I.S. Standard 1.0 for medical services data. No issues were identified with the claims processing system. **Meridian** used optical character recognition (OCR) technology for paper claims that were submitted directly to the plan. A process called vertexing allowed the organization to pend claims for manual inspection, ensuring certain fields were validated prior to adjudication. Additionally, 5 percent of each claim was audited daily by an internal claims inspector. **Meridian**'s internal system was very sophisticated and could easily toggle from electronic claims to scanned claims as seen through demonstrations during the on-site visit. **Meridian** was able to produce primary source documents effortlessly when the auditor requested them.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

Meridian was compliant with I.S. Standard 2.0 for enrollment data. No issues were identified with enrollment data. **Meridian** had sufficient processes in place to ensure enrollment data were

complete and accurate. The State submitted a file weekly with recent updates, changes, and additions. The organization reviewed the membership data received from the State against their internal MCS system. Updates, changes, or additions from the State file were then reconciled in MCS, with the State file taking precedence over any previously submitted information in MCS. This process was followed weekly and monthly. **Meridian** also did a weekly and monthly match for duplicates. A review of the duplicated processes on-site showed sufficient evidence that the plan did not maintain multiple identification numbers for the same member. **Meridian** ensured that a member was not entered into the system until it received confirmation from the State that the member was assigned to them. This process was considered to be a best practice as it eliminates confusion and unnecessary rework to the membership files.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

Meridian was fully compliant with IS 3.0 for practitioner data. No issues were identified with the practitioner data systems during the on-site visit. As in previous years, **Meridian** was able to distinguish provider types and specialties required for HEDIS reporting. All providers were paid on a fee-for service (FFS) basis, so data completeness was not an issue. The credentialing system demonstration and the primary source verification proved to be flawless. The provider records reviewed during the on-site audit were well organized and contained the appropriate primary source documents. This continued to be a best practice among health care organizations.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

Meridian reported all the measures under the scope of the audit via the administrative methodology; therefore, no medical record review was required.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

Meridian was fully compliant with IS 5.0 for supplemental data. No issues were encountered during the review of supplemental data. **Meridian** used supplemental data for all measures under review this year. The auditor randomly selected five records for each measure to determine accuracy in the reporting system. Each record reviewed passed inspection without errors.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data were not applicable to the scope of this audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Meridian was fully compliant with IS 7.0 for data integration, with no issues identified. **Meridian** had excellent processes in place to ensure data were accurate, could be reproduced, and were

backed up nightly, weekly, and monthly. A walkthrough of the systems area provided evidence that **Meridian** was sufficiently equipped for disaster recovery and that access to the system was limited. All source code was reviewed and approved, and no issues were identified with the final reported rates. Primary source verification was performed on all measures, and no issues were found.

Meridian Trended Results

Table 6.14 below provides the results of **Meridian**'s trended performance measures. Only HEDIS measures reported for both HEDIS 2011 and HEDIS 2012 are included in the table. In addition, the denominators for each measure are provided under the rate. The last column denotes the difference in the two rates. The measures highlighted in green are the incentive measures.

Table 6.14—Meridian Health Plan Trended HEDIS Rates

HEDIS Measures	HEDIS Rates for Meridian Health Plan		Difference From Baseline
	2011	**2012**	
Child and Adolescent Care			
Children's Access to PCPs (12–24 Months)	100.0 (N=78)	100.0 (N=118)	0.0
Children's Access to PCPs (25 Months–6 Years)	92.1 (N=101)	92.1 (N=239)	0.0
Adults' Access to Preventive/Ambulatory Care			
20–44 Years of Age	90.5 (N=148)	89.1 (N=313)	-1.4
Maternity-Related Measures			
Timeliness of Prenatal Care	98.2 (N=55)	93.9 (N=147)	-4.3
Postpartum Care	85.5 (N=55)	76.2 (N=147)	-9.3

Both of the rates for *Children's Access to PCPs* had identical rates for HEDIS 2011 and HEDIS 2012. *Children's Access to PCPs (12–24 Months)* was at 100 percent for both years, while *Children's Access to PCPs (25 months to 6 years)* was at 92.1 percent.

Adults' Access to Preventive/Ambulatory Care (20–44 years) had a very slight decline of 1.4 percentage points, given that the population for this measure more than doubled.

The rates for the two maternity-related measures declined. However, the HEDIS 2011 rates were based on 55 cases, while the HEDIS 2012 rates are based on 147 eligible cases. These different population sizes allow for greater variability within the rates. **Meridian** expects the eligible population to increase significantly for HEDIS 2013, and it will be important for **Meridian** to monitor these rates as their population increases.

Plan Comparisons and Recommendations

This section of the report compares the performance measure results for **FHN**, **Harmony**, and **Meridian** based on the HEDIS 2012 measures listed in Table 6.15. The measures have been classified into related categories for discussion purposes.

Table 6.15—Classification of HEDIS 2012 Measures

Category	HEDIS 2012 Measure
Child and Adolescent Care	*Childhood Immunization Status (Combinations 2 and 3)*
	Lead Screening in Children
	Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
	Adolescent Well-Care Visits
	Immunizations for Adolescents (Combined Rate)
Access to Care	*Children's and Adolescents' Access to Primary Care Practitioners*
	Adults' Access to Preventive/Ambulatory Care
Maternity-Related Care	*Frequency of Ongoing Prenatal Care (0–21 Percent and 81–100 Percent of Visits)*
	Timeliness of Prenatal Care
	Postpartum Care
Preventative Screening for Women	*Breast Cancer Screening*
	Cervical Cancer Screening
	Chlamydia Screening in Women (Combined Rate)
Chronic Conditions/Disease Management	*Controlling High Blood Pressure (Combined Rate)*
	Comprehensive Diabetes Care
	Use of Appropriate Medications for People With Asthma (Combined Rate)
	Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day)

Due to **Meridian**'s low population size for most measures, comparisons to **FHN** and **Harmony** were not applicable. **Meridian** was, however, included in the graphs for the reported measures whenever the denominator was greater than or equal to 30 eligible cases. However, comparisons should be used cautiously due to the small denominators.

Child and Adolescent Care

This section addresses HEDIS measures regarding care for children and adolescents. The HEDIS measures were *Childhood Immunization Status; Lead Screening in Children; Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life; Adolescent Well-Care Visits; and Immunizations for Adolescents.*

Childhood Immunization Status

Figure 6.1 displays comparative rates for *Childhood Immunizations—Combination 2* (i.e., diphtheria, tetanus toxoids, and acellular pertussis/diphtheria-tetanus toxoid [DTaP/DT]; inactivated poliovirus vaccine [IPV]; measles-mumps-rubella [MMR]; Haemophilus influenzae type b [HIB]; hepatitis B [Hep B]; and varicella-zoster virus [VZV]) for the past five years.

FHN's rate of 72.0 percent represented a decline of 3.7 percentage points from 2011. Overall, **FHN** has shown a small increase in the rate since HEDIS 2008. **Harmony**'s rate increased 3.0 percentage points over 2011 and overall has increased 15.1 percentage points since HEDIS 2008. Trending for both **FHN** and **Harmony** shows rates have remained about the same since HEDIS 2010.

The rate for **Meridian**, at 87.0 percent, was well above the 50th percentile of 75.1 percent. However, this rate was based on 54 eligible cases.

**Figure 6.1—Comparison of HFS MCO Performance
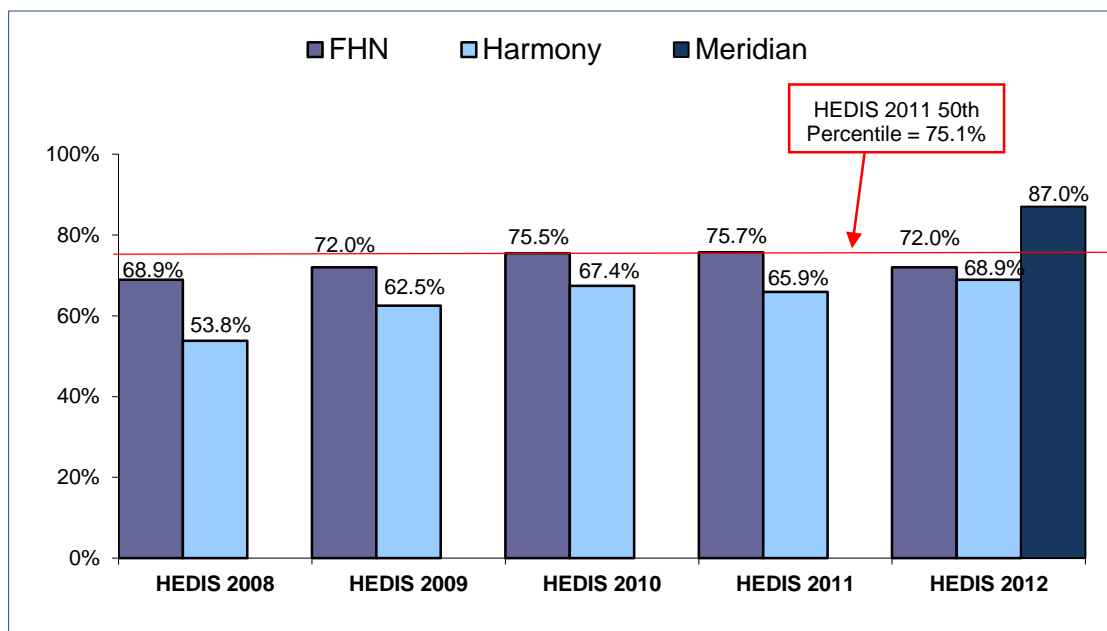for *Childhood Immunizations—Combination 2***

Figure 6.2 displays comparative rates for *Childhood Immunizations—Combination 3* (i.e., DTaP/DT, IPV, MMR, HIB, Hep B, VZV, and pneumococcal conjugate vaccine [PCV]).

FHN's rate of 69.9 percent was 1.1 percentage points below the 50th percentile, and represented a small decline of 0.5 percentage points from 2011. Overall, **FHN** has shown a 16.9 percentage point increase in the rate since HEDIS 2008. **Harmony**'s rate increased 2.4 percentage points over 2011 and overall has increased 21.2 percentage points since HEDIS 2008. The rate for **Meridian**, at 83.3 percent, was well above the 50th percentile of 71.0 percent. Again, this rate was based on 54 eligible cases.

**Figure 6.2—Comparison of HFS MCO Performance
for *Childhood Immunizations—Combination 3***
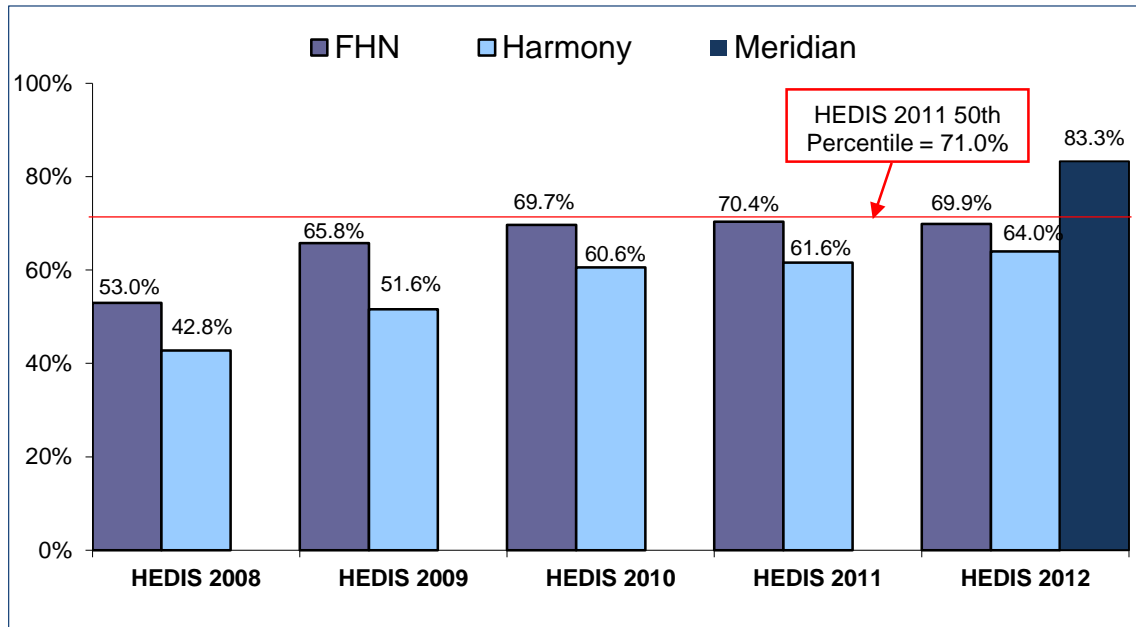
Lead Screening in Children

Figure 6.3 presents the comparative performance of the MCOs for *Lead Screening in Children*. This became a new HEDIS measure in 2008.

Both **FHN** and **Harmony** have continued to demonstrate good results for this measure. Overall, the rate has improved 12.5 percentage points for **FHN** and 13.2 percentage points for **Harmony** since HEDIS 2008. The rate for **Meridian** was the highest, at 92.2 percent, but **Meridian** had a much smaller population with only 77 eligible cases. Nevertheless, the rates for all three MCOs exceeded the National Medicaid HEDIS 2011 50th percentile of 72.2 percent.

**Figure 6.3—Comparison of HFS MCO Performance
for *Lead Screening in Children***
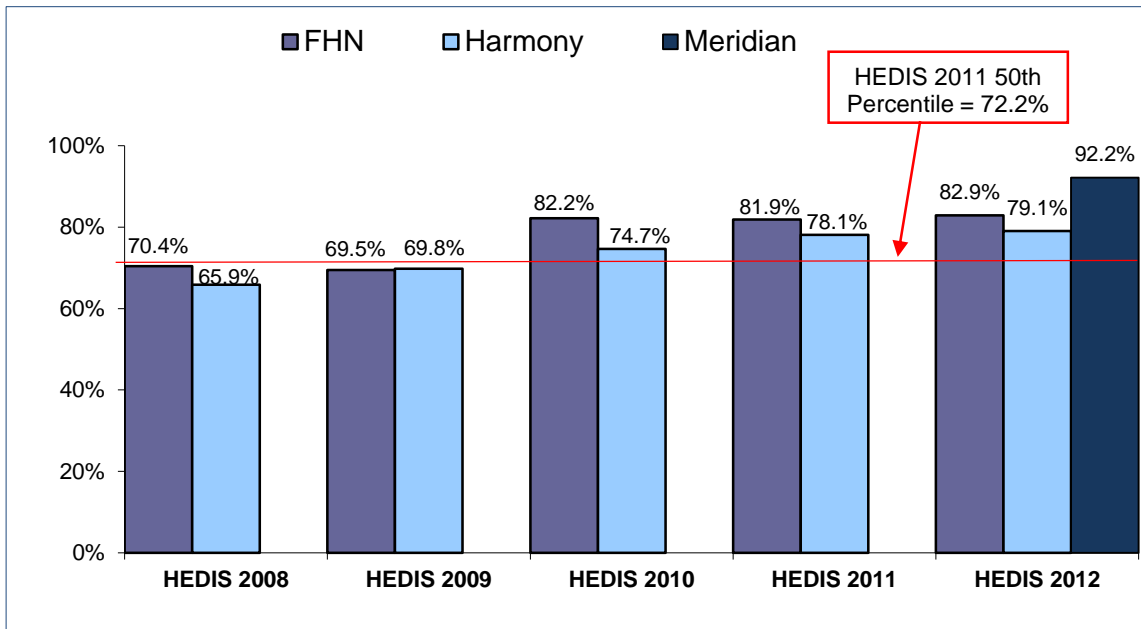
Well-Child Visits in the First 15 Months of Life

Figure 6.4 presents the comparative performance of the MCOs for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*.

Since HEDIS 2008, **FHN**'s rate has improved by 21.1 percentage points, while **Harmony**'s rate has improved by 29.6 percentage points. The rates for both **FHN** and **Harmony** are below the National Medicaid HEDIS 2011 50th percentile of 61.3 percent.

Meridian's eligible population consisted of 50 members. **Meridian** reported a rate of 82.0 percent, which was well above the 50th percentile.

**Figure 6.4—Comparison of HFS MCO Performance
for *Well-Child Visits During the First 15 Months of Life—Six or More Visits***
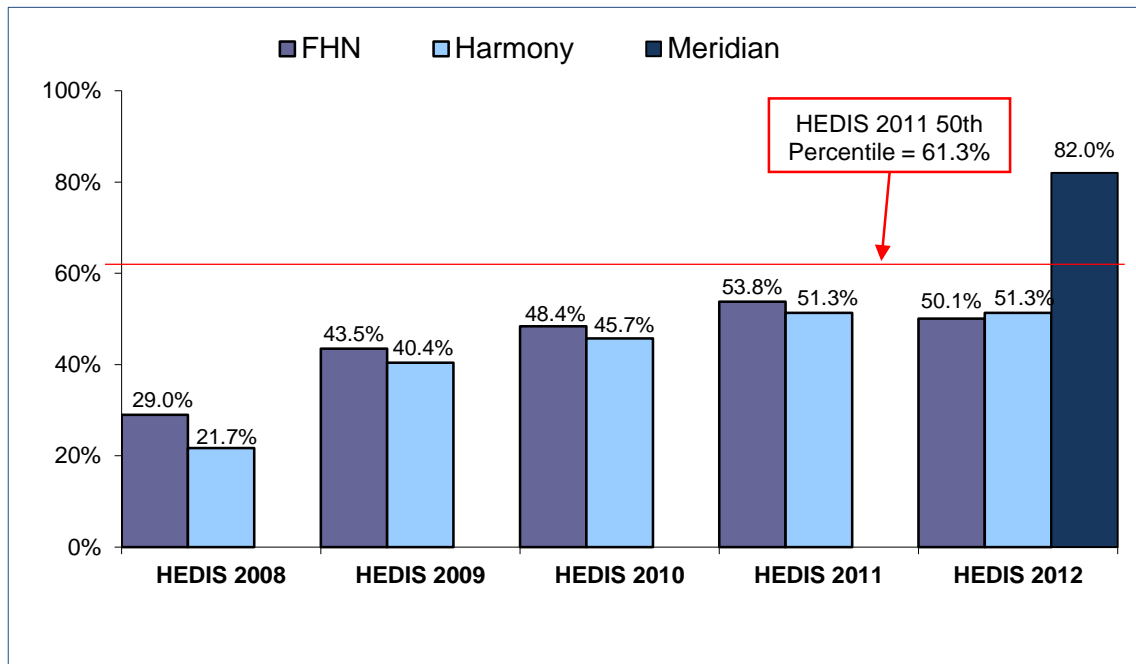
For the *Zero Visits* numerator, lower rates indicate better performance. The results indicate approximately 95.0 percent of the eligible children enrolled in **FHN** or **Harmony** received at least one well-child visit in their first 15 months of life. **FHN** has continued to improve on this measure each year since HEDIS 2008, going from 10.0 percent to a low of 2.3 percent for 2012. Overall, **Harmony**'s rate has improved since HEDIS 2008. However, since HEDIS 2009, **Harmony**'s rate has remained about the same, with slight increases or decreases each year.

For **Meridian,** there were 50 eligible cases for this measure. All 50 members had at least one well-child visit; therefore, **Meridian**'s rate was 0.0 percent. Although this rate is based on a low eligible population, it represents the best possible rate.

**Figure 6.5—Comparison of HFS MCO Performance
for *Well-Child Visits During the First 15 Months of Life—Zero Visits***
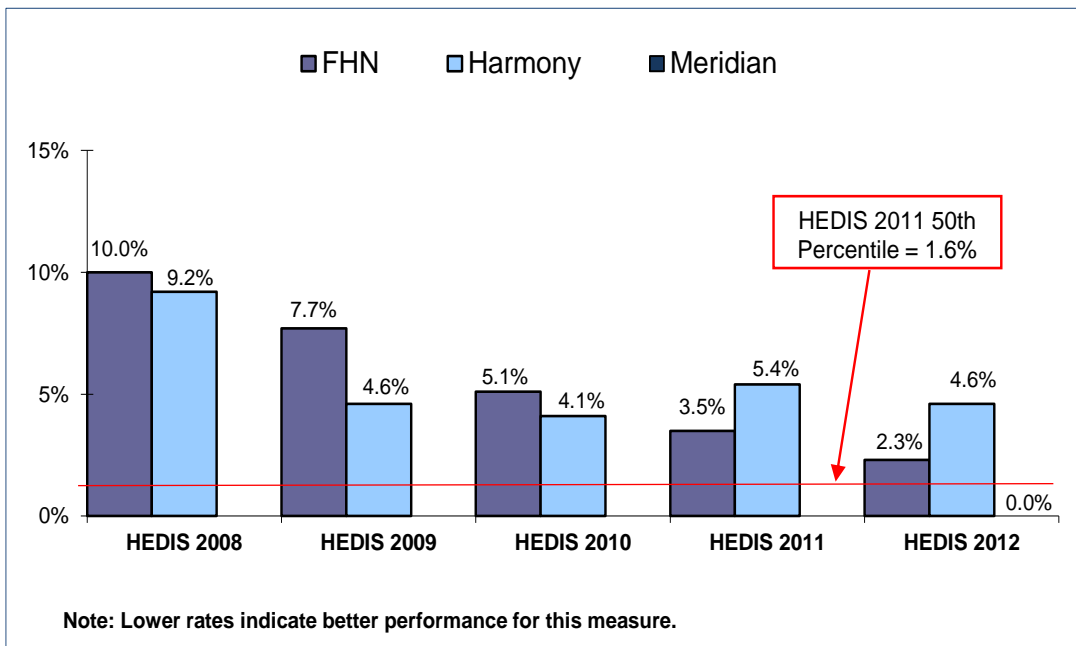
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Figure 6.6 presents the comparative rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*. HEDIS 2011 was the first year for reporting a rate for **Meridian**, and **Meridian**'s rate of 85.0 percent in 2011 was based on just 80 eligible cases. For HEDIS 2012, the rate was nearly identical, at 84.9 percent, but the population more than doubled to 166 eligible members. The reported rate for **Meridian** was well above the National Medicaid HEDIS 2011 50th percentile of 72.3 percent.

Since HEDIS 2008, the rate for **FHN** has improved from 68.4 percent to 73.0 percent. Although this improvement is relatively small (4.6 percentage points over five years), **FHN** has exceeded the 50th percentile.

The rate for **Harmony** has improved by 7.8 percentage points since HEDIS 2008, going from 57.4 percent to 65.2 percent for HEDIS 2012. **Harmony**'s rate declined sharply from 2011 and fell below the National Medicaid HEDIS 2011 50th percentile of 72.3 percent for HEDIS 2012.

**Figure 6.6—Comparison of HFS MCO Performance
for *Well-Child Visits During the Third, Fourth, Fifth, and Sixth Year of Life***
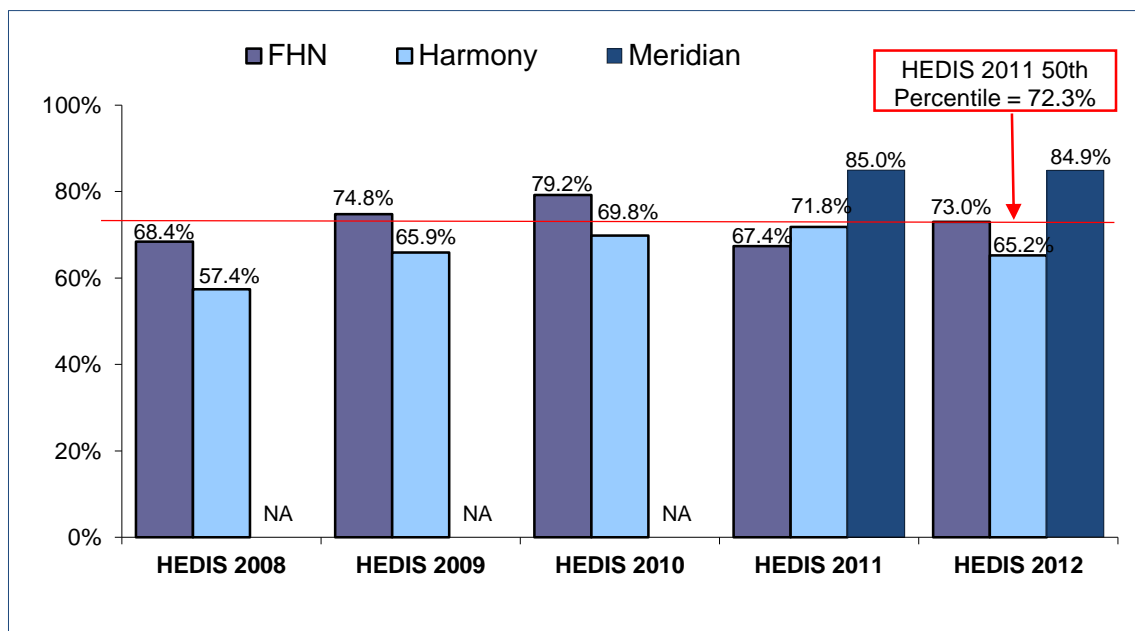
Adolescent Well-Care Visits

Figure 6.7 presents the comparative rates for *Adolescent Well-Care Visits*. HEDIS 2011 was the first year for reporting a rate for **Meridian**, and **Meridian**'s rate of 71.0 percent in 2011 was based on just 62 eligible cases. For HEDIS 2012, the rate was 66.7 percent, but the population consisted of 189 eligible members. The reported rate for **Meridian** was well above the National Medicaid HEDIS 2011 50th percentile of 46.1 percent.

Since HEDIS 2008, the rate for **FHN** has improved from 32.2 percent to 44.1 percent. The rate for **FHN** is close to the 50th percentile, but it has remained about the same for the past three years. **Harmony** has had similar difficulties with improving the rate for this measure. **Harmony**'s rate has actually declined from 37.7 percent to 35.5 percent since HEDIS 2008. Neither **FHN** nor **Harmony** exceeded the National Medicaid HEDIS 2011 50th percentile of 46.1 percent for HEDIS 2012.

**Figure 6.7—Comparison of HFS MCO Performance
for *Adolescent Well-care Visits***
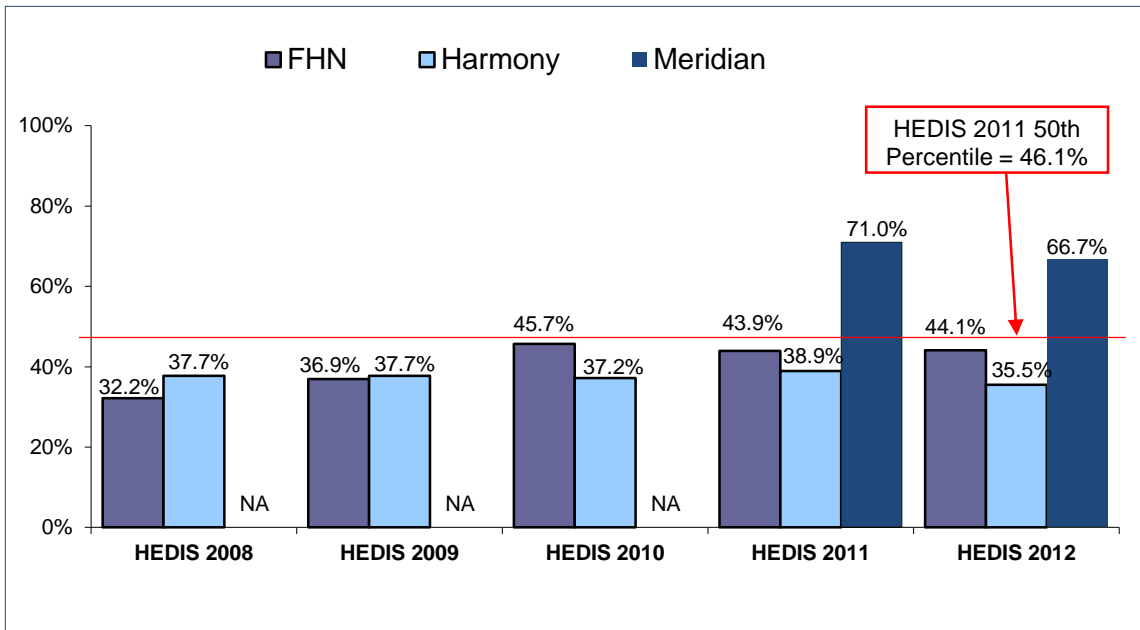
Immunizations for Adolescents

Figure 6.8 displays comparative rates for *Immunizations for Adolescents—Combined Rate* (i.e., one meningococcal vaccine, and one tetanus, diphtheria toxoids and acellular pertussis vaccine [Tdap], or one tetanus, diphtheria toxoids vaccine [Td] by the 13th birthday) for the past three years.

HEDIS 2011 was the first year for reporting this measure for both **FHN** and **Harmony**. **Meridian** has fewer than 30 eligible cases, and therefore, is not presented.

Since HEDIS 2010, the rates for both **FHN** and **Harmony** have shown improvement. **FHN**'s rate has increased 26.6 percentage points, while **Harmony**'s rate has improved by 15.3 percentage points. The rate for **FHN** is approaching the 50th percentile of 49.8 percent.

**Figure 6.8—Comparison of HFS MCO Performance
for Immunizations for Adolescents (Combined Rate)**
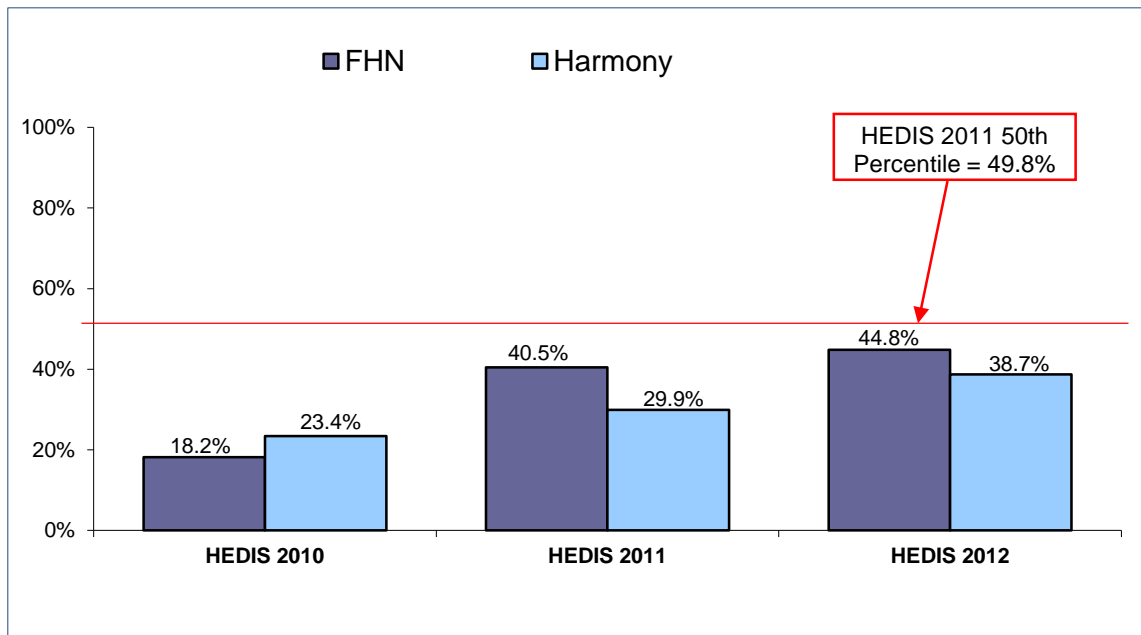
Access to Care

This section addresses HEDIS measures regarding access to care. The HEDIS measures were *Children's and Adolescents' Access to Primary Care Practitioners* (PCPs), and *Adults' Access to Preventive/Ambulatory Care* (20–44 Years of Age and 45–64 Years of Age).

Children's and Adolescents' Access to PCPs

Figure 6.9 presents the comparative rates for *Children's and Adolescents' Access to Primary Care Practitioners (12–24 Months)*. **FHN** and **Harmony** first reported this measure beginning with HEDIS 2008, while **Meridian** first began reporting a rate for this measure in 2011. However, **Meridian**'s rate of 100.0 percent was based on just 78 eligible cases for HEDIS 2011. However, for HEDIS 2012, **Meridian** had 118 eligible cases and still reported a rate of 100.0 percent.

Overall, the rate for **FHN** has improved by 14.5 percentage points since HEDIS 2008 and 9.6 percentage points over 2011. The rate for **Harmony** has improved by 6.3 percentage points overall. The rates for both MCOs remained below the National Medicaid HEDIS 2011 50th percentile of 97 percent.

**Figure 6.9—Comparison of HFS MCO Performance
for *Children's and Adolescents' Access to PCPs (12–24 Months)***

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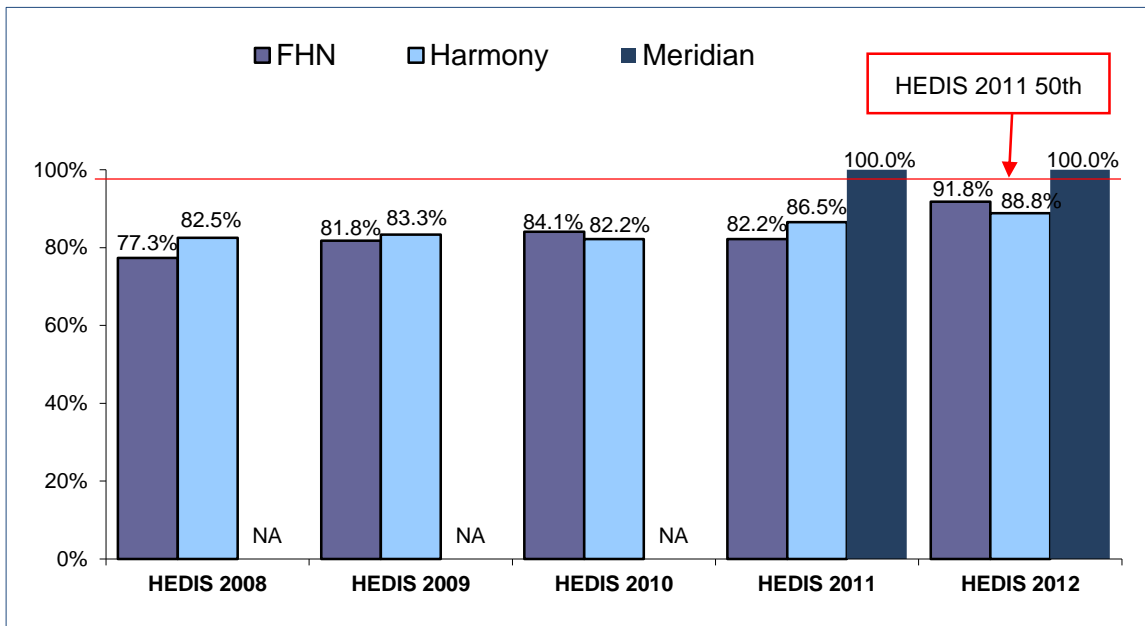Health Services Advisory Group, Inc.

Figure 6.10 presents the comparative rates for *Children's and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years).* **FHN** and **Harmony** first reported this measure beginning with HEDIS 2008, while **Meridian** first began reporting a rate for this measure in 2011.

Meridian's rate of 92.1 percent was based on 101 eligible cases for HEDIS 2011. For HEDIS 2012, **Meridian** had 239 eligible cases and reported an identical rate of 92.1 percent. This rate was above the National Medicaid HEDIS 2011 50th percentile of 89.6 percent.

Overall, the rate for **FHN** has improved by 12 percentage points since HEDIS 2008, and 7.3 percentage points over 2011. The rate for **Harmony** has improved 8.5 percentage points overall. The HEDIS 2012 rate for **Harmony** improved by less than 1 percentage point over HEDIS 2011. The rates for both **FHN** and **Harmony** remained below the National Medicaid HEDIS 2011 50th percentile of 89.6 percent.

**Figure 6.10—Comparison of HFS MCO Performance
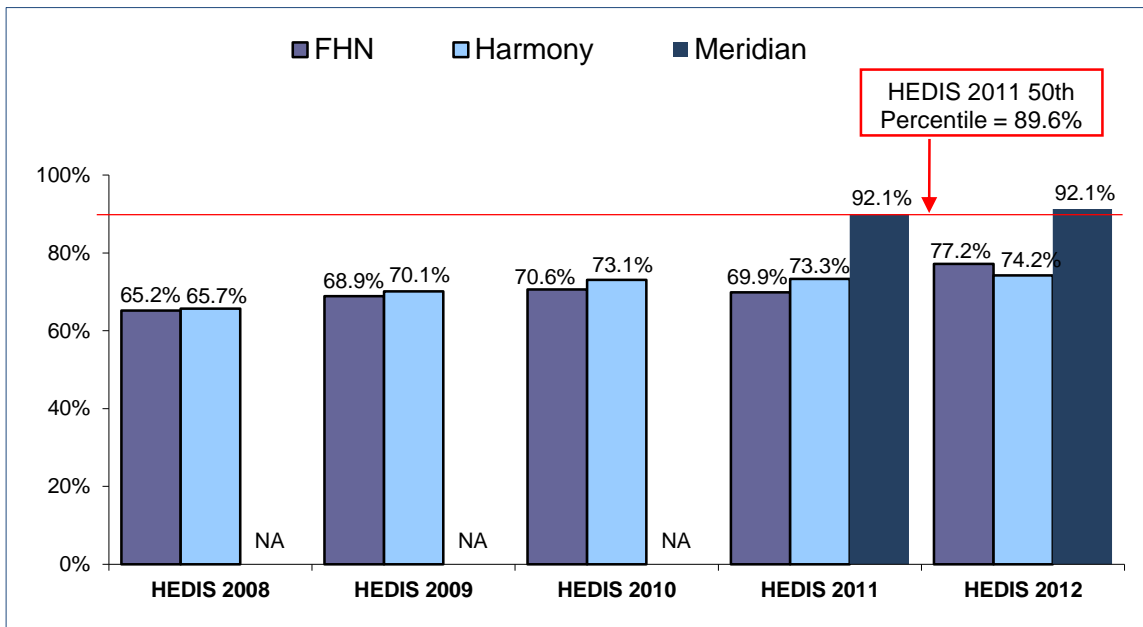for *Children's and Adolescents' Access to PCPs (25 Months–6 Years)***

Figure 6.11 presents the comparative rates for *Children's and Adolescents' Access to Primary Care Practitioners (7–11 Years).* **FHN** and **Harmony** first reported this measure beginning with HEDIS 2008, while **Meridian** first began reporting a rate for this measure last year. None of the MCOs exceeded the National Medicaid 50th percentile of 91.3 percent.

FHN's rate has remained about the same since HEDIS 2008, with just a 0.7 percentage point increase over time. This rate remains well below the 50th percentile of 91.3 percent.

By contrast, the rate for **Harmony** has improved 10.3 percentage points above the HEDIS 2008 rate of 60.7 percent. However, similarly to **FHN**, the rate for **Harmony** since HEDIS 2010 has shown very little improvement.

The rate for **Meridian**, at 81.3 percent, was based on just 48 eligible cases. This rate was 10.0 percentage points below the 50th percentile, but it was highest rate among the three MCOs.

**Figure 6.11—Comparison of HFS MCO Performance
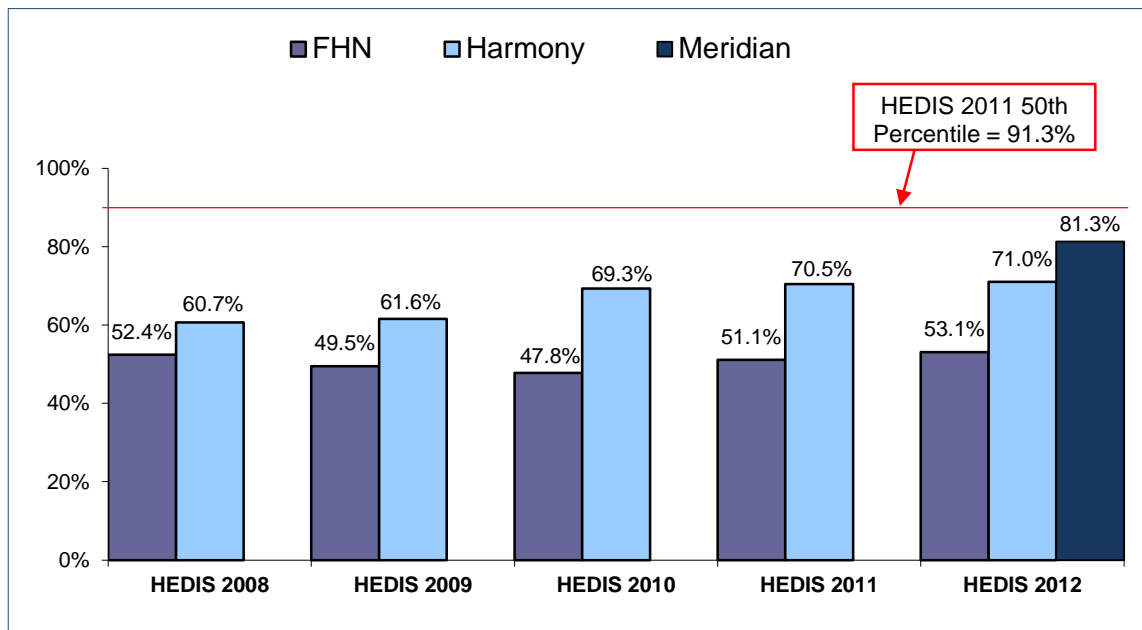for *Children's and Adolescents' Access to PCPs (7–11 Years)***

Figure 6.12 presents the comparative rates for *Children's and Adolescents' Access to PCPs (12–19 Years).* **FHN** and **Harmony** first reported this measure beginning with HEDIS 2008, while **Meridian** fist began reporting a rate for this measure last year. Only **Meridian** exceeded the National Medicaid 50th percentile of 89.7 percent, but this rate was based on just 40 eligible cases.

Overall, the rate for **FHN** has improved by 6.2 percentage points since HEDIS 2008, but remains well below the 50th percentile. The rate for **Harmony** has improved by 13.6 percentage points overall, and its rates continue to be higher than the rates for **FHN**. However, the rates for both **FHN** and **Harmony** remained below the National Medicaid HEDIS 2011 50th percentile of 89.7 percent.

**Figure 6.12—Comparison of HFS MCO Performance
for *Children's and Adolescents' Access to PCPs (12–19 Years)***
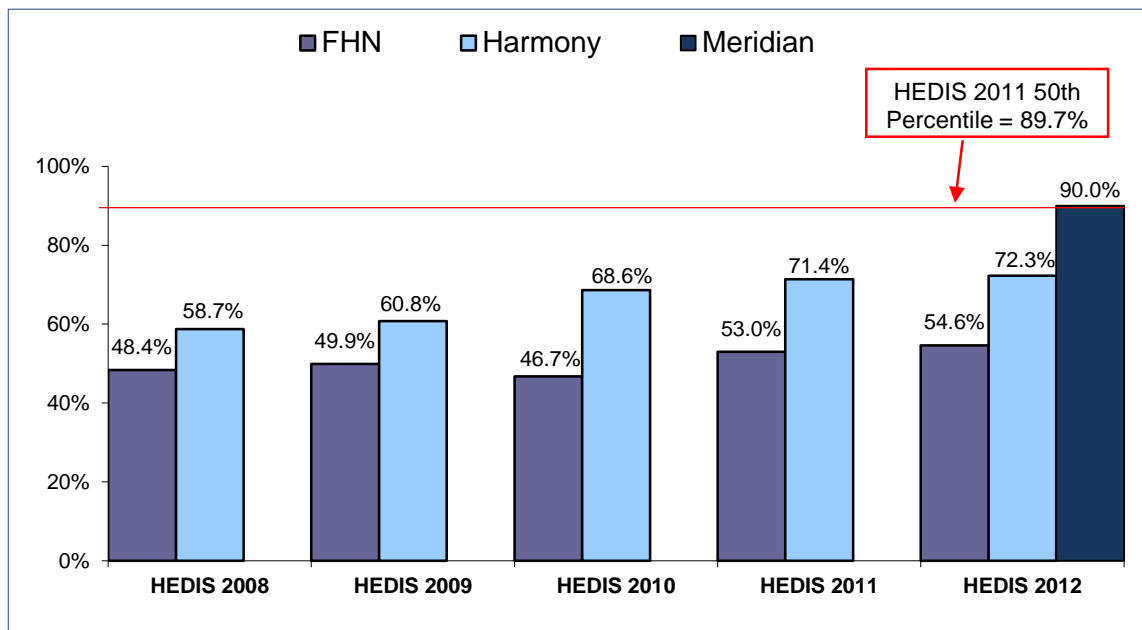
Adults' Access to Preventive/Ambulatory Care

Figure 6.13 presents the comparative rates for *Adults' Access to Preventive/Ambulatory Care (Ages 20–44)*. This was the second reporting year for **Meridian**, and both rates exceeded the National Medicaid HEDIS 2011 50th percentile of 87.4 percent. For HEDIS 2011, **Meridian**'s rate of 90.5 percent was based on 148 eligible cases, while the rate for HEDIS 2012 is based on 313 eligible cases.

Overall, the rate for **FHN** has improved 12.6 percentage points from the rate of 56.6 percent reported for HEDIS 2008. **Harmony**'s rate has improved by 13.3 percentage points. **Harmony** has consistently outperformed **FHN** each year. The rates for both MCOs, however, were well below the National Medicaid HEDIS 2011 50th percentile of 87.4 percent.

**Figure 6.13—Comparison of HFS MCO Performance
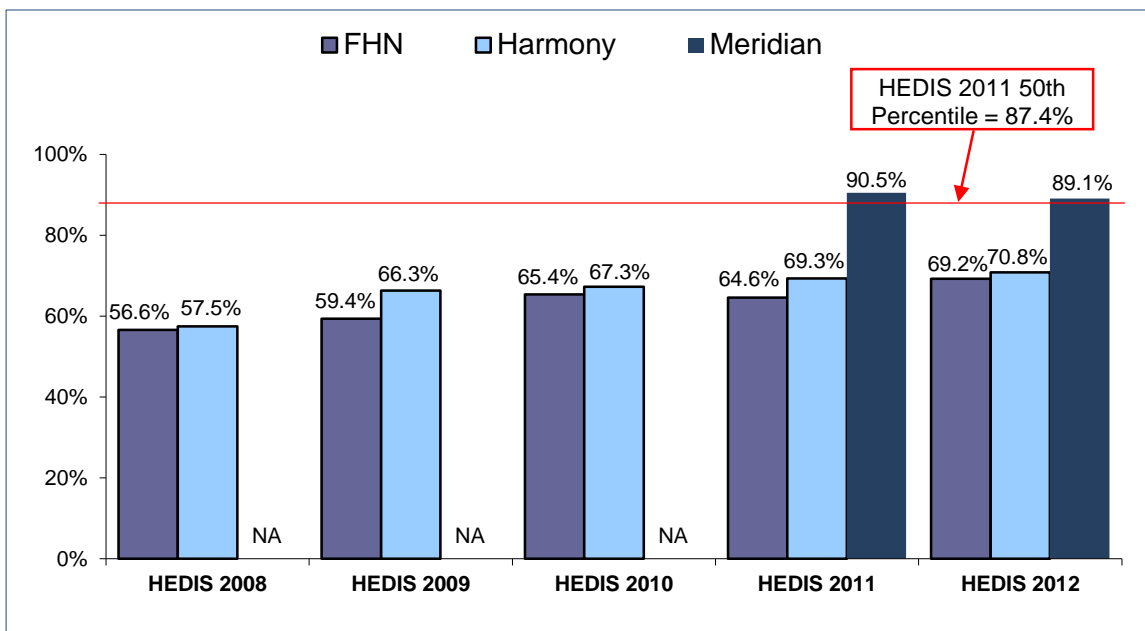for *Adults' Access to Preventive/Ambulatory Care (Ages 20–44)***

Figure 6.14 presents the comparative rates for *Adults' Access to Preventive/Ambulatory Care (Ages 45–64)*. This is the first year for reporting a rate since **Meridian** had less than 30 eligible cases for this measure last year, and in accordance with NCQA, the rate was reported as NA. For HEDIS 2012, **Meridian** had 56 eligible cases and reported a rate of 91.1 percent. This rate was above the HEDIS 2011 National Medicaid 50th percentile of 85.9 percent.

Overall, the rate for **FHN** has improved 25.5 percentage points from the rate of 48.6 percent reported for HEDIS 2008, indicating **FHN** is obtaining more encounter data for this measure. **Harmony**'s rate has improved by 16.7 percentage points. Until this year, **Harmony** had consistently outperformed **FHN,** but **FHN** surpassed **Harmony**'s rate for HEDIS 2012. The rates for both MCOs, however, were still below the National Medicaid HEDIS 2011 50th percentile of 87.4 percent.

**Figure 6.14—Comparison of HFS MCO Performance
for *Adults' Access to Preventive/Ambulatory Care (Ages 45–64)***
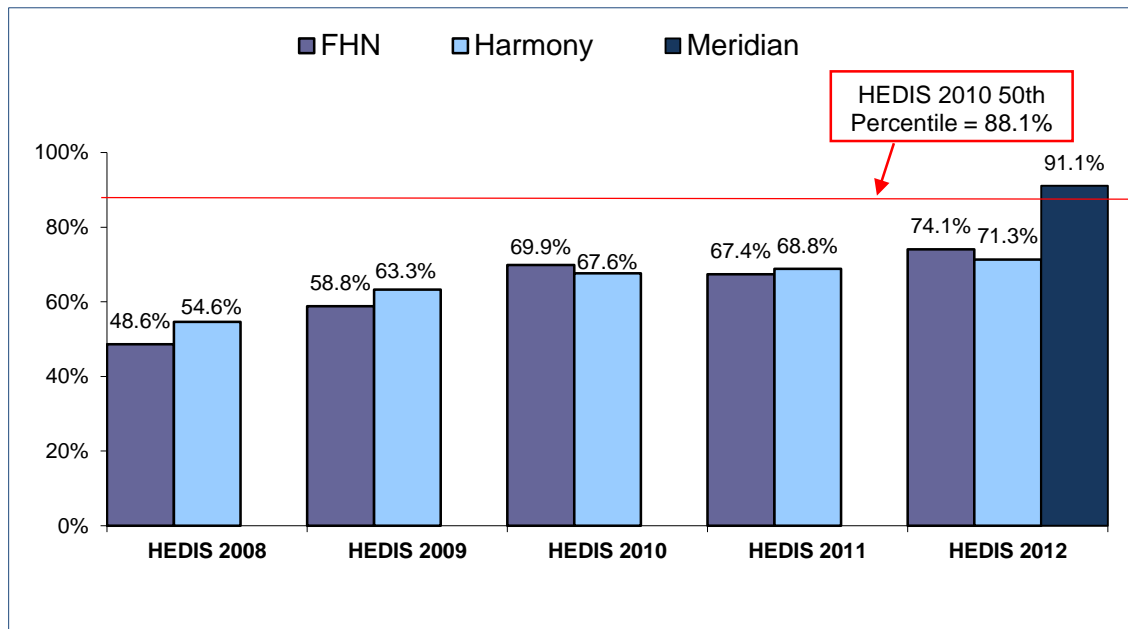
The rates for measures related to access continued to improve, but still remain low and below the national 50th percentiles. This indicates both **FHN** and **Harmony** need to improve access to care. This finding has been mentioned for several years in the annual report, and the recommendation remains the same: both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers, and evaluate internal policies regarding member and provider education. **FHN** should continue to work on improving encounter data submission from providers.

Preventive Screenings for Women

This section addresses HEDIS measures regarding preventive screenings for women. The HEDIS measures were *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women*.

Breast Cancer Screening

Figure 6.15 compares the *Breast Cancer Screening* rates for women enrolled in **FHN** or **Harmony**. **Meridian** had less than 30 eligible cases for this measure, and in accordance with NCQA, the rate was reported as NA.

The rates for both MCOs were below the HEDIS 2011 National Medicaid 50th percentile of 52.4 percent. However, the rate for **FHN** has improved 21.1 percentage points since HEDIS 2008, and the current rate is less than 5 percentage points below the 50th percentile. For HEDIS 2008, **FHN**'s rate was lower than **Harmony**'s rate, but **FHN** surpassed **Harmony** in 2009 and has continued to demonstrate good improvement each year. By contrast, the rate for **Harmony** has shown a downward trend, with an overall decline of 1.1 percentage points since HEDIS 2008.

**Figure 6.15—Comparison of HFS MCO Performance
for *Breast Cancer Screening (Combined Rate)***
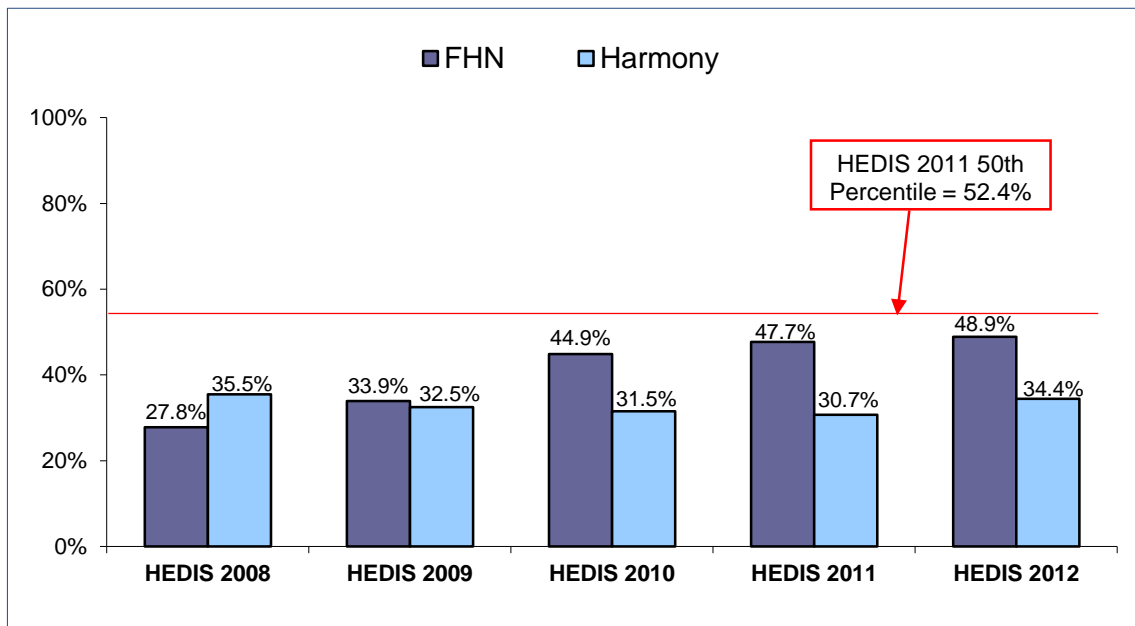
Cervical Cancer Screening

The rates for *Cervical Cancer Screening* are displayed in Figure 6.16. This was the second year for reporting a rate for **Meridian**. For HEDIS 2011, **Meridian**'s rate of 87.5 percent was based on 99 eligible cases, while the HEDIS 2012 rate of 84.4 percent was based on 225 cases. **Meridian**'s rates for both years were above the HEDIS 2011 National Medicaid 50th percentile of 69.7 percent.

The rates for both **FHN** and **Harmony** were identical, at 71.5 percent and exceeded the National HEDIS 2011 Medicaid 50th percentile of 69.7 percent. **FHN**'s rate has improved 3.5 percentage points since HEDIS 2008. **Harmony** has demonstrated greater improvement, going from 59.1 percent for HEDIS 2008 to 71.5 percent for HEDIS 2012, or a 12.4 percentage point increase.

**Figure 6.16—Comparison of HFS MCO Performance
for *Cervical Cancer Screening***
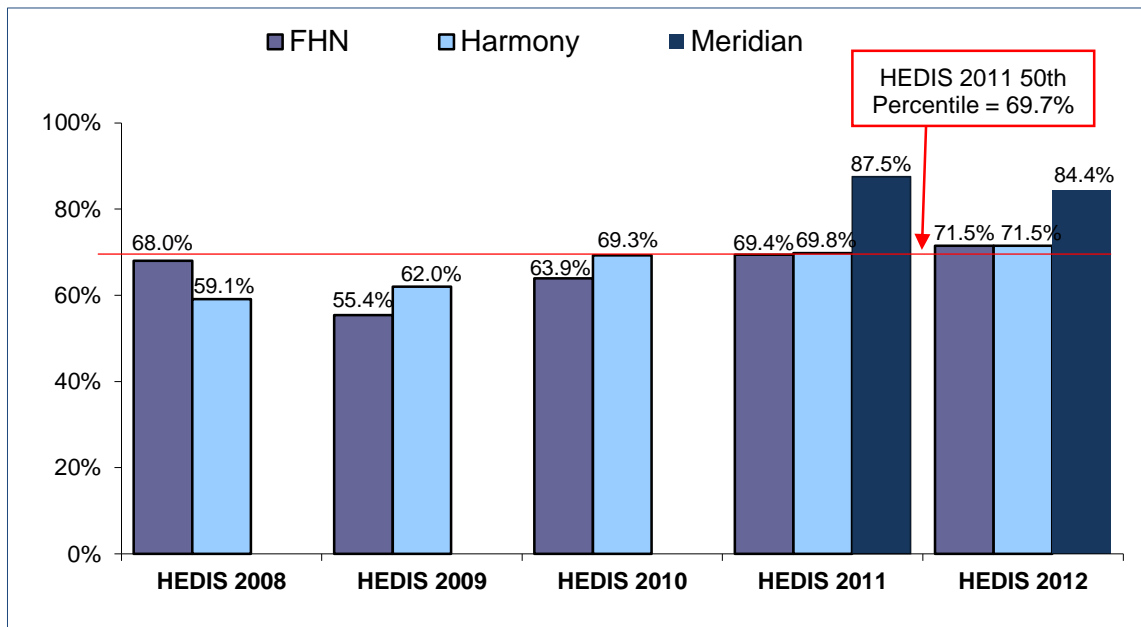
Chlamydia Screening in Women

Figure 6.17 presents the comparative rates for *Chlamydia Screening in Women*. This was the second year for reporting an actual rate for **Meridian**. For HEDIS 2011, **Meridian**'s 2011 rate of 60.6 percent was based on 33 eligible cases. In 2012, **Meridian**'s rate of 60.8 percent was based on 74 cases. Given the relatively low population for this measure, caution should be used when comparing to the other MCOs.

FHN's rate of 63.4 percent exceeded the National Medicaid 50th percentile of 57.2 percent for the second year in a row and demonstrated an improvement of 15.7 percentage points from HEDIS 2008.

Harmony's rate has remained fairly constant each year, with the largest increase occurring this year. The rate has improved 4.7 percentage points since HEDIS 2008 and remains below the 50th percentile.

**Figure 6.17—Comparison of HFS MCO Performance
for *Chlamydia Screening in Women (Combined Rate)***
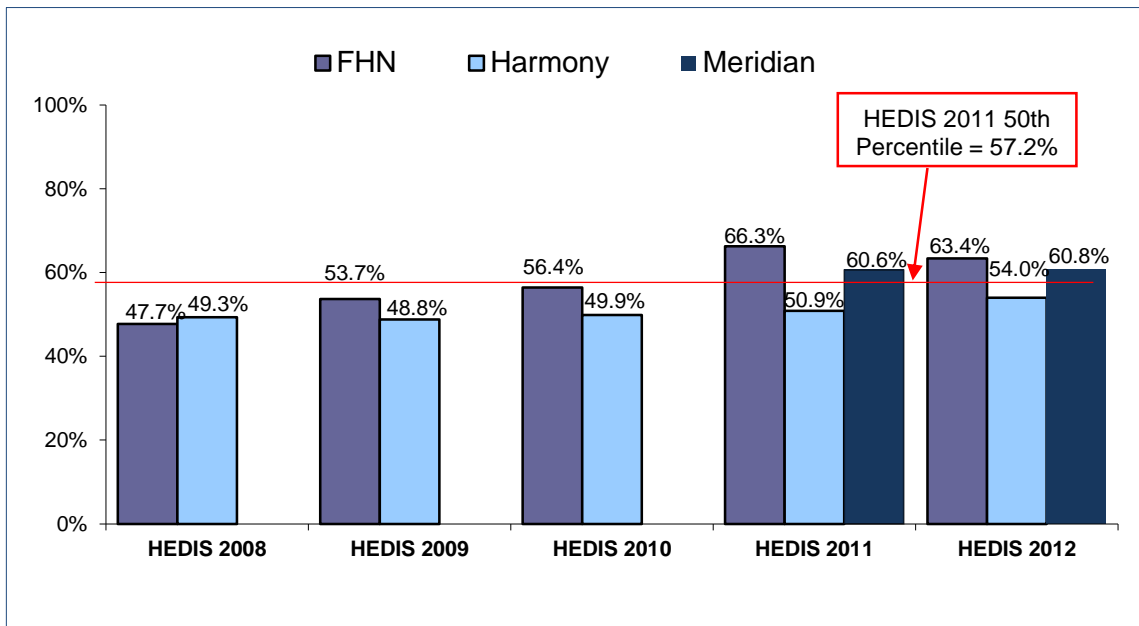
Maternity-Related Care

This section addresses HEDIS measures related to maternity care. The HEDIS measures were *Frequency of Ongoing Prenatal Care, Timeliness of Prenatal Care,* and *Postpartum Care.*

Frequency of Ongoing Prenatal Care

Figure 6.18 presents the comparative rates for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits).* Lower rates are better for this measure since this measure evaluates the percentage of women who received 0–21 percent of their total recommended prenatal care visits. 2012 was the second reporting year for **Meridian**. The HEDIS 2011 rate of 1.8 percent for **Meridian** was based on 55 eligible cases, while the HEDIS 2012 rate of 1.4 percent was based on 146 eligible cases.

Both MCOs have demonstrated improvement with this measure since HEDIS 2008, but still reported rates above the National Medicaid HEDIS 2011 50th percentile of 7.7 percent. **FHN**'s rate has improved by 13.5 percentage points since HEDIS 2008. **Harmony**'s rate has improved by 7.1 percentage points. With the exception of HEDIS 2009, the rates have trended downwards. These trended improvements may be related to the current performance improvement project (PIP) the MCOs have been conducting.

**Figure 6.18—Comparison of HFS MCO Performance
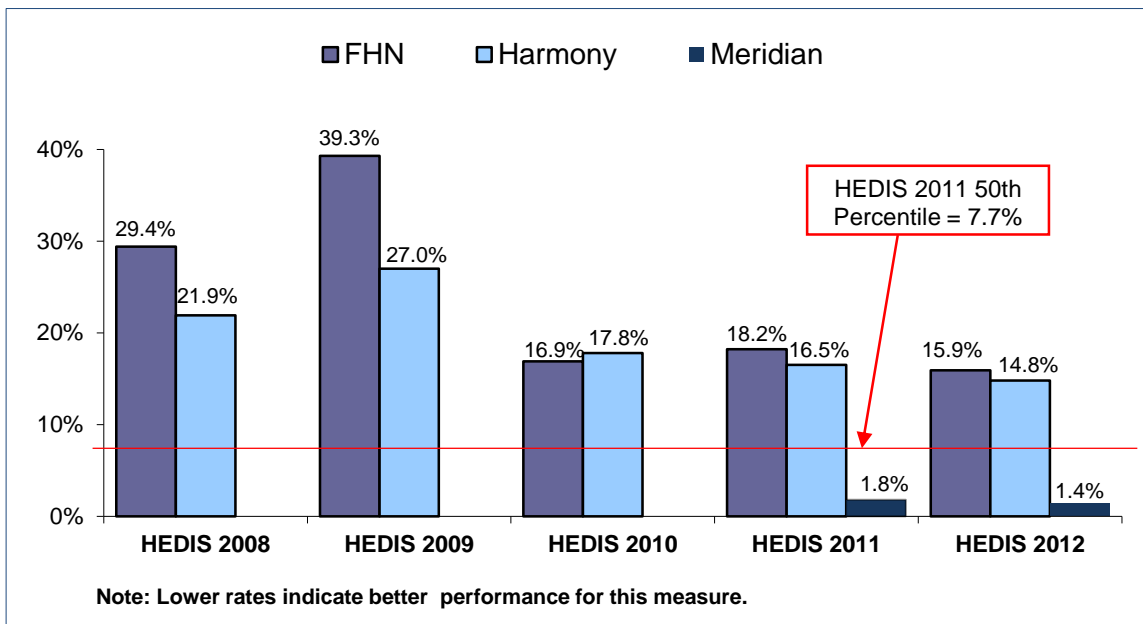for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)***

Figure 6.19 presents the comparative rates for *Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)*. In contrast to the previous measure, higher rates are better for this measure. However, this measure uses the same eligible population as *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)*. Therefore, **Meridian**'s rate of 96.4 percent for HEDIS 2011 was based on 55 eligible cases, while the HEDIS 2012 rate of 94.5 percent was based on 146 eligible cases.

The HEDIS rates for **FHN** have fluctuated, with the rates for HEDIS 2009 and HEDIS 2010 lower than the rate reported for HEDIS 2008. However, **FHN**'s rate for HEDIS 2012 improved 9.6 percentage points from HEDIS 2008. **Harmony**'s rate has shown steady improvement each year, and its 2012 rate was 10.7 percentage points higher than the HEDIS 2008 rate. The rates for both MCOs were still well below the National Medicaid HEDIS 2011 50th percentile of 64.4 percent.

**Figure 6.19—Comparison of HFS MCO Performance
for *Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)***
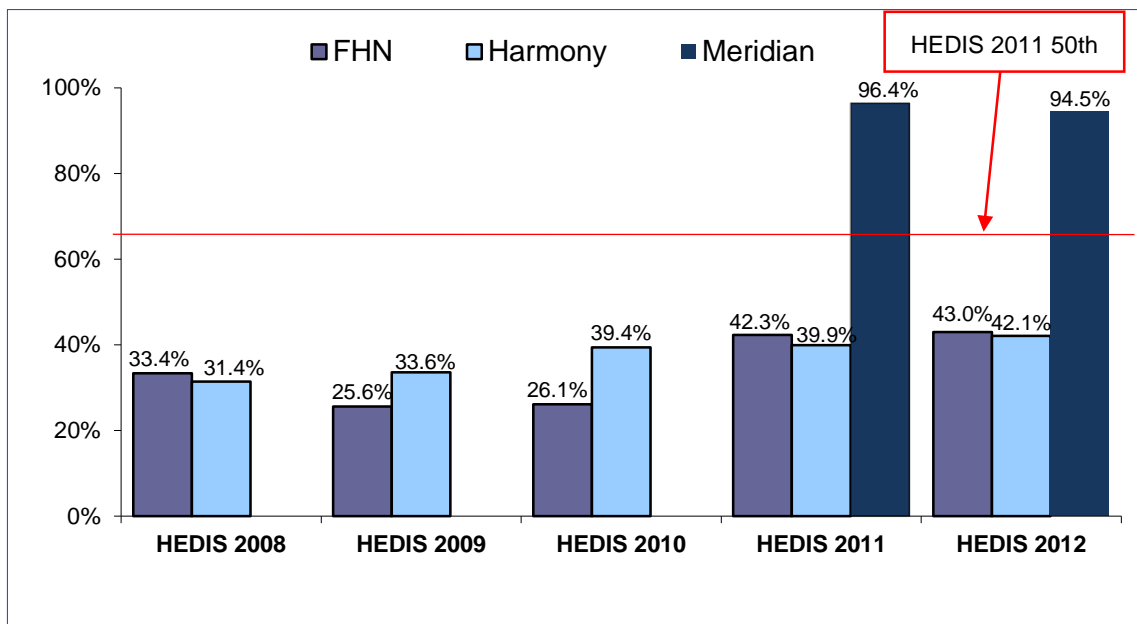
The measures related to access to care in this report and tend to have low rates, and still indicate potential issues with access. In prior years, there were several potential issues identified as probable causes for the poor rates for these measures: the encounter data may be incomplete, the MCO may have had difficulty identifying pregnant members, there may be a network adequacy issue, and there may be issues with member compliance, or any combination of these factors. The MCOs should continue, at a minimum, to conduct a root-cause analysis to determine the reason for low compliance, and develop interventions to improve the rates for measures related to access to care.

Timeliness of Prenatal Care

Figure 6.20 presents the comparative performance of the HFS MCOs for *Timeliness of Prenatal Care*. 2012 was the second reporting year for **Meridian**. For HEDIS 2011, **Meridian**'s rate of 98.2 percent was based on 55 eligible cases. **Meridian**'s 2012 rate of 93.9 percent was based on 147 cases. Both rates for **Meridian** exceeded the HEDIS 2011 National Medicaid 50th percentile of 86.0 percent.

For the first three years, the general trend for **FHN** had been relatively flat, indicating no real improvement. However, **FHN's** rate improved 13.2 percentage points for HEDIS 2011 and an additional 7.4 percentage points for HEDIS 2012. Overall, **FHN** has improved 24.4 percentage points since HEDIS 2008.

Harmony's rate has improved by 8.3 percentage points since HEDIS 2008. However, the rate for **Harmony** has a small decline for HEDIS 2011, and its 2012 rate remained the same as the previous year. Both **FHN** and **Harmony** were well below the National HEDIS 2011 Medicaid 50th percentile of 86.0 percent.

**Figure 6.20—Comparison of HFS MCO Performance
for *Timeliness of Prenatal Care***
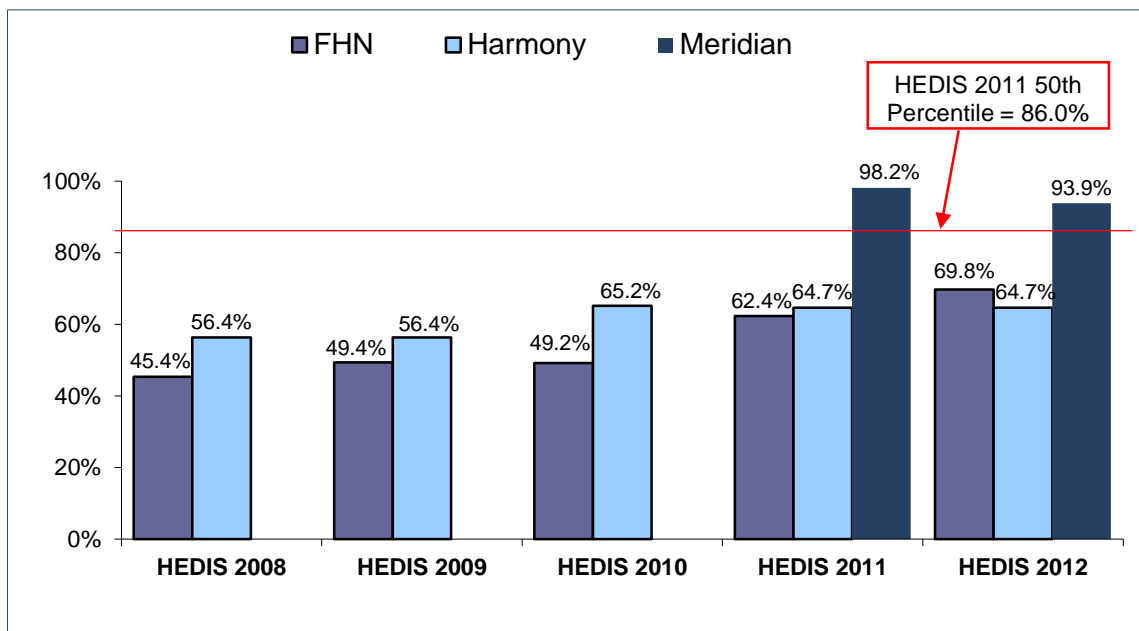
Figure 6.21 presents the comparative performance of the HFS MCOs for *Postpartum Care*. 2012 was the second year for reporting a rate for **Meridian**. For HEDIS 2011, **Meridian**'s rate of 85.5 percent was based on 55 eligible cases. **Meridian**'s 2012 rate of 76.2 percent was based on 147 cases. Both rates for **Meridian** exceeded the HEDIS 2011 National Medicaid 50th percentile of 64.6 percent.

FHN's rate increased 12.7 percentage points since HEDIS 2008, including a 4.8 percentage point increase over 2011. **Harmony**'s rate increased by 14.6 percentage points since HEDIS 2008, but only had a small increase of 0.9 percentage points compared to 2011. Both **FHN** and **Harmony** were well below the National HEDIS 2011 Medicaid 50th percentile of 64.6 percent.

**Figure 6.21—Comparison of HFS MCO Performance
for *Postpartum Care***
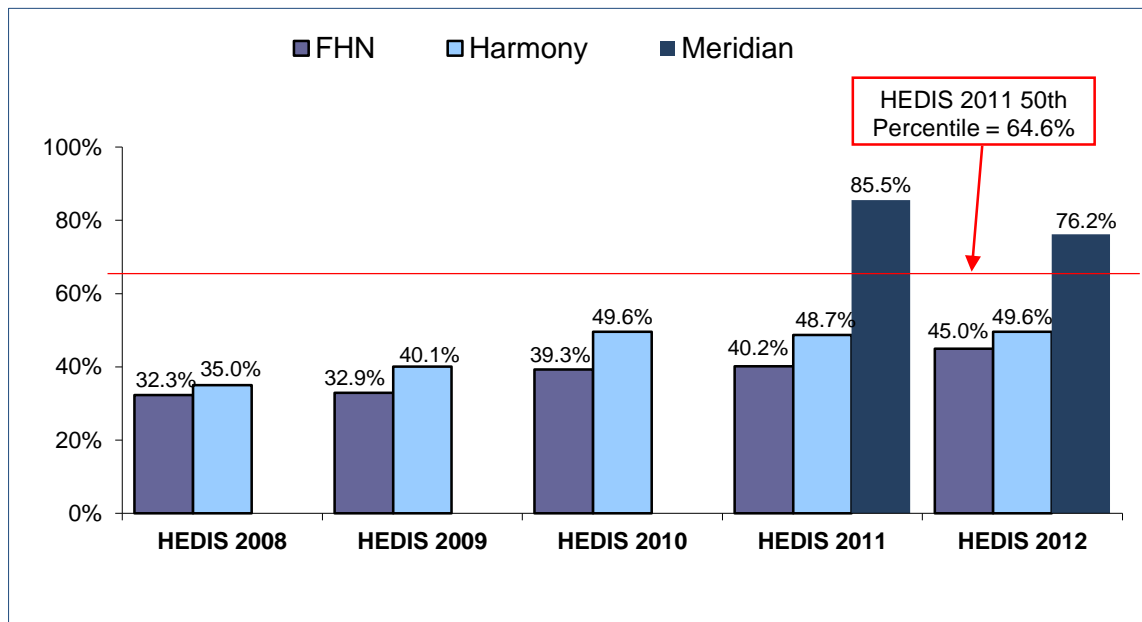
As discussed in prior technical reports, both **FHN** and **Harmony** continue to report rates well below the 50th percentiles for these maternity-related measures. In response to these low rates, the State and the MCOs began a collaborative perinatal depression screening PIP in 2006–2007. All of these maternity-related measures were included as part of the PIP, as well as several non-HEDIS measures addressing depression and follow-up (for positive depression screening) for these women. The results for the last two years have shown improvement, especially the results for **FHN** on *Timeliness of Prenatal Care*.

Chronic Conditions/Disease Management

This section addresses HEDIS measures regarding chronic conditions/disease management. The HEDIS measures were *Controlling High Blood Pressure, Comprehensive Diabetes Care, Use of Appropriate Medications for People With Asthma,* and *Follow-up After Hospitalization for Mental Illness.*

Meridian did not have more than 30 eligible cases for any of the measures in this section. In accordance with NCQA, the results for **Meridian** are NA and are not provided in this report.

Controlling High Blood Pressure

Figure 6.22 presents the comparative rates for *Controlling High Blood Pressure.* This measure has not shown real improvement since HEDIS 2008. **FHN**'s rate has decreased 1.9 percentage points since HEDIS 2008. This measure has been very unpredictable for **FHN**, with rates drastically increasing and decreasing over the years. **Harmony**'s rate has also shown fluctuation, trending upward until HEDIS 2011, and then downward through 2012, with a final rate 2.9 percentage points higher than the rate reported for HEDIS 2008. Neither of the MCOs exceeded the National Medicaid HEDIS 2011 50th percentile of 56.4 percent.

**Figure 6.22—Comparison of HFS MCO Performance
for *Controlling High Blood Pressure (Combined Rate)***
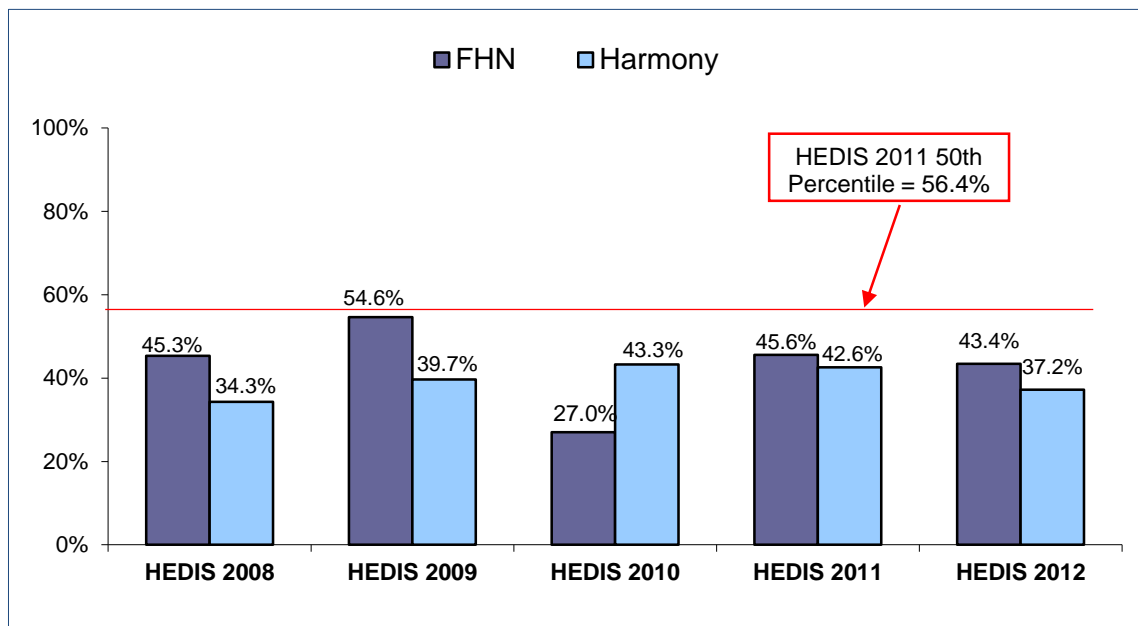
Comprehensive Diabetes Care

Figure 6.23 through Figure 6.31 show comparisons for the performance measures under *Comprehensive Diabetes Care*. The performance measures were *HbA1c Testing, Good HbA1c Control, Poor HbA1c Control, Eye Exam, LDL-C Screening, LDL-C Level <100 mg/dL, Monitoring for Diabetic Nephropathy, Blood Pressure <140/90,* and *Blood Pressure <140/80.*

Comprehensive Diabetes Care—HbA1c Testing

Figure 6.23 presents the comparative rates for *Comprehensive Diabetes Care—HbA1c Testing.*

Neither MCO had a rate above the National Medicaid HEDIS 2011 50th percentile of 82.2 percent. Overall, **FHN**'s rates have consistently improved, gaining 11.0 percentage points since HEDIS 2008. The HEDIS 2012 rate of 79.5 percent for **FHN** was just 2.7 percentage points lower than the 50th percentile.

Harmony's rate has also shown steady improvement and was 13.4 percentage points higher than the rate reported for HEDIS 2008. However, **Harmony**'s rate remains 11.1 percentage points below the 50th percentile.

**Figure 6.23—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—HbA1c Testing***
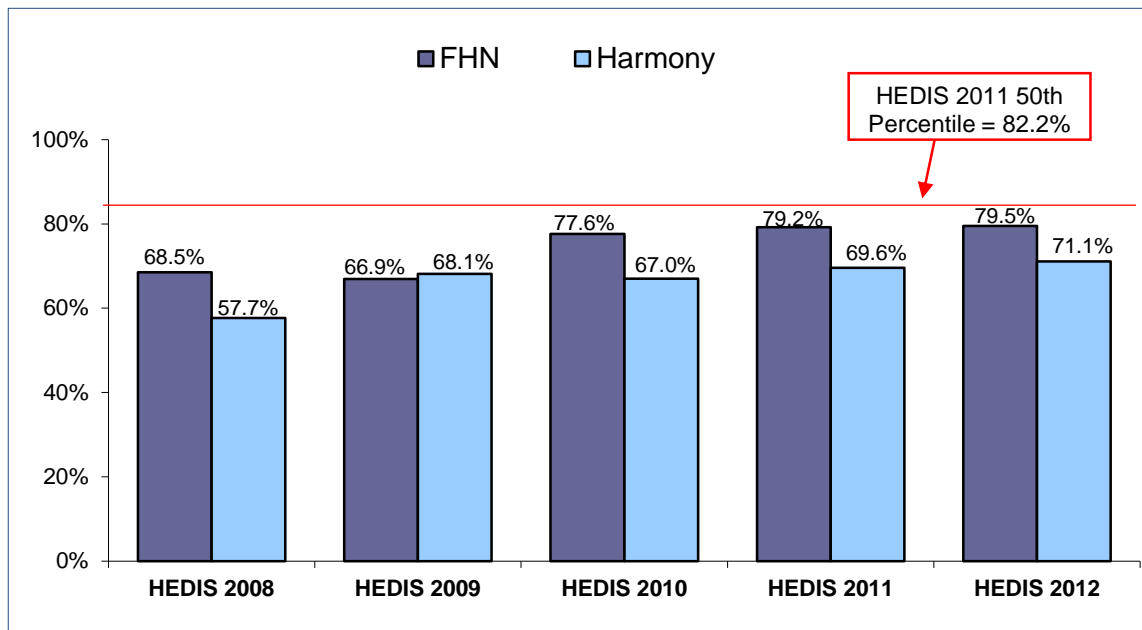
Comprehensive Diabetes Care—Good HbA1c Control

Figure 6.24 presents the comparative rates for *Comprehensive Diabetes Care—Good HbA1c Control*.

The rate for **FHN** has improved by 24.4 percentage points since HEDIS 2008, including an increase of 4.7 percentage points over 2011. Similarly to **FHN**, **Harmony**'s rate improved 13.8 percentage points since HEDIS 2008. However, compared to 2011, **Harmony**'s rate was the same. Although the rates for both MCOs continued to improve, the rates were well below the National Medicaid HEDIS 2011 50th percentile of 47.4 percent.

**Figure 6.24— Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—Good HbA1c Control***
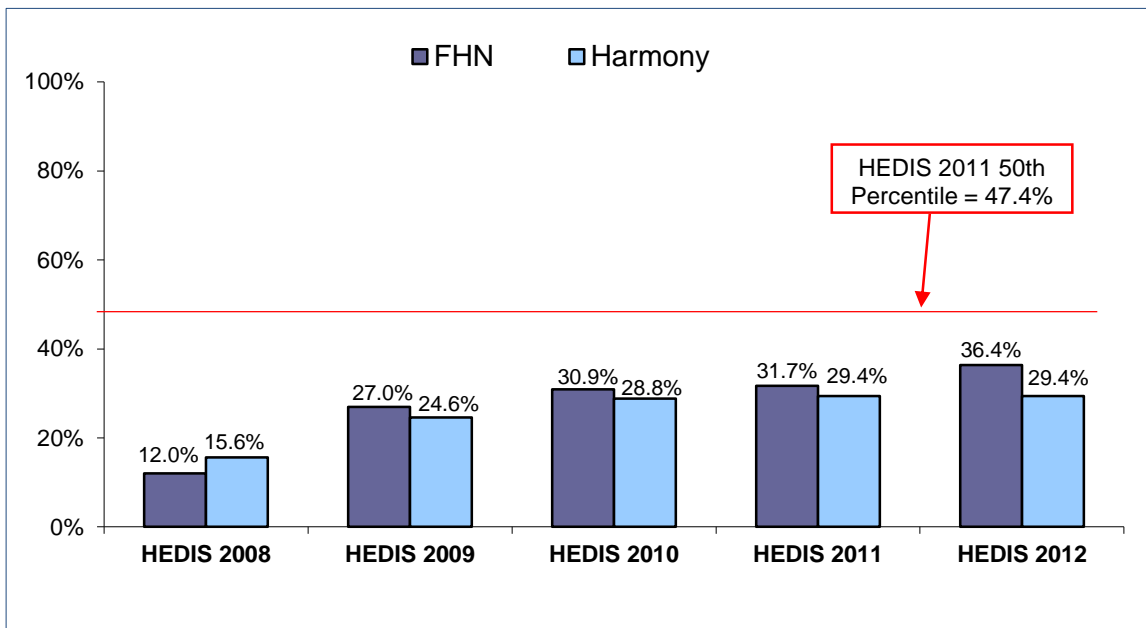
Comprehensive Diabetes Care—Poor HbA1c Control

Figure 6.25 presents the comparative rates for *Comprehensive Diabetes Care—Poor HbA1c Control.* Lower rates are better for this measure since this measure evaluates the percentage of members who were in poor control of their diabetes.

Overall, the performance for **FHN** has declined for this measure as indicated by an increase of 7.1 percentage points since HEDIS 2008. **Harmony**'s rate has made some improvement with this measure, decreasing its rate by 10.2 percentage points since HEDIS 2008. Neither MCO reported rates below the National Medicaid HEDIS 2011 50th percentile of 42.6 percent.

**Figure 6.25—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—Poor HbA1c Control***

Note: Lower rates indicate better performance for this measure.
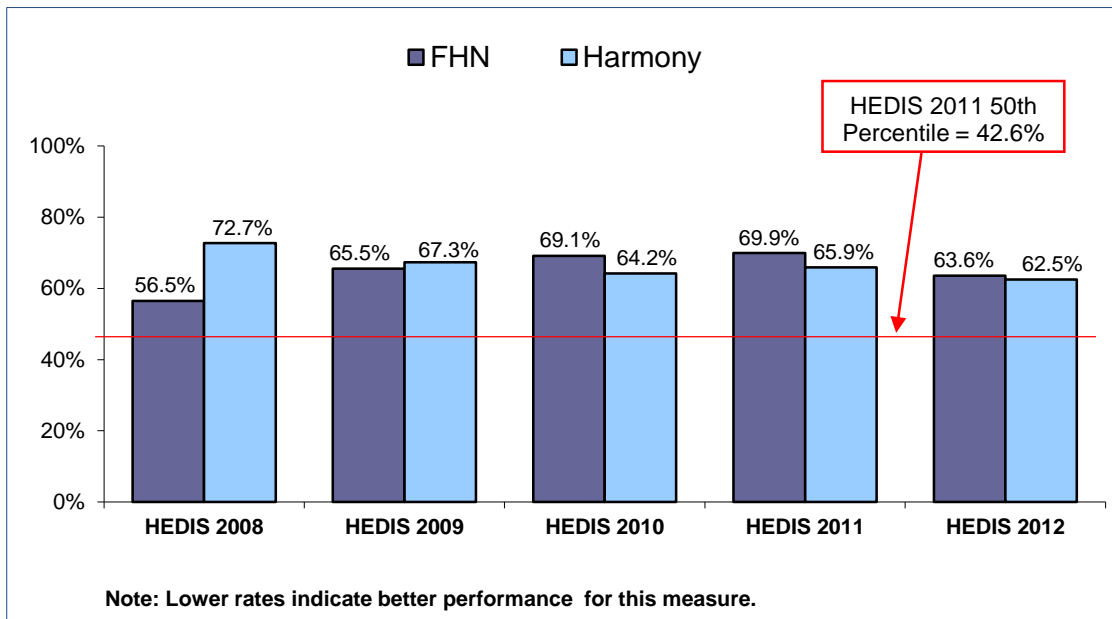
Given that the rates for *HbA1c Testing* and *HbA1c Good Control* have increased, the rate for this measure indicates the MCOs are not obtaining all of the required lab data needed to report this measure.

Comprehensive Diabetes Care—Eye Exam

Figure 6.26 presents the comparative rates for *Comprehensive Diabetes Care—Eye Exam*.

FHN showed significant improvement, with its rate increasing from 31.7 percent for HEDIS 2011 to 44.7 percent for HEDIS 2012, or an improvement of 13.0 percentage points. Overall, **FHN**'s rate has improved 21.9 percentage points from HEDIS 2008.

Harmony's rate improved 9.3 percentage points over 2011. Overall, **Harmony**'s rate has improved 18.5 percentage points since HEDIS 2008.

Despite these improvements over the last few years, the rates remain below the National Medicaid HEDIS 2011 50th percentile of 52.8 percent.

**Figure 6.26—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—Eye Exam***
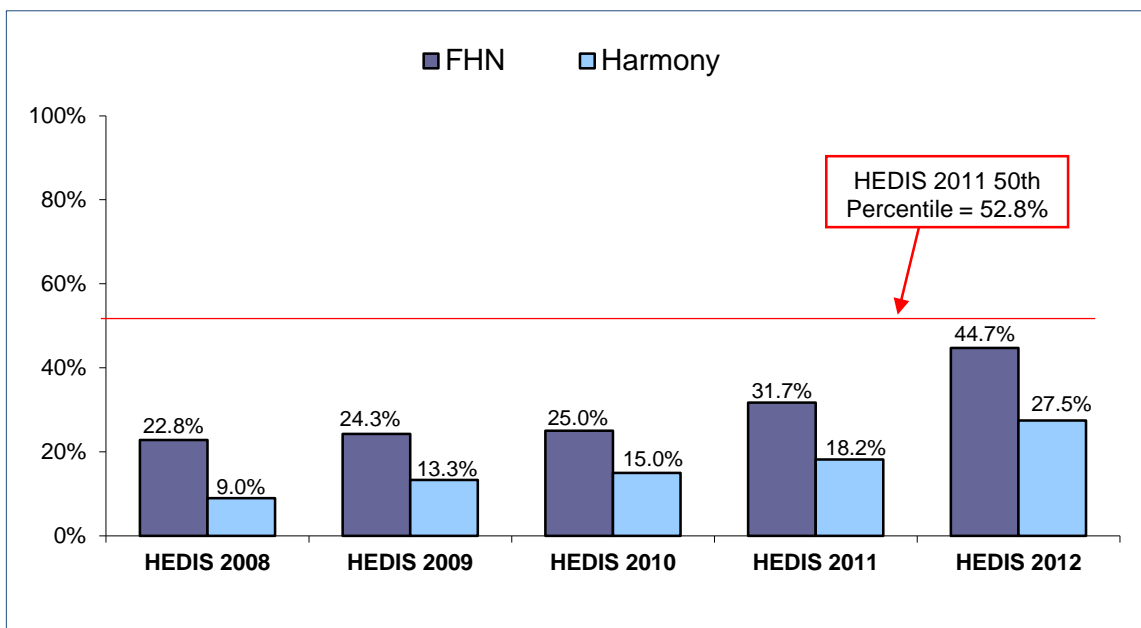
Comprehensive Diabetes Care—LDL-C Screening

Figure 6.27 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Screening*.

The rate for **FHN** has shown improvement, and the rate has increased by 13.1 percentage points since HEDIS 2008. **Harmony** has also demonstrated improvement, with an increase of 7.6 percentage points since HEDIS 2008. However, **Harmony**'s rate for 2012 represented a 3.8 percentage point decline from the previous year. Both of the rates for the MCOs remained below the National Medicaid HEDIS 2011 50th percentile of 75.4 percent.

**Figure 6.27—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—LDL-C Screening***

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Comprehensive Diabetes Care—LDL-C Level < 100mg/DL

Figure 6.28 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Level < 100mg/DL.*

FHN's rates were improving each year, but in 2012, **FHN** had a small decline of 1.8 percentage points from the previous year. Overall, the rate for **FHN** has improved 12.5 percentage points since HEDIS 2008. **Harmony**'s rate improved by 10.0 percentage points since HEDIS 2008 and had a 4.9 percentage point increase over 2011. Both MCOs had rates below the National Medicaid HEDIS 2011 50th percentile of 35.2 percent. The fairly low rates for this measure may be due to lack of encounter data from the contracted laboratories.

**Figure 6.28—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—LDL-C Level <100mg/DL***
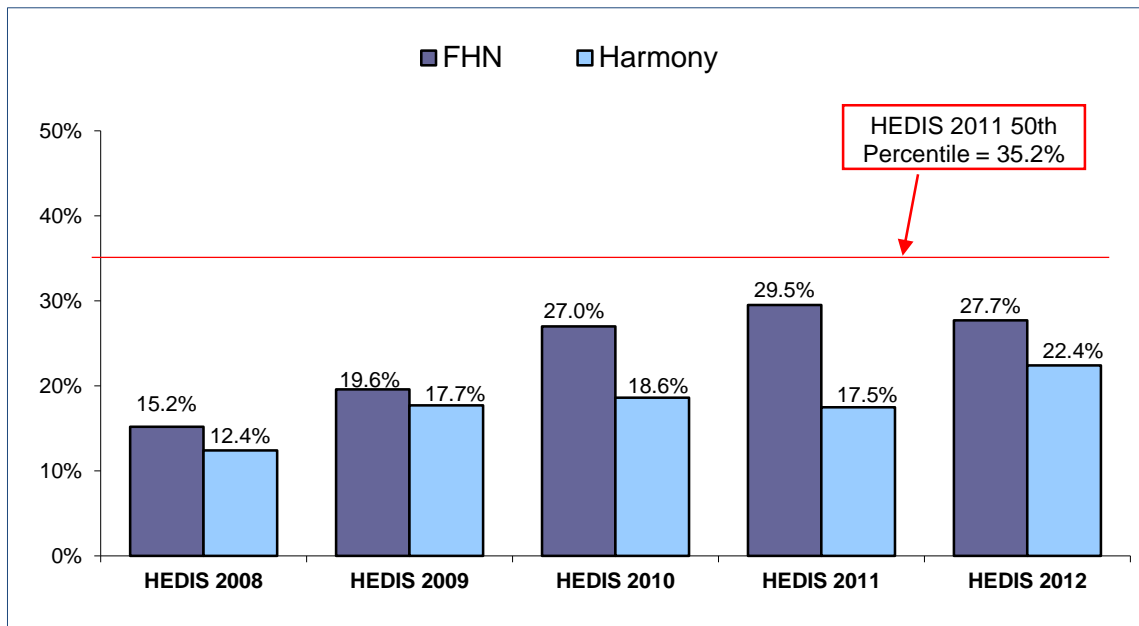
Diabetes Care— Nephropathy Monitoring

Figure 6.29 presents the comparative rates for *Comprehensive Diabetes Care—Nephropathy Monitoring*.

FHN's rate has improved 28.2 percentage points since HEDIS 2008. The rate of 85.8 percent for HEDIS 2012 was just 1.1 percentage points below the 90th percentile of 86.9 percent. This was the fourth year in a row that the reported rate for **FHN** exceeded the National Medicaid HEDIS 2011 50th percentile.

Overall, **Harmony**'s rate has increased 7.7 percentage points since HEDIS 2008. However, the rates since HEDIS 2009 have remained fairly constant, with the HEDIS 2012 rate only 0.2 percentage points higher than HEDIS 2011.

**Figure 6.29—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—Monitoring for Nephropathy***
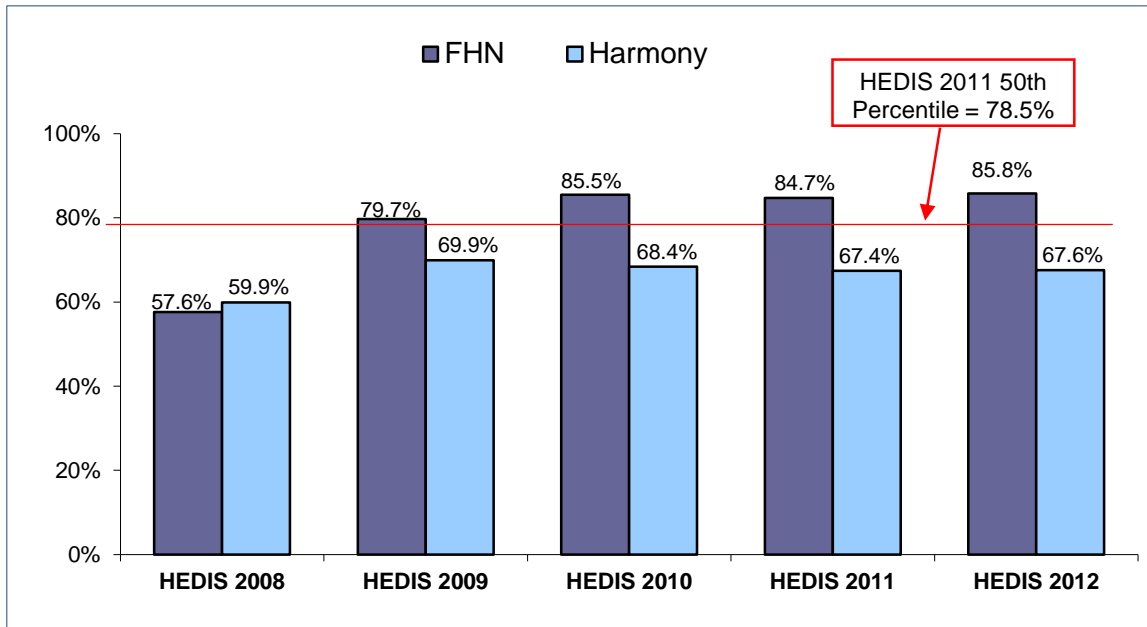
Comprehensive Diabetes Care—Blood Pressure < 140/90

Figure 6.30 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure (< 140/90).*

FHN's rate for this measure has increased 1.5 percentage points since HEDIS 2008. The HEDIS 2012 rate was 2.0 percentage points lower than HEDIS 2011.

Harmony's rate improved for HEDIS 2009, but it has shown a slight but steady decline for the past four years. Overall, **Harmony**'s rate for HEDIS 2012 was 3.7 percentage points higher than the rate reported for HEDIS 2008.

Both rates reported by the MCOs were below the National Medicaid HEDIS 2011 50th percentile of 61.2 percent.

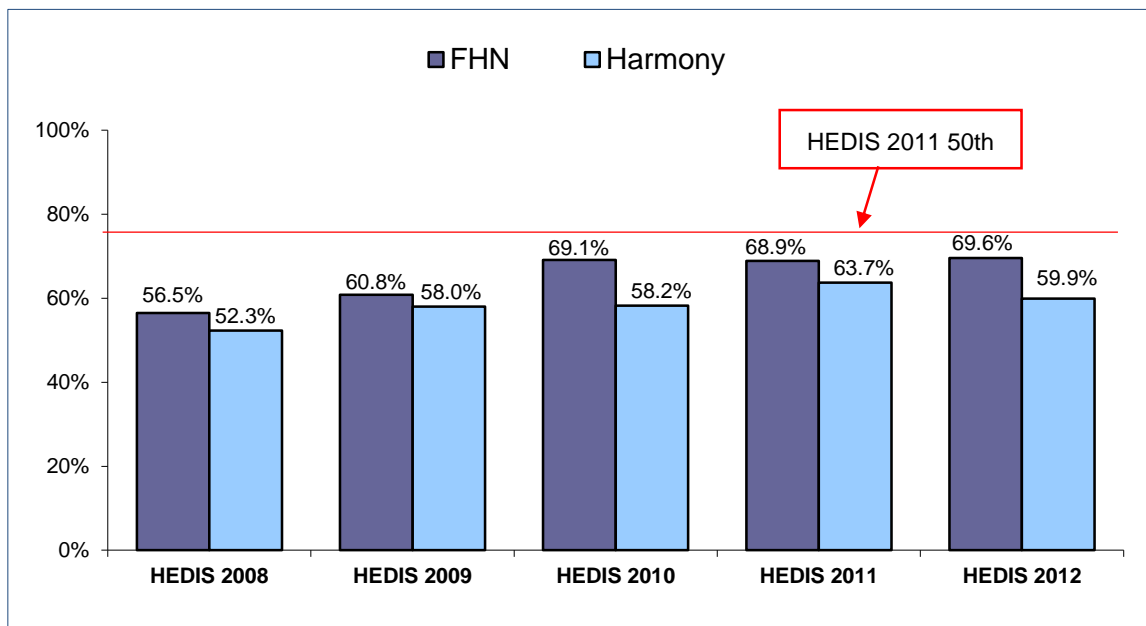**Figure 6.30—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—Blood Pressure <140/90***
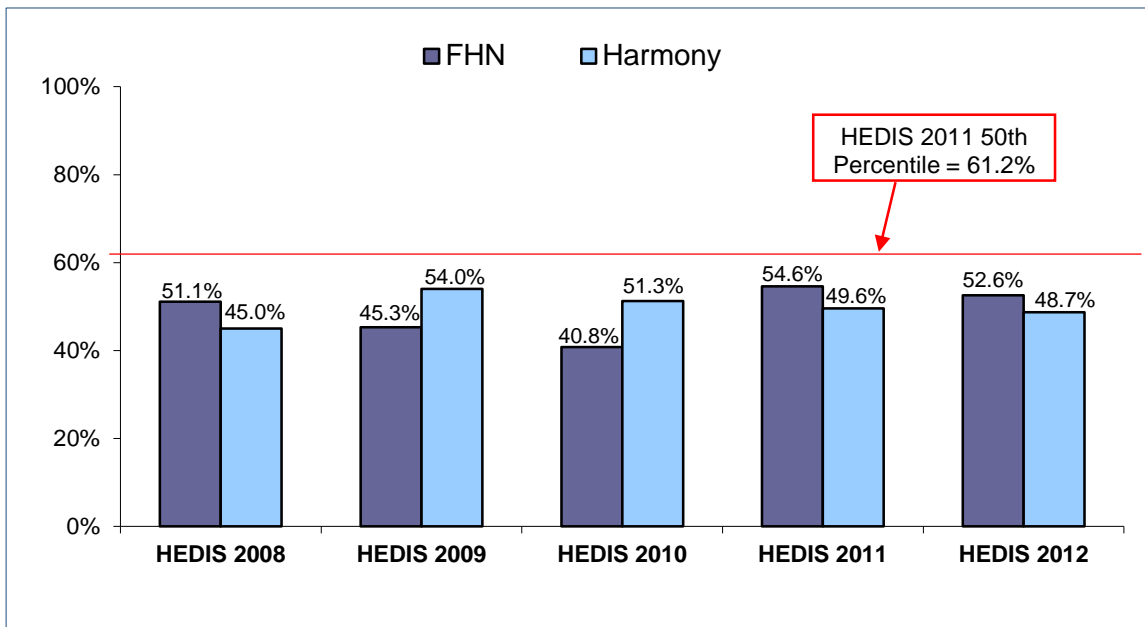
Comprehensive Diabetes Care—Blood Pressure < 140/80

Figure 6.31 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure <140/80*. Formerly, this measure was reported for blood pressure <130/80. Therefore, although displayed on the graph, comparisons to prior years should be viewed with caution. Direct comparisons between years and with percentiles are not appropriate.

The rate for **FHN** was 30.8 percent for HEDIS 2012, or approximately 3.6 percentage points lower than for the previous year. The rate for **Harmony**, at 31.1 percent, was identical to 2011.

Figure 6.31—Comparison of HFS MCO Performance
for *Comprehensive Diabetes Care—Blood Pressure <140/80*

Note: For HEDIS 2011, the specifications for this measure changed from BP<130/80 to BP<140/80.
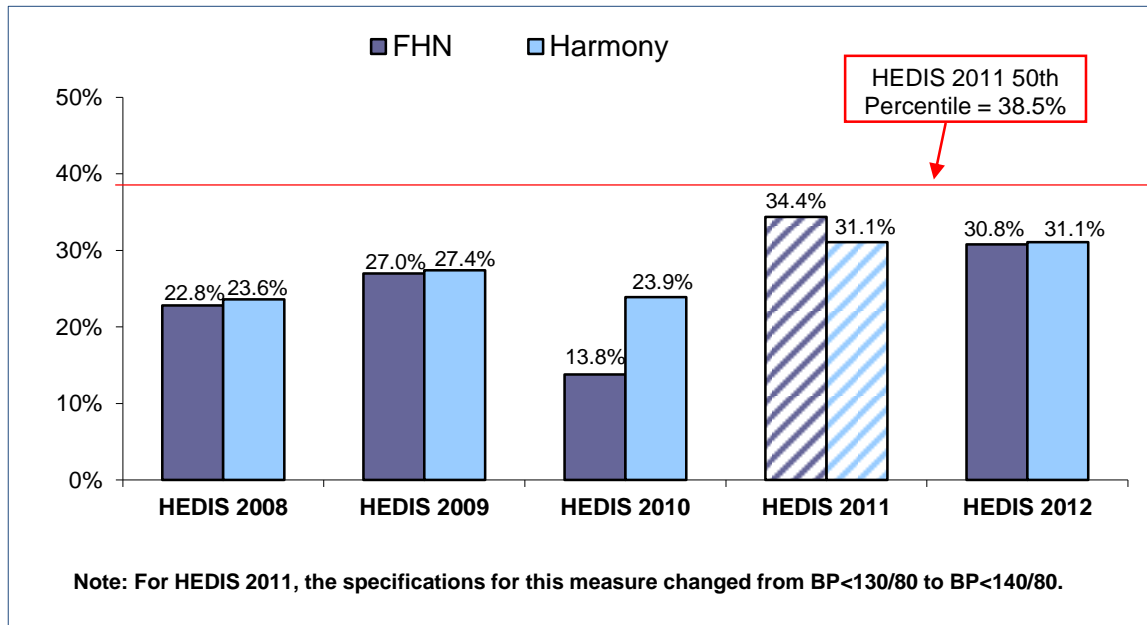
Use of Appropriate Medications for People With Asthma

Figure 6.32 presents the comparative performance of **FHN** and **Harmony** for *Use of Appropriate Medications for People With Asthma (Combined)*. This measure has undergone multiple changes to the technical specifications since HEDIS 2008. For HEDIS 2010, the HEDIS technical specifications were modified for the age range; the age range was changed from 5–56 years of age to 5–50 years of age. This year, the age range was again modified to 5–64 years of age. For both **FHN** and **Harmony,** this change had less than a 1 percentage point impact on the rates for this measure; therefore, this measure was still trended. However, due to the changes, there were no available percentiles. As mentioned earlier in this section, **Meridian** did not have at least 30 eligible cases for this measure; therefore, the rate is not presented.

The rate for **FHN** has improved by 8.8 percentage points since HEDIS 2008. The last two years have shown a slight decline in the rate each year. By contrast, the rate for **Harmony** had shown very little improvement each year, and in 2012 it declined 4.2 percentage points below the rate reported for HEDIS 2008. Additional analysis determined that this was not caused by the new age group; **Harmony**'s rate excluding the 51–64 year age group would have been 80.1 percent, or just 0.2 percentage points higher.

**Figure 6.32—Comparison of HFS MCO Performance
for *Use of Appropriate Medications for People With Asthma (Combined)***
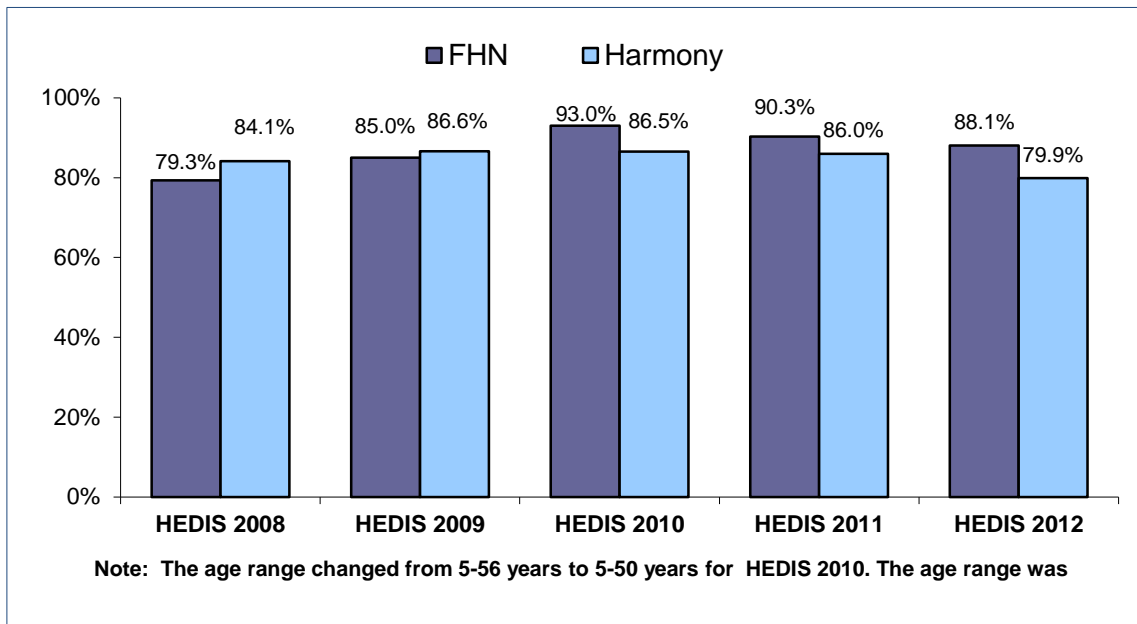
Follow-up After Hospitalization for Mental Illness—7 Days

Figure 6.33 and Figure 6.34 below present the comparative rates for *Follow-up After Hospitalization for Mental Illness (7 Days and 30 Days)*.

FHN's rate of 69.2 percent was well above the National Medicaid HEDIS 2011 50th percentile of 45.1 percent for the fifth straight year, and it was actually higher than the 90th percentile of 68.3 percent (not shown in the figure). The rate for **FHN** has improved by 12.8 percentage points since HEDIS 2008.

Harmony's rate, which had initial improvement until HEDIS 2010, declined from 42.7 percent for HEDIS 2011 to 41.8 percent for HEDIS 2012. This marked the second year of decline for **Harmony**. However, compared to HEDIS 2008, the overall trend is still up, and **Harmony** has improved 21.8 percentage points since HEDIS 2008.

**Figure 6.33—Comparison of HFS MCO Performance
for *Follow-up After Hospitalization for Mental Illness (7 Days)***

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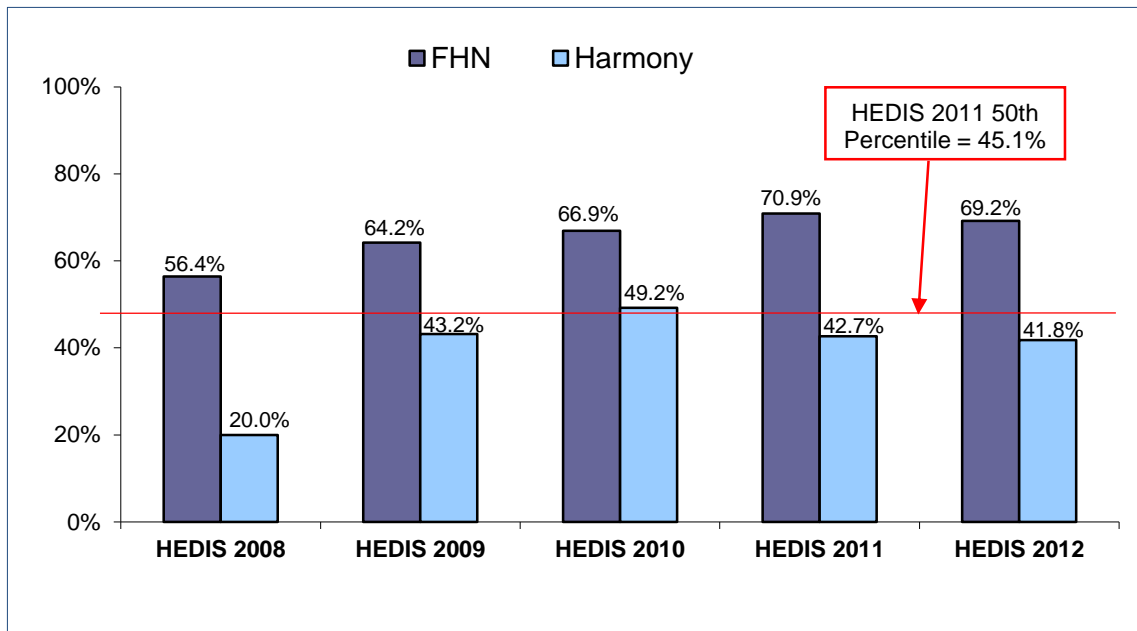
Follow-up After Hospitalization for Mental Illness—30 Days

For 30-day follow-up, **FHN**'s rate improved from 67.9 percent to 80.5 percent, or 12.6 percentage points since HEDIS 2008. This rate was once again well above the National Medicaid HEDIS 2011 50th percentile of 66.6 percent. This was the fifth straight year that **FHN** exceeded the 50th percentile.

Harmony's rate has improved by 24.8 percentage points since HEDIS 2008. However, the last three years have been fairly constant, with little to no real improvement. The rate for 2012 improved by 1.0 percentage point from the previous year, but it was still below the 50th percentile.

Figure 6.34—Comparison of HFS MCO Performance for *Follow-up After Hospitalization for Mental Illness (30 Days)*
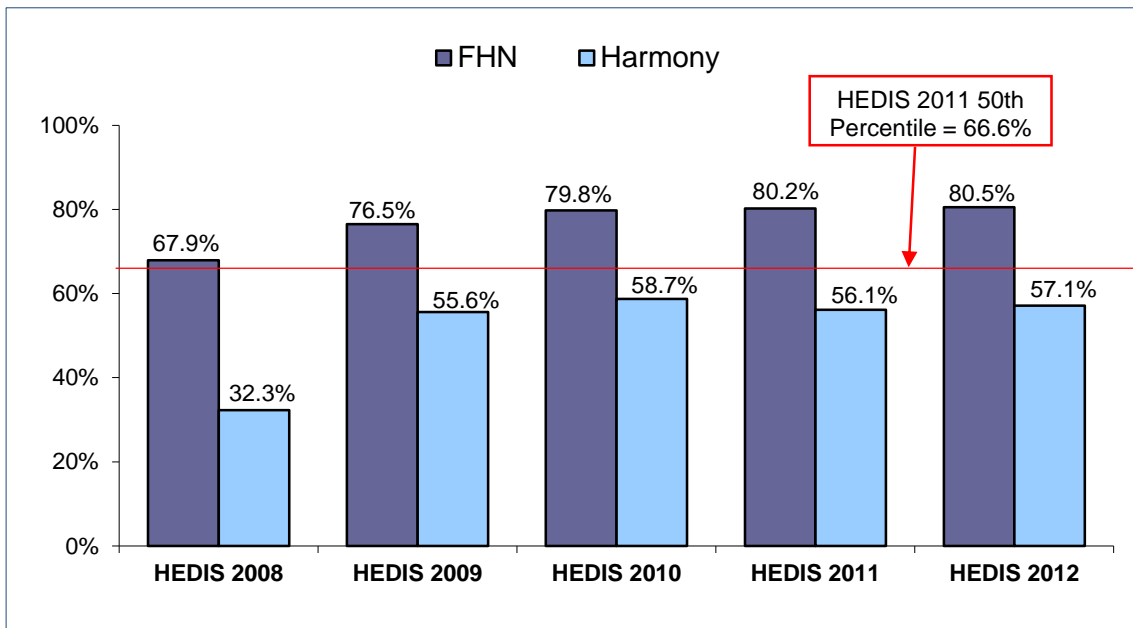
Encounter Data Completeness

Table 6.16 provides an estimate of the data completeness for the hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last two columns indicates that the encounter data was complete for that HEDIS measure. **Meridian** is not included since it only used administrative data. Rates highlighted in green indicate a 90.0 percent or more encounter data completion rate, while rates highlighted in red indicate a 50.0 percent or less encounter data completion rate.

Table 6.16—Estimated Encounter Data Completeness for Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent Encounter Data	
	FHN	**Harmony**	**FHN**	**Harmony**
Childhood Immunizations—Combo 2	72.0	68.9	**6.4**	78.3
Childhood Immunizations—Combo 3	69.9	64.0	**6.0**	69.6
Lead Screening in Children	82.9	79.1	77.1	**96.3**
Well-Child Visits in the First 15 Months (6+ Visits)	50.1	51.3	**48.8**	79.6
Well-Child Visits (3–6 Years)	73.0	65.2	84.8	**92.5**
Adolescent Well-Care Visits	44.1	35.5	83.8	**91.8**
Immunizations for Adolescents (Combined Rate)	44.8	38.7	66.5	83.0
Cervical Cancer Screening	71.5	71.5	80.4	**95.9**
Frequency of Ongoing Prenatal Care (81–100%)	43.0	42.1	52.2	82.1
Timeliness of Prenatal Care	69.8	64.7	**34.1**	54.5
Postpartum Care	45.0	49.6	**28.2**	67.6
Diabetes Care (HbA1c Testing)	79.5	71.1	**8.5**	**92.8**
Diabetes Care (Good HbA1c Control)	36.4	29.4	**0.0**	**22.3**
Diabetes Care (Eye Exam)	44.7	27.5	62.8	**90.3**
Diabetes Care (LDL-C Screening)	69.6	59.9	**12.5**	**90.2**
Diabetes Care (LDL-C Level <100 mg/Dl)	27.7	22.4	**0.0**	**37.0**
Diabetes Care (Nephropathy Monitoring)	85.8	67.6	**34.6**	**95.3**

None of the encounter data was more than 90.0 percent complete for **FHN.** Three measures had encounter data completeness rates of more than 80.0 percent, an additional measure was above 70 percent, and three measures had data completeness rates between 50.0 and 70.0 percent. The other 10 measures had data completeness rates below 50 percent. Although some encounter data

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completeness has improved, these results indicate that **FHN** continues to have difficulty obtaining complete encounter data for all the measures. **FHN** is strongly encouraged to continue its efforts on improving encounter data submission.

Harmony's encounter data submission rates were higher than **FHN**'s rates for every measure. **Harmony** had eight measures with more than a 90.0 percent encounter data completeness (compared to two measures for HEDIS 2011). Only two measures had less than a 50.0 percent data completeness level for HEDIS 2012. **Harmony** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission.

Summary of Findings and Recommendations

The following is a brief summary of the findings and recommendations regarding the performance measures in this report:

◆ **FHN** had nine measures with rates that exceeded the 2011 HEDIS Medicaid 50th percentiles. These included two measures in the Child and Adolescent Care category, four measures in Preventive Screening for Women, and three measures in the Chronic Conditions/Disease Management category. In addition, **FHN** had 33 of the 35 trended measures improve since HEDIS 2008, with 23 of those measures improving by more than 10.0 percentage points. Compared to the 50th percentiles, **FHN** performed the lowest on measures related to maternity care and access to care where none of the measures exceeded the 50th percentiles.

◆ **Harmony** reported two measures with rates at or above the Medicaid 2011 HEDIS 50th percentiles: *Lead Screening in Children* and *Cervical Cancer Screening.* In addition, 32 of the 35 trended measures improved since HEDIS 2008 or the baseline rate, and 19 measures improved by more than 10.0 percentage points. Four rates improved by more than 20.0 percentage points: *Childhood Immunization Status (Combo 3)*, *Well-Child Visits in the First 15 Months of Life (6+ Visits)*, and *Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day).* Compared to the 50th percentiles, **Harmony** generally performed the lowest on maternity-related measures, diabetes care measures, and access measures.

◆ Due to its low population size, **Meridian** did not have more than 30 eligible members for many of the HEDIS 2012 measures. **Meridian** reported 19 out of 20 measures with rates at or above the Medicaid 2011 HEDIS 50th percentiles. An additional 16 measures had NA recorded for the rate since **Meridian** had fewer than 30 eligible cases for those measures. Only *Children's Access to PCPs (7–11 Years)*, at 81.3 percent, was below the HEDIS 2011 Medicaid 50th percentile.

◆ The low rates for *Children's Access to PCPs* and *Adults' Access to Preventive Ambulatory Care* services indicate that both **FHN** and **Harmony** need to improve access to care. The rates continued to improve, but they still remain low and well below the national 50th percentiles. This finding

was mentioned in the past three annual reports, and the recommendation remains the same: both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers, and evaluate internal policies regarding member and provider education. The MCOs and the State should also consider a PIP around these measures.

◆ The rates for **FHN** for measures in the Preventive Screening for Women category improved over 2011, but they remain fairly low. **FHN** showed improvement over 2011 for *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women*; however, the rate for *Breast Cancer Screening* still remained below the 50th percentile. The rates for **Harmony** improved over 2011 for *Breast Cancer Screening* , *Cervical Cancer Screening*, and *Chlamydia Screening*; however, the *Breast Cancer Screening* and *Chlamydia Screening* rates still remain below the 50th percentiles. **FHN** and **Harmony** continue to report rates well below the 25th percentile for the maternity-related measures. In 2007, the MCOs began a PIP that includes these maternity-related measures. In 2012, **FHN** reported improved rates for *Frequency of Ongoing Prenatal Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*. In contrast, the rates for **Harmony** remained about the same for *Timeliness of Prenatal Care* as reported in 2011. **Harmony** did show improved rates for *Frequency of Ongoing Prenatal Care* and *Postpartum Care*. The MCOs should begin evaluating the effectiveness of their interventions for these PIPs, which may lead to improvement in their HEDIS rates.

◆ As also mentioned in the annual report for the past few years, both **FHN** and **Harmony** continue to struggle to improve their rates for the *Comprehensive Diabetes Care—Eye Exam* measure. **FHN** has shown significant improvement in this measure; however, both **FHN** and **Harmony** need to conduct an analysis to determine the reason the rate continues to be so low for this measure. The MCOs and the State should also consider a PIP around this measure.

◆ The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7-day rate exceeding the 90th percentile and the 30-day rate exceeding the 75th percentile. However, both rates for **Harmony** fell, with the 7-day rate below the 50th percentile and the 30-day rate at the 25th percentile.

◆ Overall, the results show that **FHN** does not receive all of its encounter data although it has improved since 2011. Ten measures had less than a 50.0 percent encounter data completeness rate (compared to 12 measures in 2011). Seven of the HEDIS measures had more than a 50.0 percent encounter data completeness rate, but none of the measures had a data completion rate at or above 90.0 percent. **FHN** continues to demonstrate difficulty in obtaining complete encounter data for childhood immunizations, timeliness of prenatal care, postpartum care, and the lab-related measures for diabetes care. **FHN** should concentrate efforts on obtaining more complete encounter data from providers.

◆ The rates indicate **Harmony** has reasonably good encounter data completeness. Eight measures had more than a 90.0 percent data completion rate, two were above 80.0 percent, two were above 70.0 percent, and two measures were above 60.0 percent. However, two of the

measures had data completeness rates of less than 50.0 percent. Both of these measures were related to lab results for the *Comprehensive Diabetes Care* measure. **Harmony** should concentrate its efforts toward obtaining complete lab data.

Validation of Performance Improvement Projects

Objectives

As part of its quality assessment and performance improvement program, HFS requires each VMCO to conduct PIPs in accordance with 42 CFR 438.240. The purpose of a PIP is to achieve through ongoing measurements and intervention significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving VMCO processes can have a favorable effect on health outcomes and member satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted VMCOs and prepaid inpatient health plans (PIHPs). HFS contracted with HSAG to meet this validation requirement.

The primary objective of PIP validation was to determine each health plan's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measuring performance using objective quality indicators.

- Implementation of systematic interventions to achieve improvement in quality.

- Evaluation of the effectiveness of the interventions.

- Planning and initiation of activities for increasing or sustaining improvement.

Conducting the Review

For such projects to achieve real improvements in care and member satisfaction, as well as confidence in the reported improvements, PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time period.

Technical Methods of Data Collection and Analysis

The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities,* Final Protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with HFS, developed the PIP Summary Form, which each MCO completed and submitted to HSAG for review and evaluation. The PIP Summary

Form standardized the process for submitting information regarding PIPs and ensured that the projects addressed all CMS PIP protocol requirements.

HSAG, with HFS's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS PIP Protocol activities:

- Activity I. Appropriate Study Topic

- Activity II. Clearly Defined, Answerable Study Question

- Activity III. Clearly Defined Study Indicator(s)

- Activity IV. Correctly Identified Study Population

- Activity V. Valid Sampling Techniques (if Sampling Was Used)

- Activity VI. Accurate/Complete Data Collection

- Activity VII. Appropriate Improvement Strategies

- Activity VIII. Sufficient Data Analysis and Interpretation

- Activity IX. Real Improvement Achieved

- Activity X. Sustained Improvement Achieved

HSAG calculated the percentage score of evaluation elements met for each MCO and ICP by dividing the total elements *Met* by the total elements *Met*, *Partially Met*, and *Not Met*. Any evaluation element that received a *Not Applicable* or *Not Assessed* designation was not included in the overall score. While all elements are important in assessing a PIP, HSAG designated some elements as critical to producing valid and reliable results and for demonstrating high confidence in the PIP findings. These critical elements must be *Met* for the PIP to be in compliance. The percentage score of critical elements *Met* was calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*. A *Partially Met* validation status indicates low confidence in the reported PIP results.

Findings

Table 7.1 displays the overall validation results for each activity and each stage of the PIP across all PIPs validated by HSAG.

Table 7.1—Validation Results Across all VMCO PIPs

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Appropriate Study Topic	100% (90/90)	0% (0/90)	0% (0/90)
	II. Clearly Defined, Answerable Study Question(s)	100% (30/30)	0% (0/30)	0% (0/30)
	III. Clearly Defined Study Indicator(s)	99% (95/96)	1% (1/96)	0% (0/96)
	IV. Correctly Identified Study Population	100% (45/45)	0% (0/45)	0% (0/45)
Design Total†		100% (260/261)	0% (1/261)	0% (0/261)
Implementation	V. Valid Sampling Techniques (if sampling was used)	100% (42/42)	0% (0/42)	0% (0/42)
	VI. Accurate/Complete Data Collection	91% (139/152)	4% (6/152)	5% (7/152)
	VII. Appropriate Improvement Strategies	94% (44/47)	6% (3/47)	0% (0/47)
Implementation Total		93% (225/241)	4% (9/241)	3% (7/241)
Outcomes	VIII. Sufficient Data Analysis and Interpretation†	76% (91/119)	18% (22/119)	5% (6/119)
	IX. Real Improvement Achieved†	36% (20/56)	54% (30/56)	11% (6/56)
	X. Sustained Improvement Achieved	40% (2/5)	60% (3/5)	0% (0/5)
Outcomes Total†		63% (113/180)	31% (55/180)	7% (12/180)
Overall PIP Results†		88% (598/682)	10% (65/682)	3% (19/682)

† The sum of the *Met*, *Partially Met*, and *Not Met* scores in each activity, stage, or overall may not equal 100 percent due to rounding.

Table 7.2 shows the current evaluation scoring for each MCO, the PIPs for which each MCO is responsible, and the current validation status of each PIP.

Table 7.2—Percent of All Elements *Met*

PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	96%	98%	88%
Perinatal Care and Depression Screening	88%	92%	93%
Improving Ambulatory Follow-Up and PCP Communication	84%	94%	86%

The validation scores of **FHN**, **Harmony**, and **Meridian**, demonstrate strong performance in the design and implementation phases for all three MCOs, indicating that each PIP was designed and implemented appropriately to measure outcomes and improvement. Opportunities for improvement exist for all three MCOs in achieving real and sustained improvement across all study indicators.

During SFY 2011–2012, HSAG conducted a validation and analysis of the *EPSDT Screening*, *Perinatal Care and Depression Screening*, and *Improving Ambulatory Follow-Up and PCP Communication* PIPs to evaluate the VMCOs' performance on the PIP indicators. The following is a result of that analysis.

EPSDT Screening PIP

Background

HFS required each VMCO to participate in a mandatory statewide PIP focused on improving performance related to EPSDT screenings and visits, including the content of care for children younger than 3 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and treatment becomes more costly. The goals of the *EPSDT Screening* PIP were to:

◆ Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.

◆ Improve the quantity and quality of EPSDT examinations through a collaborative process.

◆ Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

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Table 7.3 provides a list of the *EPSDT Screening* PIP study indicators validated for FY 2010–2011.

Table 7.3—*EPSDT Screening* PIP Study Indicators

Indicator	Description of Indicator
1	Total number of members with a health history documented on every EPSDT visit
2	Total number of members with a nutritional assessment performed on every EPSDT visit
3	Total number of members with a developmental screening documented on every EPSDT visit (Subjective and Objective)
4	Total number of members with anticipatory guidance documented on every EPSDT visit
5	Total number of members with a physical exam performed on every EPSDT visit
6	Total number of members with growth measurement documentation on every EPSDT visit
7	Total number of members with a hearing screening documented on every EPSDT visit
8	Total number of members with a vision screening documented on every EPSDT visit
9	Total number of members with a hematocrit or hemoglobin performed
10	Total number of members with other referrals documented

**Table 7.4—SFY 2011 Performance Improvement Project Outcomes
for the *EPSDT Screening* PIPs (N=3)**

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement[1]
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Family Health Network, Inc.	*	*	*	*	*	*	*
Harmony Health Plan of Illinois, Inc.	10	0	0	10	2	0	10
Meridian Health Plan, Inc.	10	4	2	6	2	0	‡
Overall Totals	**20**	**4**	**2**	**16**	**4**	**0**	**10**

[1] The number of study indicators that demonstrated sustained improvement.

‡ The PIP(s) did not progress to this phase during the review period and could not be assessed for sustained improvement.

*Per the PIP timeline, FHN was not required to submit HEDIS 2012 (CY 2011) data for the 2011-2012 validation cycle.

Results

Table 7.4 displays the outcomes for the EPSDT study indicators for each VMCO.

FHN was not required to submit remeasurement data for its EPSDT PIP this validation cycle. HSAG will assess **FHN**'s study indicator performance during the 2012–2013 validation.

Harmony demonstrated improvement for all 10 of its indicators, and the improvement achieved has been sustained. However, of the 10 indicators achieving improvement, only two achieved

statistically significant improvement. The lowest reported rate was 16.6 percent for members with a hematocrit or hemoglobin performed. Conversely, the highest rate, 48.2 percent, was reported for members with a nutritional assessment performed.

Meridian progressed to reporting Remeasurement 1 rates. Rates ranged from 0.5 percent for vision and hearing screening to 94.4 percent for nutritional assessments performed.

With the progression of the EPSDT PIP, 80 percent of all study indicators demonstrated improvement, and only 20 percent of this improvement was statistically significant. **Harmony** was the only plan that could be assessed for sustained improvement this year, and 100 percent of its study indicators met the criteria for sustaining the improvement.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The VMCOs' choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the performance improvement project's overall success.

For the *EPSDT Screening* PIP, all three VMCOs identified both member and provider barriers. The majority of the barriers across all plans were lack of provider knowledge about EPSDT criteria and medical record review guidelines, the need for standardized EPSDT documentation, lack of correct member contact information, and member's lack of knowledge regarding EPSDT well-child visits. To address and overcome these barriers, the following interventions were implemented:

- Conducted EPSDT chart reviews on 0–15 well-child noncompliant providers.

- One-on-one provider education was conducted by provider representatives on the EPSDT audit tool.

- Development of an educational EPSDT visit brochure for both providers and members.

- Noncompliance lists mailed or faxed to providers quarterly.

- Provider Pay for Performance incentive program.

- Improved member outreach efforts with health education mailings and Touchstar outbound calls.

- Community outreach events.

- Automated medical request process to improve the efficiency of the MRR process and decreasing repetitive outreach efforts to providers' offices and facilities for the EPSDT records.

◆ Issued education and growth charts for use in providers' offices for plotting growth and determining BMI percentiles.

The VMCOs participated in the Project LAUNCH collaborative, which is a cross-agency initiative that supports the EPSDT PIP interventions. The focus of Illinois Project LAUNCH is to promote mental health wellness, to link families with community-based programs, and to encourage families and providers to regularly access and use services that promote family wellness. The goal of Project LAUNCH is to ensure the healthy development of children from birth through age 8 in targeted zip codes. The program is being piloted in four Chicago zip codes: 60608, 60612, 60623, and 60624. Aims of this project are to increase screening and appropriate intervention services for children with developmental challenges, and to improve child well-being and school readiness by increasing families' ability to access appropriate services in their communities.

The VMCOs joined the partnership with Illinois Project LAUNCH to connect with hard-to-reach enrollees who reside in a targeted low-income, high-violence geographic area in Chicago. The extraordinary social issues in this area cause significant barriers for enrollees in prioritizing health care and accessing their medical home for preventive health care, including well-child screening services. Barriers to accessing health care identified for residents in this area included lack of transportation to medical appointments, lack of awareness of benefits available through the VMCOs, and lack of knowledge or relationship with their primary care provider or medical home.

Among the collaborative activities currently in process is the development of a member resource card and a provider resource card for use by Project LAUNCH outreach coordinators and community partners.

Perinatal Care and Depression Screening PIP

Background

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

The PIPs were based on the *Timeliness of Prenatal Care* and *Postpartum Care* HEDIS measures to identify the eligible population and to improve rates for these two measures. In addition to the HEDIS measures, the State and the VMCOs chose to determine the percentage of women who were enrolled in an Illinois Medicaid VMCO and were screened for depression during the prenatal and/or postpartum period. The primary purpose of this collaborative PIP was to determine if

VMCO interventions have helped to improve the rates for the perinatal HEDIS measures, along with depression screening for eligible women. A secondary goal was to determine potential opportunities to improve the rate of objective depression screening, along with appropriate treatment when depression is identified through screening and assessment. The study indicators for this PIP are as follows:

Table 7.5—*Perinatal Care and Depression Screening* PIP Study Indicators

Indicator	Description of Indicator
1	Timeliness of Prenatal Care (HEDIS Specifications)
2	Postpartum Care (HEDIS Specifications)
3a	Frequency of Ongoing Prenatal Care < 21%
3b	Frequency of Ongoing Prenatal Care 81%+
4	Women Who Were Screened for Depression During the Pregnancy and Prior to delivery
4a	Women Who Were Screened for Depression Within 56 days After Delivery
4b	Women Who Were Screened for Depression During the Pregnancy and Prior to Delivery or Within 56 days After Delivery
5	Women Who Had Treatment Within 7 Days for a Positive Depression Screen
6	Women Who Had a Referral Within 7 Days for a Positive Depression Screen
7	Women Who Had Follow-Up Within 7 Days for a Positive Depression Screen
8	Women Who Had Treatment Within 14 Days for a Positive Depression Screen
9	Women Who Had a Referral Within 14 Days for a Positive Depression Screen
10	Women Who Had Follow-Up Within 14 Days for a Positive Depression Screen
11	Women Who Had Treatment Within 30 Days for a Positive Depression Screen
12	Women Who Had a Referral Within 30 Days for a Positive Depression Screen
13	Women Who Had Follow-Up Within 30 Days for a Positive Depression Screen

**Table 7.6—SFY 2011 Performance Improvement Project Outcomes
for the *Perinatal Care and Depression Screening* PIPs (N=3)**

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement[1]
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Family Health Network, Inc.	13¥	1	0	11	6	1*	6
Harmony Health Plan of Illinois, Inc.	16	8	3	8	0	0	11
Meridian Health Plan, Inc.	16	4	1	9	6	3*	‡
Overall Totals	**45**	**13**	**4**	**28**	**12**	**4**	**17**

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

Results

Table 7.6 displays the outcomes for the *Perinatal Care and Depression Screening* study indicators for each VMCO.

Overall, for the most recent measurement period, **FHN** demonstrated the best performance with 11 of its study indicators achieving improvement; and for six of those indicators, the improvement was statistically significant. Rates ranged from 0 percent for treatment and referral within 30 days following a positive screen for depression to 62.4 percent for members with timely prenatal care.

Eight of **Harmony**'s 16 study indicators demonstrated improvement, and eight declined. Three of the declines in performance were statistically significant during the most recent measurement period, while none of the improvement achieved was statistically significant. Although **Harmony**'s performance was not optimal, overall, 11 of the indicators have sustained improvement over comparable time periods without a statistical decline. The lowest reported rate was 17 percent for frequency of ongoing prenatal care <21 percent, and the highest reported rate was 64.7 percent for timeliness of prenatal care.

Meridian progressed to reporting Remeasurement 1 data for this measurement period. Of its 16 study indicators, nine indicators improved with six of the indicator's improvement statistically significant. Four study indicators demonstrated declines in performance with one of the declines statistically significant (women who were screened for depression during the pregnancy and prior to delivery). Rates ranged from 0 percent for treatment within 7, 14, or 30 days for women with a positive screen for depression to 100 percent for women who had a referral or follow-up within 7, 14, and 30 days of a positive depression screening.

With the progression of the PIPs, 62 percent of all study indicators evaluated achieved improvement, and 38 percent were able to sustain the improvement.

Barriers/Interventions

Based on the barriers identified and discussed for the *Perinatal Care and Depression Screening* PIP, **FHN** implemented its "2 Part Pay for Quality Program." Part 1 of this program included payment for electronically submitted encounter data for HFS Pay for Quality measures and Part 2 included HFS Pay for Quality Program. All monies earned are paid to the medical groups. The MCO also implemented a $25 incentive to providers for notifying **FHN** of pregnant members. The incentive was paid at the first notification. **FHN** also enhanced its provider education concerning availability and use of PsycHealth (**FHN**'s behavioral health subcontractor). **FHN** is confident that implementation of these interventions will have a favorable impact on health care outcomes in future remeasurement years.

In 2011, **Harmony** documented that lack of member knowledge and its member reach rate continued to be barriers that need to be addressed. To address the identified barriers, **Harmony** member services staff updated member contact information each time there was contact with a member. Additionally, hospital discharge follow-up telephone calls are made to members to assist with scheduling the postpartum visit and arrange transportation, if needed. **Harmony** also made changes to its "Harmony Hugs" program. The previous program was an opt-in program, and not all members were included in the program. Now, all members are eligible for the program and receive a packet that includes a booklet containing articles about prenatal care, postpartum care, and depression screening.

The MCO also identified lack of knowledge of the Independent Physicians Association (IPA) and providers as a barrier. To overcome this barrier, **Harmony** conducted one-on-one on-site education with the IPAs. During these educational meetings, the IPAs are educated on IPA and physician report cards, member noncompliant lists, using correct billing codes, importance of submitting encounters, importance of screening members for depression, and how to document screenings in the medical record. The MCOs executive staff is also educating the IPAs and providers about the importance of referrals.

Meridian obtained approval from HFS to implement approved incentives to members who initiate prenatal care within the first trimester, as well as an incentive for providers to reward them for delivering prenatal care, the frequency of ongoing prenatal care, and postpartum care within the national guidelines for HEDIS. The MCO also implemented and educated providers on the use of a standardized prenatal and postpartum screening tool. The Edinburgh Perinatal Depression Screening tool will assist the providers in performing objective perinatal depression screenings for early identification, assessment, referral, and treatment. **Meridian** established a process to overcome inaccurate member telephone contact information. For those members whose telephone number was invalid on the demographic information provided by the State of Illinois Medicaid Program eligibility information or had changed without the MCO being notified, the MCO sends a "no phone no answer" tri-fold brochure urging them to contact the MCO as soon as possible to discuss very important preventive health information. The MCO also developed a process whereby all prenatal high-risk and prenatal and postpartum depression results are faxed to the OB practitioner and primary care provider to review and perform additional assessment, referral, and treatment, as necessary.

Improving Ambulatory Follow-Up and PCP Communication PIP

Background

In SFY 2008–2009, HFS required that each VMCO participate in a statewide PIP on improving ambulatory follow-up and PCP communication. This is a two-part collaborative study between the

State, EQRO, and MCOs that began in 2009. The study was developed based on the HEDIS 2010 Technical Specifications for the *Follow-up After Hospitalization for Mental Illness* measure. Appropriate follow-up care reduces the risk of repeat hospitalization and identifies those in need of further hospitalization before the member reaches the point of crisis. Communication and coordination of care between medical and behavioral health providers is a best practice principle essential to ensure consumer safety and optimal clinical outcomes. The goals of this PIP are to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral health care providers. The *Improving Ambulatory Follow-up and PCP Communication* PIP had four study indicators that are outlined in Table 7.7.

Table 7.7—*Improving Ambulatory Follow-Up and PCP Communication* PIP Study Indicators

Indicator	Description of Indicator
1	Total Number of Discharges from an Acute Care Facility for Members Who Had an Outpatient or Intermediate Mental Health Visit on the Date of Discharge up to 7 Days after Hospitalization
2	Total Number of Discharges from an Acute Care Facility for Members Who Had an Outpatient or Intermediate Mental Health Visit on the Date of Discharge up to 30 Days after Hospitalization
3	Total Number of Inpatient Treatment Records and MCO Care Management Records Having Communication With the Members Primary Care Physician (PCP) or Primary Medical Provider
4*	Total Number of MCO Care Management Electronic Records Having Documented Communication With The Members Primary Care Physician (PCP) or Primary Medical Provider

*Only Harmony Health Plan measured Study Indicator 4 for internal tracking purposes. The other two MCOs did not measure this study indicator.

Table 7.8—SFY 2011 Performance Improvement Project Outcomes for the *Improving Ambulatory Follow-Up and PCP Communication* PIPs (N=3)

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement[1]
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Family Health Network, Inc.	3	1	0	2	0	0	‡
Harmony Health Plan of Illinois, Inc.	3	3	2	0	0	0	‡
Meridian Health Plan, Inc.	3	1	0	1	0	1*	‡

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement[1]
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Overall Totals	9	5	2	3	0	1	‡

[1] The number of study indicators that demonstrated sustained improvement.
‡ The PIP(s) did not progress to the point of being assessed for sustained improvement.
* The rates did not change between the prior measurement period and the current measurement period.

Results

Table 7.8 displays the outcomes for the Improving Ambulatory Follow-Up and PCP Communication study indicators for each VMCO.

FHN's performance at Remeasurement 1 shows two study indicators with non-statistically significant improvement and one with a non-statistically significant decline. The results ranged from 0.9 percent for total number of inpatient treatment records and MCO Care Management records having communication with the member's primary care physician (PCP) or primary medical provider to 80.2 percent for total number of discharges from an acute care facility for members who had an outpatient or intermediate mental health visit on the date of discharge up to 30 days after hospitalization.

Harmony's performance demonstrates that all three study indicators declined with two of the declines statistically significant. The rates ranged from 46.7 percent for total number of inpatient treatment records and MCO Care Management records having communication with the member's primary care physician (PCP) or primary medical provider to 56.1 percent for total number of discharges from an acute care facility for members who had an outpatient or intermediate mental health visit on the date of discharge up to 30 days after hospitalization.

Meridian's rates showed mixed performance. Study Indicator 1 achieved non-statistically significant improvement at Remeasurement 1 with a rate of 71 percent; and Study Indicator 3 demonstrated a non-statistically significant decline with a rate of 0 percent. Study Indicator 2's baseline rate was 100 percent, and the MCO was able to maintain that 100 percent at the first remeasurement.

With the progression of this PIP, only 30 percent of all indicators demonstrated improvement and 50 percent declined in performance. These results show that opportunities for improvement exist for all three VMCOs.

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Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The VMCO's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the PIP's overall success.

For the *Improving Ambulatory Follow-up and PCP Communication* PIP, a collaborative meeting occurred between the State, EQRO, and MCOs to discuss barriers. Based on the outcomes of this meeting, the MCOs implemented the following interventions:

◆ Member outreach calls within two business days of discharge from an inpatient facility to confirm the treatment plan.

◆ Provider outreach call after an appointment within seven calendar days to confirm that follow-up occurred.

◆ If unable to confirm follow-up within seven days, a minimum of two additional outreach calls to the member are made to continue efforts to link the member with timely follow-up within 30 days.

◆ If unable to reach the member after a minimum of three telephone contacts, an outreach letter is sent to the member informing the member of the importance of continued care and available services.

In addition to these collaborative efforts, the VMCOs implemented plan-specific interventions such as providing transportation, educating inpatient facility staff on the importance of coordinating care with other providers, and creating provider and member educational newsletters.

Community Based Care Coordination PIP—Integrated Care Program

Background

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

HFS required each Integrated Care Plan (ICP) to participate in a mandatory statewide PIP focused on improving care coordination and the linkage of the member/client to ambulatory care and community services. Through monthly and quarterly meetings the ICPs with assistance from HSAG developed the study question, indicators, and data sources. The PIP focused on the

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relationship between care coordination, timely ambulatory care services and readmission rates < 30 days post discharge. The study population was members stratified as high and moderate risk in order to:

◆ Decrease the rate of medical inpatient readmissions within 30 days of a previous admission with the same diagnoses for identified members.

◆ Improve health outcomes, baseline level of functioning and quality of life.

◆ Promote patient-centered care.

◆ Foster member engagement and accountability and improve ability to effectively manage their own health conditions.

◆ 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.

◆ The baseline measurement data for this PIP will be collected in SFY 2013.

The Community Based Care Coordination PIP had three study indicators that are outlined in Table 7.9.

Table 7.9—Community Based Care Coordination PIP Study Indicators

Indicator	Description of Indicator
1	Total number of high to moderate risk members who do not have a readmission within 30 days of an acute care hospitalization.
2	Total number of high to moderate risk members who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge.
3	Total number of high to moderate risk members accessing community resources within 14 days of discharge.

Table 7.10 displays the validation results for each activity and each stage of the PIP for both ICP plans. Both ICPs did not progress to the point of reporting data during this validation period; therefore, only Activities I through V were validated.

Table 7.10—PIP Validation Results Across All ICP PIPs

PIP Study Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	I. Appropriate Study Topic	100% 4/4	0% 0/4	0% 0/4
	II. Clearly Defined, Answerable Study Question(s)	100% 2/2	0% 0/2	0% 0/2

PIP Study Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	III. Clearly Defined Study Indicator(s)	100% 6/6	0% 0/6	0% 0/6
	IV. Correctly Identified Study Population	100% 2/2	0% 0/2	0% 0/2
Design Total		100% 14/14	0% 0/14	0% 0/14
Implementation	V. Valid Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Accurate/Complete Data Collection	Not Assessed		
	VII. Sufficient Data Analysis and Interpretation	Not Assessed		
Implementation Total		Not Assessed		
Outcomes	VIII. Appropriate Improvement Strategies	Not Assessed		
	IX. Real Improvement Achieved†	Not Assessed		
	X. Sustained Improvement Achieved	Not Assessed		
Outcomes Total†		Not Assessed		
Overall PIP Results†		100% 26/26		

Table 7.11 displays the overall validation percentage for each individual ICP.

Table 7.11—PIP Validation Results Across All ICP PIPs

PIP Topics	Aetna Better Health Plan	IlliniCare Health Plan
Community Based Care Coordination	100%	100%

Both **Aetna** and **IlliniCare** developed solid study designs on which to build as the PIP progresses.

Overall Recommendations

◆ The MCOs should build on any existing momentum for study indicators demonstrating statistically significant improvement and implement new and/or enhanced quality improvement interventions for study indicators lacking the desired outcomes.

◆ The MCOs should implement a method to evaluate the effectiveness of each intervention implemented. The results of each intervention's evaluation should be included in the PIP documentation. If the interventions are not having the desired effect, the MCO should discuss how it will address these deficiencies by modifying or discontinuing current interventions or implementing new improvement strategies.

◆ The MCOs should continue to conduct and document an annual causal/barrier analysis and drill-down analysis in addition to periodic analyses of its most recent data. The results of this

analysis should be well documented in the PIP Summary Form. The MCOs should prioritize barriers and ensure that all interventions implemented are logically linked to the barriers and can directly impact study indicator outcomes.

◆ As the ICPs progress to collecting and analyzing baseline data, each plan should be conducting its causal/barrier analysis, prioritizing the identified barriers, and implementing active interventions that are logically linked to the barriers and will directly impact study indicator outcomes.

Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **Aetna**, **FHN**, **Harmony**, and **IlliniCare** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. **Aetna**'s, **FHN**'s, **Harmony**'s, and **IlliniCare**'s results were forwarded to HSAG for analysis. The CAHPS results are presented by program type with **FHN**, **Harmony**, and **Meridian** included under Voluntary Managed Care Programs (VMCOs), and **Aetna** and **IlliniCare** included under Integrated Care Plan (ICP) programs.

Due to its size, **Meridian** was allowed to create and administer its own consumer satisfaction survey. The survey questions asked patients to report on their experiences with **Meridian** and addressed health care topics, such as patient wait time, doctor communication, office staff, smoking cessation, and rating of doctor and were based on the Adult CAHPS survey questions. As such, **Meridian**'s Member Satisfaction Survey was not congruent with the CAHPS surveys and the technical methods of data collection and analysis differed. A description of these technical methods is included with **Meridian**'s survey results later in this section of the report.

The overarching objective of the CAHPS surveys and **Meridian**'s Member Satisfaction Survey was to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences. **Meridian**'s survey results are included later in this section of the report following those of **FHN**'s **and Harmony**'s for the VMCOs.

CAHPS Survey

Technical Methods of Data Collection and Analysis

Voluntary Managed Care Organizations (VMCOs)

For **FHN** and **Harmony**, the adult Medicaid and child Medicaid populations were surveyed. The Myers Group administered the CAHPS surveys on behalf of **FHN** and **Harmony**.

The technical method of data collection was through administration of the CAHPS 4.0H Adult Medicaid Survey to the adult population and the CAHPS 4.0H Child Medicaid Survey to the child population. **FHN** and **Harmony** used a mixed methodology for data collection, which included

both a mail and telephone surveys for data collection, and offered the surveys in English or Spanish. **Meridian**'s survey, technical methods of data collection, and analysis are discussed below as they differed from the CAHPS survey.

Integrated Care Plans (ICPs)

For **Aetna** and **IlliniCare**, the adult Medicaid populations were surveyed. The Myers Group administered the CAHPS surveys on behalf of **IlliniCare.** The Center for the Study of Services (CSS) administered the CAHPS survey on behalf of **Aetna**.

The technical method of data collection was through administration of the CAHPS 4.0H Adult Medicaid Survey to the adult population. **Aetna** and **IlliniCare** used a mixed methodology for data collection, which included both mail and telephone surveys for data collection and offered the surveys in English or Spanish.

Survey Measures

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). NCQA requires a minimum of 100 responses on each item to report the measure as a valid CAHPS Survey result; however, for purposes of this report, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. Measures that did not meet the minimum number of 100 responses are denoted in the tables with an asterisk (*).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box response).

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always," or (2) "Definitely No," "Somewhat No," "Somewhat Yes," and "Definitely Yes." For 2012, a positive or top-box response for four of the composites (*Getting Needed Care, Getting Care Quickly, How Well Doctors*

Communicate, and *Customer Service*) was defined as a response of "Usually" or "Always." [8-1] For one composite (*Shared Decision Making*), a positive or top-box response was defined as a response of "Definitely Yes." The percentage of top-box responses was referred to as a global proportion for the composite scores.

For **FHN**'s and **Harmony**'s plan-specific findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points from 2011 to 2012. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points from 2011 to 2012.[8-2] Additionally, for **FHN**, **Harmony**, **Aetna**, and **IlliniCare,** a substantial difference is noted when a measure's rate is 5 percentage points higher or lower than the 2012 NCQA CAHPS top-box average.

Program-Specific Findings—VMCOs

Family Health Network

Adult Medicaid

The Myers Group collected 304 valid surveys from the eligible **FHN** adult Medicaid population from January through May 2012, yielding a response rate of 17.6 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2011 and 2012 adult Medicaid CAHPS top-box percentages are presented in Table 8.1, along with NCQA's 2012 CAHPS top-box national averages.

Table 8.1—FHN Adult Medicaid CAHPS Results

	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	68.1%*	63.8%*	75.6%
Getting Care Quickly	79.9%*	80.6%*	80.4%
How Well Doctors Communicate	86.4%	89.6%	87.8%
Customer Service	81.8%*	75.6%*	80.4%
Shared Decision Making	58.7%*	67.2%*	60.9%

[8-1] Due to changes in the NCQA CAHPS top-box national averages available for the *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* composite measures, the 2011 CAHPS top-box percentages for these composite measures were recalculated for **FHN** and **Harmony**. Therefore, the 2011 CAHPS top-box percentages presented in this section for **FHN**'s and **Harmony**'s adult and child Medicaid populations will not match the previous year's report.

[8-2] 2012 represents the first year **Aetna** and **IlliniCare** administered CAHPS surveys to their adult Medicaid populations; as such, 2011 CAHPS measure's rates are not available for these plans, and comparisons to previous year's 2011 rates could not be performed.

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	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Global Ratings			
Rating of All Health Care	38.8%	44.5%	49.8%
Rating of Personal Doctor	52.9%	64.1%	61.9%
Rating of Specialist Seen Most Often	60.7%*	48.0%*	62.1%
Rating of Health Plan	43.5%	54.3%	55.6%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

A comparison of **FHN**'s 2011 results to its 2012 results revealed that **FHN**'s rates increased for six measures: *Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan.* The increase in rates were substantial for *Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan.* However, a comparison of **FHN**'s 2011 to its 2012 results revealed that **FHN**'s rates decreased for four measures: *Getting Needed Care, Customer Service, Rating of Specialist Seen Most Often,* and *Rating of Health Plan.* The decrease in rates was substantial for all four measures. **FHN** scored more than 5 points below the 2012 NCQA CAHPS top-box national average on three measures: *Getting Needed Care, Rating of All Health Care,* and *Rating of Specialist Seen Most Often.*

Child Medicaid

The Myers Group collected 408 valid surveys from the eligible **FHN** child Medicaid population from January through May 2012, yielding a response rate of 19.3 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2011 and 2012 child Medicaid CAHPS top-box percentages are presented in Table 8.2, along with NCQA's 2012 CAHPS top-box national averages.

Table 8.2—FHN Child Medicaid CAHPS Results

	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	60.8%*	61.8%*	79.3%
Getting Care Quickly	80.0%	82.4%	87.3%
How Well Doctors Communicate	88.2%	85.9%	91.8%
Customer Service	89.3%*	74.0%*	83.0%
Shared Decision Making	64.8%*	66.5%*	68.5%

	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Global Ratings			
Rating of All Health Care	59.4%	53.3%	64.1%
Rating of Personal Doctor	67.2%	63.4%	72.1%
Rating of Specialist Seen Most Often	47.4%*	50.0%*	67.3%
Rating of Health Plan	54.1%	56.8%	67.4%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

A comparison of **FHN**'s 2011 results to its 2012 results revealed that **FHN**'s rates increased for five measures: *Getting Needed Care, Getting Care Quickly, Shared Decision Making, Rating of Specialist Seen Most Often,* and *Rating of Health Plan.* Four measures decreased from 2011, including *How Well Doctors Communicate, Customer Service, Rating of All Health Care*, and *Rating of Personal Doctor.* The decrease in rates was substantial for *Customer Service* and *Rating of All Health Care.* In comparison to NCQA national averages, **FHN** scored below the 2012 NCQA CAHPS top-box national average on all nine measures.

Harmony Health Plan

Adult Medicaid

The Myers Group collected 433 valid surveys from the eligible **Harmony** adult Medicaid population from January through May 2012, yielding a response rate of 16.6 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2011 and 2012 adult Medicaid CAHPS top-box percentages are presented in Table 8.3, along with NCQA's 2012 CAHPS top-box national averages.

Table 8.3—Harmony Adult Medicaid CAHPS Results

	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	60.3%	62.7%	75.6%
Getting Care Quickly	75.0%	77.9%	80.4%
How Well Doctors Communicate	87.6%	90.1%	87.8%
Customer Service	69.9%*	74.3%*	80.4%
Shared Decision Making	70.2%	61.5%	60.9%

	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Global Ratings			
Rating of All Health Care	43.8%	44.0%	49.8%
Rating of Personal Doctor	60.6%	64.0%	61.9%
Rating of Specialist Seen Most Often	48.4%*	53.8%*	62.1%
Rating of Health Plan	40.9%	45.2%	55.6%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

A comparison of **Harmony**'s 2011 results to its 2012 results showed an increase in rates for eight of the nine measures: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan*. One measure, *Rating of Specialist Seen Most Often*, displayed a substantial increase from 2011 to 2012. One measure, *Shared Decision Making,* showed a substantial decrease from 2011 to 2012. **Harmony** scored above the 2012 NCQA CAHPS top-box national averages on three measures: *How Well Doctors Communicate, Shared Decision Making*, and *Rating of Personal Doctor*. **Harmony** scored substantially below the 2012 NCQA CAHPS top-box national averages on five measures: *Getting Needed Care, Customer Service, Rating of All Health Care, Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Child Medicaid

The Myers Group collected 488 valid surveys from the eligible **Harmony** child Medicaid population from January through May 2012, yielding a response rate of 17.7 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2011 and 2012 child Medicaid CAHPS top-box percentages are presented in Table 8.4**,** along with NCQA's 2012 CAHPS top-box national averages.

Table 8.4—Harmony Child Medicaid CAHPS Results

	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	70.3%*	63.8%*	79.3%
Getting Care Quickly	78.3%	73.6%	87.3%
How Well Doctors Communicate	86.1%	87.7%	91.8%
Customer Service	77.3%*	77.9%*	83.0%
Shared Decision Making	61.4%	64.0%	68.5%

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	2011 Top-Box Percentages	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Global Ratings			
Rating of All Health Care	49.4%	49.2%	64.1%
Rating of Personal Doctor	64.3%	61.3%	72.1%
Rating of Specialist Seen Most Often	53.1%*	60.9%*	67.3%
Rating of Health Plan	53.4%	48.2%	67.4%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

A comparison of **Harmony**'s 2011 results to its 2012 results showed an increase in rates for four measures: *How Well Doctors Communicate*, *Customer Service, Shared Decision Making,* and *Rating of Specialist Seen Most Often*. One measure, *Rating of Specialist Seen Most Often*, displayed a substantial increase. **Harmony**'s rates decreased from 2011 to 2012 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Two measures showed a substantial decrease from 2011 to 2012: *Getting Needed Care* and *Rating of Health Plan.* **Harmony** did not score above the 2012 NCQA CAHPS top-box national averages on any measures. **Harmony** scored substantially below the 2012 NCQA CAHPS top-box national averages for seven measures: *Getting Needed Care, Getting Care Quickly, Customer Service, Rating of All Health Care, Rating of Personal Doctor, Rating of Special Seen Most Often*, and *Rating of Health Plan.*

Plan Comparisons—VMCOs

Due to its small size, **Meridian** was allowed to conduct its own survey. Due to differences in survey instruments, **Meridian**'s results are not directly comparable with those of **FHN** and **Harmony**. For this reason, **Meridian**'s results are not displayed in this section of the report.

Adult Medicaid

Table 8.5 presents the 2012 adult Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2012 NCQA national averages.

Table 8.5—2012 Adult Medicaid CAHPS Results

	FHN	Harmony	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	63.8%*	62.7%	75.6%

	FHN	Harmony	2012 NCQA CAHPS National Averages
Getting Care Quickly	80.6%*	77.9%	80.4%
How Well Doctors Communicate	89.6%	90.1%	87.8%
Customer Service	75.6%*	74.3%*	80.4%
Shared Decision Making	67.2%*	61.5%	60.9%
Global Ratings			
Rating of All Health Care	44.5%	44.0%	49.8%
Rating of Personal Doctor	64.1%	64.0%	61.9%
Rating of Specialist Seen Most Often	48.0%*	53.8%*	62.1%
Rating of Health Plan	54.3%	45.2%	55.6%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

FHN and **Harmony** scored above the 2012 NCQA Adult CAHPS top-box national average for *How Well Doctors Communicate, Shared Decision Making*, and *Rating of Personal Doctor*.

Harmony scored more than 10 percentage points below the national average for *Rating of Health Plan*, and also scored more than 9 percentage points below the national average for *Getting Needed Care*.

FHN and **Harmony** scored more than 5 percentage points below the national average for *Rating of All Health Care*. In addition, **Harmony** scored below the national average for *Getting Care Quickly*.

A comparison of the health plans' results to one another showed rates varied widely among the health plans. For *Shared Decision Making* and *Rating of Health Plan*, **FHN** scored substantially higher than **Harmony**. In contrast, **FHN** scored substantially lower than **Harmony** for *Rating of Specialist Most Often Seen*.

Child Medicaid

Table 8.6 presents the 2012 child Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2012 NCQA national averages.

Table 8.6—2012 Child Medicaid CAHPS Results

	FHN	Harmony	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	61.8%*	63.8%*	79.3%
Getting Care Quickly	82.4%	73.6%	87.3%
How Well Doctors Communicate	85.9%	87.7%	91.8%
Customer Service	74.0%*	77.9%*	83.0%
Shared Decision Making	66.5%*	64.0%	68.5%
Global Ratings			
Rating of All Health Care	53.3%	49.2%	64.1%
Rating of Personal Doctor	63.4%	61.3%	72.1%
Rating of Specialist Seen Most Often	50.0%*	60.9%*	67.3%
Rating of Health Plan	56.8%	48.2%	67.4%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

Both **FHN** and **Harmony** scored more than 10 percentage points below the national average for *Getting Needed Care, Rating of All Health Care*, and *Rating of Health Plan*. **Harmony** also scored more than 10 percentage points below the national average for *Getting Care Quickly* and *Rating of Personal Doctor*.

A comparison of **FHN**'s and **Harmony**'s results shows that **FHN** outperformed **Harmony** on five of the CAHPS measures: *Getting Care Quickly, Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan*. **FHN** scored substantially higher than **Harmony** on *Getting Care Quickly* and *Rating of Health Plan*. In contrast, **FHN** scored substantially lower than **Harmony** on *Rating of Specialist Seen Most Often*.

Meridian Member Satisfaction Survey

Technical Methods of Data Collection and Analysis

For **Meridian**, adult and child members were selected for the Member Satisfaction Survey. The survey consisted of a random sample of 774 adult and child members combined from the eligible population. At the time the sample was selected, the eligible population criteria was as follows: (a) continuously enrolled with **Meridian** for a six-month period beginning in January 2012, (b) currently eligible with **Meridian** without any pending termination notifications, and (c) had one or more visits with a **Meridian** primary care physician during 2012.

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The technical method of data collection was through the administration of **Meridian**'s Member Satisfaction Survey to adult and child members. The survey was conducted telephonically. The results were captured and analyzed by **Meridian**. Of the 3,664 members selected for survey administration, 774 members completed a survey yielding a 21.0 percent response rate.

The percentage of members who chose a positive response was calculated for each survey question. For Question 1 and Questions 3 through 7, a positive response was defined as a response of "Usually" or "Always." For Question 2, a positive response was defined as a response of "Never." For Questions 8, 9, and 12, from the pre-qualified responses of "Yes," a positive response is defined as "Always" or "Usually." For Questions 10a through 10c (not including the percentage of identified smokers), a positive response was defined as a response of "Yes." For Questions 11 and 13, the percentage of members who chose a satisfaction rating of "8, 9, or 10" on a scale of 0 to 10 (with 0 being the worst and 10 being the best) was defined as a positive response.

These questions were not sufficiently congruent with the CAHPS 4.0H Adult and Child Medicaid Surveys' questions to juxtapose **Meridian**'s results with NCQA CAHPS national averages. Furthermore, **Meridian**'s results did not include sufficient members to disaggregate the results to adult versus child members.

Meridian Health Plan Survey Results

Table 8.7 presents **Meridian**'s 2011 and 2012 results (i.e., percentage of positive responses) for each survey question from its Member Satisfaction Survey.

Table 8.7—Meridian Member Satisfaction Survey Results

Member Satisfaction Survey Question	2011 Results	2012 Results
1. Respondents stating they are always or usually able to get in to see the doctor as soon as needed	77.1%	87.7%
2. Respondents stating they never had to wait more than 30 minutes to see their doctor	60.2%	54.9%
3. Respondents stating their doctor always or usually listens to them and explains things in a way they can understand	95.0%	94.7%
4. Respondents stating the office staff is always or usually courteous and helpful to them	90.0%	89.8%
5. Respondents stating their doctor always or usually shows respect for what they have to say	94.7%	97.7%
6. Respondents stating their doctor always or usually spends enough time with them	89.4%	91.9%
7. Respondents stating it was easy to get an appointment with a specialist	85.6%	88.8%
8. Respondents identified as getting care, tests, or treatment through their health plan	NR	NR
a. The identified patient always or usually thought it was easy to get care, tests, or treatment through their health plan	97.0%	95.1%
9. Respondents identified as getting behavioral health care or substance abuse services through their health plan	NR	NR
a. The identified patient always or usually thought it was easy to get behavioral health care or substance abuse services through their health plan	93.8%	92.0%
10. Respondents identified as smokers	NR	NR
a. The identified smokers stating their doctor recommended they quit smoking	81.7%	NR
b. The identified smokers stating their doctor discussed medications to help them quit	67.1%	64.3%
c. The identified smokers stating their doctor discussed strategies other than medication to help them quit	55.7%	57.1%
11. Respondents stating they would rate their doctor as an 8, 9, or 10 on a scale of 0-10 with 10 being the best	87.0%	87.1%
12. Respondents identified as trying to get information or help from their health plan's customer service	NR	NR
a. The identified respondents stating their health plan's customer service gave them the information or help they needed	94.6%	NR
13. Respondents stating they would rate **Meridian** as an 8, 9, or 10 on a scale of 0-10 with 10 being the best	92.1%	93.9%
NR: Indicates "No Rate" was provided by Meridian in their 2011 or 2012 Member Satisfaction Survey summary report.		

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A comparison of **Meridian**'s 2011 results to its 2012 results reveals that **Meridian** improved on seven of the 13 reportable measures. These measures include:

- *Respondents getting in to see a doctor as soon as needed.*

- *Doctors who show respect for what patients say.*

- *Doctors who spend enough time with patients.*

- *Ease of getting an appointment with a specialist.*

- *Identified smokers who state their doctor discussed strategies other than medication to help them quit smoking.*

- *Rating of doctor.*

- *Rating of Meridian.*

Overall, **Meridian** showed the most improvement in the area of patients who reported they were always or usually able to see their doctor as soon as needed, which increased from 77.1 percent in 2011 to 87.7 percent in 2012.

Meridian showed a decrease in rates from 2011 to 2012 for six of the 13 reportable measures to include.

- *Doctor's office wait time.*

- *Doctors who listen and explain things in an understandable way.*

- *Office staff is courteous and helpful.*

- *Identified patients who found it was easy to get care, tests, or treatment through their health plan.*

- *Identified patients who found it easy to get behavioral health care or substance abuse services through their health plan.*

- *Identified smokers who say their doctor discussed smoking cessation medications.*

Meridian decreased in the area of office wait time from 60.2 percent in 2011 to 54.9 percent in 2012, with approximately half of respondents reporting having waited more than 30 minutes to see their doctor. As such, **Meridian** should explore ways to improve physician office wait time.

Comparisons and trends could not be made for some measures, such as identified smokers stating that their doctor recommended quitting and respondents stating that their health plan's customer service gave them the information or help they needed, since these results were not included in the 2012 **Meridian** report.

ICPs

Aetna Better Health

Adult Medicaid

CSS collected 456 valid surveys from the eligible **Aetna** adult Medicaid population from March through May 2012, yielding a response rate of 37.5 percent. The overall NCQA target number of valid surveys is 411. It is important to note that 2012 represents the first year **Aetna** participated in the CAHPS surveys. Because the first year baseline measurement occurred after launch of a new program, the rates represent a period when the ICP plans were in the process of building networks and engaging providers to participate, and there was some reluctance on the part of providers to participate in the plan. **Aetna**'s 2012 Adult Medicaid CAHPS top-box percentages are presented in Table 8.8 along with NCQA's 2012 CAHPS top-box national averages.

Table 8.8—Aetna Adult Medicaid CAHPS Results

	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Composite Measures		
Getting Needed Care	63.2%	75.6%
Getting Care Quickly	71.2%	80.4%
How Well Doctors Communicate	85.0%	87.8%
Customer Service	78.0%	80.4%
Shared Decision Making	57.4%	60.9%
Global Ratings		
Rating of All Health Care	40.8%†	49.8%
Rating of Personal Doctor	55.5%†	61.9%
Rating of Specialist Seen Most Often	59.8%†	62.1%
Rating of Health Plan	41.4%†	55.6%
† For the global ratings, Aetna's rates were calculated based on the Appendix Cross Tabulation of Survey Results.		

Aetna scored below the 2012 NCQA CAHPS top-box national average for all nine measures. **Aetna** scored more than 5 percentage points below the 2012 NCQA CAHPS top-box national average for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

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IlliniCare Health Plan

Adult Medicaid

The Myers Group collected 493 valid surveys from the eligible **IlliniCare** adult Medicaid population from January through May 2012, yielding a response rate of 30.3 percent. The overall NCQA target number of valid surveys is 411. It is important to note that 2012 represents the first year **IlliniCare** participated in the CAHPS surveys. **IlliniCare**'s 2012 Adult Medicaid CAHPS top-box percentages are presented in Table 8.9, along with NCQA's 2012 CAHPS top-box national averages.

Table 8.9—IlliniCare Adult Medicaid CAHPS Results

	2012 Top-Box Percentages	2012 NCQA CAHPS National Averages
Composite Measures		
Getting Needed Care	66.2%	75.6%
Getting Care Quickly	79.2%	80.4%
How Well Doctors Communicate	89.8%	87.8%
Customer Service	83.8%	80.4%
Shared Decision Making	61.3%	60.9%
Global Ratings		
Rating of All Health Care	47.5%	49.8%
Rating of Personal Doctor	65.1%	61.9%
Rating of Specialist Seen Most Often	56.5%	62.1%
Rating of Health Plan	45.4%	55.6%

IlliniCare scored above the 2012 NCQA CAHPS top-box national average on four measures: *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, and *Rating of Personal Doctor*. **IlliniCare** scored below the 2012 NCQA CAHPS top-box average on the other five measures, and it scored more than 5 percentage points below the 2012 NCQA CAHPS top-box national average on three measures: *Getting Needed Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Plan Comparisons—ICPs

Adult Medicaid

Table 8.10 presents the 2012 adult Medicaid CAHPS results for **Aetna** and **IlliniCare**, as well as the 2012 NCQA national averages.

Table 8.10—2012 Adult Medicaid CAHPS Results

	Aetna	IlliniCare	2012 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	63.2%	66.2%	75.6%
Getting Care Quickly	71.2%	79.2%	80.4%
How Well Doctors Communicate	85.0%	89.8%	87.8%
Customer Service	78.0%	83.8%	80.4%
Shared Decision Making	57.4%	61.3%	60.9%
Global Ratings			
Rating of All Health Care	40.8%†	47.5%	49.8%
Rating of Personal Doctor	55.5%†	65.1%	61.9%
Rating of Specialist Seen Most Often	59.8%†	56.5%	62.1%
Rating of Health Plan	41.4%†	45.4%	55.6%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results. † Aetna rates from the Appendix Cross Tabulation of Survey Results.			

IlliniCare scored above the 2012 NCQA Adult CAHPS top-box national average for *How Well Doctors Communicate, Shared Decision Making*, and *Rating of Personal Doctor*.

Aetna and **IlliniCare** scored more than 10 percentage points below the national average for *Rating of Health Plan* and also scored more than 9 percentage points below the national average for *Getting Needed Care.*

Aetna and **IlliniCare** scored more than 5 percentage points below the national average for *Rating of All Health Care*. In addition, **Aetna** and **IlliniCare** scored below the national averages for *Getting Care Quickly*, with **Aetna** scoring more than 9 percentage points below the national average.

For *Customer Service*, **Aetna** scored substantially higher than **IlliniCare**. **IlliniCare** scored substantially lower than **Aetna** for *Getting Care Quickly* and *Rating of Personal Doctor*.

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Conclusions and Recommendations for VMCOs

The following provides a summary of the CAHPS survey findings for **FHN**, **Harmony**, and **Meridian**'s findings from the Member Satisfaction Survey. Recommendations have been provided for all health plans based on survey findings. For **FHN** and **Harmony**, areas of improvement have been identified based on a comparison of the health plans' CAHPS survey results to NCQA national averages, as well as prior years' results, where applicable. For **Meridian**, areas for improvement have been identified based on a comparison to prior year's Member Satisfaction Survey results, where applicable. **Meridian**'s recommendations for improvement are included following those of the other health plans.

CAHPS Survey Conclusions—VMCOs

Family Health Network

Based on **FHN**'s 2012 adult and child Medicaid CAHPS results, **FHN** has several areas that can be improved. **FHN** should focus on those areas where rates were both below CAHPS national averages and had decreased from 2011 to 2012.

For the adult Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Needed Care, Customer Service*, and *Rating of Specialist Seen Most Often.*

For the child Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Needed Care, How Well Doctors Communicate, Customer Service, Rating of All Health Care*, and *Rating of Personal Doctor.*

Harmony Health Plan

Based on **Harmony**'s 2012 adult and child Medicaid CAHPS results, **Harmony** should focus on those areas where rates were both below CAHPS national averages and had decreased from 2011 to 2012.

For the adult Medicaid population, **Harmony** scored substantially below the adult CAHPS national average for *Getting Needed Care, Customer Service, Rating of All Health Care, Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* As such, **Harmony** should continue to focus on improving in these areas.

For the child Medicaid population, **Harmony** should focus improving performance in the areas of *Getting Needed Care, Getting Care Quickly, Customer Service, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Most Often Seen*, and *Rating of Health Plan.*

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Meridian Member Satisfaction Survey—Meridian Health Plan, Inc.

A comparison of **Meridian**'s 2011 results to 2012 results reveal that **Meridian** improved most in the area of patients being able to get care quickly. **Meridian**'s percentage rates remained strong in the areas of patients reporting that their doctor showed respect, doctors spent enough time with them, and it was easy to get an appointment with a specialist.

Meridian should focus on improving in those areas where performance decreased from 2011 to 2012. For **Meridian**, rates fell in the area of office wait time from 2011 to 2012; approximately half of respondents reported having waited more than 30 minutes to see their doctor. No trends could be determined for the smoking measures as **Meridian** did not provide all the data for these measures. **Meridian** also did not provide 2012 rates for the customer service measure.

CAHPS Recommendations—VMCOs

Based on **FHN**'s and **Harmony**'s CAHPS surveys results, the following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was low and opportunities for improvement exist for all four health plans. Each health plan should evaluate these general recommendations in the context of its own operational and quality improvement (QI) activities.

Getting Needed Care

- Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production and automated updates of provider directories are essential to ensure that the most current information is available. The utility of the provider directory can be enhanced by highlighting/emphasizing those providers who are currently accepting new patients.

- Health plans should ensure that patients are receiving care from physicians who are most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care.

How Well Doctors Communicate

- Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.

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◆ Often, health information is presented to patients in a manner that is too complex and technical, which can result in patient non-adherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy-to-understand based on patients' needs and preferences. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

Getting Care Quickly

◆ An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.

◆ A patient flow analysis can be conducted to determine if dissatisfaction with timely care may be partly due to bottlenecks and redundancies in administrative and clinical patient flow processes (e.g., diagnostic tests). A patient flow analysis involves tracking a patient's experience throughout a visit or clinical process (i.e., the time it takes to complete various parts of the visit/service).

◆ Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Furthermore, an online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.

◆ Health plans can establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s). Additionally, a 24-hour help line can improve members' perceptions of getting care quickly by providing quick, easy access to the resources and expertise of clinical staff.

Customer Service

◆ Training and access to information are two keys to successful customer service. Health plans must invest the resources to ensure that customer service agents are courteous, professional, and informed. Training should focus on best practices in communication and handling customer concerns.

◆ Access to information is essential for customer services. Without up-to-date information systems, it is difficult if not impossible for customer service agents to help customers with their needs. Databases and systems should be easy to navigate and updated with the latest patient data and policies.

◆ Staffing should be sufficient to address the volume of inquiries. When staffing is low, wait times can frustrate customers and prevent them from having their concerns addressed. Customer service should strive to minimize wait times in a way that is both efficient and economical.

Shared Decision Making

◆ Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision making process, ensuring that physicians understand the importance of taking each patient's values into consideration, understanding patients' preferences and needs, and improving communication skills.

◆ Physicians will be able to better encourage their patients to participate in shared decision making if the health plan provides physicians with literature that conveys the importance of the shared decision making model. Furthermore, health plans can provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

Rating of All Health Care

◆ Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.

◆ To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.

◆ Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Rating of Personal Doctor

◆ Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans also can create specialized workshops focused on

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enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.

◆ Health plans should request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

Rating of Health Plan

◆ It is important for health plans to view their organization as a collection of microsystems, (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

◆ A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care.

◆ Implementation of organization-wide QI initiatives are most successful when health plan staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

Meridian Member Satisfaction Survey Recommendations

Based on **Meridian**'s Member Satisfaction Survey results, the following are general recommendations and are intended to address those areas where performance was low and opportunities for improvement exist. **Meridian** should evaluate these general recommendations in the context of its own operational and QI activities.

Office Wait Time

To improve in the area of office wait time, **Meridian** could encourage physicians to monitor patient flow. **Meridian** could provide instructions and/or assistance to those physicians that are

unfamiliar with this type of evaluation. Dissatisfaction with timely care is often a result of bottlenecks and redundancies in the physician office flow processes. One method that can be used to identify these problems is to conduct a patient flow analysis. A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check in, wait time in the waiting room, wait time in the exam room, and time with provider. This type of analysis can help physicians identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

A patient flow analysis should include measuring the amount of time it takes to complete a scheduled visit for various appointment types. By creating a schedule template that accurately reflects patient flow, physicians can reduce patient dissatisfaction with prolonged wait times and office staff time spent explaining appointment delays.

Physician Appointments

To improve in the area of patients getting a physician appointment as soon as needed, **Meridian** could encourage physicians to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.

Smoking Cessation

Some strategies for improving discussion between physicians and patients regarding smoking cessation could include providing physicians with educational materials that they can use to become more informed about the smoking cessation programs **Meridian** offers and similar resources that are available to members. **Meridian** also could explore the option of creating similar smoking cessation educational materials for members.

Conclusions and Recommendations for ICPs

The following provides a summary of the CAHPS survey findings for **Aetna** and **IlliniCare**. Recommendations have been provided for all health plans based on survey findings.

CAHPS Survey Conclusions—ICP

Aetna Better Health

It should be noted that 2012 was the first year **Aetna** participated in the CAHPS surveys. Therefore, the 2012 CAHPS results presented in this report represent a baseline assessment of **Aetna**'s adult Medicaid population's satisfaction with the health plan. Several areas for improvement are noted, wherever rates fell below the national average.

For the adult Medicaid population, **Aetna** scored below the CAHPS national average for all nine measures. In particular, **Aetna** should focus on the five measures substantially below the CAHPS national average: *Getting Needed Care, Getting Care Quickly, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan*.

IlliniCare

It should be noted that 2012 represents the first year that **IlliniCare** participated in the CAHPS survey. Therefore, the 2012 CAHPS results presented in this report represent a baseline assessment of **IlliniCare**'s adult Medicaid population's satisfaction with the health plan.

For the adult Medicaid population, **IlliniCare** scored below the CAHPS national average for *Getting Care Quickly* and *Rating of All Health Care*, and **IlliniCare** scored below the CAHPS national average by a substantial amount for *Getting Needed Care, Rating of Specialist Seen Most Often,* and *Rating of Health Plan*. **IlliniCare** should focus on improving the rates for these five measures.

CAHPS Recommendations—ICPs

Based on **Aetna**'s and **IlliniCare**'s CAHPS surveys results, the following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was low and opportunities for improvement exist for all four health plans. Each health plan should evaluate these general recommendations in the context of its own operational and quality improvement (QI) activities.

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Getting Needed Care

◆ Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production and automated updates of provider directories are essential to ensure that the most current information is available. The utility of the provider directory can be enhanced by highlighting/emphasizing those providers who are currently accepting new patients.

◆ Health plans should ensure that patients are receiving care from physicians who are most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care.

How Well Doctors Communicate

◆ Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.

◆ Often, health information is presented to patients in a manner that is too complex and technical, which can result in patient non-adherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy-to-understand based on patients' needs and preferences. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

Getting Care Quickly

◆ An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.

◆ A patient flow analysis can be conducted to determine if dissatisfaction with timely care may be partly due to bottlenecks and redundancies in administrative and clinical patient flow processes (e.g., diagnostic tests). A patient flow analysis involves tracking a patient's experience throughout a visit or clinical process (i.e., the time it takes to complete various parts of the visit/service).

◆ Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Furthermore, an online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.

◆ Health plans can establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s). Additionally, a 24-hour help line can improve members' perceptions of getting care quickly by providing quick, easy access to the resources and expertise of clinical staff.

Customer Service

◆ Training and access to information are two keys to successful customer service. Health plans must invest the resources to ensure that customer service agents are courteous, professional, and informed. Training should focus on best practices in communication and handling customer concerns.

◆ Access to information is essential for customer services. Without up-to-date information systems, it is difficult if not impossible for customer service agents to help customers with their needs. Databases and systems should be easy to navigate and updated with the latest patient data and policies.

◆ Staffing should be sufficient to address the volume of inquiries. When staffing is low, wait times can frustrate customers and prevent them from having their concerns addressed. Customer service should strive to minimize wait times in a way that is both efficient and economical.

Shared Decision Making

◆ Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision making process, ensuring that physicians understand the importance of taking each patient's values into consideration, understanding patients' preferences and needs, and improving communication skills.

◆ Physicians will be able to better encourage their patients to participate in shared decision making if the health plan provides physicians with literature that conveys the importance of the shared decision making model. Furthermore, health plans can provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

Rating of All Health Care

◆ Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.

◆ To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.

◆ Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Rating of Personal Doctor

◆ Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans also can create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.

◆ Health plans should request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

Rating of Health Plan

◆ It is important for health plans to view their organization as a collection of microsystems, (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

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◆ A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care.

◆ Implementation of organization-wide QI initiatives are most successful when health plan staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

Introduction

As set forth in 42 CFR 438.364(a)(5), this section includes an assessment of the degree to which each Managed Care Organization (MCO) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

In this section, HSAG provides an assessment of how each MCO has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. The following sources were used to conduct this assessment:

◆ The prior year's EQR technical report.

◆ An evaluation of each health plan's annual report against criteria outlined by HFS. (At the request of the State, HSAG performed this evaluation during SFY 2009–2010.)

All of HSAG's recommendations for SFY 2010–2011are complied, by MCO, and by categories of care and activities in the tables below. Each recommendation is followed by the health plan's response (e.g., initiatives, program changes, or other actions taken by the health plan to address the EQRO's prior year's recommendation.)

Family Health Network

Child and Adolescent Care

Previous Recommendation: FHN demonstrated statistically significant improvement for seven of the 10 PIP indicators and achieved sustained improvement for one indicator. Of the eight measures in the Child and Adolescent Care category, **FHN**'s rates exceeded the 2010 HEDIS Medicaid 50th percentiles on only one measure—*Lead Screening in Children*—improving 11.5 percentage points since HEDIS 2008. Though demonstrating trended improvement, the rates for **FHN** were well below the National Medicaid HEDIS 2010 50th percentile for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*. Overall recommendations for PIPs include:

- Build on the existing momentum for study indicators with improving rates and implement new and/or enhanced quality improvement interventions for these PIPs.

- Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.

- Identify study outcome barriers specific to the interventions already implemented.

- Conduct a "drill-down" type of analysis before and after the implementation of any intervention.

- Perform interim evaluations of the results in addition to the formal annual evaluation.

FHN Response:

- Continue with provider education on coding, using standardized forms, appropriate completion of standardized forms, importance of submission encounter/claims data, appropriate content of well-child visits and periodicity schedule. Additional QA staff has been added in 2012. A .5 FTE began in January and initially was dedicated to HEDIS along with a temporary staff and the regular full-time QA nurse. In August, due to the continued issues with documentation and coding, the .5 FTE and the temp staff were both hired full-time and a fourth position was created. The addition of QA staff will allow increased focus on provider education visits, beginning with **FHN**'s independent practitioners.

- Member services to continue to update telephone numbers and addresses from every member calling.

- Continue to emphasize the importance of well-child care in the member newsletter.

- Continue to remind members that transportation to and from well-child care is a covered benefit.

- Continue with semiannual reminder letters to case holders identifying missing services for their children.

- Continue with quarterly submissions to medical groups of children with incomplete preventive services based on claims/encounter data.

Child and Adolescent Care

◆ Continue the Diaper Program. The incentive consists of mailing a monthly coupon for one free package of Osco brand diapers to case holders of children under 3 years of age who are enrolled in the program and whose immunizations are up to date. Between 10,000 and 11,000 coupons are mailed monthly. Reminders are sent every six months to case holders with children that are not up to date with immunizations based on encounter data.

◆ Continued collaborative outreach with Project LAUNCH. The goals of the project were to ensure that children maintain their physical and emotional health by increasing parent knowledge, ensure that families are connected to all the services they need, and ensure that children enter school ready to learn. The collaborative group is working with community-based organizations and providers, both medical and non-medical, to achieve these goals. As Project LAUNCH is limited to certain zip codes/neighborhoods in Chicago, the MCOs see this collaborative effort as a pilot intervention for the EPSDT PIP. Should these collaborative strategies, once developed, be effective, then the potential exists to expand into other areas of Chicago.

◆ Partnership with Pfizer for immunization reminders. **FHN** has partnered with Pfizer since 2007. This program is a free service to **FHN**. Each month, **FHN** sends Pfizer a list of members aged 8–9 months and 16–17 months who are missing encounters for Prevnar, the pneumococcal vaccine. Pfizer has partnered with Televox, who makes immunization reminder calls to **FHN**'s members on the list. Monthly reports indicate that on average, 20–21 percent of the calls are answered and the entire message is listened to and 38–40 percent of the calls are answered by voicemail or answering machine and the entire message is recorded. On the negative side, on average 7 percent of calls were answered and the member hung up before listening to the entire message; 8 percent of telephones are out of order; and 14 percent are invalid telephone numbers. **FHN** believes these calls are having a positive effect as our Combo 3 immunization rate has steadily increased over the last few years.

Access to Care

Previous Recommendation: The low rates for *Children's Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Care* services indicate that **FHN** needs to improve access to care. The rates continued to improve but still remain low and well below the national 50th percentiles. **FHN** should examine its network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education.

FHN Response:

◆ Monthly member newsletters will continue. Articles on preventive and chronic care as well as seasonal items will be updated and/or developed as needed. In addition, the newsletter contains information on **FHN**'s extra benefits and health incentives. **FHN** has received good feedback from members on a consistent basis about the newsletter. Members attending the Consumer Advisory

Access to Care

Committee meetings report that they almost always read the newsletter. Moreover, anecdotally, calls to member services about articles in the newsletter increase in the first week after the newsletter is mailed.

◆ Missing Service Reminders to medical groups (quarterly) and to members semiannually (March and September). These reports have been in place since September 2009. As **FHN** has multiple improvement initiatives in place, it is difficult to determine the effectiveness of any single intervention. However, **FHN** does receive a few calls from members concerning the reports, and the members are directed to the PCP to receive the missing services. Members have also called to report that their services are up to date.

◆ Member services will continue to update addresses and telephone numbers for each call received by the representatives. This is a highly effective initiative, but updates are made only on those that call. Updates cannot be made on members that do not call.

◆ In SFY 2012, **FHN** expanded access by growing the provider network. The PCP network expanded by 45 percent; the WHCP network expanded by nearly 55 percent; the specialist network expanded by over 45 percent; behavioral health providers expanded by 10 percent; and hospitals expanded by 30 percent.

Maternity-Related Care

Previous Recommendations: FHN continues to report rates well below the HEDIS Medicaid 50th percentile for maternity-related measures. In response to these low rates, the State and the VMCOs began a collaborative perinatal depression screening PIP in 2006–2007.

FHN Response:

◆ The Brighter Beginnings program for pregnant members and their babies continued. **FHN** believes that the current staff person is having a positive impact as evidenced by improved HEDIS rates in 2012. The postpartum incentive increased in 2010 and the additional requirement of completing a depression screening remains in place. For calendar year 2011, 1,822 $10 gift cards and 178 $25 gift cards were mailed.

◆ The Baby Photo program, started in July 2010, remains in place. A coupon for a free 8X10 baby photo from Sears is mailed to those qualified. The first coupon is mailed to moms who meet the same criteria for the $25 postpartum incentive. Subsequent coupons are mailed annually around the baby's birthday for each child that was continuously enrolled for the year. This annual coupon continues up to age 5 as long as the child is continuously enrolled and immunizations are up to date. For calendar year 2011, 178 Baby Photo coupons were mailed for newborns and two were mailed for one-year olds. The program has not been in effect long enough to send coupons to children aged 2 through 5.

Maternity-Related Care

- **FHN** began a partnership with "Text4Baby," which remains in place. Information about the program has been included in member newsletters and in the prenatal information packet mailed to all known pregnant members. Members who sign up for this free program receive text messages concerning pregnancy and concerning baby information up to age 1. The messages are pertinent to the gestational age and age of the baby.

- **FHN** is continuing the provider incentive for early notification of pregnant members begun in early 2011. An incentive of $25 is paid to PCPs and OBs the first time they notify **FHN** of a pregnant member. From inception through June 2012, 197 notifications have been received. **FHN** will continue to inform providers of this incentive via the provider newsletter and via provider relations staff.

Preventive Screening for Women

Previous Recommendation: The measures examine whether female members are screened for breast and cervical cancer and chlamydia. **FHN**'s rate of 66.3 percent for *Chlamydia Screening in Women* exceeded the National Medicaid 50th percentile and demonstrated an improvement of 18.6 percentage points from HEDIS 2008.

FHN Response:

- Mammography Incentive. **FHN**'s Mammography incentive of a $25 gift card from Payless Shoe Source has been in place since 2007. Letters are mailed in October to coincide with Breast Cancer Awareness Month. The percentage of gift cards sent has increased significantly, and **FHN** believes that this has contributed to the increase in the HEDIS breast cancer screening measure. **FHN** has seen steady increase in the number of incentives mailed from 57 in 2009, to 78 in 2010, to 159 in 2011. The increase from 2010 to 2011 was 104 percent. These efforts have resulted in an increase in the HEDIS measure from 33.9 percent in 2009 to 47.7 percent in 2011, to 48.9 percent in 2012.

- PsycHealth and **FHN** integrate and coordinate care of perinatal members through the Brighter Beginnings Perinatal Depression Screening Program. All members screened, regardless of the score, are mailed an educational packet. Members scoring 10 or above on the Edinburgh Perinatal Depression Screening (EPDS) are contacted directly via telephone to schedule an appointment with an in-network mental health provider. Completion of the EPDS screen for pregnant women increased from 7.8 percent in 2007 to 63 percent in 2011 due to case management activities at **FHN** and at PsycHealth. There was a 20 point increase from 2010 to 2011.

Chronic Conditions/Disease Management

Previous Recommendation: FHN had two measures with rates that exceeded the 2010 HEDIS Medicaid 50th percentile in the Chronic Conditions/Disease Management category: *Diabetes Care (Nephropathy Monitoring)* and *Appropriate Medications for Asthma (Combined Rate).* Although **FHN**'s rates on many of the diabetes care measures have consistently improved, rates for all but one of those measures remained below the National Medicaid HEDIS 50th percentiles.

FHN Response:

◆ Comprehensive case/disease management for asthmatic and diabetic members that began in February 2011 expanded in June 2011, and continues. Case management is also in place for members with obesity, hypertension, and children with special health care needs.

◆ Diabetes care management began in earnest in June 2011. Identified members are contacted, assessed, risk stratified and enrolled into the program. Educational material is sent to all. **FHN** developed a diabetes action plan, which is completed for all active participants. The plan is completed by the PCP and a copy is mailed to the member. A collaborative care plan is developed with problems, interventions, and goals established. The member and the PCP are sent copies of the care plan and the PCP faxes the care plan back to **FHN** indicating his/her approval or listing recommendations. Diabetic members are offered **FHN**'s healthy lifestyle affiliations with Weight Watchers and Curves as needed.

◆ Health risk surveys/screening tools continued to be mailed monthly to new enrollees, with telephonic follow-up by member services representatives. After two telephonic follow-up attempts without contacting the member, a letter is sent.

◆ In October 2011, a diabetes member incentive was implemented. All diabetic members in case management were mailed details on the incentive. The member is awarded a $50 gift card for submitting proof of a PCP visit, HbA1c testing, LDL testing, microalbumin screening, and eye exam. As this was implemented late in 2011, only 11 gift cards were mailed by yearend. Through June 2012, 19 gift cards have been mailed. Those that have not submitted their documentation for the incentive will be given reminder calls and/or letters during July/August 2012.

◆ Continued to educate providers on case/disease management program in general via provider newsletter.

◆ Continued to educate providers one on one about case/disease management as their members are enrolled in the program.

◆ Continued to evaluate effectiveness/outcomes of the Osco Asthma Program and the Sinai Urban Health Institute Asthma Program.

◆ Provided care management staff with educational information on health literacy and motivational interviewing/coaching.

Behavioral Health

Previous Recommendation: FHN had two measures with rates that exceeded the 2010 HEDIS Medicaid 50th in the Behavioral Health category: *Follow-up After Hospitalization for Mental Illness—7 Days and Follow-up After Hospitalization for Mental Illness—30 Days*. The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7-day rate exceeding the 90th percentile and the 30-day rate exceeding the 75th percentile.

FHN Response:

FHN's behavioral health vendor, PsycHealth, worked with **FHN** to continue and/or implement the following QI initiatives:

◆ The continuation of the Close the Loop process has assisted in the facilitation of members obtaining outpatient services. In 2011, 657 Close the Loop letters were sent.

◆ During the first quarter of 2011, the Readmission Outreach Project was initiated. PsycHealth targeted those members who have been hospitalized in the past year for outreach and calls to contact and provide status. In addition, triggers or warning symptoms are reviewed, services offered, and methods for reaching PsycHealth in case of an emergency can be reinforced.

◆ The behavioral health vendor continued its intensive case management (ICM) program designed to provide a much more intensive level of care coordination for members who have serious comorbid medical conditions, a history of noncompliance with behavioral health treatment recommendations, or chronic mental illness. Forty-one total ICM cases identified, invited, and/or enrolled in program in 2011.

◆ Continued the Home Intervention and Transitional Care Program (HIP/TCP) targeted at improving mental health follow-up rates and decreasing readmissions rates. All members being discharged from an inpatient setting receive a comprehensive aftercare plan for continued care including, at a minimum, an outpatient appointment within seven days of discharge and how to access 24-hour, on-call services if needed at any time. An in-home Transitional Care Visit (TCV) is also offered to every member being discharged with the focuses of the visit to reinforce the importance of the aftercare plan and troubleshoot any potential barriers to the plan.

◆ In addition to the in-home TCV, PsycHealth, Ltd. offers a member incentive, Aftercare Rewards Program, in which the member is given a $20/$10 gift card upon proof of visit within 7/30 days of discharge, respectively. Both of these programs in combination have resulted in consistently positive HEDIS rates for the ambulatory follow-up within 7 days after DC from IP MH. The 2012 HEDIS (2011 data) follow-up rates for this measure remain in the 90th percentile.

◆ Continued the discharge outreach program: every member discharged from the acute care setting is contacted to ensure knowledge of follow-up appointments with a therapist, psychiatrist, and PCP.

Consumer Satisfaction

Previous Recommendation: Overall recommendations for **FHN** to improve CAHPS results include:

- Identify potential barriers for patients receiving appropriate access to care.

- Identify and eliminate patient challenges when receiving health care.

- Consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve.

- Encourage physician-patient communication to improve patient satisfaction and outcomes.

- Request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit.

- Consider establishing an online patient portal or integrating online tools and services into current Web-based systems that focus on patient-centered care.

- Create an environment that promotes quality improvement (QI) in all aspects of care to encourage organization-wide participation in QI efforts.

- Encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians.

- Revise existing and create new print materials that are easy to understand based on patients' needs and preferences, and provide training for health care workers on how to use these materials.

- Consider an open access scheduling model to match the demand for appointments with physician supply.

- Conduct a patient flow analysis.

- Establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s).

- Enhance provider directories.

- Ensure physicians are properly trained to facilitate the shared decision making process with patients.

FHN Response:

- The ad hoc committee planned to develop improvement strategies for the CAHPS surveys was not convened due to extreme difficulty in coordinating schedules of all participants. This will remain a goal for FY 2013.

Encounter Data

Previous Recommendation: Overall, the results show that **FHN** did not receive all of its encounter data. Twelve measures had less than a 50.0 percent encounter data completeness rate, and none of the measures had a data completion rate at or above 90.0 percent. These results indicate that **FHN** continues to have difficulty obtaining complete encounter data and is strongly encouraged to focus efforts on improving encounter data submission.

FHN Response:

- **FHN** is reviewing certified HEDIS software and also evaluating other analytic software to assist with identifying members missing services/gaps in care. Final decisions are planned for September 2012 so that installation and implementation will be complete for HEDIS 2013.

- Each medical group submitted an action plan as required to improve encounter data. Evidence of implementation is seen in the improvement of the administrative only HEDIS measures of, *Children and Adolescents' Access to Preventive/Ambulatory Health Services* and *Ambulatory Care*. All three measures had statistically significant increases in the 2012 rates.

- Fully implemented its Pay for Performance Program. Initial payments were made in July 2012 for 2011 HEDIS and 2011 electronic encounter data. In January 2012, **FHN** continued its "Pay for Quality Program." The program has two components. Payment has been made in 2012 for dates of service in 2011. Payment will be made in 2013 for 2012 dates of service. Part A of the program is reimbursement for electronic submission of encounter data for the eight HEDIS measures in the State's pay for quality withhold program. Part B of the program is payment for the State's eight pay for quality measures with payment following the State's payment methodology for reimbursement of the withhold and payment of the bonus incentive to **FHN**.

- Assessed ways to leverage connectivity between EMRs and TriZetto QNXT to improve encounter data submission.

- Continued to emphasize encounter data submission to all physician providers and to the medical groups. **FHN** IS department continues to work with IS departments of the medical groups to ensure all encounter information is being submitted to **FHN**. Additional IS staff members have been added to increase the emphasis and monitoring of encounter data from the medical groups. The medical groups are stressing the importance of encounter submission with their providers. **FHN** believes this emphasis is having a positive impact as evidenced by the increase in administrative only HEDIS rates.

- **FHN** is considering implementing a capitation withhold for all medical groups as another incentive to improve encounter data submission and improve care provider to members, and thus improve HEDIS rates.

Focused Administrative Review Recommendations

Previous Recommendations: Review of **FHN**'s measurement and improvement standards included in the focused review identified that **FHN** did not have a system established for tracking and trending of health care utilization data. In addition, **FHN**'s oversight and monitoring of QA activities lacked development of corrective action recommendations for correcting noncompliance with delegation oversight activities. **FHN** will need to continue to evaluate the effectiveness of its quality improvement interventions and work with network providers to create, implement, and sustain quality improvement initiatives.

FHN Response:

For the past several years, **FHN** has had a fully functioning Peer Review process and Committee. The oversight and monitoring activities have been switched from early in the calendar year to September and after to not conflict with the HEDIS season. In 2012, due to the changes in utilization tasks and peer review, the monitoring tools will be updated. All medical groups will be audited by the end of calendar year 2012. Results will be reported to FHN's Administrative QA Committee. **FHN** will continue to offer assistance to groups needing help correcting deficiencies.

Previous Recommendations: Review of the structure and operations standards included in the review identified that **FHN** failed to monitor the performance of its delegated entities through routine reporting and follow-up, ongoing monitoring, and evaluation to determine whether the delegated activities were being carried out according to BBA, HFS, and **FHN** requirements.

FHN Response:

This has been an area that has been challenging for **FHN** in the past and in which **FHN** made significant improvements in 2011. All medical groups are delegated for UM and Peer Review and most are delegated for credentialing. The behavioral health vendor is also delegated for quality. In calendar year 2011, all groups were audited and results were brought to the QA Committee. All groups that were required a corrective action plan submitted one. The result has been improved compliance with delegated activities and timely quarterly submissions. For 2011, all groups are compliant with utilization management activities. All groups also have peer review occurring, but some groups are more advanced in this area than others. Some groups have minor deficiencies with credentialing, and improvements have been made.

In 2012, all groups were delegated the additional UM task of collecting data and making the approval/denial determination on inpatient stays. Also in 2012, the groups were de-delegated Peer Review activities, except to credentialing/recredentialing activities for those groups delegated credentialing.

Case Management—Care Coordination Program

Previous Recommendation: In April 2011, a focused review of **FHN** resulted in a recommendation to continue to improve its case management and oversight and monitoring activities. Many of **FHN**'s policies and procedures for continuity of care and case management were found deficient and not in compliance with federal Medicaid managed care regulations, State rules, and the associated Illinois contract requirements for access standards.

FHN Response:

◆ Reorganization of care management to separate utilization management and case management functions. Additional positions added beginning January 2012 resulting in three utilization management nurses, five case managers, and two non-professional staff. Two additional case managers to start September 2012.

◆ Plan to evaluate and implement other analytic software to improve the process of identifying members with missing services/gaps in care. This software will ensure timely running of these reports for distribution to the medical groups and members. This software will also assist in identification of members for case/disease management and in identification of high-utilizers of the emergency room.

Harmony Health Plan of Illinois, Inc.

Child and Adolescent Care

Previous Recommendation: Overall recommendations for PIPs include:

◆ Build on the existing momentum for study indicators with improving rates and implement new and/or enhanced quality improvement interventions for these PIPs.

◆ Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.

◆ Identify study outcome barriers specific to the interventions already implemented.

◆ Conduct a "drill-down" type of analysis before and after the implementation of any intervention.

◆ Perform interim evaluations of the results in addition to the formal annual evaluation.

◆ Nine of the 10 indicators for **Harmony** demonstrated statistically significant improvement and achieved sustained improvement for four of the 10 indicators.

◆ **Harmony** reported two measures with rates at or above the Medicaid 2010 HEDIS 50th percentiles. For *Lead Screening in Children,* Harmony improved 12.2 percentage points while increasing its rates for *Well-Child Visits (3–6 Years)* by 14.4 percentage points. Though demonstrating trended improvement, the rates for **Harmony** were well below the National Medicaid HEDIS 2010 50th percentile for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*.

Harmony Response:

◆ Continue the MCO collaborative with Project LAUNCH to increase marketing of the importance of well-child visits to the targeted zip codes to ensure the healthy development of all young children from birth through age 8 within a specific demographic area of Chicago. In the two largest zip codes of the Project LAUNCH target (60623 and 60624), Harmony Health Plan has approximately 4,000 children 8 years of age alone.

◆ Continued to send all new members the Preventive Care booklet (53,820) which is a short, colorful booklet that highlights the importance of receiving preventive services including well-child visits and immunizations.

◆ Continued the HEDIS Inbound Care Gap program. This intervention involves members who call inbound to Customer Service and are identified as having a HEDIS Care Gap. Customer Service educates the member on the importance of scheduling and receiving preventive care services and offers to assist them in scheduling their doctor appointment via a three-way telephone call to the member's physician office.

◆ Continued centralized telephonic outreach to parents/caregivers of children regarding the

Child and Adolescent Care

importance of scheduling well-child visits and childhood immunizations, reaching nearly 6,500 members, leaving over 15,000 messages, and scheduling over 900 member appointments.

◆ Awarded 23 gift cards for completion of recommended well-child visits in the first 15 months of life (6+ Visits). The card can be used at one of several retail stores.

◆ Enhanced maternity discharge planning calls with the component of assisting with the scheduling of newborn well-care visit for well-child visits 0–15 months; 942 members reached.

◆ Continued communication and education of providers regarding the capture of missed opportunities for the PCP to perform an EPSDT/well-child visit when a hard-to-reach member presents for a sick visit.

◆ 51 executive-level face-to-face HEDIS focused provider meetings.

◆ Send all new members a preventive care booklet which lists the recommended well-child visit and highlights the importance of preventive services.

Access to Care

Previous Recommendation: The low rates for *Children's Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Care* services indicate that **Harmony** needs to improve access to care. The rates continued to improve but still remain low and well below the national 50th percentiles. **Harmony** should examine its network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education.

Harmony Response:

◆ An access and availability audit in 2011 demonstrated that many members were not able to reach their PCPs after hours. To resolve the accessibility issue, the network management team engaged providers to implement corrective action plans to remedy or at least increase compliance with the after-hours accessibility requirements. Providers who were unresponsive to the request for a corrective action plan were called and reminded of this requirement for network participation.

◆ Continued HEDIS Inbound Care Gap program. This intervention will involve members who call inbound to the Customer Service Department and are identified as having a preventive service HEDIS care gap. Customer service representatives educate the member on the importance of scheduling and receiving preventive care services and offer to assist them in scheduling their doctor appointment via a three-way telephone call to the member's physician office.

◆ Continued QI nurse focused clinical HEDIS visits to discuss the components of and recommended schedule of well-child visits and childhood immunizations.

Access to Care

Previous Recommendation: Continue to strengthen the case management and care coordination program.

Harmony Response:

Harmony's Case Management Program and Department went through significant changes in 2011 through April 2012 including:

- Redesigned to an Integrated Team Specific Telephonic and Field Based Model comprised of short-term case management and complex case management differentiation. Short Term Case Management's (SCM) focus is on assisting members with urgent or event-specific needs. The SCM screens the member to confirm that the discharge plan has been implemented, identifies gaps and barriers in care that may negatively impact the member's health status, and provides resolution of issues identified. SCM refers the member to Complex Case Management (CCM) as appropriate.

- Improved process for the identification of members for Case Management through Case and Disease Management Claims/Encounters Algorithm.

- Modifications of the Case Management database fields to standardize case management documentation requirements. All CM workflows and processes were revised to provide consistency in documentation.

- Revised process for assessing children and youth for special health care needs by creating a specific flag in the current medical management platform for CSHCN; revised assessment to be NCQA compliant.

- Increased focus of patient self-management education and skills building through motivational interviewing techniques. All case managers were provided motivational interviewing training.

- Provided case managers with access to the Care Gaps database. Included identification and assistance with closure of member care gaps as an individual and department metric and goal.

Harmony reported that the number of cases identified and referred to Case Management increased substantially from contract year 2011 (632 members) to contract year 2012 (2,219 members).

Maternity-Related Care

Previous Recommendation: Harmony continues to report rates well below the HEDIS Medicaid 50th percentile for maternity-related measures. In response to these low rates, the State and the VMCOs began a collaborative perinatal depression screening PIP in 2006–2007. The interventions **Harmony** has implemented were expected to result in higher rates for these HEDIS measures. **Harmony** has had limited success, improving less than 1.5 percentage points for *Frequency of Ongoing Prenatal Care (0– 21 Percent of Visits and 81–100 Percent of Visits)*.

Maternity-Related Care

- For the *Perinatal Care and Depression Screening* PIP, the percentage of women who had a depression screen both before delivery and within 56 days after delivery has more than doubled (from 6.5 percent to 14.6 percent) but still presents an opportunity for improvement.

- Track and monitor pregnant beneficiaries through claims/encounter data, case management, or other available data. These women should be encouraged to have regular prenatal care appointments and a postpartum care visit.

- Continue case management strategies for pregnant enrollees. The MCOs should work more closely with the Family Case Management Program to ensure coordination of services.

- Consider having the case managers arrange for postpartum care appointments while women are in the hospital following delivery or follow up immediately after hospital discharge.

- Continue incentives for women completing the recommended number of visits prior to delivery and for women who receive their postpartum care visit.

- Continue to regularly conduct provider profiling (e.g., once per quarter) to determine the rates for the three HEDIS measures, by provider. This information should be given to the providers to help improve results.

- Continue to educate providers on the importance of depression screening for women before and after delivery. The MCOs should educate their network providers on screening, assessment, treatment, or referral for further assessment and treatment, as needed. At a minimum, providers should attempt to screen for depression during the initial visit and periodically during subsequent prenatal care visits, as well as during the postpartum care visit.

Harmony Response:

- Continued **Harmony** Hugs. All pregnant **Harmony** members receive an initial Hugs enrollment call. This call describes the benefits of the Hugs program, services provided, and the incentives provided. The **Harmony** Hugs team members, beginning in March 2011, began completing the EPDS during pregnancy if the member has any history or current signs or symptoms of depression, and began completing the EPDS during postpartum interviews with all the members contacted.

- Continue distribution of the maternity booklets which provide prenatal, postpartum, and newborn care education to all known pregnant members.

- Strollers were given to members for completion of the requirements for the OB Prenatal Reward Program. The OB Prenatal Reward Program has been revised and is awaiting State approval. The postpartum visit requirement was removed and now the member can receive either a stroller or a "pack and play" upon completion of the requirements.

- Provided pediatric preventive health information through the Maternity Education and Reward Program (MERP). (3,355 MERP booklets were mailed, and 79 strollers and 12 "Pack and Plays" were

Maternity-Related Care
distributed to members during the reporting period).

- In 2011, changes in capitation terms with the largest contracted medical group allows for coding separately for specific services rendered during Prenatal and Postpartum visits resulting in services that are payable outside the Primary Care Capitation. The goal is to increase the quantity/quality of services and capture the codes through encounters.

- Continued to provide OB education regarding **Harmony** Hugs program and the Utilize the OB Notification form so providers can receive the $25 OB Incentive Program reward.

- Continued HEDIS Postpartum Discharge Planning initiative to contact members who recently delivered a baby, remind them of the importance of scheduling a postpartum appointment, and remind them of the importance of well-child visits for their baby, including immunizations and lead screening.

Preventive Screening for Women

Previous Recommendation: Harmony's rates for *Cervical Cancer Screening* exceeded the National HEDIS Medicaid 50th percentile. **Harmony** has struggled to improve its rate for *Breast Cancer Screening*, demonstrating a continued decrease each year, with an overall decline of 4.8 percentage points since HEDIS 2008. Harmony must address performance for this measure.

Harmony Response:

- Continued centralized telephonic outreach regarding the importance of scheduling a Pap smear and sending periodicity letters.

- HEDIS Inbound Care Gap program was launched in August 2011. Members who have a HEDIS Care Gap(s) are flagged in CAREConnects. A total of 13,973 noncompliant members received education on the importance of scheduling and receiving preventive care services. Out of those 13,973 members, 568 appointments were scheduled.

- 40,264 New member booklets which highlight the importance of receiving preventive services.

- 613 QI Nurse outreach visits were made to medical groups and providers.

- Continued the HEDIS Targeted Outreach Letter initiative. This mailing provides members with education on breast cancer screening and a list of provider offices where they could go and receive the screening in their county. The goal of this outreach is to improve compliance with preventive health measures and a corresponding improvement in HEDIS rates.

Chronic Conditions/Disease Management

Previous Recommendation: Harmony continues to struggle to improve performance for the *Diabetes Care—Eye Exam* measure. One barrier to consider is that Illinois law allows eye examinations for retinopathy to be performed by an optometrist. Optometry services are carved out of the MCO agreement as a covered service; therefore, the MCOs do not receive the encounter data. However, **Harmony** needs to conduct an analysis to determine the reason the rate continues to be so low. The VMCOs and the State might also consider conducting a PIP around this measure.

Harmony Response:

♦ The focus for chronic conditions of asthma and diabetes during this contract year has been to continue member education (HEDIS Education and Screening Program [ESP]) and the improvement has been to substantially increase the number of members in the disease management program. These major improvements are the following:

  ▪ HEDIS Education and Screening Program (ESP), formally known as HEDIS Focused Disease Management Initiative.

  ▪ Maintaining the "opt-out" program parameter.

♦ The purpose of ESP is to contact members identified by **Harmony** who have asthma, diabetes, high cholesterol, or COPD and have a care gap as defined by the HEDIS measures. In 2011, this initiative was redesigned to streamline the outreach initiative in order to reach more members in a timely manner. The assessment and screening tool was revised to focus on the care gap identified.

♦ For the 2012 calendar year, the HEDIS ESP initiative was modified so that all calls were completed by full-time **Harmony** associates. These changes allow our agents to better service members, screen for case management, and stratify for more intensive disease management.

♦ Short Term Case Management has been incorporated into case management to ensure that the hospital-to-home program focusing on members with complex discharge needs with the goal of decreasing hospital inpatient re-admissions continues to be successful.

♦ Enhanced individual and departmental metrics around case management process and workflows.

♦ Standardized documentation and workflows for all of case management.

♦ Revised process for assessing children and youth for special health care needs.

♦ Provided case managers with access to member care gaps and incorporated member care gap closure into individual, departmental, and company success metrics.

♦ Continued to send periodicity letters to members.

♦ Continued the QI nurse outreach visits to medical groups and providers.

Behavioral Health

Previous Recommendation: Harmony's rates for the *Follow-up After Hospitalization for Mental Illness—7 Days and Follow-up After Hospitalization for Mental Illness—30 Days* measures improved significantly between HEDIS 2008 and HEDIS 2009, and its 7-day rate exceeded the National Medicaid HEDIS 50th percentile last year. However, **Harmony**'s 7-day rate declined from 49.2 percent last year to 42.7 percent for HEDIS 2011, and its 30-day rate has been fairly constant over the last three years with little to no improvement.

Harmony Response:

- Provided PCP Communication tool template to providers with treatment record review activity results and in provider forums.

- Magellan (**Harmony**'s behavioral health vendor) continued to implement the Bridge program in Illinois which facilitates a member being seen by an outpatient provider after discharge but prior to leaving the facility.

- Continued Hospital to Home initiative which offers members an opportunity to be evaluated in their home within seven days of discharge.

- Distributed a letter to members following discharge from hospital with the purpose of educating them on the importance of the continuum of treatment and the need to attend any and all outpatient appointments upon discharge; it also gives information on what to expect from an outpatient provider and how to prepare for the appointment.

- Followed up after discharge from an inpatient admission through an outreach call to the member to confirm the discharge plan. The outpatient provider is also called within seven days after the appointment was scheduled to confirm if the appointment was kept.

Consumer Satisfaction

Previous Recommendation: Overall recommendations for **Harmony** to improve CAHPS results include:

- Identify potential barriers for patients receiving appropriate access to care.

- Identify and eliminate patient challenges when receiving health care.

- Consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve.

- Encourage physician-patient communication to improve patient satisfaction and outcomes.

- Request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit.

Consumer Satisfaction

◆ Consider establishing an online patient portal or integrating online tools and services into current Web-based systems that focus on patient-centered care.

◆ Create an environment that promotes quality improvement (QI) in all aspects of care to encourage organization-wide participation in QI efforts.

◆ Encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians.

◆ Revise existing and create new print materials that are easy to understand based on patients' needs and preferences, and provide training for health care workers on how to use these materials.

◆ Consider an open access scheduling model to match the demand for appointments with physician supply.

◆ Conduct a patient flow analysis.

◆ Establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s).

◆ Enhance provider directories.

◆ Ensure physicians are properly trained to facilitate the shared decision making process with patients.

Harmony Response:

◆ Conducted access and availability surveys.

◆ Monitored referral process via customer service statistics to determine the IPAs/PCPs with the greatest issues and educate.

◆ Reviewed current training at call center and made script changes.

◆ Implementation of Member Escalation Team. Eight representatives within the Member Services department were designated to solely handle escalated issues, member concerns related directly to desiring disenrollment, and all PCP changes.

◆ Provider issues referred to Network Management and additional staff hired to handle issues identified through Customer Service, Sales, and the Retention Channels.

◆ Monthly membership retention meetings and Customer Service workgroups.

◆ Educated medical groups and physician on the quality initiative and HEDIS measures.

◆ Beginning in late 2011, **Harmony** attempted to make welcome calls to all newly enrolled members through a vendor. Through June 2012, 26,150 case holders have been attempted to be contacted and 1,384 were successfully reached. Process improvements have been implemented that should continue to improve contact rates. Within the calls, the members' demographic information, their

Consumer Satisfaction

intended PCP, and receipt of their ID card are confirmed, along with a review of **Harmony**'s benefits. Also during the welcome calls, members are offered assistance in setting up appointments with their PCPs. These calls have been scripted in both English and Spanish to improve the ability to relay the information to the members.

◆ Two retention specialists in the Chicago office began making calls in April to case holders of members who were disenrolling to speak directly to the decision maker in hopes of better understanding the reasons that members are disenrolling. In addition, these retention specialists look up in MEDI where the members are moving to so that we have a better understanding of how competitors and eligibility are impacting our disenrollment.

Encounter Data

Previous Recommendations: The rates indicate that **Harmony** has reasonably good encounter data completeness. Two measures had more than a 90.0 percent data completion rate, two were above 80.0 percent, seven were above 70.0 percent, and one measure was above 60.0 percent. However, five of the measures had a data completion rate of less than 50.0 percent. **Harmony** should continue to reinforce efforts to improve submission of encounter data, concentrating efforts toward obtaining complete lab data.

Harmony Response:

◆ Continued encounter data tracking by medical group, date of submission, and date of service for all direct submitters.

◆ Continued identification of data issues by medical group, by type of measure. Solved for root cause with each medical group, focusing by volume.

◆ Continued to provide noncompliant lists and report cards (by PCP and medical group) on an ongoing basis.

Focused Administrative Review Recommendations

Previous Recommendations: Review of **Harmony**'s measurement and improvement standards included a review of the annual Quality Improvement Program (QIP) Evaluation which revealed that the plan will need to continue to strengthen its annual review process through continued evaluation of the barriers to quality improvement and the development of innovative interventions that will address the barriers identified.

Harmony Response:

◆ Developed the methodology for the Targeted Clinical HEDIS Provider Visits where providers are

Focused Administrative Review Recommendations
provided with their specific information on "missed opportunities." This new program, implemented in August, 2012, will be a key priority for the Quality team for the future.

- Increased data analytics and implemented some new programs such as the secure Web portal where providers can obtain all the care gaps for their members on a real-time basis.

Previous Recommendations: Review of the structure and operations standards identified that **Harmony**'s case management delegation oversight tool lacked all the required components necessary to ensure compliance with contract requirements. In addition, **Harmony** did not have a vendor oversight process in place to ensure coordination and continuity of care and involvement of the PCP in aftercare for members with behavioral health conditions. **Harmony** was in compliance with the credentialing and recredentialing policies and procedures and implemented changes to its grievance system.

Harmony Response:

- Revised all policy and procedures, workflows, and processes for the department.

- Cross-trained delegation auditors to complete a variety of functional audits.

- Developed Enterprise Delegation Oversight Training to define what delegation is; describe delegated providers' responsibilities; identify what functions WellCare routinely delegates; identify the key parties in the delegation process; and describe the monitoring, auditing, and reporting process for delegated entities.

- Established reporting subcommittee and interface with Corporate Compliance and Legal.

- Coordinated all pre-delegation audits for current and expansion markets.

- Established linkage and communication for regulatory updates with internal compliance and market Regulatory Affairs.

- Received recognition by NCQA as "Best Practice."

- Received recognition during URAC mid-cycle monitoring as "Best Practice."

- Implemented weekly Vendor Management/Delegation coordination meetings.

- Implemented Medicare/Medicaid ongoing compliance-focused reviews.

- Established automated database for tracking, trending, and reporting of delegated entity performance.

- Established end-to-end audit process with delegated entities administered jointly with the contract owner, delegated entity, and delegation auditor.

Meridian Health Plan, Inc.

Child and Adolescent Care

Previous Recommendation: Meridian reported baseline rates only and could not be assessed for improvement or sustained improvement.

Meridian Response: NA

Access to Care

Previous Recommendation: Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **Meridian** is expected to have a larger population in SFY 2013 and should be able to report for some measures.

Meridian Response: NA

Maternity-Related Care

Previous Recommendation: Meridian reported baseline rates only for the *Perinatal Care and Depression Screening* PIP and could not be assessed for improvement or sustained improvement.

Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **Meridian** is expected to have a larger population in SFY 2013 and should be able to report for some measures.

Meridian Response: NA

Preventive Screening for Women

Previous Recommendation: Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **Meridian** is expected to have a larger population in SFY 2013 and should be able to report for some measures.

Meridian Response: NA

Chronic Conditions/Disease Management

Previous Recommendation: Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **Meridian** is expected to have a larger population in SFY 2013 and should be able to report for some measures.

Meridian Response: NA

Behavioral Health

Previous Recommendation: Due to **Meridian**'s low population, **Meridian** did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **Meridian** is expected to have a larger population in SFY 2013 and should be able to report for some measures.

Meridian Response: NA

Consumer Satisfaction

Previous Recommendation: Overall recommendations for **Meridian** to improve member satisfaction include:

- Provide physicians with educational materials that they can use to become more informed about the smoking cessation programs and explore the option of creating similar smoking cessation educational materials for members.

- Improve in the area of office wait time and encourage physicians to monitor patient flow by conducting a patient flow analysis.

- Encourage physicians to explore open access scheduling to improve in the area of patients getting a physician appointment as soon as needed.

Meridian Response:

- Continued to expand provider network so members receive appointments in a timely fashion. Focused on the counties that were identified as having the majority of the lower ratings.

- Considering surveying all members utilizing the identified high volume practice to determine if all members are having similar concerns with appointment access and office wait times.

- Continued to educate providers and members about available smoking cessation programs. Reviewing and revising the existing provider education piece on smoking cessation to include the

Consumer Satisfaction

Illinois Medicaid formulary or the link for information about this formulary.

◆ Considering a bonus for provider-based smoking cessation efforts.

Case Management—Care Coordination Program

Previous Recommendation: A review of the case management and care coordination program identified that **Meridian** used the Managed Care Information System (MCS), its internally developed proprietary software system, for documentation of case management activities. A review of medical and behavioral case management files found that while the files provided documentation of timely development of care treatment plans, **Meridian** will need to ensure that the member and the member's primary care physician/specialist are consistently informed that the member has been enrolled into case management services and that the PCP receives a copy of the care treatment plan. **Meridian** must also continue its efforts to facilitate and coordinate communication between service providers and the member/member's family.

Meridian Response:

◆ Implemented and expanded an integrated system in **Meridian**'s Managed Care System (MCS) to track referrals to and from Disease Management (DM) and Case Management (CM) from various sources.

◆ Develop algorithm to identify current members who become pregnant to promote early intervention.

◆ Measure member satisfaction with the case management process.

◆ Measure status of the member's plan of care goals upon case closure.

◆ Measure baseline clinical case management outcomes and utilization case management outcomes.

◆ Educate SASS and other behavioral health providers on the quality access standards for follow-up care after a behavioral health admission.

◆ Implemented two communication forms that will be modified to enhance communication between the PCP and BH specialist.

◆ Continued using the Outpatient Treatment Notification Report form and the Hospital Discharge form.

◆ Provide written notification to all medical and behavioral providers advising of the recent amendment to the Mental Health and Developmental Disabilities Confidentiality Act. The legislation allows disclosure of mental health records for persons enrolled in DHS or HFS programs. Records may be disclosed to medical personnel and members of an interdisciplinary treatment team for

Case Management—Care Coordination Program

purposes of treatment and coordination of care.

◆ Implement process to automatically trigger CM referrals based on HRA responses.

◆ Create written report of Case Management members to determine the appropriate level of intervention. The levels will be stratified into three levels: low, moderate, and high risk.

◆ Review and update Case Management short-term goals to include measureable time frames for completion.

◆ Coordination of care between members' PCP and all relevant specialists and community programs, including OB/GYNs and Family Case Management for High Risk Prenatal Cases. Care coordination letters are generated in MCS to go out to members and their PCP. For pregnant members, the OB/GYN receives a copy with problems and goals listed.

Technical Assistance to HFS and MCOs

HSAG has provided a variety of technical assistance to HFS that has led to quality outcomes. This includes technical assistance in the following areas: PIPs, grievance and appeals process, care management programs, performance tracking tools, children's special health care needs, the Pay-for-Performance (P4P) program, MCO compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, and much more. HSAG has worked with HFS and the MCOs to develop models of stakeholder collaboration for quality improvement projects, essential for identifying and implementing sustainable activities that lead to improved preventive and developmental services. The Illinois collaborative PIPs have improved EPSDT screening services for children; improved perinatal care, post-partum care and depression screening for women; and improved communication between behavioral health and medical providers for participants with behavioral health conditions.

HSAG understands the importance of providing ongoing and specific technical assistance to each MCO, as needed, and provides consultation, expertise, suggestions, and advice to assist with decision-making and strategic planning. HSAG works in partnership and collaboration with the State and MCOs to ensure that it delivers effective technical support that facilitates the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG has continued to provide technical guidance to the MCOs to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). HSAG, at the request of HFS, provided technical assistance training to the MCOs in conducting root cause analyses and implementing meaningful interventions to address the findings outlined in the MCOs' annual program evaluations and the results of PIPs and performance measures.

Specific examples of technical assistance topics conducted in SFY 2011–2012 are listed below.

Conducting PIPs

- Selecting PIP Topics
- Development of Study Question(s)
- Selection of Study Indicator(s)

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- ◆ Selection of Study Population

- ◆ Sampling Methods

- ◆ Data Collection/Analyses

- ◆ Assessment of Quality Improvement Strategies

- ◆ Sustained Improvement

Performance Measures

- ◆ Provided Consultation on Identification and Selection of ABD Performance Measures

- ◆ Provided HEDIS and HEDIS-like Measure Recommendations

- ◆ Provided Consultation on Selection of P4P Measures for the ICP Program

Participation in Monthly and Quarterly Managed Care Quarterly Meetings

HSAG meets regularly with HFS throughout the term of its EQRO contract in order to partner effectively and efficiently with the State. Currently, both the executive director and the project manager assist and attend HFS' on-site quarterly meetings with the MCOs as well as the monthly teleconference meetings. The purpose of these meetings is to review all current and upcoming EQR activities, discuss any barriers or progress, design solutions or a course of action, and review the goals of the quality strategy. The meetings include discussion of compliance with the State's quality strategy, ongoing monitoring of performance of the VMCO and ICP programs, program changes or additions, and future initiatives. In addition, the on-site quarterly meetings serve as a forum for review of the MCOs' progress in managing their quality assessment and performance improvement programs, as well as provide time for technical assistance and training sessions provided by HSAG.

For both monthly and quarterly meetings, HSAG is responsible for consulting with HFS in selecting meeting content, preparing the agenda and any necessary meeting materials, forwarding materials to participants in advance of the meeting, and facilitating the meeting. Meeting materials may include slide handouts, worksheets, PowerPoint presentations, or technical demonstrations. Subject matter experts, including clinical and analytical staff as required, are involved in the development of meeting content; and appropriate staff will provide the instruction and/or facilitation, as appropriate. Following each meeting, HSAG prepares meeting minutes, and upon HFS' approval forwards them to all meeting participants. As part of this process, HSAG creates an action item list and then follows up with the MCOs and HFS to ensure timely completion of those items. HSAG provides status updates to HFS so it can track MCO progress on completing follow-up items.

Development of Integrated Care Plan Performance Measures

The Center for Health Care Strategies, Inc. (CHCS) outlines the following information about developing effective performance measures:

◆ The performance measures available to purchasers and providers today are unevenly distributed across the acute medical, behavioral health, and long-term care sectors. Quality measures for preventive and acute medical care and common chronic illnesses (e.g., asthma and diabetes) are fairly well developed, in contrast with performance measures related to behavioral health and long-term care. Many sources have documented the need for more comprehensive and holistic measures for people with disabilities and chronic illnesses, but this need is only addressed to a limited extent in current nationally recognized measurement sets such as HEDIS. The driving force in health plan performance measurement today is the NCQA's HEDIS measures, which are used to evaluate the performance of commercial, Medicaid, and Medicare managed care plans nationally.

◆ For the most part, the HEDIS measures focus on acute medical care, with an emphasis on preventive care screenings and care delivery processes for a few of the most common health conditions and chronic illnesses. While many of these measures are relevant to individuals in integrated care programs, the measures only address a portion of their acute and chronic health care conditions and needs. In addition, there is no comprehensive measurement set that addresses the complexity of health issues and support services common to those in long-term care settings (e.g., consumer transitions between health care settings, care coordination, etc.). As a result, many health plans and researchers specializing in the care of people with chronic illnesses believe that alternative quality measures are needed to accurately assess performance for plans and providers caring for frail elders and people with disabilities.[10-1]

◆ To assist HFS in developing performance measures that would meet the unique demands of the Integrated Care Program, HSAG completed a literature review to determine if there were applicable measures currently being developed and identified existing measures that could be adapted for use. HSAG worked collaboratively with HFS and the ICPs to identify and develop performance measures specific to ICP members. Through this collaboration, 30 performance measures were identified; and data specifications were developed for each of the performance measures. The 30 ICP performance measures that were developed by HFS and the ICPs are a mix of HEDIS, HEDIS-like, and State-defined measures.

[10-1] http://www.chcs.org/usr_doc/ICP_Resource_Paper.pdf

Performance Tracking Tool

Modifications to the PTT were completed in SFY 2011–2012. The modifications included current benchmarks along with the new quality incentive measures and methodology, as well as performance measure goals for SFY 2012–2013.

The PTT includes the following:

- A key timeline for reporting requirements.

- Compliance monitoring activities, including areas for targeted improvement for the MCOs.

- A simplified process for entering rates for the various activities (e.g., HEDIS, CAHPS, PIPs).

- Links to automatically trend, graph, determine HEDIS percentile rankings, determine next goals, and calculate incentive payment qualification.

- PIP summary tables to determine validation status and improvements on individual PIP quality indicators.

- A Chi-square and p value calculator to facilitate the MCOs' ability to determine if changes were statistically significant.

FHN, **Harmony**, and **Meridian** use the PTT for tracking and monitoring rates and activities, quality improvement efforts, and comparisons to benchmarks; setting and achieving goals; and internal and external reporting (e.g., the MCO's annual report to HFS).

HFS may use the PTT to enhance reporting to CMS and to the State legislature, as well as to enhance other interdepartmental reporting, and determine areas that need focused attention (e.g., HFS can use the PTT to develop collaborative PIPs).

Case Management and Care Coordination Programs

To address the goals of improving care coordination for Illinois Medicaid beneficiaries and to align with the national priorities for improved care coordination, HFS, HSAG, and the VMCOs have focused their efforts to improve case management information systems and coordination of care for their enrollees. Case management was one area which continued to be assessed during focused reviews conducted by HSAG in 2011–2012. The review in SFY 2012 was expanded to the Integrated Care Program (ICP).

To monitor the case management and disease management programs within the VMCOs and ICPs, HFS requires HSAG to conduct reviews of the programs and the VMCOs and ICPs to submit monthly, quarterly, and annual reports. These reports describe the VMCOs' and ICP

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efforts to identify and intervene for enrollees with special health care needs, or with social circumstances or behavioral health issues that place the enrollee at risk for poor health outcomes.

Using an internal algorithm and systems to determine the conditions and risk levels of enrollees, VMCOs and ICPs are required to identify at-risk enrollees; assign a stratification level such as high, moderate, or low; and report the risk stratification level for its enrollees. The risk stratification information reported by the VMCOs and ICPs enables HFS to monitor risk levels of the VMCOs' and ICP enrollees and subsequent trends and movement of the VMCO and ICP enrollees to higher or lower risk levels.

The focused reviews and readiness reviews conducted by HSAG centered on assessing VMCO and ICP compliance with HFS case management/care coordination contract requirements including methods for member identification and selection for case management services, activities of assessment, problem identification, care planning, care delivery, monitoring, evaluation of the care provided, and the health care team's ability to meet the desired outcomes and established goals for members receiving case management services.

During the on-site focused reviews and readiness reviews, HSAG provided ongoing technical assistance to the VMCOs and ICPs to ensure that they had addressed all non-compliant areas. HSAG provided technical assistance in the development and implementation of corrective actions plans. Implementation of the CAPs were reviewed periodically for progress toward full compliance with updates provided to HFS. The corrective actions taken by the VMCOs and ICPs was validated through document review and will continue to be evaluated through on-site review in subsequent years.

Case management and care coordination will continue to be an area of focus until HFS is assured that the VMCO and ICP case management and care coordination programs increase access to health care services, improve outcomes of the care delivered, improve the overall quality of care, and reduce the cost of health care services to HFS beneficiaries.

Table A.1—Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Care Measures

HEDIS Measures	Meridian	FHN	Harmony	National Medicaid HEDIS 2011 Percentiles				
				10th	25th	50th	75th	90th
Child and Adolescent Care								
Childhood Immunizations—Combo 2	87.04	71.99	68.86	62.3	69.0	75.1	80.7	85.8
Childhood Immunizations—Combo 3	83.33	69.91	63.99	56.8	64.4	71.0	76.7	82.6
Lead Screening in Children	92.21	82.87	79.08	34.6	55.5	72.2	80.5	87.6
Well-Child Visits in the First 15 Months (0 Visits)*	0.00	2.31	4.62	0.5	0.8	1.6	2.7	4.4
Well-Child Visits in the First 15 Months (6+ Visits)	82.00	50.12	51.34	41.9	52.2	61.3	68.9	77.1
Well-Child Visits (3–6 Years)	84.94	72.98	65.21	60.9	66.1	72.3	77.6	82.9
Adolescent Well-Care Visits	66.67	44.11	35.52	35.0	39.6	46.1	57.2	64.1
Immunizations for Adolescents	NA	44.80	38.69	33.8	40.0	49.8	63.7	75.5
Children's Access to PCPs (12–24 Months)	100.00	91.84	88.82	92.6	95.1	97.0	97.8	98.6
Children's Access to PCPs (25 months–6 Years)	92.05	77.22	74.20	82.0	86.8	89.6	91.2	92.7
Children's Access to PCPs (7–11 Years)	81.25	53.08	70.95	85.2	87.9	91.3	93.3	94.7
Adolescent's Access to PCPs (12–19 Years)	90.00	54.61	72.32	81.1	86.5	89.7	91.9	93.4
Adults' Access to Preventive/Ambulatory Care								
20–44 Years of Age	89.14	69.22	70.81	78.7	84.5	87.4	89.8	91.0
45–64 Years of Age	91.07	74.11	71.33	73.1	78.5	85.5	89.5	91.9
* Lower rates indicate better performance for this measure.								

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

Table A.2—Preventive Screening for Women and Maternity-Related Measures

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

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

Table A.3—Chronic Conditions/Disease Management Measures

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

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