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 2012-2013

Prepared by: Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite #300
Phoenix, Arizona 85016-4544
Phone: 602.264.6382
Fax: 602.241.0757
www.hsag.com

TABLE OF CONTENTS

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) 2012–2013 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 during the evaluation period was delivered through three models: Voluntary Managed Care (VMC), Primary Care Case Management (PCCM) and the Integrated Care Program (ICP). This executive summary outlines the mandatory and optional EQR activities performed by HSAG in SFY 2012–2013.

Purpose of Report

The SFY 2012–2013 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 2012–2013 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the federal and State requirements.

Federal regulations require 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 federal regulation 42 CFR 438.364 which 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, healthcare services furnished to HFS beneficiaries. The report also offers recommendations for improving the quality of healthcare services furnished by each MCO, makes comparisons of MCO performance, and describes performance improvement efforts.

Overview of the SFY 2012–2013 External Quality Review

Mandatory EQR Activities

The SFY 2012–2013 EQR Technical Report focuses on the three federally-mandated EQR activities that HSAG performed for the MCOs over a 12-month period (July 1, 2012, to June 30, 2013). 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.** HSAG spent SFY 2012–2013 working with HFS to develop and conduct the operational readiness review process for the ICP and the Care Coordination Entities (CCEs) as part of the Care Coordination Innovations expansion. During this reporting period, HSAG did not conduct a review of the Voluntary Managed Care (VMCOs) compliance with state standards.
- **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

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

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

- **Validation of performance improvement projects (PIPs).** As part of the SFY 2012–2013 review, HSAG validated PIPs conducted by the MCOs regarding compliance with requirements set forth in 42 CFR 438.240(b)(1). In SFY 2012–2013, 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 ICP plans 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 2012–2013 review, HSAG evaluated the results of adult and child (Consumer Assessment of Healthcare Providers and Systems (CAHPS® [1-2]) surveys conducted in 2012 and 2013 by The Myers Group and the Center for the Study of Services (CSS) to identify trends, strengths, and opportunities for improvement.[1-3] **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 healthcare services furnished by each MCO.

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

[1-2] CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-3] The Myers Group administered the CAHPS surveys on behalf of FHN, Harmony, and IlliniCare. The Center for the Study of Services (CSS) administered the CAHPS survey on behalf of Aetna.

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.

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

- Performance measure audits using National Committee for Quality Assurance's (NCQA's) [1-4] standardized audit methodology (as described in Section 6 of this report).
- PIP results (as described in Section 7 of this report).
- Member satisfaction survey results (as described in Section 8 of this report).
- Operational readiness reviews findings (as described in Section 5 of this report).
- Technical assistance to HFS and MCOs (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 healthcare 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 healthcare providers, and timeliness of care. Utilization and Relative Resource measures provide information on resource

[1-4] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

management and how the VMCO uses available health services and resources to manage chronic diseases. The following table presents HEDIS measures regarding care for children and adolescents.

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** exceeded the 2012 HEDIS Medicaid 50th percentiles for three measures—*Childhood Immunization Status (Combinations 2 and 3)*, and *Lead Screening in Children*.

Harmony reported one measure with a rate at or above the Medicaid 2012 HEDIS 50th percentile (*Lead Screening in Children*). **Meridian** achieved rates at or above the Medicaid 2012 HEDIS 50th percentiles on all eight measures in this domain.

For the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure, only **Meridian** reported a rate above the National HEDIS 2012 Medicaid 50th percentile. Though **FHN** and **Harmony** did not achieve rates above the National HEDIS 2012 Medicaid 50th percentiles for this measure, both VMCOs displayed an overall rate improvement since the 2011 reporting year. The overall results for this measure signified that approximately 95.0 percent of the eligible children received at least one well-child visit in their first 15 month of life for the 2013 measurement year.

For **Harmony** and **FHN**, the *Immunization for Adolescents* measure demonstrated the greatest possibility for improvement when compared to National HEDIS 2012 Medicaid 50th percentiles.

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 healthcare services offered by the VMCO. The measures look at preventive and ambulatory services for adult, children, and adolescent members. The following table presents HEDIS measures regarding access to care.

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)

For this domain, when compared to last year's result, **FHN**'s rates declined for four out of six measures and improved for two measures. **Harmony**'s rates improved for all six measures. However, even with this improvement, since both **FHN** and **Harmony** performed well below the National HEDIS 2012 Medicaid 50th percentiles, internal policies regarding member and provider education should be evaluated.

When compared to last year's results, **Meridian**'s rates declined for three measures and increased for three measures. However, even with these mixed results, **Meridian** performed above the National HEDIS 2012 Medicaid 50th percentiles for all but one (*Children's and Adolescent's Access to PCPs (12–24 Months*)) measure in this domain. In addition, **Meridian** continued to outperform the other two VMCOs for all measures.

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 VMCO 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 VMCO impacts the VMCO'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

As with the last reporting year, the rates reported by **FHN** continue to fall below the National HEDIS 2012 Medicaid 10th percentiles for all measures in the Maternity-Related Care domain. **FHN** did improve the rate for the *Postpartum Care* measure by 3.2 percentage points but its rates declined for the other three measures, with declines ranging from 6.8 percentage points to 8.0 percentage points.

Postpartum Care was the only measure in this domain for which **Harmony** displayed a slight rate decline (0.2 percentage points). The VMCO showed higher rates for the other three measures, with rate increases ranging from 0.2 percentage points to 10.0 percentage points. However, even though the rates demonstrated overall improvement, all maternity-related measures reported by **Harmony** fell below the National HEDIS 2012 Medicaid 50th percentiles.

Meridian exceeded the National HEDIS 2012 Medicaid 50th percentiles for all four measures in this domain and outperformed the other two VMCOs. In addition, **Meridian** demonstrated rate improvements for all maternity-related measures, with rate increases ranging from 0.6 percentage points to 6.9 percentage points.

For **FHN** and **Harmony**, potential issues were identified as possible causes for lack of improvement: incomplete encounter data, difficulty identifying pregnant members, member compliance issues, and a network adequacy issue. These potential issues were also identified during the prior year's audit process. To determine the reason for the low compliance, the VMCOs should continue to conduct root-cause analysis and develop interventions to improve the rates in this domain.

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 Preventive Screening for Women

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

FHN and **Harmony** reported rates for *Breast Cancer Screening* that did not meet the National HEDIS 2012 Medicaid 50th percentiles. However, when comparing results to the 2012 measurement year's rates, both VMCOs' rates improved for this measure. **FHN** improved its rate by 0.1 percentage points and **Harmony** improved its rate by 2.5 percentage points. For the current reporting period, **Meridian** received a Not Applicable (*NA*) designation for the *Breast Cancer Screening* measure due to its low population.

All three VMCOs exceeded the National HEDIS 2012 Medicaid 50th percentiles for the *Cervical Cancer Screening* measure. When compared to last year's results, **Meridian**'s reported rate declined

3.8 percentage points. **FHN**'s reported rate increased 1.4 percentage points and **Harmony**'s rate increased 1.3 percentage points from the prior year.

For the *Chlamydia Screening in Women* measure, two of the VMCOs (**FHN** and **Meridian**) exceeded the National HEDIS 2012 Medicaid 50th percentiles. When compared to last year's results, all three VMCOs demonstrated slight increases in rates; **Meridian**'s rate demonstrated the largest increase (4.8 percentage points).

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 VMCOs' healthcare delivery system helps members cope with their illness. The following table presents HEDIS measures regarding chronic conditions/disease management.

Table 1.5—HEDIS Measures for Chronic Conditions/Disease Management

Category	HEDIS Measure—(Nine measures in this Category)
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)

None of the measures reported by **FHN** met the National HEDIS 2012 Medicaid 50th percentiles for measures in the Chronic Condition/Disease Management domain. However, when compared to last year's rates, **FHN** improved its performance for five out of 11 measures, with rate increases ranging from 0.1 to 8.2 percentage points. **FHN**'s rates declined for six measures in this domain, with rate declines ranging from 0.1 to 14.1 percentage points.

Similar to **FHN**, **Harmony** performed below the National HEDIS 2012 Medicaid 50th percentiles for all reported measures in this domain. However, **Harmony** demonstrated improved rates for eight measures, with improvements between 0.2 to 7.1 percentage points. However, **Harmony** had three measures where reported rates fell slightly below last year's rates.

Both VMCOs had the lowest performance for the *Comprehensive Diabetes Care–Eye Exam* measure. **FHN**'s rate was 16.8 percentage points below the National HEDIS 2012 Medicaid 50th percentile, and **Harmony**'s rate was 25.6 percentage points below that standard. One barrier to improving this rate may be that optometry services are carved out of the VMCO agreement as a covered service.

This was the first year that **Meridian** reported nine measures in this domain. For two of the nine measures it reported, *Controlling High Blood Pressure* and *Use of Appropriate Medication for People With Asthma*, **Meridian** had less than 30 eligible cases; therefore, the rates are not presented. VMCO comparison for this domain should be used with caution since **Meridian** is reporting its rates based on small population size. Of the nine rates reported by **Meridian**, rates for three measures (*Comprehensive Diabetes Care—HbA1c Testing, Eye Exam,* and *LDL-C Screening*) exceeded the National HEDIS 2012 Medicaid 50th percentiles.

Compliance Audit Results

As a result of the HEDIS 2013 compliance audit, **FHN**, **Meridian**, and **Harmony** were fully compliant with the HEDIS 2013 Technical Specifications. Medical and membership data were fully compliant with the audit standards. All HEDIS performance measures obtained a *Report* (*R*) audit 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)*

Compared to the previous year, **FHN**'s rates for both *Follow-Up After Hospitalization for Mental Illness* measures fell—by 5.2 percentage points for the *7 Days* measure and by 9.1 percentage points for the *30 Days* measure. However, even with the decline in rates, **FHN** still exceeded the National HEDIS 2012 Medicaid 50th percentile targets for both measures.

Harmony demonstrated a rate increase compared to last year for both Behavioral Health measures. The *7 Days* rate increased 8.6 percentage points and the *30 Days* rate increased 7.3 percentage points. In addition, **Harmony** exceeded the National HEDIS 2012 Medicaid 50th percentile for the *7 Days* follow-up rate.

Meridian had less than 30 eligible cases for these measures; therefore, the rates are not presented.

Encounter Data Completeness

The VMCOs are also assessed for encounter data completeness based on the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. **FHN** was not able to reach the 90.0 percent encounter data completeness for any of the

measures. Four measures showed data completeness less than 50.0 percent. Although nine measures demonstrated increase in data completeness since last year, **FHN** is still struggling to obtain complete encounter data for the measures. Continued efforts to acquire encounter data is strongly encouraged for this VMCO.

Harmony exceeded 90.0 percent data completeness for eight out of 14 measures. In addition, **Harmony** continued to outperform **FHN** in data completeness for all but one measure. None of the 14 measures had data completeness less than 50.0 percent. However, when compared to last year's results, **Harmony**'s data completeness improved for seven measures and declined for seven. **Harmony** should continue to strengthen its efforts to improve submission, in order to maintain the level of encounter data submission.

Meridian only uses administrative data and does not use medical record data to supplement the measure results.

Voluntary Managed Care Program Performance Improvement Projects (PIPs)

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. PIPs must be designed, conducted, and reported in a methodologically sound manner. In accordance with federal regulations, HFS' EQRO validates PIPs to determine if the PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs will have a favorable effect on health outcomes and member satisfaction. HSAG evaluated two key components of the quality improvement process, as follows:

- HSAG evaluated the technical structure of the PIPs to ensure the VMCOs and ICP plans designed, conducted, and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs. HSAG's review determined whether a PIP could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring real and sustained improvement.
- HSAG evaluated the outcomes of the PIPs. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. Evaluation of each PIP's outcomes determined whether the VMCO or ICP plan improved its rates through the implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results) and, through these processes, achieved statistically significant improvement. Once statistically significant improvement is achieved, HSAG evaluates whether the VMCOs and ICP plans were successful in sustaining the improvement. The goal of HSAG's PIP validation is to ensure that HFS and key stakeholders can have confidence that reported improvement in study indicator outcomes is supported by statistically significant change and the VMCOs' and ICP plans' improvement strategies.

HFS required each VMCO delivering services to participate in a mandatory statewide PIP focused on the following two topics:

- *Early Periodic Screening, Diagnosis, and Treatment (EPSDT)*
- *Perinatal Care and Depression Screening*

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 children who received six or more well-child visits in the first 15 months of life.*

During SFY 2012–2013, HSAG conducted a validation and analysis of the two above-mentioned PIPs to evaluate the VMCOs' performance on the PIP study indicators. The following summarizes the results of that analysis.

Seven study indicators were validated for the newly revised *EPSDT* PIP, which focused on improving performance related to well-child visits and developmental screenings. Because the *EPSDT* PIP was revised with new study questions and study indicators, each VMCO reported baseline data for this validation cycle, and not all plans had progressed to developing or implementing interventions. HSAG will assess each VMCO's study indicator performance and quality improvement efforts and strategies with the next annual validation when first remeasurement data are reported.

The primary purpose of the *Perinatal Care and Depression Screening* PIP is to determine if VMCO interventions have helped to improve rates for the perinatal care and depression screening. **FHN** showed improvement for eight of its 13 indicators; however, improvement for only one of the study indicators was statistically significant. **FHN** achieved sustained improvement over comparable measurement periods for six of these indicators. **Harmony** demonstrated improvement for 14 of the 16 indicators, with only one indicator demonstrating statistically significant improvement. One study indicator showed a decline in performance, and one indicator rate was unchanged from the previous year. Twelve of the 14 study indicators achieving improvement sustained the improvement over comparable measurement periods without a statistically significant decline. **Meridian** had mixed results for its 16 indicators as it progressed to the first remeasurement. Five study indicators demonstrated improvement, with four of these indicators achieving statistically significant improvement. Five indicators showed declines in performance, with two of these declines being statistically significant. The remaining six indicator rates were unchanged from baseline, with a rate of 100 percent.

Overall recommendations for the VMCOs are as follows:

- For study indicators that do not achieve statistically significant improvement or demonstrate declines in performance, the VMCOs should conduct further drill-down analyses to determine the root cause for not achieving the desired outcomes.
- The VMCOs should conduct causal/barrier analyses more frequently than annually and incorporate quality improvement science such as the Plan-Do-Study-Act (PDSA) cycle into its quality improvement strategies and action plans.
- The VMCOs should ensure that the interventions implemented address a specific barrier, are directly linked to that barrier, and will directly impact study indicator outcomes.
- The VMCOs should evaluate the efficacy of each intervention to determine if it is being successfully implemented and achieving the desired outcome. The results of each intervention's evaluation for each remeasurement period should be included in the PIP documentation.
- The VMCOs should ensure that all statistical testing is done correctly and the documentation of the statistical testing outcomes is accurate and consistent throughout the PIP.
- The VMCOs should consider designing small-scale tests coupled with analysis of results to determine the success of the intervention. If the small-scale test results suggest that the intervention has been unsuccessful, the VMCO should determine: (1) if the true root cause was identified—if not, the VMCO should conduct another causal/barrier analysis to isolate the true root cause or issue that is impacting improvement; and (2) if the interventions need to be revised because a new root cause was identified, or the intervention was unsuccessful. In evaluating the results of intervention testing, the VMCO may find that the results of the test yield more information that directs the VMCO to modify an existing intervention to yield a greater result. If the existing intervention is modified, the VMCO should develop another test to evaluate the modified intervention's effectiveness if the current test is obsolete.

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 healthcare. **Aetna**, **FHN**, **Harmony**, and **IlliniCare** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. Due to its size, **Meridian** was allowed to create and administer its own member satisfaction survey. 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 the CAHPS survey measures is provided below. The areas of satisfaction evaluated through **Meridian**'s Member

Satisfaction Survey are included with **Meridian**'s survey results following those of **FHN** and **Harmony**.

CAHPS Survey

The CAHPS measures evaluated for **FHN** and **Harmony** fall into the Experience of Care HEDIS domain. The surveys ask adult Medicaid members and parents/caretakers of Medicaid children to report on and evaluate their experiences with healthcare. 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 of satisfaction. These measures include five composite scores and four global ratings. The composite scores reflect the satisfaction of adult members and parents/caretakers of children with different aspects of care: getting needed care, getting care quickly, how well doctors communicate, customer service, and shared decision making. The global ratings reflect the overall satisfaction of adult members and parents/caretakers of children with their personal doctor, specialist, health plan, and all healthcare.

The following tables present the CAHPS measures regarding member satisfaction.

Table 1.7—CAHPS Measures for Member Satisfaction

Category	CAHPS® 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® Measure
Member Satisfaction—Global Ratings	*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 2012 results to its 2013 results revealed that **FHN**'s rates increased for five measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. The rate increases were substantial for *Getting Needed Care*, *Customer Service*, and *Rating of Specialist Seen Most Often*. However, a comparison of **FHN**'s 2012 to its 2013 results revealed that **FHN**'s rates decreased for three measures: *Getting Care Quickly*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The decrease in rates was substantial for all three of these measures. **FHN** scored more than 5 percent

below the 2013 NCQA CAHPS top-box national average on two measures: *Getting Care Quickly* and *Rating of Health Plan*.

For the child Medicaid surveys, a comparison of **FHN**'s 2012 results to its 2013 results revealed that **FHN**'s rates increased for seven measures: *Getting Needed Care*, *How Well Doctor's Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. The increases were substantial for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* One measure decreased from 2012, *Getting Care Quickly.* In comparison to NCQA national averages, **FHN** scored substantially below the 2013 NCQA CAHPS top-box national average on five measures, including *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

For the adult Medicaid surveys, a comparison of **Harmony**'s 2012 results to its 2013 results showed an increase in rates for only two measures: *Getting Needed Care* and *Customer Service*. Both of these measures displayed a substantial increase. Six measures showed a decrease in rates from 2012 to 2013: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* Two measures, *Rating of Personal Doctor* and *Rating of Health Plan,* showed a substantial decrease from 2012 to 2013. **Harmony** scored substantially below the 2013 NCQA CAHPS top-box national averages on six measures: *Getting Needed Care*, *Getting Care Quickly, Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

For the child Medicaid surveys, a comparison of **Harmony**'s 2012 results to its 2013 results showed an increase in rates for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care, Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. All of these measures except *How Well Doctors Communicate* displayed a substantial increase. **Harmony**'s rate decreased from 2012 to 2013 for one measure, *Rating of Health Plan*, with this rate showing a substantial decrease. **Harmony** scored substantially below the 2013 NCQA CAHPS top-box national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, 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 healthcare.
- 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 healthcare 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 healthcare 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.
- Enhance provider directories.
- Ensure physicians are properly trained to facilitate the shared decision making process with patients.

Meridian Member Satisfaction Survey

As previously noted, because its size, **Meridian** was allowed to create and administer its own consumer satisfaction survey and therefore cannot be compared with the other health plans. The survey questions asked patients to report on their experiences with **Meridian** and addressed healthcare topics such as patient wait time, doctor communication, office staff, smoking cessation, and rating of doctor.

A comparison of **Meridian**'s 2011 results to its 2012 results showed **Meridian** improved on seven of the 13 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*, *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*, and *Rating of Meridian.*

Rates decreased from 2011 to 2012 for six measures, including *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 with their health plan*; *Identified patients who found it easy to get behavioral health or substance abuse services*; and *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.
- Encourage physician-patient communication to improve patient satisfaction and outcomes.
- Encourage physicians to listen to patients and explain treatment in an understandable way.
- Encourage office staff to be more courteous and helpful to patients.
- Identify ways to improve patient access to care, tests, and treatment available through their health plan.
- Identify ways to improve patient access to behavioral healthcare or substance abuse services through their health plan.
- Encourage physicians to discuss medications to help smokers quit smoking.

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.

Integrated Care Program

Performance Measures

This was the first year for reporting the ICP measures, though a baseline rate was established for each measure based on data prior to implementation of the ICP whenever possible.

Aetna's rates for four measures represented a decline from the baseline rates. Overall, 14 rates improved, with five rates improving by more than 5.0 percentage points. The rates for **IlliniCare** showed that five measures had a decline from the baseline rates. Overall, **IlliniCare** showed that 12 rates improved, with three rates improving by more than 5.0 percentage points. The rates for both ICP plans were similar for most measures.

This was also the first year for reporting pay-for-performance measures for **Aetna** and **IlliniCare**, and both plans showed improvement for a number of measures. Overall, **Aetna** achieved a *Met* status for five measures, which included meeting the target goals for 12 of the individual rates. Nine rates did not meet the target goals. **IlliniCare** achieved a *Met* status for three measures, including eight individual rates; the other 13 rates did not meet the target goals. Both ICP plans achieved a *Met* status for *Congestive Heart Failure* (*CHF*) and *Pharmacotherapy Management of COPD Exacerbation* (*PCE*), and showed improvement in reducing ambulatory care ED visits.

Aetna and **IlliniCare** both failed to meet the overall goals for *Comprehensive Diabetes Care* (*CDC*) and *Coronary Artery Disease* (*CAD*). In addition, neither ICP plan met the target goals for *Follow-up After Hospitalization for Mental Illness*, *Annual Dental Visit*, *Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department Visit*, and *Antidepressant Medication Management Effective Acute Phase Treatment*.

Some of the rates for **Aetna** and **IlliniCare** may be low due to the relative newness of the program, and members not fully utilizing the services provided by the plans.

Performance Improvement Projects

HFS required the ICP plans to participate in a mandatory statewide Care Coordination PIP. This PIP aims to decrease readmissions within 30 days of discharge, improve care coordination during hospitalization and post-acute care discharge, and improve access to community care resources.

Both **Aetna** and **IlliniCare** progressed to reporting baseline data for the three study indicators and had not developed or implemented interventions for the SFY 2012–2013 validation cycle. HSAG will assess each ICP plan's study indicator performance and quality improvement efforts and strategies with the next annual validation when first remeasurement data are reported.

Overall recommendations for the ICP plans include the following:

- As the PIP progresses, each ICP 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. The causal/barrier analyses should be conducted more frequently than annually, and the ICP plans should incorporate quality improvement science such as the PDSA cycle into its quality improvement strategies and action plans.
- As the PIP progresses, the ICP plans should evaluate the efficacy of each intervention to determine if it is being successfully implemented and achieving the desired outcome. The results of each intervention's evaluation for each remeasurement period should be included in the PIP documentation.
- As the PIPs progresses, the ICP plans should consider designing small-scale tests coupled with analysis of results to determine the success of the intervention. If the small-scale test results suggest that the intervention has been unsuccessful, the ICP plan should determine: (1) if the true root cause was identified—if not, the ICP plan should conduct another causal/barrier analysis to isolate the true root cause or issue that is impacting improvement; and (2) if the interventions need to be revised because a new root cause was identified, or the intervention was unsuccessful. In evaluating the results of intervention testing, the ICP plan may find that the results of the test yield more information that directs the ICP plan to modify an existing intervention to yield a greater result. If the existing intervention is modified, the ICP plan should develop another test to evaluate the modified intervention's effectiveness if the current test is obsolete.

Member Satisfaction Surveys

Member satisfaction surveys are designed to capture accurate and reliable information from consumers about their experiences with healthcare. It is important to note that 2013 represents the second year **Aetna** and **IlliniCare** participated in the CAHPS surveys. The 2013 CAHPS survey results represent the first year that comparisons can be made.

From 2012 to 2013, **Aetna** showed improvement in eight of the nine measures, including *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*. Three measures displayed a substantial increase: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of All Health Care*. **Aetna** scored more than 5 percentage points below the 2013 NCQA CAHPS top-box national average for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

Seven out of nine measures for **IlliniCare** showed an increase in rates from 2012 to 2013: *Getting Needed Care, Getting Care Quickly*, *How Well Doctors Communicate, Customer Service, Rating of All Health Care, Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* One measure showed a substantial increase, *Getting Needed Care.* One measure showed a decline, *Rating of Personal Doctor.* **IlliniCare** scored more than 5 percentage points below the 2013 NCQA CAHPS top-box average on one measure, *Rating of Health Plan.*

Aetna should focus on the one measure which showed the least improvement from 2012 to 2013: *Rating of Health Plan.*

Aetna scored higher than **IlliniCare** in one area, *Rating of Specialist Seen Most Often.* **IlliniCare** scored higher than **Aetna** for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan.* **IlliniCare** scored substantially higher than **Aetna** for *Rating of Personal Doctor.*

IlliniCare showed a decrease in rate for *Rating of Personal Doctor.* **IlliniCare** should focus on improving the rate for this measure.

Aetna and **IlliniCare** did not score substantially above any 2013 NCQA CAHPS top-box average in any measure.

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 healthcare.
- 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.
- Encourage office staff to be more courteous and helpful to patients.
- Create an environment that promotes quality improvement (QI) in all aspects of care to encourage organization-wide participation in QI efforts.
- Establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s).
- Enhance provider directories.

ICP Operational Readiness Reviews

HSAG is contracted by HFS to conduct a pre- and post-implementation operational readiness review for the ICP plans contracted to implement HFS' ICP. The primary objectives of HSAG's pre-implementation reviews were, prior to enrollee enrollment in the ICP, to provide information that would allow HFS and the ICP plans 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 *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 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 2012–2013, HSAG conducted the pre-implementation activities for the following ICP plans: **Meridian Health Plan, Inc.** (**Meridian**); **Community Care Alliance of Illinois** (**CCAI**); **Health Alliance Medical Plans, Inc. (HAMP)**; and **Molina Healthcare of Illinois, Inc.** (**Molina**).

On-site review activities included a review of additional documents, policies, and committee minutes to determine compliance with federal healthcare regulations and implementation of the organizations' policies. HSAG used the on-site interviews to provide clarity and perspective to the documents reviewed both prior to the site review and on-site.

Upon completion of the on-site review, HSAG aggregated all information obtained and analyzed the findings from the document and record reviews and from the interviews. HSAG identified any elements that were assigned a score of *Partially Met* or *Not Met* and identified the corrective action the ICP plan 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. Corrective actions were monitored by HSAG and HFS until successfully completed.

Using information obtained during the on-site readiness review and desk review, HSAG and HFS determined, prior to client enrollment, whether each ICP plan's internal organizational structure, health information systems, staffing, and oversight were sufficient to ensure ongoing compliance with contract requirements, quality oversight, and monitoring.

Once the ICP began enrollment, monthly reports monitoring care coordination, enrollment, network development, and staffing were submitted to both HFS and HSAG. The reports were reviewed and analyzed by HSAG and HFS. Ongoing feedback was provided by HSAG and HFS to the ICP plans following review of the required reports.

Table 1.9 below presents a summary of ICP readiness pre-implementation scores and follow-up scores prior to implementation.

Table 1.9–Summary of Scores for the Standards

Standard		Pre-Implementation Audit Score	Prior to Implementation Score
Community Care Alliance of Illinois—Service Package I			
I	Access Standards	80%	99%
II	Structure and Operations Standards	81%	96%
III	Measurement and Improvement Standards	77%	100%
IV	Program Integrity	100%	100%
Health Alliance Medical Plans, Inc.—Service Package I and II			
I	Access Standards	82%	100%
II	Structure and Operations Standards	79%	100%
III	Measurement and Improvement Standards	80%	100%
IV	Program Integrity	100%	100%
Meridian Health Plan, Inc.—Service Package I and II			
I	Access Standards	87%	100%
II	Structure and Operations Standards	92%	100%
III	Measurement and Improvement Standards	83%	100%
IV	Program Integrity	100%	100%
Molina Healthcare of Illinois, Inc.—Service Package I and II			
I	Access Standards	57%	100%
II	Structure and Operations Standards	87%	100%
III	Measurement and Improvement Standards	73%	100%
IV	Program Integrity	100%	100%

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve all four ICP plans to proceed with ICP enrollment in the designated service areas, with continued monitoring of the following areas: (1) care management/care coordination staffing and training, (2) monitoring of care coordination activities, (3) member call center capacity, and (4) provider network capacity.

Care Coordination Entities

Operational Readiness Reviews

In 2012, HFS awarded six provider groups to become part of the Illinois Care Coordination Innovations Project. The provider groups chosen formed CCEs to provide care coordination services to seniors and adults with disabilities using holistic, cost-efficient approaches to coordinate and deliver services to the recipients. The EQRO for HFS, HSAG, was contracted to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. As part of the contract, HSAG developed the customized readiness review tools and was required to conduct readiness reviews for each of the CCEs. In SFY 2013, HSAG conducted pre-implementation readiness reviews for the following CCEs:

- **EntireCare Coordination** (**EntireCare**)
- **My Health Care Coordination Entity** (**My Health**)
- **Precedence Care Coordination Entity, LLC** (**Precedence**)

The readiness review tools included the global CCE model requirements but also focused on each CCE's proposed care coordination model as described in the Request for Proposal (RFP) response. The CCEs were required to submit thorough documentation in the areas of Governance Structure, Scope of Collaboration, and Leadership; Population and Providers; Care Coordination Model; and Health Information Technology (HIT). HSAG reviewed these areas to determine those that required additional focus during the on-site review. During the on-site readiness review, HSAG conducted CCE staff interviews to obtain further information to determine the CCE's compliance with contract requirements and reviewed systems demonstrations when systems were in place for review.

HSAG analyzed the review information to determine the organization's performance, and an iterative process began to improve compliance. All results and necessary corrective actions were documented within the standardized monitoring tools. Certain elements were designated by HFS and HSAG as critical and had to be in compliance prior to the CCE receiving enrollment. The CCEs updated their efforts toward any necessary corrective actions in the standardized monitoring tool (e.g., updating policies and procedures, staff hiring, or system upgrades), and HSAG and HFS monitored their progress.

HSAG provided extensive technical assistance to help the CCEs develop sufficient program descriptions, policies and procedures, and other necessary corrective actions through a series of conference calls and email communication. HSAG conducted frequent follow-up to review documents, provide assistance, and monitor progress toward compliance.

Prior to client enrollment, HFS and HSAG used the findings from the readiness review process to determine whether each CCE's internal organizational structure, health information systems, staffing, and oversight were sufficient for enrollment. Once the CCE was approved to accept enrollment, monthly reports monitoring care coordination, enrollment, network development, and staffing were submitted to both HFS and HSAG. The reports were reviewed and analyzed by HSAG and HFS with monthly and quarterly meetings held with the CCEs.

Technical Assistance to HFS and MCOs

Throughout 2012–2013 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, children's special healthcare needs, the Pay-for-Performance (P4P) program, identification and selection of program-specific performance measures, and developing and implementing new Medicaid programs.

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).

Specific examples of technical assistance topics conducted in SFY 2012–2013 are listed below.

- Conducting PIPs (Selecting PIP Topics, Development of Study Question(s), Selection of Study Indicator(s) Selection of Study Population, Sampling Methods, Data Collection/Analyses, Assessment of Quality Improvement Strategies, Sustained Improvement)
- Provided ongoing Consultation on the Selection of ICP Performance Measures
- Provided HEDIS and HEDIS-like Measure Recommendations
- Provided Consultation on Selection of P4P Measures for the ICP Program
- Development of the ICP Performance Measures
- Participation in Monthly and Quarterly Managed Care Quarterly Meetings
- Home and Community Based Waivers Training for ICP Care Coordinators
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
- Assisted University of Illinois at Chicago (UIC) with Independent Evaluation of the Integrated Care Program

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 2013 and trended HEDIS measures from 2011–2013.
- **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 2012–2013.
- **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.

- **Appendix B**—displays the plan-specific, trended HEDIS measures from 2011–2013.
- **Appendix C**—displays the VCMOs' CHIPRA Performance Measures.

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.

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

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

Illinois has continued to work to develop comprehensive approaches to target the wider Medicaid population through new coordinated/managed care models that would augment Illinois' managed care delivery programs. In 2009, the Medicaid Reform Committee was created in the House and the Deficit Reduction Committee was created in the Senate, both of which urged for more use of MCOs. The administration recognized some flaws in the fragmented fee-for-service Medicaid

system and set in process a new model for integrated care for Medicaid enrollees. After many months of development and involvement from multiple stakeholder groups, HFS implemented the State's first integrated healthcare program for seniors and adults with disabilities on May 1, 2011. The Integrated Care Program (ICP) provides integration of all of the individual's physical, behavioral, and social needs to improve enrollees' health outcomes and enhance their quality of life by providing individuals the support necessary to live more independently in the community. The launch of the ICP program was in direct response to HFS beginning to implement 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 (ICP plans), coordinated care entities (CCEs), managed care community networks (MCCNs), and accountable care entities (ACEs).

Care coordination is the centerpiece of Illinois' Medicaid reform. It's aligned with Illinois' Medicaid reform law and the federal Affordable Care Act. HFS' approach is to initially focus on the most complex, expensive clients and develop an integrated approach to care which brings together local primary care providers (PCPs), specialists, hospitals, nursing homes, behavioral health and other providers to organize care around a patient's needs.

As part of its care coordination expansion efforts, HFS conducted the following activities in SFY 2012–2013:

- Began expansion of the ICP program. HFS contracted HSAG to conduct a pre- and post-implementation operational readiness review for additional health plans contracted to implement HFS' Integrated Care Program. The purpose of the review was to determine the ICP plans' 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 2012–2013, HSAG conducted the pre-implementation activities for the following ICP plans: **Meridian Health Plan, Inc.** (**Meridian**); **Community Care Alliance of Illinois** (**CCAI**); **Health Alliance Medical Plans, Inc.** (**HAMP**); and **Molina Healthcare of Illinois, Inc.** (**Molina**).

- Began the implementation of the Care Coordination Innovations Project, which 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 who are Seniors

and Persons with Disabilities. These provider-based networks will be organized as Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs). In the reporting period, pre-implementation activities were conducted with **EntireCare Coordination** (**EntireCare**), **My Health Care Coordination Entity** (**My Health**), and **Precedence Care Coordination Entity, LLC** (**Precedence**).

- Received approval from the Centers for Medicare & Medicaid Services (CMS) in February 2013 to begin the implementation process for the Medicare-Medicaid Alignment Initiative (MMAI) program. The MMAI program was an undertaking to improve care delivery to clients eligible for both Medicare and Medicaid Services throughout the five mandatory regions in the State of Illinois. HFS contracted with eight Illinois health plans to participate in the MMAI program: **Aetna Better Health** (**Aetna**); **Blue Cross Blue Shield of Illinois** (**BCBS**); **Health Alliance Medical Plans, Inc.** (**HAMP**); **HealthSpring of Illinois** (**HSI**); **Humana**; **IlliniCare Health Plan, Inc.** (**IlliniCare**); **Meridian Health Plan, Inc.** (**Meridian**); and **Molina Healthcare of Illinois, Inc.** (**Molina**).

- Began preliminary readiness activities such as reviewing CMS MMAI Draft Readiness Review tools, conducting MMAI Desk Reviews for each of the MMAI plans, and holding weekly planning meetings with CMS and HFS.

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

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

Necessary medical benefits, as well as preventive care for children, are covered for eligible persons when provided by a healthcare provider enrolled with HFS. Eligibility requirements vary by program. Most people who enroll are covered for comprehensive services, including, 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.

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.

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.

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

Voluntary Managed Care

During the report period, HFS contracted with three MCOs—**FHN**, **Harmony**, and **Meridian**—to participate in VMC in Illinois and provide healthcare 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 2012–2013. **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 2012–2013. **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 SFY 2012–2013.[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

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

services. Recipients can receive their healthcare 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 healthcare 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 healthcare for women while they are pregnant and for 60 days after the baby is born. This program covers outpatient healthcare and inpatient hospital care, including delivery.

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 healthcare services in the most appropriate setting and ensure access to preventive healthcare 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.

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. A mandatory program for older adults and adults with disabilities who are eligible for Medicaid but not Medicare, the Integrated Care Program operates in suburban Cook (zip codes that do not begin with "606"), DuPage, Kane, Kankakee, Lake, and Will counties. The expansion of this program will include Greater Chicago, Rockford Region, Central Illinois–North and South, Quad Cities Region, and Metro East Region.

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 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 healthcare needs
- Additional programs and services to help them live a healthy life

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

The ICP plans 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 ICP plans 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 plan. 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 waiver 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 healthcare services that result in better health for the member, better quality of life for the member, and reduction in the cost of the service over time.

Enrollment

In SFY 2013, Medicaid, and the associated means-tested medical programs, provided comprehensive healthcare coverage to approximately 3 million Illinoisans and partial benefits to over 85,000 [2-2] Illinoisans.

On average, each month, HFS programs cover over 1.6 million children; nearly 200,000 seniors; over 250,000 adults with disabilities; and more than 700,000 other (non-disabled, non-senior) adults. Enrollment figures as of June 30, 2013, are displayed in Table 2.1 below.

Table 2.1—Illinois Medicaid Enrollment SFY 2013

Type of Benefits	Enrollment
Comprehensive Benefits	
Children	1,647,167
Adults with Disabilities	266,419
Other Adults	713,402
Seniors	181,449
Total Comprehensive	2,808,437
Partial Benefits	
Members with Partial Benefits	86,083
Total Members	
Total Members	2,894,520

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

[2-2] http://www2.illinois.gov/hfs/agency/Program%20Enrollment/Pages/Statewide.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 healthcare 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.

The purpose of the Quality Strategy, to be achieved through consistent application, is to ensure that quality healthcare services are delivered with timely access to appropriate covered services; coordination and continuity of care; prevention and early intervention, including risk assessment and health education; improved health outcomes; and ongoing quality improvement.

In SFY 2012–2013, HFS continued to focus on measuring progress and outcomes, and establishing thresholds for improved performance. In addition, HFS began implementing both the PA96-1501 (also known as "Medicaid Reform") 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 requires that 50 percent of Medicaid clients be enrolled in care coordination programs by 2015. To meet this challenge, care coordination is the centerpiece of Illinois' Medicaid reform and is aligned with Illinois' Medicaid reform law and the federal Affordable Care Act. HFS' approach is to initially focus on the most complex, expensive clients and develop an integrated approach to care which brings together local primary care providers (PCPs), specialists, hospitals, nursing homes, behavioral health, and other providers to organize care around a patient's needs.

To further HFS' mission to improve the health of Illinois families by providing access to quality healthcare, in consideration of the health needs of the participants served, in preparation for major programmatic changes to address legislative changes, and in compliance with federal and State regulations, HFS overhauled its Quality Strategy.

Through the review process outlined in this section, HFS used the *Centers for Medicare & Medicaid Services State Quality Strategy Tool Kit for State Medicaid and Children's Health Insurance Agencies* to restructure its Quality Strategy and ensure that this strategy meets the guidelines and fulfills the intended purpose—to serve as a road map for states and their contracted health plans in assessing

the quality of care that beneficiaries receive, as well as for setting measurable goals and targets for improvement.

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 (P4P) incentives, value-based purchasing incentives or disincentives, telemedicine, and health information technology changes.

Quality Strategy Review Process

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

The process HFS uses to refine the Quality Strategy includes stakeholder involvement, 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 healthcare 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.

A stakeholder quality strategy meeting was held on November 7, 2012. Representatives from HFS including the Medicaid director, additional State departments such as the Department of Health, Medicaid Managed Care Plans, hospital administration, community agencies and providers, physical and behavioral health providers, and other community stakeholders attended the meeting. Members reviewed and discussed the revised Quality Strategy, and their feedback was captured for incorporation. In addition, all attendees and their designees were given a review period following the meeting. All submitted feedback was considered by HFS and incorporated as appropriate.

The fully revised State Quality Strategy was published in December 2012, and HFS will begin another review cycle in SFY 2014 to reflect ongoing program changes.

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 do not earn an incentive.

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 were 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. The ICPs 2013 baseline rates were 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.

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*

Table 3.1—ICP P4P Measures

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*
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 Spirometry 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.

Quality Strategy Review Schedule

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.

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 continues to 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

Expansion of Managed Care

Pursuant to P.A. 96-1501 ("Medicaid Reform") signed into law in January 2011, Illinois must have enrolled 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. Care coordination is also the key strategy to contain the Medicaid budget.

Integrated Care Program

HFS implemented the State's first integrated healthcare program on May 1, 2011. Two health maintenance organizations (HMOs), **Aetna** and **IlliniCare**, were selected to administer the program. The Integrated Care Program (ICP) is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of chronic health conditions, and coordination and continuity of care. 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 healthcare 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 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 healthcare 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.

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.

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 that will serve 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 healthcare delivery system that is more patient-centered, with focus on improved health outcomes and evidence-based treatments, enhanced patient access, and patient safety.

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 Statewide *EPSDT Screening* performance improvement project (PIP) was redesigned in calendar year 2012. The number of indicators was decreased to simplify data collection and intervention development. With the redesign of the *EPSDT Screening* PIP, all three VMCOs reported baseline data. Indicator performance was evaluated in SFY 2014 when first remeasurement data were reported.

The VMCOs continued to participate in the Project LAUNCH collaborative, which is a cross-agency initiative that supports the *EPSDT Screening* PIP interventions. In addition, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs.

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.
  - Continued to emphasize the importance of well-child care in the member newsletter.
  - Continued to remind members that transportation to and from well-child care is a covered benefit.

- Continued with semiannual reminder letters to case holders identifying missing services for their children.

Provider Initiatives

- Continued 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.
- Continued quarterly submissions to medical groups of children with incomplete preventive services based on claims/encounter data.

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.
  - Continued HEDIS Education and Screening Program (ESP) which educates members who have a care gap and provides education regarding the care gap and the disease process.
- 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 healthcare services.

Provider Initiatives

- Continued to educate providers on Harmony's Secure Provider Portal which allows online review of a member's current care gap status on a real-time basis.

Meridian

Member and Provider Initiatives

- Conducted drill-down data analysis of medical record documentation to reveal that routine 2-year-old visits are more focused on immunizations/routine lab tests as opposed to full and comprehensive EPSDT visits despite the opportunity that these routine preventive healthcare visits offer. This presents an educational opportunity for both members and providers.
- Conducted additional drill-down analysis of the total population, which identified a trend among pediatric providers on the west side of the State that offer same-day appointments. It appears that same-day appointments result in lower developmental screening rates. **Meridian** will work with these providers to establish office flows to ensure EPSDT visits that include consistent developmental screenings.

Illinois Project LAUNCH

Project LAUNCH collaborative is a cross-agency initiative that supports the *EPSDT Screening* 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 healthcare and accessing their medical home for preventive healthcare, including well-child screening services. Barriers to accessing healthcare 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.

The collaborative activities for SFY 2012–2013 included the finalization and distribution 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 were printed and distributed 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 healthcare priorities. The *Perinatal Care and Depression Screening PIP* was 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 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.
  - 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. Between 10,000 and 11,000 coupons are mailed monthly.
- 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 continued to complete 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.

Harmony

Member Initiatives

- 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.
  - In 2012 there was a significant increase in the number of Harmony Hugs members who had a compliant prenatal visit—66 members in 2012 compared to 12 members in 2011. Frequency of ongoing prenatal care also had a significant increase in the number of compliant Harmony Hugs members: 44 members in 2012 compared to nine in 2011.
  - Continued the Maternity Education and Reward Program (MERP) to distribute educational materials, strollers, "pack and plays," and diapers upon completion of the requirements. A total of 1,675 MERP booklets were mailed, and 61 strollers and 36 "pack and plays" were distributed to members during the reporting period.

Provider Initiatives

- Harmony Hugs
  - The field case manager coordinates efforts with federally qualified health center (FQHC) groups, collaborating with family case managers and the Centering Pregnancy programs if available. The field case manager also refers as appropriate to Magellan Behavioral Heath, especially if the member is having depression issues or has an addiction.

Meridian

Member Initiatives

- Mailings
  - Created an automated process for prenatal tri-folds to be sent when a prenatal claim is Provider Initiatives

Provider Initiatives

- Mailings
  - Created automation efficiencies within the prenatal care authorizations based on information collected in the prenatal assessment tool.

- Updated the stratification within the screening tool to determine whether the member is a low-, moderate-, or high-risk pregnancy.

- Developed an automatic referral process to **Meridian**'s behavioral health department when a maternity member scores 10 or higher on the EPDST screening during or after pregnancy.

Improving Ambulatory Follow-Up and PCP Communication PIP

Prior to this reporting period, each MCO participated in a statewide PIP on improving ambulatory follow-up and PCP communication. This two-part collaborative study between the State, EQRO, and MCOs began in 2009. The goals were to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral healthcare providers. This PIP was retired by HFS in SFY 2012–2013.

Community-Based Care Coordination PIP—Integrated Care Program

HFS required each ICP plan 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 ICP plans, with assistance from HSAG, developed the study question, indicators, and data sources. The PIP focused on the relationship between care coordination, timely ambulatory care services, and readmission rates <30 days post discharge. Both ICP plans did not progress to the point of reporting data during this reporting period. The baseline measurement period for this study is from January 1, 2012–December 31, 2012. Remeasurement 1 is from January 1, 2013–December 31, 2013; Remeasurement 2 is from January 1, 2014–December 31, 2014.

Aetna

- **Aetna** initiated the following interventions anticipating significant impact on readmission rates:
  - Care management staff monitor a daily inpatient census for all members with a readmit risk score >60 and/or CORE score of 4, 5, and 6 for initiation of targeted interventions.
  - Members identified with a readmit risk score >60 and/or CORE score of 4, 5, and 6 are targeted for integrated care (UM/CM/BH staff) case rounds.
  - Discharge calls are made to targeted members within 24 hours post-acute care discharge.

IlliniCare

- **IlliniCare** reported that the PIP plan document, data abstraction tool, instructions, and measurement strategy were validated by HSAG. In April 2013 **IlliniCare** submitted the PIP

summary document and all related support documents for analysis. After review of the initial submission, several action items/adjustments were recommended in May. **IlliniCare** completed the suggested changes, resubmitted the documents, and is awaiting the final analysis of baseline data.

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 that federal and State 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.

During SFY 2012–2013, HSAG focused on working with HFS to continue the readiness reviews for the Integrated Care Program (ICP) expansion and begin the readiness review process for the Care Coordination Entities (CCEs) participating in the Illinois Care Coordination Innovations Project. In addition, HSAG conducted post-implementation readiness reviews on the two existing ICP plans: **Aetna Better Health Network** (**Aetna**) and **IlliniCare Health Plan, Inc.** (**IlliniCare**).

Care Coordination Expansion

As part of its care coordination expansion efforts, HFS conducted the following activities in SFY 2012–2013:

- Began expansion of the Integrated Care Program. HFS contracted HSAG to conduct pre- and post-implementation operational readiness reviews for additional health plans contracted to implement HFS' Integrated Care Program. The purpose of the review was to determine the ICP plans' 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 2012–2013, HSAG conducted the pre-implementation activities for the following ICP plans: **Meridian Health Plan, Inc.** (**Meridian**); **Community Care Alliance of Illinois** (**CCAI**); **Health Alliance Medical Plans, Inc.** (**HAMP**); and **Molina Healthcare of Illinois, Inc.** (**Molina**).

- Began the implementation of the Care Coordination Innovations Project which 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 who are Seniors and Persons with Disabilities. These provider-based networks will be organized as Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs). In the reporting period, pre-implementation readiness review activities were conducted with **EntireCare Coordination** (**EntireCare**), **My Health Care Coordination Entity** (**My Health**), and **Precedence Care Coordination Entity, LLC** (**Precedence**).
- Received approval from the Centers for Medicare & Medicaid Services in February 2013, to begin the implementation process for the Medicare-Medicaid Alignment Initiative (MMAI) program. The MMAI program was an undertaking to improve care delivery to clients eligible for both Medicare and Medicaid Services throughout the five mandatory regions in the State of Illinois. HFS contracted with eight Illinois health plans to participate in the MMAI program: **Aetna Better Health** (**Aetna**); **Blue Cross Blue Shield of Illinois** (**BCBS**); **Health Alliance Medical Plans, Inc.** (**HAMP**); **HealthSpring of Illinois** (**HSI**); **Humana**; **IlliniCare Health Plan, Inc.** (**IlliniCare**); **Meridian Health Plan, Inc.** (**Meridian**); and **Molina Healthcare of Illinois, Inc.** (**Molina**).
- Began preliminary readiness activities such as reviewing CMS MMAI Draft Readiness Review tools, conducting MMAI Desk Reviews for each of the MMAI plans, and holding weekly planning meetings with CMS and HFS.

Table 5.1 below provides a list of the ICP plans and CCEs and the counties served during the reporting period.

Table 5.1–Counties Served by ICP Plans and CCE Expansion

Care Coordination Expansion	
Integrated Care Program Plans	**Region/Counties Served**
Community Care Alliance of Illinois	Rockford region–(Winnebago, Boone, and McHenry Counties)
Health Alliance Medical Plans, Inc.	Central Illinois North–(Knox, Stark, Peoria, and Tazewell Counties) and South–(McLean, Ford, Champaign, Vermillion, Piatt, Macon, Christian, Sangamon, Menard, Logan, and DeWitt Counties)
Meridian Health Plan, Inc.	Central Illinois (N)—(Knox, Stark, Peoria, and Tazewell Counties), Metro East–(Madison, St. Clair, and Clinton Counties)
Molina Healthcare of Illinois, Inc.	Central–North—(Knox, Stark, Peoria, and Tazewell Counties) and South–(McLean, Ford, Champaign, Vermillion, Piatt, Macon, Christian, Sangamon, Menard, Logan, and DeWitt Counties); Metro East-(Madison, St. Clair, and Clinton Counties)

Table 5.1–Counties Served by ICP Plans and CCE Expansion

Care Coordination Expansion	
Care Coordination Entities	**Region/Counties Served**
EntireCare Coordination	Mandatory Counties—Rock Island and Mercer Voluntary Choice Counties—Bureau , Carroll, LaSalle, Lee, Mercer, Ogle, Putnam, and Whiteside
My Health Care Coordination Entity	Mandatory Counties—Central South Counties—Macon, Logan, Piatt, and DeWitt Voluntary Choice Counties—Moultrie and Shelby
Precedence Care Coordination Entity, LLC	Mandatory Counties—Rock Island and Mercer Counties Voluntary Choice–Bureau , Carroll, LaSalle, Lee, Mercer, Ogle, Putnam, and Whiteside Counties

Operational Readiness Reviews—Integrated Care Program

HSAG is contracted by HFS to conduct a pre- and post-implementation operational readiness review for the health plans contracted to implement HFS' Integrated Care Program. The primary objectives of HSAG's pre-implementation reviews were, prior to enrollee enrollment in the Integrated Care Program, provide information that would allow HFS and the ICP plans 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 *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 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.

For each of the ICP 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 MCO reports prepared by HSAG.

Procedure

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 ICP plans.
- Identify the ICP plans' 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 ICP plans of their integrated care programs and readiness to provide services to aged, blind, and disabled (ABD) adults enrolled that 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 assess and document each ICP plan'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 operational areas as displayed in Table 5.2 below.

Table 5.2–Operational Readiness Review Standards

Operational Readiness Review Standards		
Standard Domain	**Standard Number**	**Standard Description**
Access	I	Availability of Services
	II	Assurance of Adequate Capacity and Services
	III	Coordination and Continuity of Care (including Transition of Care)
	IV	Coverage and Authorization of Services
Structure and Operations	V	Credentialing and Recredentialing
	VI	Sub-contractual Relationships and Delegation
	VII	Enrollee Information/Enrollee Rights
	VIII	Confidentiality
	IX	Enrollment and Disenrollment
	X	Grievance Process
	XIV	Critical Incidents

Table 5.2–Operational Readiness Review Standards

Operational Readiness Review Standards		
Standard Domain	**Standard Number**	**Standard Description**
Measurement and Improvement	XI	Practice Guidelines
	XII	Quality Assessment and Performance Improvement Program
	XIII	Health Information System
Program Integrity	XV	Fraud and Abuse

Data Collection and Analysis

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

Pre-on-site review activities consisted of scheduling and developing timelines for the site reviews and report development; developing data collection tools, report templates, and on-site agendas; and reviewing the ICP plan's documents prior to the on-site portion of the review.

On-site review activities included a review of additional documents, policies, and committee minutes to determine compliance with federal healthcare regulations and implementation of the organizations' policies. HSAG conducted an opening conference to review the agenda and objectives of the site review and to allow the ICP plan to present any important information to assist the reviewers in understanding the unique attributes of each organization. HSAG used the on-site interviews to provide clarity and perspective to the documents reviewed both prior to the site review and on-site. HSAG then conducted a closing conference to summarize preliminary findings and anticipated recommendations and opportunities for improvement.

Upon completion of the on-site review, HSAG aggregated all information obtained. HSAG analyzed the findings from the document and record reviews and from the interviews. HSAG identified any elements that were assigned a score of *Partially Met* or *Not Met* and identified the corrective action the ICP plan 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. Corrective actions were monitored by HSAG and HFS until successfully completed.

Using information obtained the on-site readiness review and desk review, HSAG and HFS determined, prior to client enrollment, whether each ICP plan's internal organizational structure, health information systems, staffing and oversight were sufficient to ensure ongoing compliance with contract requirements, quality oversight, and monitoring.

Once the ICP plan began enrollment, monthly reports monitoring care coordination, enrollment, network development and staffing were submitted to both HFS and HSAG. The reports were reviewed and analyzed by HSAG and HFS. Ongoing feedback was provided by HSAG and HFS to the ICP plans following review of the required reports.

ICP Plan Overall Findings

Table 5.3 below presents a summary of ICP plan readiness pre-implementation scores and follow-up scores prior to implementation.

Table 5.3—Summary of Scores for the Standards

Standard		Pre-Implementation Audit Score	Prior to Implementation Score
Community Care Alliance of Illinois—Service Package I			
I	Access Standards	80%	99%
II	Structure and Operations Standards	81%	96%
III	Measurement and Improvement Standards	77%	100%
IV	Program Integrity	100%	100%
Health Alliance Medical Plans, Inc.—Service Packages I and II			
I	Access Standards	82%	100%
II	Structure and Operations Standards	79%	100%
III	Measurement and Improvement Standards	80%	100%
IV	Program Integrity	100%	100%
Meridian Health Plan, Inc.—Service Packages I and II			
I	Access Standards	87%	100%
II	Structure and Operations Standards	92%	100%
III	Measurement and Improvement Standards	83%	100%
IV	Program Integrity	100%	100%
Molina Healthcare of Illinois, Inc.—Service Packages I and II			
I	Access Standards	57%	100%
II	Structure and Operations Standards	87%	100%
III	Measurement and Improvement Standards	73%	100%
IV	Program Integrity	100%	100%

ICP Plan-Specific Findings

Community Care Alliance of Illinois (CCAI)

Community Care Alliance of Illinois (**CCAI**) [5-1] was created to provide an innovative, integrated, coordinated, comprehensive, and patient-centered approach which aligns with the Illinois Department of Healthcare and Family Services (HFS) Care Coordination Innovations Project. **CCAI** is a licensed Illinois LLC, a wholly owned subsidiary of **Family Health Network**. (**FHN**), which is a Safety Net Provider Sponsored not-for-profit MCCN. **CCAI** will be converted to an Illinois not-for-profit MCCN. **CCAI**, organized by a steering committee, has a seven-member Enrollee Board including four providers, two consumers, and two representatives of **FHN** (one of whom will also be one of the four providers on the board). The one provider, two consumers, and one **FHN** representative on the current board will remain on the MCCN's board. Additional enrollees will be added to meet the regulatory requirements for a MCCN board or as useful to **CCAI**'s growth and development.

HSAG conducted an on-site pre-implementation readiness review for **CCAI** for Service Package I on March 13–14, 2013. In addition, HSAG conducted an on-site pre-implementation readiness review for **CCAI** on June 19, 2013. Following the pre-implementation readiness reviews, **CCAI** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review Corrective Action Plan (CAP) grid. The majority of items identified on the CAP grid were completed and approved by the end of August 2013 prior to accepting ICP enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **CCAI** to proceed with ICP enrollment in the designated service areas, with continued monitoring of the following areas: (1) care management/care coordination staffing and training, (2) monitoring of care coordination activities, (3) member call center capacity, and (4) provider network capacity.

A summary of the readiness review findings is included below.

Access Standards

CCAI 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.

Network Management staff members are responsible for monitoring the provider network to ensure that a sufficient number and types of primary care providers/medical homes and specialty

[5-1] CCAI Pre-Assessment Form

physicians, dentists, behavioral health (including substance abuse), home and community-based providers, and other ancillary services are available to meet members' medical and behavioral health needs. **CCAI** demonstrated that it had a process in place and can analyze the geographic distribution of its provider network quarterly, using Quest Analytics software. In addition, **CCAI** was able to demonstrate that it has a process in place to monitor appointment availability through a "Secret Shopper" survey process. **CCAI** also monitored other network adequacy indicators such as complaints/grievances related to access received through the enrollee and provider call center.

CCAI began working with HSAG at the end of SFY 2013 to begin submission of the provider network data to HSAG. Following receipt of the data, HSAG will complete an analysis of the current **CCAI** provider network capacity and monitor ongoing development of the Service Package I and Service Package II provider networks.

During the on-site reviews, HSAG evaluated the effectiveness of the case management software, CareEnhance Clinical Care Management System (CCMS). CCMS was used by Enrollee Services and Care Management staff to complete the initial health risk survey, comprehensive risk assessments, and enrollee care plans. All notes were dated and time stamped in the system.

Through review of the staffing worksheet, organizational charts, and interview, **CCAI** demonstrated a sufficient number of staff to begin accepting ICP enrollment for Service Packages I and II. The Integrated Care Team (ICT) staff was composed of nurse care coordinators (registered nurses), Long Term Services and Support (LTSS) coordinators that were master level social workers, as well as LTSS care coordinators with bachelor degrees and experience in working with individuals receiving HCBS Waiver services. **CCAI** was in the process of training the HCBS Waiver Care Coordination staff at the time of the Service Package II on-site review. **CCAI** continued to provide updates on the status of staff training following the pre-implementation review.

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. **CCAI** had nationally recognized standards and practice guidelines (InterQual) for reviewing and making decisions on provider and member requests for services. **CCAI** had qualified staff available to review and make authorization and denial of service decisions.

For the access standards, **CCAI** was required to follow up on the following items following the pre-implementation review:

- Provide ongoing network capacity reports to HFS both before, during, and post-implementation of the Integrated Care Program

- Revise the provider contract template to include compliance with the MCOs Cultural Competency Plan, and provide updates to the gaps identified in the provider network for urology, neurology and orthopedic providers.
- Revise its Care Management/Disease Management Program Description to include all requirements as outlined in the ICP contract including the design and functions of the care transition team, and include workflows for the Care Coordination Team and caseload requirements. In addition, policies and procedures were revised to describe efficient transitions for the enrollee's care, while corresponding with the requisites of the Integrated Care Program.
- Submit updated staffing reports to HSAG following the readiness review. HSAG will monitor **CCAI**'s care management/care coordination staffing capacity during the post-implementation period.
- Submit updates to the status of HCBS Waiver staff training until training is complete.

Structure and Operations Standards

CCAI had established policies and procedures that addressed provider selection, subcontractual relationships and delegation, enrollee information, confidentiality and privacy, enrollment and disenrollment, grievance systems, health and safety monitoring, and critical incidents. 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.

HFS provided template information for the LTSS insert for the Enrollee Handbook, which included information specific to the Waiver enrollees. **CCAI** worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the LTSS insert.

Enrollee 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. **CCAI** completed training of all staff, which included information regarding enrollee rights and responsibilities.

Policies and procedures were developed by **CCAI** to protect enrollee privacy and confidentiality. Critical Incidents, and Abuse, Neglect, and Exploitation training for employees was completed by **CCAI**, and a system to track reported critical incidents was developed.

CCAI had policies, procedures, and processes in place for monitoring the performance of its affiliated providers and subcontractors. **CCAI** also had mechanisms in place for quarterly, semiannual, and annual oversight and monitoring of its affiliated providers and subcontractors. **CCAI** had a process in place to monitor 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.

CCAI had established a grievance system for enrollees 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. In addition, **CCAI** had an established process for registering written or oral appeals that included documentation of the appeal, consent from the enrollee 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.

Following HFS' review of the grievance and appeals requirements for the HCBS Waiver enrollees, HFS worked with Waiver agency staff to develop specific templates and requirements for the grievance and appeals process. Fair hearings staff provided training to the MCOs on the changes needed to ensure the plans were in compliance with State, federal, and waiver requirements.

For the structure and operations standards, **CCAI** was required to follow up on the following items following the pre-implementation review.

- Work with HFS to complete the necessary revisions to the Enrollee Handbook including the LTSS inserts.
- Submit copies of the delegation agreements with PsycHealth and CareMark.
- Submit the pre-delegation audit findings for PsycHealth and CareMark.
- Develop policies and procedures and establish a mechanism for oversight of the delegated vendors. The oversight plan was required to include the prior authorization and denials activities of the delegated vendors.
- Submit updated grievance and appeals letters, policies, and procedures in compliance with the templates and directions provided by HFS.

Measurement and Improvement Standards

CCAI had established policies and procedures in place that addressed the Quality Assessment and Performance Improvement (QAPI) program and health information systems in compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements.

CCAI'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 **CCAI** Quality Assurance/Utilization Management (QA/UM) Committee consisted of the medical directors, physicians, and other primary care providers (as indicated) from the participating anchor medical homes, the **CCAI** medical director, the **CCAI** vice president of healthcare management, the **CCAI** director of quality and QA staff, and representatives of the anchor medical homes' Quality Assurance/Utilization Management staffs. Representatives from anchor sites and providers with greater than 100 enrollees are required to attend meetings and participate in the QA/UM Committee. Representatives of subcontracted service providers (e.g., the behavioral health services subcontractor) also participate in the committee. The committee is chaired by the **CCAI** medical director and meets bimonthly, or more frequently, as determined by the medical director and the members of the committee.

The clinical practice guidelines (CPGs) adopted for use by **CCAI** were written using evidence-based, standardized practices. The Clinical Guidelines were available to enrollees and providers on the **CCAI** website. **CCAI** had established mechanisms for dissemination of practice guidelines to providers and upon request to consumers. **CCAI** had a process in place to annually evaluate provider adherence to the practice guidelines through review of medical records and utilization management reports.

CCAI 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 taken to implement and promote an understanding of and respect for the diverse cultural backgrounds, attitudes, and beliefs of its service population.

CCAI 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, and enrollee characteristics.

For the measurement and improvement standards**, CCAI** was required to follow up on the following items following the pre-implementation review.

- Revise the QAPI Program Description to include oversight of the Fraud, Waste, and Abuse Program; reporting structure for the compliance officer; and health and safety monitoring.
- Submit meeting minutes to demonstrate review and approval of the CPGs, evidence of staff training, and a link to the location of the CPGs on the **CCAI** Web portal.

Program Integrity

CCAI's Fraud, Waste, and Abuse training outlined the responsibilities and procedures for prevention, investigation, reporting, correction, as well as deterrence of fraud, waste, and abuse (FWA). The compliance staff developed an auditing schedule to review identified high-risk areas

such as medical claims review and pharmacy. The training the employees received included who to contact, and that contact could be made anonymously if the employees had questions or concerns regarding FWA.

For the program integrity standards, **CCAI** required no follow-up.

Health Alliance Medical Plans, Inc.

Health Alliance Medical Plans, Inc. (**HAMP**)[5-2] was founded in 1979 as CarleCare, an Illinois not-for-profit health maintenance organization. In February 1988 CarleCare converted to for-profit status and in November 1989, (**HAMP**) was reorganized as a for-profit Illinois domestic stock insurance company owned by a single shareholder, Carle Clinic Association. As such, **HAMP** is able to underwrite and administer a full range of managed care products on a fully-insured or self-funded basis.

In 1994, **HAMP** implemented a growth strategy through partnerships with healthcare providers throughout Illinois and central Iowa. To further diversify its product portfolio, **HAMP** launched a PPO product in 1990, a gated PPO product in 1994, and a POS product in 2000. In 2003, Health Alliance introduced a line of health plan options created specifically for individuals who are not covered by health insurance through an employer plan.

Due to the **HAMP** growth strategy in Iowa, **HAMP** formed Health Alliance-Midwest, Inc., a wholly-owned subsidiary, which was organized as an Illinois domestic corporation under the Illinois Business Corporation Act. Health Alliance-Midwest, Inc., was granted approval by the Illinois Secretary of State on February 16, 1996, as an Illinois domestic health maintenance organization.

HSAG conducted an on-site pre-implementation readiness review for **HAMP** for Service Packages I and II on May 20–21, 2013. Following the pre-implementation readiness review **HAMP** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review CAP grid. The majority of items identified on the CAP grid were completed and approved by the end of August 2013 prior to accepting ICP enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **HAMP** to proceed with ICP enrollment in the designated service areas, with continued monitoring of the following areas: (1) care management/care coordination staffing and training, (2) monitoring of care coordination activities, (3) member call center capacity, and (4) provider network capacity.

A summary of the readiness review findings is included below.

[5-2] Health Alliance Pre-Assessment Form_Exhibit 1_Health Alliance History

Access Standards

HAMP 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 **HAMP** Contracting and Provider Services Department is responsible for quarterly GeoAccess reporting to monitor the network standards and identify any gaps in the provider network. The **HAMP** network analysis included the distribution of LTSS enrollees to ensure the HCBS waiver providers were contracted and available in the network. In addition, **HAMP** had policies and procedures in place to monitor enrollee access to timely appointments.

HAMP began working with HSAG at the end of SFY 2013 to begin submission of the provider network data to HSAG. Following receipt of the data HSAG will complete an analysis of the current **HAMP** provider network capacity and monitor ongoing development of the Service Package I and Service Package II provider networks.

HAMP 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.

During the on-site readiness review **HAMP** demonstrated the McKesson case management software Coordinated Care Management System (CCMS), which will be used to document care management/care coordination activities. **HAMP** described its plans to upgrade CCMS to version 7.1 which will enhance documentation of enrollee assessments and care planning.

HAMP will use the Chronic Illness and Disability Payment System (CDPS) to predict enrollee risk. **HAMP** described using predictive modeling reports and other surveillance data (such as referrals, transition information, service authorizations, alerts, memos, results of the Determination of Need (DON), to determine enrollee risk level. The **HAMP** Integrated Care Teams (ICTs) consisted of nurse care managers and member resource coordinators. The nurse care manager is identified as responsible for care coordination for the ICT. Additional members of the ICT included behavioral health professionals, physical therapists, pharmacists, and LTSS coordinators. The chief medical officer and the director of care management were identified as responsible for oversight of the ICT. **HAMP** provided an overview of its staffing plan which identified projected staffing from April 2013 through December 2013. **HAMP** had developed reports to monitor completion of health risk assessments (HRAs), comprehensive assessments, and individual plans of care.

HAMP had a staff training program in place for the ICT which included:

- Person-Centered planning
- Cultural Competency (annual)
- Accessibility and accommodations
- Disability Competency (annual)
- American Disabilities Act (ADA) training (annual)
- Independent Living and Recovery training
- Wellness principles

HAMP was in the process of training the HCBS Waiver Care Coordination staff at the time of the on-site review. **HAMP** continued to provide updates on the status of staff training following the pre-implementation review.

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. **HAMP** had nationally recognized standards and practice guidelines (InterQual) for reviewing and making decisions on provider and member requests for services. **HAMP** had qualified staff available to review and make authorization and denial of service decisions.

For the access standards**, HAMP** was required to follow up on the following items following the pre-implementation review:

- Provide ongoing network capacity reports to HFS both before, during, and post-implementation of the Integrated Care Program.
- Submit updated staffing reports to HSAG following the readiness review. HSAG will monitor **HAMP**'s care management/care coordination staffing capacity during the post-implementation period.
- Revise the Care Management Program to include monitoring and oversight of the Waiver program. Revisions to the care management policies were also required to include requirements specific to the LTSS and Waiver populations—specifically, risk assessment, predictive modeling, and development of the individual plan of care.

Structure and Operations Standards

HAMP had established policies and procedures that addressed provider selection, subcontractual relationships and delegation, enrollee information, confidentiality and privacy, enrollment and disenrollment, grievance systems, health and safety monitoring, and critical incidents. 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.

HAMP worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the LTSS insert. HFS provided template information for the LTSS insert based on Waiver program requirements that were required to be included in the LTSS insert. Written enrollee materials were at the fourth-grade level and available in alternative formats and languages. **HAMP** developed cultural competency training materials which were used for training **HAMP** staff and network providers. The training will be provided during orientation and annually for **HAMP** employees and affiliated providers.

HAMP had policies and procedures regarding protected health information (PHI) and confidentiality. **HAMP** completed Critical Incidents and Abuse, Neglect, and Exploitation training for employees and had a system to track reported critical incidents, abuse, neglect, and exploitation.

HAMP had established a grievance system for enrollees 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. In addition, **HAMP** had an established process for registering written or oral appeals that included documentation of the appeal, consent from the enrollee 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. The grievance policy did not include the process for handling a quality of care grievance. Review of staff training on enrollee grievances identified that no documentation was available to verify training of the member resource coordinators.

Following HFS review of the grievance and appeals requirements for the HCBS Waiver enrollees, HFS worked with the waiver agency staff to develop specific templates and requirements for the grievance and appeals process. Fair hearings staff provided training to the MCOs on the changes needed to ensure the plans were in compliance with State, federal, and waiver requirements.

For the structure and operations standards, **HAMP** was required to follow up on the following items following the pre-implementation review.

- Work with HFS to complete the necessary revisions to the Enrollee Handbook including the LTSS inserts.
- Submit a sample member ID card and work with HFS on the approval process.
- Develop and submit a work plan for transportation.
- Develop an oversight and monitoring plan for monitoring the transportation vendor.
- Submit updated grievance and appeals letters, policies, and procedures in compliance with the templates and directions provided by HFS.

- Revise the grievance policy and procedure to include the process for handling a quality of care grievance.
- Submit copies of the call center monitoring reports.
- Submit documentation of training for the member resource coordinators, including the receipt and processing of enrollee grievances.
- Submit a link to the member portal when the site is ready to "go live."

Measurement and Improvement Standards

HAMP had established policies and procedures in place that addressed the QAPI program and health information systems in compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements.

HAMP's Quality and Medical Management Program (QMMP) integrated the primary functions of the Quality, Medical Management, and Pharmacy departments. The departments worked in tandem to establish, coordinate, and execute a structure to support **HAMP** enrollees.

HAMP had clinical guidelines in place that had been reviewed and approved and available to the providers through the Provider Manual which was accessible through the **HAMP** website.

At the time of the on-site review, **HAMP** was in the process of developing the database for receiving, tracking, and reporting critical incidents, abuse, neglect, and exploitation. Review of policies and procedures identified that **HAMP** would need to revise the policies and procedures to include all requirements in the ICP contract. **HAMP** will also need to submit evidence of training for critical incidents, abuse, neglect, and exploitation for **HAMP** staff, providers, and subcontractors.

HAMP had an information system capable of integrating incoming enrollment and disenrollment data files, including all member demographic information. Clinical Care Management System (CCMS) is used by medical management for case management, referral events, service events, admission events, and disease management. Members, providers, facilities, coverage, enrollment, PCP history, and support tables are transferred to CCMS nightly from MC 400. The Core Managed Care System (MC400) is used to capture, store, and adjudicate data for members, groups, providers, plans, and claims. All medical claims processing is completed on this system. The MC400 was also used as the data warehouse to report on performance measures, utilization data, case and disease management, and enrollee demographics.

For the measurement and improvement standards**, HAMP** was required to follow up on the following items following the pre-implementation review:

- Submit evidence of training on critical incidents, abuse, neglect, and exploitation for staff, providers, and subcontractors.
  - Complete the development of the health and safety database and submit screenshots when complete.
- Revise the health and safety monitoring policies and procedures to include the following:
  - Revise the Elder Abuse and Neglect Training and Reporting Policy and the Member Abuse and Neglect Training and Reporting Policy to contain all incidents as detailed in Attachments XVIII and XIX and all critical incidents included on the Health Alliance Critical Incident Definitions document.
  - Submit the Critical Incident Reporting Form.
- Review the McKesson Analytics Advisor software to determine if the software can be used for provider profiling.
- Revise the QMMP/UM Program Description to include oversight of LTSS services; oversight of critical incidents, abuse, neglect, and exploitation reporting, and evaluation of the ICT.

Program Integrity

HAMP has an annual compliance training that included these components: Ethics and Compliance in the Workplace; Standards of Employee Conduct; Fraud, Waste, and Abuse and Reporting FWA; Compliance Violations; and Suspecting Misconduct or a Privacy or Security Incident. **HAMP** had a quarterly audit process in place to review claims and pharmacy to detect suspected fraud and abuse.

For the program integrity standards**, HAMP** required no follow-up.

Meridian Health Plan, Inc.

The mission of **Meridian Health Plan, Inc.** (**Meridian**)[5-3] is to continuously improve the quality of care in a low-resource environment. As a physician-owned and member-focused organization, **Meridian** and its affiliates blend innovative proprietary technologies with a commitment to premier customer service in support of this mission. They embody the "Triple Aim" concept:

1. Improve the health of the population.
2. Enhance the patient experience of care (including quality, access, and reliability).
3. Reduce the per capita cost of care.

[5-3] Meridian Pre-Assessment Form

Meridian was founded by Dr. David B. Cotton, a high-risk obstetrician, by trade, from the merger of two plans, Central Michigan Health Plan (CMHP) and American Preferred Provider Plan of Michigan (APPPM). In August 1997, Dr. Cotton acquired a majority position in CMHP and assumed fiscal and administrative responsibility for the plan, which had approximately 1,400 enrollees. CMHP acquired APPPM in January 1999 and ultimately became operational as Health Plan of Michigan (HPM) in May 1999.

Operating as a full-service HMO since January 2000, HPM obtained NCQA accreditation in May 2002 and URAC accreditation in March 2011. On January 1, 2012, Health Plan of Michigan became **Meridian Health Plan**, done simply to ensure consistency across several lines of business. **Meridian Health Plan** remains a physician-owned and physician-managed health plan.

HSAG conducted an on-site pre-implementation readiness review for **Meridian** for Service Packages I and II on April 24–25, 2013. Following the pre-implementation readiness review, **Meridian** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review CAP grid. The majority of items identified on the CAP grid were completed and approved by the end of September 2013 prior to accepting ICP enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **Meridian** to proceed with ICP enrollment in the designated service areas, with continued monitoring of the following areas: (1) care management/care coordination staffing and training, (2) monitoring of care coordination activities, (3) member call center capacity, and (4) provider network capacity.

A summary of the readiness review findings is included below.

Access Standards

Meridian 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.

Meridian's Provider Services Department in conjunction with the Quality Improvement Department evaluated the sufficiency of providers and provider types, cultural diversity, and the geographic distribution of contracted providers annually. The evaluation included ratios of enrollee-to-PCP and enrollee-to-specialist availability as well as the number of sites accepting new enrollees. Quest Analytics was used to display distribution of enrollee to PCP through graphs and maps. **Meridian** submitted network capacity reports regularly to HSAG.

Meridian began working with HSAG at the end of SFY 2013 to begin submission of the provider network data to HSAG. Following receipt of the data, HSAG will complete an analysis of the current **Meridian** provider network capacity and monitor ongoing development of the Service Package I and Service Package II provider networks.

All documentation recorded by members of the integrated Care Coordination Team is included in the member's care coordination record that resides in **Meridian**'s Managed Care System (MCS). Each member of the care team has access to the member's medical record, plan of care, authorizations, member and provider contacts, transitions of care, and progress notes at the time they are recorded. MCS is designed to provide the team with automatic alerts of care transitions (i.e., acute admissions, referrals entered, follow-up contact and actions based on the plan of care, and claim ER utilization), and completion of required time-sensitive tasks (i.e., HRA completion, and scheduled contact to member or provider). Gaps in care are tracked in MCS and alerts are triggered based on medication adherence and outstanding HEDIS needs. Reports are generated and used by the team leads to monitor timeliness of required member assessments and other activities.

Meridian uses the John's Hopkins predictive modeling software to identify patterns of uncoordinated care using criteria-driven algorithms that apply a method for risk stratification based on claims. Data derived from member assessments are also included in the algorithms such as the status of the member's caretaker and social needs.

Each Care Coordination Team is composed of a primary care coordinator and consultants to meet various member needs as follows:

1. Medical director: oversees the team's activities and meets for daily case review to provide direction in relation to the medical and social plan of care.
2. Nutrition consultant: provides nutritional counseling and weight management program information for members on the consultant's assigned team.
3. Behavioral health consultant: provides behavioral health support for members on teams other than Behavioral Health primary; these members may have some behavioral health concerns but not a driving diagnosis that affects their everyday functioning.
4. Medical consultant: provides medical support for members on the Behavioral Health team who have a primary behavioral health diagnosis but still require medical coordination. (
5. Pharmacy consultant: provides medication reconciliation and review for potentially harmful drug interactions or gaps in prescription fills.
6. Community health outreach worker: assists with access to community resources and supports members in other nonclinical needs as requested.

Case management policies and procedures were amended by **Meridian** to meet Waiver-specific requirements. **Meridian**'s Care Coordination program focused on enrollees with special healthcare needs and their families. The goal of the program was to link the enrollee with needed or additional services and resources to achieve access to care and increase self-management.

Meridian was in the process of training the HCBS Waiver Care Coordination staff at the time of the Service Package II on-site review. **Meridian** continued to provide updates on the status of staff training following the pre-implementation review.

The **Meridian** care management/ Care Coordination Team training program included HCBS Waiver-required topics that met the requirements as outlined in the contract. The **Meridian** Key Personnel Training Tracker provides comprehensive tracking of key personnel training and education monitoring. The key personnel tracker's detailed course content identified the following topics: waiver-specific services, motivational interviewing, confidentiality, health and safety monitoring; cultural competency, case management policies and procedures, roles and responsibilities, assessment, person-centered care planning, self-determination, fair hearing, grievance and appeals, ethics, recovery and resiliency, and peer mentoring.

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. **Meridian** had nationally recognized preventive care and clinical practice guidelines for reviewing and making decisions on provider and member requests for services. **Meridian** had qualified staff available to review and make authorization and denial of service decisions.

For the access standards, **Meridian** was required to follow up on the following items following the pre-implementation review:

- Provide ongoing network capacity reports to HFS both before, during, and post-implementation of the Integrated Care Program.
- Submit updated staffing reports to HSAG following the readiness review. HSAG will monitor **Meridian**'s care management/care coordination staffing capacity during the post-implementation period.
- Develop and submit an organizational chart of the care management structure for Illinois including SPI and SPII.
- Revise the following Care Management/Care Coordination policies and procedures:
  - Revise Policy 16.07 Person Centered Plan of Care Development to include waiver-specific timelines in Section II F for member contact.
  - Revise Policy 16.08 Interdisciplinary Care Team Policy to include waiver-specific requirement and waiver-specific timelines for member contact.

- Revise Policy 16.15 Comprehensive Assessment Policy to include waiver-specific requirement and waiver specific timelines for member contact.
- Revise Policy 16.18 Care Coordination Staff Qualifications to include waiver-specific training requirements for each waiver for care coordinators.
- Revise Policy 16.22 Self Directed Care Policy Section 1.c regarding personal assistants.

Structure and Operations Standards

Meridian had established policies and procedures that addressed provider selection, subcontractual relationships and delegation, enrollee information, confidentiality and privacy, enrollment and disenrollment, grievance systems, health and safety monitoring, and critical incidents. 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.

Meridian worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the LTSS insert. HFS provided template information for the LTSS insert based on Waiver program requirements that were required to be included in the LTSS insert. **Meridian**'s Enrollee Handbook described the **Meridian** member portal, the **Meridian** website, member services, the PCP, hospital care, benefits, and special healthcare Programs.

Confidentiality policies and procedures described **Meridian**'s processes which were in place to protect enrollee health information. **Meridian** had formal processes in place to report incidents regarding abuse, neglect, or exploitation of an enrollee. **Meridian** developed a quick-look guide and algorithm related to reporting requirements for employees.

The **Meridian** Corporate Quality Improvement Committee was responsible for the oversight of enrollee appeals and grievances. Training was provided during employee orientation, and on an on-going and annual basis.

Following HFS' review of the grievance and appeals requirements for the HCBS Waiver enrollees, HFS worked with the Waiver agency staff to develop specific templates and requirements for the grievance and appeals process. The staff fair hearings staff provided training to the MCOs on the changes needed to ensure the plans were in compliance with State, federal, and waiver requirements.

For the structure and operations standards, **Meridian** was required to follow up on the following items following the pre-implementation review:

- Work with HFS to complete the necessary revisions to the Enrollee Handbook including the LTSS inserts.
- Submit updated grievance and appeals letters, policies, and procedures in compliance with the templates and directions provided by HFS.

Measurement and Improvement Standards

Meridian had established policies and procedures in place that addressed the QAPI program and health information systems in compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements.

The Meridian Health Plan of Illinois 2013 Quality Improvement Program Description identified 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.

Meridian used evidence-based and established clinical practice and preventive health guidelines which were made available to providers and enrollees through the **Meridian** website. Provider adherence to both sets of guidelines were monitored by **Meridian** and reported to the Quality Improvement Committee.

Claims, credentialing, provider, member, preventive services, authorizations, and case and disease management data are all housed in **Meridian**'s Managed Care System (MCS) allowing the programs to function together to simplify and streamline member and provider interactions with **Meridian** as well as among **Meridian** staff members.

For the measurement and improvement standards**, Meridian** required no follow-up.

Program Integrity

Meridian created a Fraud, Waste, and Abuse Process Manual and an annual Fraud, Waste, and Abuse training. Training was provided to staff, providers, vendors, and subcontractors on an on-going and annual basis. The **Meridian** Employee Handbook also discusses fraud, waste, and abuse. **Meridian** monitored pharmacy utilization through the use of a monthly report which provided a detailed description of prescription patterns of providers and identified aberrant patterns of pharmacy utilization.

For the program integrity standards**, Meridian** required no follow-up.

Molina Healthcare of Illinois, Inc.

Molina Healthcare, Inc. (**Molina**),[5-4] the parent organization of **Molina Healthcare of Illinois**, is a multi-state healthcare organization focused exclusively on Medicaid, Medicare, and other government-sponsored healthcare programs for low income families and individuals. **Molina Healthcare, Inc.,** is a publicly traded (NYSE: MOH) Fortune 500 company. **Molina Healthcare, Inc.,** was founded under the name Molina Medical Centers in 1980 by C. David Molina, MD, an emergency room physician, as a safety net provider for Medicaid patients. The initial clinic sites started by Dr. Molina served patients who had previously turned to emergency rooms for care because they lacked adequate access to primary care services.

Three decades later, **Molina** is still led by a physician, Dr. J. Mario Molina, who is the founder's son. The organization receives strategic direction and cultural influence from the Molina family. **Molina** is committed to:

- Advocating on behalf of the people it serves.
- Delivering quality services, promoting healthier populations, and removing barriers to health services.
- Being healthcare innovators and embracing change quickly.
- Serving as a trustworthy partner and being prudent stewards of the public's funds.
- Respecting the dignity of every member.
- Valuing ethical business practices.

Molina operates Medicaid health plans in the states of California, Florida, Illinois, Michigan, Ohio, New Mexico, Texas, Utah, Washington, and Wisconsin, serving 1.8 million members. **Molina** operates Medicare Advantage plans designed to meet the needs of individuals with Medicare or both Medicaid and Medicare coverage. **Molina**'s Medicare plans provide comprehensive quality benefits and programs including access to a large selection of doctors, hospitals, and other healthcare providers at little or no out-of-pocket cost.

Molina had a pre-implementation review for Service Packages I and II on May 7–8, 2013. Following the pre-implementation readiness review, **Molina** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review CAP grid. The majority of items identified on the CAP grid were completed and approved by the end of September 2013 prior to accepting ICP enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **Molina** to proceed with ICP enrollment in the designated service areas, with continued monitoring of the following

[5-4] Molina Pre-Assessment Form

areas: (1) care management/care coordination staffing and training, (2) monitoring of care coordination activities, (3) member call center capacity, and (4) provider network capacity.

A summary of the readiness review findings is included below.

Access Standards

Molina 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.

A quarterly network analysis was completed by the **Molina** Provider Network department to review any PCP capacity or panel deficiencies, using GeoAccess software to measure time and distance between contracted providers and enrollees. Deficiencies were identified by comparing the minimum required capacity and panel requirements to the actual contracted capacity and the provider network.

Molina began working with HSAG at the end of SFY 2013 to begin submission of the provider network data to HSAG. Following receipt of the data, HSAG will complete an analysis of the current **Molina** provider network capacity and monitor ongoing development of the Service Package I and Service Package II provider networks.

Molina's Integrated Care Management program policy identified that the integrated care management program consists of four programmatic levels: Level 1—Health Management for low-risk members, Level 2—Case Management for medium-risk members, Level 3—Complex Case Management for high-risk members, and Level 4—Imminent Risk. The program incorporates assessment, stratification of acuity, interventions with individualized person-centered care plan development, reassessment, and outcomes evaluation through person-centered planning and coordination.

Molina's electronic Health Care Services (HCS) staff documentation provides each member of the care team access to the enrollee's care management/care coordination record, plan of care, authorizations, member and provider contacts, transitions of care, and progress notes from the time they are recorded. Scheduled prompts that pop up automatically when due (called "tasks") are an integral part of the system, and they serve as reminders to the HCS staff for follow-up activities as required by the case management plan.

Molina uses the Chronic Illness and Disability Payment System (CPDS) to assign risk level based on regulatory standards outlined in the acuity grid upon enrollment. Data derived from the initial

health risk assessment, and any other available historical data, are applied to the care management level of care criteria built into the electronic health management platforms.

The **Molina** 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.

Molina had to revise the Health Care Services Program Description to include the monitoring and oversight of the LTSS interdisciplinary care team. **Molina** provided a demonstration of its case management software, the Clinical CareAdvance application, during an on-site readiness review. The application supported completing health risk assessments and comprehensive assessments, and developing complex care plans.

The Interdisciplinary Care Team (ICT) will be composed of cross-functional representatives including registered nurses, medical directors, behavioral health clinicians, licensed clinical social workers, and nonclinical staff providing support to the ICT. **Molina** has a process in place to ensure that current staff and new hires will be evaluated against the required experience and qualifications as outlined in the contract.

Molina has executed a contract with the Care Coordination Alliance (CCA) to assist with managing members who are difficult to reach, care transition activities, and providing Level IV crises intervention as indicated. **Molina**'s partnership with the CCA provides adjunct staff members who are familiar with the geographic or regional challenges and who have established relationships with the provider community.

The **Molina** care management team training program included HCBS topics that met the requirements as outlined in the contract. The HCBS staffing, training, and qualifications report provided documentation of the type and number of hours of training for the care management/care coordination staff.

Review of the training materials and course outline identified the following topics: waiver-specific services, motivational interviewing, confidentiality, health and safety monitoring, cultural competency, case management policies and procedures, roles and responsibilities, assessment, person-centered care planning, self-determination, fair hearing, grievance and appeals, health literacy, and recovery and resiliency.

Review of the organizational charts, staffing, and training grids identified that the staffing and training plan appeared to be adequate to provide care management/care coordination services to the ICP population.

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. **Molina** had nationally recognized preventive healthcare and clinical practice guidelines for reviewing and making decisions on provider and member requests for services. **Molina** had qualified staff available to review and make authorization and denial of service decisions. **Molina** will need to include the UM activities for the HCBS Waiver program in the UM description.

For the access standards**, Molina** was required to follow up on the following items following the pre-implementation review:

- Provide ongoing network capacity reports to HFS both before, during, and post-implementation of the Integrated Care Program.
- Submit updated staffing reports to HSAG following the readiness review. HSAG will monitor **Molina**'s care management/care coordination staffing capacity during the post-implementation period.
- Identify providers that will cover the requirements of the SNFIST Program—develop a method to report SNFIST providers in the Network analysis. (Section 5.5.10).
- Submit a copy the Medical Home Assessment tools—PCP to conduct self-assessment (Sections 5.5.7.2, 5.5.7.2.1-5.5.7.2.).
- Revise policies and procedures to include provision of tools and resources if requested to assist the PCP in assessing their performance as a medical home.
- Develop a policy to ensure fair distribution of enrollees—and meet the MCO quality standards *(Section 5.5.1.2.4)*
- Update the Provider Manual and Provider Directory to include languages spoken by providers.

Care Coordination and Continuity of Care Follow-Up:

- Revise the HCS Program Description to include monitoring and oversight of the LTSS interdisciplinary care team.
- Develop and submit an organizational chart of the care management structure for Illinois including SPI and SPII.
- Revise all care management policies and procedures to include the requirements specific to HCBS Waiver Services.
- Develop and submit a staffing model for SP II—define the roles and responsibilities for HCBS Coordinators, community connectors, care review processor, care managers, and supervisory staff. Clearly define the roles and responsibilities for the Integrated Care Team for SPI and SPII.

- Develop policies and procedures to include the requirements for assessing, negotiating, and documenting risk:
- Identify and evaluate risks associated with the enrollee's care. Factors considered include, but are not limited to:
  - Potential for deterioration of the enrollee's health status.
  - Enrollee's ability to comprehend risk.
  - Caregiver qualifications.
  - Appropriateness of the residence for the enrollee.
  - Behavioral or other compliance risks.
- Revise policies and procedures to include evaluation of predictive modeling reports, in addition to other surveillance data, monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and Enrollee Care Plans and interventions updated.
- Revise policies and procedures to include all required elements of the Enrollee Care Plan. Based on the needs and preferences of the enrollee as identified through the HRA, the Enrollee Care Plan includes, as appropriate, the elements as described in Standard III—Element 9 and/or Sections 5.14.8.1.5 and 5.14.8.1.5.1 through 5.14.8.1.5.19 of the contract.
- Submit an implementation and training plan for the integrated care team staff on use of the care management/care coordination system.
- Develop a procedure and member form to detail the steps in developing a back-up/contingency plan for HCBS members receiving in-home caregiver services. The contingency plan is expected to reduce service interruption or disruption of critical services received in the member's home.
- Develop and submit a Contingency Plan Form that documents name and phone number of the back-up; the form must be completed initially and at the annual assessment and signed by the member or member representative.
- Develop a procedure for the Member Service Preference Level—based on the member's choice for how quickly a replacement caregiver will be needed if the scheduled caregiver becomes unavailable. Members must be informed that they have the right to a back-up caregiver within three hours if they choose.
- Revise and submit the HCS Continuity of Care New Members and Current Members policy to include the 180-day transition time and 90-day requirement for new Waiver enrollees and enrollees who are identified as high- or moderate-risk.
- Revise policies to include the required care coordinator contact standards for each of the Waiver programs including face-to-face visits. (Section 5.12.2–5.12.2.1 through 5.12.3.5).
- Revise policies and procedures to include the following requirement:

  - At a minimum, the MCO shall conduct a reassessment annually for each enrollee. In addition, the MCO will conduct a face-to-face reassessment for enrollees receiving HCBS Waiver services or residing in Nursing Facilities each time there is a significant change in the enrollee's condition or an enrollee requests reassessment. (Section 5.14.7).
- Revise policies and procedures to include the following requirement:
  - The MCO will encourage providers to support enrollees in directing their own care and Enrollee Care Plan development. This shall include giving PCPs a copy of the Enrollee Care Plan. (Section 5.14.5).
- Revise policies and procedures to include the maximum weighted caseload requirements that the caseloads will not exceed the following requirements:
  - Caseloads of Care Coordinators shall not exceed the following standards, on average, during a calendar year:
    1. High-risk enrollees: 75 enrollees
    2. Moderate-risk enrollees: 150 enrollees
    3. Low-risk enrollees: 600 enrollees
    4. For enrollees in the Persons with Brain Injury Waiver or the Persons with HIV/AIDS Waiver, the caseloads shall not exceed 30.
- Develop a policy and procedure for completion of the Participant Outcome and Status Measures (POSM) Survey for enrollees in the Elderly and Skilled Living Facility (SLF) Waivers. New plans are required to complete the POSM Survey at the time of enrollment, and the second and subsequent survey should be completed annually during the months of September, October, and November.
- Revise the Utilization Management (UM) Program Description to include UM oversight of the HCBS Waiver services.

Structure and Operations Standards

Molina had established policies and procedures that addressed provider selection, subcontractual relationships and delegation, enrollee information, confidentiality and privacy, enrollment and disenrollment, grievance systems, health and safety monitoring, and critical incidents. 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.

Molina identified that it had delegation agreements in place with the following vendors:

- March Vision
- Avesis (Dental)
- LogistiCare (transportation)

- Ohio St. Francis, Concentra, and Southern Illinois Healthcare Foundation (Credentialing)

At the time of the on-site readiness review, **Molina** had not completed the pre-delegation audits for Avesis and LogistiCare. **Molina**'s delegation policy did not include provision for quarterly delegation oversight and monthly operations meetings of the delegated vendors.

Molina worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the LTSS insert. HFS provided template information for the LTSS insert based on Waiver program requirements that were required to be included in the LTSS insert.

The **Molina** Enrollee Handbook, once approved by HFS, was available on the **Molina** website in both Spanish and English. A printed copy of the Enrollee Handbook could be obtained by contacting the Member Services Department. The handbook described the on-line services available to the enrollee, benefits, transition of care information, emergency services, and how to access routine medical services. Enrollee rights and responsibilities were also discussed in the **Molina** Enrollee Handbook.

Molina's confidentiality policies and procedures described the processes to protect enrollee health information. Employees were trained on compliance and Health Insurance Portability and Accountability Act of 1996 (HIPAA) during orientation and annually. Oversight of critical incidents, abuse, neglect, and exploitation was managed by the **Molina** Quality Improvement Department. Web-based training was completed during orientation and annually. The **Molina** Quality Improvement Department had developed formal processes to report incidents regarding critical incidents, abuse, neglect, or exploitation of an enrollee and included them in employee training.

Molina had 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.

Following HFS' review of the grievance and appeals requirements for the HCBS Waiver enrollees, HFS worked with the Waiver agency staff to develop specific templates and requirements for the grievance and appeals process. The fair hearings staff provided training to the MCOs on the changes needed to ensure the plans were in compliance with State, federal, and waiver requirements.

For the structure and operations standards, **Molina** was required to follow up on the following items following the pre-implementation review.

- Submit the pre-delegation agreement for Avesis and LogistiCare.

- Revise the delegation policies and procedures to include quarterly delegation oversight and monthly operations meetings with the delegated vendors.
- Work with HFS to complete the necessary revisions to the Enrollee Handbook including the LTSS inserts.
- Submit documentation of training for member services staff, including Illinois Integrated Care Program benefits and enrollee grievances.
- Submit a link to the member portal when live.
- Submit updated grievance and appeals letters, policies, and procedures in compliance with the templates and directions provided by HFS.

Measurement and Improvement Standards

Molina had established policies and procedures in place that addressed the QAPI program and health information systems in compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements.

The Molina Healthcare 2013 Health Care Services (HCS) Program Description identified 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 **Molina** Quality Improvement Program targeted populations composed of enrollees with multiple chronic illnesses and those who were disabled, frail, and culturally diverse requiring coordination between providers, specialists, and care transitions.

Molina's Quality Improvement Program established and approved the implementation of preventive and evidence-based clinical practice guidelines. The preventive health and clinical practice guidelines were available on **Molina**'s website and were included in **Molina** Provider Manual, also available on **Molina**'s website.

Molina used QNXT as its core health technology and Clinical CareAdvance as its care management system. The health information systems supported the activities of the quality improvement program. Interfaces were built to include pharmacy data, predictive modeling information, and HEDIS reporting. **Molina** 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.

For the measurement and improvement standards, **Molina** was required to follow up on the following items following the pre-implementation review:

- Revise the QMM Program Description to include oversight of LTSS services.
- Revise the QMM Program Description to include evaluation of the effectiveness of the ICT.

Health and Safety Follow-Up:

- Submit the Health and Safety training program for **Molina** staff, providers, and subcontractors. (*Section 5.20.4*).
- Develop policies and procedures for health and safety monitoring.
- Update Policy QM P&P - 08 Potential Quality of Care (PQOC), Serious Reportable Adverse Events Policy and 2013 Quality Improvement Program Description to direct notification to Adult Protective Services (APS) for enrollees who are age 18 and older.
- Complete development of a testing, acceptance, and implementation plan for PQOC database. Include staff training in the implementation plan.
- Submit a copy of the manual data collection tool for critical incidents. Include the contact phone numbers for reporting incidents to the appropriate agencies.

Program Integrity

The **Molina** Fraud, Waste, and Abuse Program Description, policies, procedures, and training program described the prevention, detection, and reporting of fraud and abuse. A 24/7 FWA Hotline is available to employees, members, business partners, and business providers.

For the program integrity standards**, Molina** required no follow-up.

Integrated Care Program—Network Capacity Review

Federal Medicaid regulations (CFR 438.207) do not require minimum criteria for provider networks of Medicaid managed care programs. The federal regulations require states to ensure that networks are "sufficient to provide adequate access to all covered services" and require the state to monitor the network and take into account the "expected utilization" of services based on "the characteristics and health care needs of specific Medicaid populations represented in the particular MCO."

Measuring and reporting the adequacy of the MCO provider networks was a high priority for HFS during SFY 2013 to ensure that the MCOs networks are adequate and meet the needs of their Medicaid Managed Care enrollees. HSAG began review of the ICP plan networks for **Aetna** and **IlliniCare** toward the end of SFY 2013; however, the network capacity review will be expanded to include all MCOs.

Access to Care—Network Capacity and Provider Availability

Review of the MCO provider network analysis and monitoring identified the following challenges with determining the adequacy of the MCO provider networks which HFS identified as a critical component of the expansion of the Medicaid Managed Care Program. The following barriers were identified as a result of the network capacity review by HSAG:

- MCOs differed considerably in the geo-mapping process they used to evaluate the adequacy of their provider networks in terms of proximity of their providers to members.
- Obtaining a count of providers that can be used for reliable comparisons among the MCOs proved difficult due to the inconsistency and inaccuracy of the reported network data.
- MCOs typically use different categories to classify and report their providers, making it difficult to compare different provider types among the MCOs.
- If a reliable and comparable count of providers could be obtained, it would still be difficult to determine the "capacity" of a provider network (e.g., not all "available" providers can or will equally serve Medicaid members, and provider panels may be limited or at capacity).
- Maintaining an accurate, complete, and up-to-date provider directory for use by the members appears to be a complex and difficult task for the MCOs.
- It is difficult to evaluate the accessibility of the network in terms of the physical accessibility of provider sites.
- MCOs conduct provider availability audits to evaluate the access standards; however, it is difficult to access overall appointment availability across all MCO provider networks.

HFS contracted with HSAG to monitor the development and maintenance of the MCO provider networks. HSAG worked with HFS and the MCOs to standardize the format that the MCOs

would use to report the providers in their networks. HSAG created standardized provider categories, instituted an active protocol to detect and minimize duplications of providers, and expanded reporting to include counts of providers by counties within each MCO. As a result, HSAG developed standard templates for the MCOs to begin using to report the providers in their networks. In addition, HSAG included a count of the HCBS Waiver providers to the network analysis.

HSAG will continue to work with HFS to continue development of the analysis of the MCO provider networks to assess the number of network providers who can offer timely appointments and improve the accuracy of MCO information. In addition, HSAG will continue to work with HFS to determine if the current access standards are sufficient or need revision.

Finally, HFS and HSAG will also consider the following recommendations identified through the University of Illinois at Chicago (UIC) evaluation of the ICP implementation in regard to network capacity as efforts continue to strengthen monitoring of the MCO provider networks and associated capacity.

University of Illinois at Chicago Evaluation Recommendations

- The State should develop standards for what an adequate network looks like, including standards for "adequate" numbers or provider "coverage" for select key provider types across counties.
- The State should continue to work with HSAG to ensure that networks are maintained.
- The State and the MCOs should develop plans for ensuring accessibility of provider offices which would minimally include criteria of what "accessibility" means, especially in regard to exam tables and diagnostic equipment, and also would include some proactive audits of providers by the MCOs.
- HFS should work with other State agencies to ensure that procedures are in place that minimize the need for providers to enter duplicate billing and service information into electronic databases.
- The State should hold at least annual meetings with providers to solicit feedback regarding their experience with submitting claims and being paid by the MCOs.
- The MCOs should expand the number of specialists available in the suburbs further away from Chicago.

Operational Readiness Reviews—Care Coordination Entities

Introduction

In 2012, the Illinois Department of Healthcare and Family Services (HFS) awarded six provider groups to become part of the Illinois Care Coordination Innovations Project. Public Act 96-1501 required HFS to move at least 50 percent of recipients eligible for comprehensive medical benefits to a risk-based care coordination program by January 1, 2015. A goal of the Innovations Project was to allow providers to design and offer care coordination models other than traditional managed care organizations (MCOs), while continuing to support the recipients as they transitioned from a fee-for-service program into managed care. This goal was achieved by allowing provider groups to submit responses to the Solicitation for Care Coordination Entities and Managed Care Community Network for Seniors and Adults with Disabilities. The provider groups chosen formed Care Coordination Entities (CCEs) to provide care coordination services to seniors and adults with disabilities using holistic, cost-efficient approaches to coordinate and deliver services to the recipients. The External Quality Review Organization (EQRO) for HFS, Health Services Advisory Group, Inc. (HSAG), is contracted to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. As part of the contract, HSAG developed the customized readiness review tools and is required to conduct readiness reviews for each of the CCEs. In SFY 2013, HSAG conducted pre-implementation readiness reviews for the following CCEs:

- **EntireCare Coordination** (**EntireCare**)
- **My Health Care Coordination Entity** (**My Health**)
- **Precedence Care Coordination Entity, LLC** (**Precedence**)

Procedure

HSAG in collaboration with HFS determined the scope of the review, data collection methods, schedules, and agendas for the desk and on-site review activities. The process used for the readiness reviews was a combination of:

- Collection and review of documents in comparison to a specified set of criteria.
- On-site demonstrations and discussions with CCE staff.
- Aggregation and analysis of data and information collected.
- Preparation of reports based on a compilation of all findings.

HSAG developed tools and documents using specific criteria from applicable Code of Federal Regulations (CFRs), the Illinois Compiled Statutes (ILCS), Care Coordination Entity Program contract, and the related Request for Proposal (RFP 2013-24-002). Each CCE received a pre-assessment form and document checklist and a customized set of readiness review tools which facilitated the CCEs' preparation for the pre-implementation readiness review. The pre-assessment form and document checklist contained detailed instructions for preparing for each area of review (e.g., documents to collect, staff to interview). The readiness review tools included the global CCE model requirements but also focused on each CCE's proposed care coordination model as described in the RFP response.

The pre-implementation readiness review included a review of the following areas to ensure that plans had the system capacity needed to enroll recipients in their designated service areas. The CCE was expected to describe in detail and provide supporting policies and procedures for the following:

Governance Structure, Scope of Collaboration, and Leadership

- Execution of Collaborator agreements/contracts
- Execution of Business Associate Agreements with Collaborators
- Roles, responsibilities, and experience of collaborators
- Administrative policies and procedures
- Staffing plan including qualifications and training
- CCE Program implementation work plan

Population and Providers

- Identification of priority and non-priority populations
- Adequacy of the Provider network—including provider to enrollee ratios
- Capacity of the Provider network to serve the assigned population

Care Coordination Model

- Structure and composition of the CCE care coordination model and how it will meet the needs of the population served
- Description of the Integrated Care Team (ICT)
- Definitions of the roles and responsibilities of each ICT member
- Description of care manager/care coordinator case load assignments

- Description of oversight and monitoring of the ICT—including medical and behavioral health input
- Description of Health Risk Assessment
- Description of risk stratification and development of the enrollee care plan
- Description of frequency of enrollee contract and frequency of actions/responsibilities of each team member
- Description of enrollee and provider outreach and engagement strategies
- Description of how the enrollee care plan will be shared among the ICT, providers and the enrollee
- Description of approaches to address language and cultural considerations of enrollees
- Description of Health Home including methods for tracking enrollees assigned to a Health Home

Health Information Technology (HIT)

- Methods for receipt of the proprietary file from HFS—enrollment file
- HIT processes including current technology and proposed enhancements to existing technology
- Description of direct messaging capability with providers
- HIT capabilities of the collaborators—strategies for receiving data from collaborators including emergency department, inpatient admission, and discharge data

Data Collection and Analysis

Prior to the on-site review, HSAG staff evaluated the documents submitted by the CCE. The desk review assisted in determining areas that required additional focus during the on-site review.

During the on-site readiness review, HSAG conducted CCE staff interviews to obtain further information to determine the CCE's compliance with contract requirements and reviewed systems demonstrations. 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 CCEs complied with the requirements. Certain elements were designated by HFS and HSAG as critical and had to be in compliance prior to the CCE receiving enrollment.

Based on the results from the comprehensive pre-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 CCE 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.

The tool was then sent to the CCE requesting additional documentation, including revised policies and procedures and updated implementation work plans. This exchange between HSAG and the CCE continued until the CCE was in compliance with all critical elements and working toward compliance with the remaining elements.

Prior to client enrollment, using the findings from the desk and the on-site readiness reviews, HFS and HSAG determined whether each CCE's internal organizational structure, health information systems, staffing, and oversight were sufficient prior to enrollment.

Once the CCE accepted enrollment, monthly reports monitoring care coordination, enrollment, network development, and staffing were submitted to both HFS and HSAG. The reports were reviewed and analyzed by HSAG and HFS with monthly and quarterly meetings held with the CCEs.

Precedence Care Coordination Entity, LLC (Precedence)

Precedence CCE is a collaboration of providers and community organizations located in a nine-county region in northwest and central Illinois. This newly established CCE creates a governance structure to enable a range of accountable care strategies, including innovative care coordination activities envisioned by the DHFS Innovations Project 2013-24-002 and section 2703 of the federal Affordable Care Act.

Pre-Implementation Operational Readiness Review Findings

HSAG conducted a pre-implementation on-site readiness review for **Precedence** on May 15–16, 2013. Following the pre-implementation readiness reviews, **Precedence** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review CAP grid. The majority of items identified on the CAP grid were completed and approved by the end of December 2013 prior to accepting CCE enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **Precedence** to proceed with CCE enrollment in the designated service areas, with continued monitoring of the following areas: (1) care management/care coordination staffing, (2) monitoring of care coordination activities, and (3) care coordination software implementation.

Governance Structure, Scope of Collaboration, and Leadership

Pre-implementation activities including on-site interview and document review identified that **Precedence** had the required network providers, and had representation from the network providers on the **Precedence** Board. **Precedence** had a process in place to engage an enrollee representative to participate on the **Precedence** Advisory Council. The Advisory Council is required to be established within 60 days after execution of the CCE contract.

Precedence has three major geographical hubs described below:

- *Rock Island and Mercer County*—The Robert Young Community Mental Health Center is affiliated with Unitypoint Health Trinity Hospital and also has a partnership with the local federally qualified health center (FQHC) called Community Health, Inc.
- *Bureau, Putnam, and LaSalle Counties*—North Central Behavioral Health Center is partnered with St. Margaret's and Illinois Valley Community Hospitals. Their primary care partner is the Hygienic Institute of Community Health Center.
- *Whiteside, Carroll, Ogle, and Lee Counties*—Sinnissippi Behavioral Health Center is partnered with the Katherine Shaw Bethea (KSB) Hospital and KSB clinics in these counties.

Review of the organizational structure and proposed staffing for the care coordination model demonstrated that **Precedence** had provisions to recruit and hire the required resources to support the care coordination model. The proposed Care Coordination Team resources included the PCP, a care navigator, care coordinator, nursing care coordinator, and a psychiatrist. **Precedence** described the addition of other specialists and representatives of community support agencies based on the enrollees' needs.

For the Governance Structure, Scope of Collaboration, and Leadership requirements **Precedence** was required to follow up on the items below following the pre-implementation review:

- Identify the structure and participants of the **Precedence** CCE Board.
- Execute the Memorandum of Understanding (MOU) with the collaborators.
- Develop the committee charters and describe the roles, responsibilities, composition, and meeting frequency for the following committees:
  - Leadership
  - Quality and Cost of Care
  - Client Social Needs Advisory
- Update and submit the overall implementation work plan.
- Work with HFS to finalize and execute the CCE contract.

Population and Providers

Review of the **Precedence** proposed structure and network partnerships identified that it had the required network participation from PCPs, hospitals, mental health providers, substance abuse providers, and social service agencies.

The population that **Precedence** CCE will serve will be individuals with a chronic diagnosis who are seniors, individuals with disabilities, and those with a serious mental illness.

For the Population and Providers requirements, **Precedence** was required to follow up on the items below following the pre-implementation review.

- Work with HFS to clarify the targeted and priority populations for the assigned counties.
- Continue development of the process for accepting the proprietary file and tracking CCE enrollment.
- Develop and submit a description of the Health Home and a method to identify eligible enrollees.

Care Coordination Model

Precedence described its model of care [5-5] as an integrated team approach that will use care coordination to link consumers with multiple healthcare organizations and providers. Services will be delivered along a full continuum of outpatient and inpatient services including primary care, mental health, substance abuse, and hospital-based services. The model assesses consumers individually and provides wraparound services that are focused on improving consumer health outcomes.

The Care Coordination Model is predicated on putting the patient in the center with his or her PCP/psychiatrist. The PCP/psychiatrist and the patient are supported with information provided by the care navigator. The care navigator has access to clinical and claims data via various applications. The care navigator provides the PCP/psychiatrist with information about the patient's care history and evidence-based suggestions for additions to the care plan.

Review of the Care Coordination Model description identified that while it contained many components of the care model description, it lacked specific details including a description of the Care Coordination Team as well as the roles and responsibilities of team members. In addition, the description did not include oversight and monitoring of the Care Coordination Team.

A training program for the Integrated Care Team (ICT) was developed and included an overview of the Care Coordination program including roles and responsibilities of the ICT, communication

[5-5] Precedence CCE Care Coordination Model

protocol, risk assessment, completion of the care plan, role of the medical director, and cultural sensitivity and diversity training.

For the Care Coordination Model requirements, **Precedence** was required to follow up on the items below following the pre-implementation review.

- Develop job descriptions for all Care Coordination Team members.
- Develop a training plan for the care coordination staff.
- Develop a description for the Care Coordination Team that includes roles, responsibilities, and communication within the care team.
- Develop policies and procedures to address the completion of the health risk assessment, comprehensive assessment, and the care plan.
- Revise the care coordination policies and procedures to include oversight and monitoring of the Care Coordination Team by the clinical nurse manager.
- Develop a policy to describe the enrollee outreach strategy for locating "hard to reach" enrollees.
- Develop a care coordination model program description that includes, staffing, training, risk screening, assessment, care planning, oversight of the care team, and role of the medical director.
- Develop policies and procedures to receive, process, resolve, and track enrollee complaints and grievances.
- Obtain HFS approval on marketing material and the Enrollee Handbook.

Health Information Technology (HIT)

A work plan had to be designed and submitted for the development, testing, training, and implementation of an electronic case management/care coordination software and Illinois Health Information Exchange (ILHIE) direct messaging.

For the HIT requirements, **Precedence** was required to follow up on the items below following the pre-implementation review.

- Establish ongoing communication with HFS to obtain claims data to assist with reporting outcome data.
- Continue to explore opportunities with collaborators to obtain data for oversight and reporting purposes, such as:
  - Emergency Department visits.
  - Inpatient admissions and discharge.

  - Pharmacy data.
- Continue to evaluate current electronic medical record (EMR) capabilities to streamline communication of health information across collaborators.
- Develop and submit a work plan for the development, testing, training, and rollout of the electronic case management/care coordination software (INFORMED) and ILHIE direct messaging software.

My Health Care Coordination (My Health)

The Macon County Mental Health Board was created by referendum in 1965. By Illinois Statute, the Macon County Board appoints the nine members of the Macon County Mental Health Board and approves a tax levy assessment. State statute requires this Board—a unit of local government—to plan, fund, coordinate, and evaluate public mental health/mental illness, developmental disabilities, and substance abuse services in Macon County.

My Health is organized as a program of the Macon County Mental Health Board, partnering with key medical and behavioral health service providers in Macon County. The core collaborators are elected to establish a program design with the lead entity, supported by a care coordination agreement signed by all core collaborators. In addition, the core collaborators, as network service providers, have agreed via Business Associate Agreements, to exchange electronic health information for the purpose of care coordination. In addition, the core collaborators have entered into Memorandum of Understanding agreements with **My Health** to serve as providers of service for the solicitation proposal's target populations. All network service providers will be asked to enter into a Memorandum of Understanding with **My Health** for collaboration in service provision and in care coordination for enrolled individuals.

Pre-Implementation Operational Readiness Review Findings

HSAG conducted a pre-implementation on-site readiness review for **My Health** on May 22–23, 2013.

Following the pre-implementation readiness reviews, **My Health** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review CAP grid. The majority of items identified on the CAP grid were completed and approved by the end of December 2013 prior to accepting CCE enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **My Health** to proceed with CCE enrollment in the designed service areas, with continued monitoring of the

following areas: (1) care management/care coordination staffing, (2) monitoring of care coordination activities, and (3) care coordination software implementation.

Governance Structure, Scope of Collaboration, and Leadership

Pre-implementation activities including on-site interview and document review identified that **My Health** had the required network providers, and had representation from the network providers on the **My Health** Board. **My Health** had a process in place to engage an enrollee representative to participate on the **My Health** Advisory Council. The Advisory Council is required to be established within 60 days after execution of the CCE contract.

The core collaborators were identified as:

- Macon County Mental Health Board
- Community Health Improvement Center
- Decatur Memorial Hospital
- Heritage Behavioral Health Center
- Macon County Health Department
- St. Mary's Hospital
- Decatur Housing Authority
- Southern Illinois School of Medicine

For the Governance Structure, Scope of Collaboration, and Leadership requirements, **My Health** was required to follow up on the items below following the pre-implementation review:

- Expand the Governance Structure description, to include:
  - Roles, responsibilities, composition, and meeting frequency of the collaborators' monthly meetings.
  - Participation of the medical director/behavioral health representative:
    - Provide medical/behavioral health oversight for the CCE Program.
    - Provide consultation to the CCT for member-specific needs.
    - Provide oversight of performance outcome data including enrollee satisfaction.
- Following approval of the contract, complete the Network Provider Agreements with the collaborators prior to implementation of the program. Include:
  - Cooperation with use of direct messaging.
  - Cooperation with the Integrated Care Team—including participation in the care planning process.
  - Cooperation with Health Information Technology (HIT).

- Build on the foundation of the core collaboration meetings to establish a framework for a quality oversight program.
- Work with HFS to finalize and execute the CCE contract.

Population and Providers

The population that **My Health** CCE will serve will be individuals with a chronic diagnosis who are seniors, individuals with disabilities, and those with a serious mental illness.

For the Population and Providers requirements, **My Health** was required to follow up on the items below following the pre-implementation review.

- Identify an internal process for loading the proprietary file and tracking membership for the CCE Program.
- Work with HFS to determine frequency of receipt of the proprietary file.
- Develop a description of the Health Home and a method to identify members assigned to the Health Home.

Care Coordination Model

My Health developed a Care Coordination Model Program Description[5-6] that outlined the essential elements of its Care Coordination Model as described below.

- Engagement: Engage the enrollee; initial contact; completion of risk/triage screen and risk stratification.
- Assessment: Completion of a comprehensive assessment.
- Plan of Care: Development of an individualized plan of care.
- Plan of Care: Implementation:
  - Health conditions: coaching and teaching the enrollee on condition(s) and conditions management.
  - Self-management: assisting and supporting the development of self-management skills and abilities.
  - Medication management: developing a medication management plan.
  - Referral and coordination: coordinating care and services across the continuum of care.
  - Health promotion: ensuring health promotion activities are completed.
  - Transitional care: managing care transitions.
- Proactive monitoring and evaluation.

[5-6] MHCC Care Coordination Model Description

The **My Health** Care Coordination Team composition was also described in the Care Coordination Model Description as follows:

Team 1	**Team 2**
RN—Care Coordinator 1 (100 enrollees)	RN—Care Coordinator 1(100 enrollees)
CDAC—Care Coordinator 2 (200 enrollees)	MSW—Care Coordinator 2 (200 enrollees)
Community Navigator (support staff)	Community Navigator 1(support staff)

For the Care Coordination Model requirements, **My Health** was required to follow up on the items below following the pre-implementation review.

- Develop policies and procedures for the care coordination model activities to include oversight, monitoring, and completion of health risk screenings, comprehensive assessments, and care plans.
- Develop policies and procedures addressing communication between the Care Coordination Team, the providers, and facilities.
- Submit and obtain HFS approval of the **My Health** educational fact sheet and brochure prior to distribution to providers and enrollees.
- Develop policies and procedures to receive, process, resolve, and track enrollee complaints and grievances.
- Revise the critical incident reporting process to include the time frames and contact numbers for reporting incidents.
- Obtain HFS approval on marketing material and the Enrollee Handbook.

Health Information Technology (HIT)

My Health had contracted with Streamline Healthcare Solutions, LLC, for its case management software. Streamline also developed a database for logging and tracking critical incident information. The Streamline software also included direct messaging software; **My Health** had to receive permission from HFS to use this messaging to communicate with providers.

For the HIT requirements, **My Health** was required to follow up on the items below following the pre-implementation review.

- Establish ongoing communication with HFS to obtain claims data to assist with reporting and outcome data.
- Continue to explore opportunities with collaborators to obtain data for oversight and reporting purposes, such as:
  - Emergency Department visits.

  - Inpatient admissions and discharge.
  - Pharmacy data.
- Develop a work plan for the development, testing, training, and rollout of the Streamline and direct messaging software.

EntireCare Coordination

Healthcare Consortium of Illinois (HCI) is a not-for-profit community-based agency that was established in 1991 under the name Southside Heath Consortium. HSAI collaborated with four hospital systems to identify the healthcare needs of the Medicaid members in the southern regions of Chicago and in an effort to establish a network of physicians and community-based organizations to better serve the healthcare needs of this population.

HCI's membership consists of 37 diverse organizations representing all facets of health and human services. Its mission is "to improve the health of families through the development of comprehensive, integrated health and human services."[5-7] HCI brings its mission to fruition by being a "network of networks" which provides a full range of health and social services from birth to death through its membership organizations.

EntireCare will be an operating sub-unit of HCI. It will be accountable to the HCI Board of Directors and subject to HCI's existing operating policies and procedures, as well as requirements imposed by other HCI federal and State grants and programs. The HCI Board of Directors is composed of individuals from its member organizations who have been nominated, vetted, and elected to the Board, and may serve a pre-determined one-, two-, or three-year term. HCI Board leadership is nominated and elected by members of the Board.

Pre-Implementation Operational Readiness Review Findings

HSAG conducted a pre-implementation on-site readiness review for **EntireCare** on June 20–21, 2013. Following the pre-implementation readiness reviews, **EntireCare** continued to work with HSAG to complete follow-up on all items identified in the SFY 2013 Readiness Review CAP grid. The majority of items identified on the CAP grid were completed and approved by the end of December 2013 prior to accepting CCE enrollment.

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve **EntireCare** to proceed with CCE enrollment in the designated service areas, with continued monitoring of the following areas: (1) care management/care coordination staffing, (2) monitoring of care coordination activities, and (3) care coordination software implementation.

[5-7] EntireCare Key Collaborators and Partners

Governance Structure, Scope of Collaboration, and Leadership

Pre-implementation activities including on-site interview and document review identified that **EntireCare** had the required network providers, and had representation from the network providers on the **EntireCare** Board. **EntireCare** had a process in place to engage an enrollee representative to participate on the **EntireCare** Advisory Council. The Advisory Council is required to be established within 60 days after execution of the CCE contract.

The initial key collaborators were chosen based on their locations to provide the broadest coverage in the geographic area, their scope of services and experience in currently serving the medical, behavioral, and social needs of the intended population, and their financial stability so that **EntireCare** can not only enroll, but also retain, the largest number of eligible seniors in care coordination. In addition, many of the key collaborators are also members of the Healthcare Consortium of Illinois and have representatives who sit on the Board of Directors. [5-8]

EntireCare identified the following collaborators:

- The University of Chicago Medicine
- Roseland Community Hospital
- St. Bernard Hospital and Health Center
- South Shore Hospital
- Human Resources Development Institute
- Comprehensive Quality Care

For the Governance Structure, Scope of Collaboration, and Leadership requirements, **EntireCare** was required to follow up on the items below following the pre-implementation review:

- Develop a formal description of the key collaborators and partners.
- Expand the Governance Structure description, to include:
  - Roles, responsibilities, composition, and meeting frequency of the collaborators' monthly meetings.
  - Participation of the medical director/behavioral health representative:
    - Provide medical/behavioral health oversight for the CCE Program.
    - Provide consultation to the CCT for member-specific needs.
    - Provide oversight of performance outcome data including enrollee satisfaction.
- Develop participating provider agreements for use in contracting with network providers.
- Execute Business Associate Agreements with all participating collaborators.

[5-8] EntireCare Key Collaborators and Partners

- Develop a Quality Management Program and work plan.
- Develop a description of the structure, role, and responsibilities of the Member's Advisory Council.
- Work with HFS to finalize and execute the CCE contract.

Population and Providers

EntireCare identified its targeted population to include seniors (55 and older) and persons who were enrolled in Medicaid.

EntireCare had developed an internal process to accept and use the proprietary file from HFS to track membership.

For the Population and Providers requirements, **EntireCare** was required to follow up on the items below following the pre-implementation review.

- Continue development of the internal process for loading the proprietary file and tracking membership for the CCE Program.
- Work with HFS to determine frequency of receipt of the proprietary file.

Care Coordination Model

HCI CCE's[5-9] Care Coordination model is based on a person-centered, assessment based, interdisciplinary (PAI) approach that identifies a senior's required clinical care and nonclinical services and facilitates linkages between all facets of the care and services. At the core of the model is a comprehensive care plan which is managed and monitored by evidence-based processes. Principles in the provision of care coordination are based on adaptations from Rosenberg & Shure's Bridge Model and Boult's Guided Care Model. The focus will be to move from "disease focus" to a "person focus." The HCI CCE care coordination model addresses the inter-relational aspects of physical, psychological, and social determinants on a senior's health status.

The organizational chart identified the Care Coordination Team (CCT) structure consisting of the director of care management, care managers, patient navigators, and a call center manager.

EntireCare will stratify the enrollees into four levels:

- Tier 1—Intensive Care Coordination
- Tier 2—Supportive Standard Care Coordination

[5-9] EntireCare Care Coordination Model Description

- Tier 3—Service Coordination and Support
- Tier 4—Community Health Monitoring

EntireCare developed a training program which included an overview of the CCE model, the roles and responsibilities of the coordinated care team, the role of the medical director, and training and use of the case management software.

HSAG provided technical assistance to assist **EntireCare** with the development of a Care Coordination Program Description. HSAG produced template documents for a generic care coordination program description and a quality improvement program description.

For the Care Coordination Model requirements, **EntireCare** was required to follow up on the items below following the pre-implementation review.

- Develop job descriptions for care managers, director of care management, medical director, and executive director.
- Develop policies and procedures to receive, process, resolve, and track enrollee complaints and grievances.
- Revise the critical incident reporting process to include the time frames and contact numbers for reporting incidents.
- Develop a policy to describe the enrollee outreach strategy for locating "hard to reach" enrollees.
- Develop a Care Coordination Model Program Description that includes, staffing, training, risk screening, assessment, care planning, oversight of the care team, and role of the medical director.
- Develop policies and procedures for the care coordination model activities to include oversight, monitoring, and completion of health risk screenings, comprehensive assessments, and care plans.
- Obtain HFS approval on marketing material and the Enrollee Handbook.

Health Information Technology (HIT)

For the HIT requirements, **EntireCare** was required to follow up on the items below following the pre-implementation review.

- Develop and submit a work plan for the development, testing, training, and rollout of the electronic case management/care coordination software and direct messaging software.
- Establish ongoing communication with HFS to obtain claims data to assist with reporting and outcome data.

- Continue to explore opportunities with collaborators to obtain data for oversight and reporting purposes, such as:
  - Emergency Department visits.
  - Inpatient admissions and discharge.
  - Pharmacy data.

Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2012–2013

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. Healthcare 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 healthcare 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) 2012 data. The State contracted with HSAG to audit **FHN**, **Harmony**, and **Meridian**. The audits were conducted in a manner consistent with the 2013 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 FY 2012 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)*
- *Children's and Adolescent's Access to Primary Care Practitioners (PCPs)*
- *Adults' Access to Preventative/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-Day, and 30-Day)*

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, the HSAG team 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 healthcare. *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 -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 2013 rates for **FHN** and the National Medicaid 2012 HEDIS 50th percentiles are presented below (Table 6.2). 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 6.2—FHN HEDIS 2013 Rates

	FHN Rates for HEDIS 2013	2012 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	78.70	75.35
Childhood Immunizations—Combo 3	72.92	71.93
Lead Screening in Children	82.41	71.41
*Well-Child Visits in the First 15 Months (0 Visits)**	3.24	1.22
Well-Child Visits in the First 15 Months (6+ Visits)	50.23	62.95
Well-Child Visits (3–6 Years)	69.21	72.26
Adolescent Well-Care Visits	45.60	49.65
Immunizations for Adolescents	50.23	62.29
Children's Access to PCPs (12–24 Months)	75.42	97.02
Children's Access to PCPs (25 months–6 Years)	61.74	89.19
Children's Access to PCPs (7–11 Years)	60.84	90.58
Adolescent's Access to PCPs (12–19 Years)	61.20	89.21
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	64.90	82.34
45–64 Years of Age	67.54	87.31
Preventive Screening for Women		
Breast Cancer Screening	49.04	50.46
Cervical Cancer Screening	72.85	69.10
Chlamydia Screening (16–20 Years of Age)	58.02	54.18
Chlamydia Screening (21–24 Years of Age)	70.39	64.36
Chlamydia Screening (Combined Rate)	64.23	58.40
Maternity-Related Measures		
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	23.84	6.58
Frequency of Ongoing Prenatal Care (81–100% of Visits)	35.42	64.65
Timeliness of Prenatal Care	62.96	86.13
Postpartum Care	48.15	64.98
Chronic Conditions/Disease Management		
Controlling High Blood Pressure	46.02	57.52
Diabetes Care (HbA1C Testing)	77.43	82.38
*Diabetes Care (Poor HbA1c Control)**	55.43	41.68
Diabetes Care (Good HbA1c Control)	36.29	48.72
Diabetes Care (Eye Exam)	36.00	52.88
Diabetes Care (LDL-C Screening)	69.71	76.16
Diabetes Care (LDL-C Level <100 mg/dL)	26.86	35.86
Diabetes Care (Nephropathy Monitoring)	71.71	78.71

Table 6.2—FHN HEDIS 2013 Rates

	FHN Rates for HEDIS 2013	2012 HEDIS 50th Percentiles
*Diabetes Care (BP < 140/80)***	31.43	NA
Diabetes Care (BP < 140/90)	54.29	63.50
Appropriate Medications for Asthma (Combined)	84.51	85.87
Follow-up After Hospitalization for Mental Illness-7 Days	63.98	46.06
Follow-up After Hospitalization for Mental Illness-30 Days	71.43	67.65

* 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 2012 HEDIS Medicaid 50th percentiles, including three measures in the Child and Adolescent Care category, four in Preventive Screening for Women, and the other two measures were in the Chronic Conditions/Disease Management category. Only one of the nine measures was part of the incentive measures.

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

Compliance Audit Results for FHN

The HEDIS 2013compliance audit indicated that **FHN** was in compliance with the *HEDIS 2012 Technical Specifications* (Table 6.3). 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 6.3—FHN 2013 HEDIS Compliance Audit Results

Main Information Systems			Selected 2013 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 fully compliant with IS standard 1.0 for medical services data. **FHN** planned on converting to QNXT during the measurement year; however, the conversion took place in late January 2013. For the entire measurement year 2012, claims and encounters were processed on the Proclaim system as they were in the previous year. The Proclaim system contained sufficient edits to ensure claims were processed appropriately. Coding schemes were verified during the system walkthrough and non-standard codes were not used. A claim could not be processed through Proclaim if required fields were absent. The Proclaim system demonstration provided sufficient evidence that **FHN** could distinguish between primary and secondary codes, and there was no limit to the number of codes that could be entered. **FHN** was still processing 40 percent of its claims on paper. Most of these claims were for transportation and out-of-area/non-participating provider services. **FHN** manually entered these claims directly into Proclaim, and evidence provided in the Roadmap showed that this process was monitored tightly. The types of services that went through the manual process have minimal impact on the measures under review. Encounters, on the other hand, did not receive the same rigorous validation as claims. As noted in the Roadmap, **FHN** did not validate proper coding (e.g., checking for member gender match). Because encounters represented a fair amount of primary care services for **FHN** members, this may have a larger impact on measures that rely on a member's gender to be valid. This has the potential to impact the *Prenatal and Postpartum Care* (PPC) measure, which is gender-specific. The audit team will review these members in the denominator to determine if there was any impact. **FHN** continued its efforts to increase encounter data submission. No recommendations were made specific to claims processing since **FHN** had converted to QNXT in 2013. **FHN** understands that the focus of the audit next year will include a more in-depth review of the systems and claim processing. The encounters will be specifically reviewed to determine if appropriate coding validation was implemented. Additionally, full system conversion documentation should be included with the Roadmap submission. **FHN**'s incentive programs did not change during the measurement year. As in the past, they targeted many of the key HEDIS measures including *Well Child Visits in the First 15 Months of Life* (W15), *Childhood Immunization Status* (CIS), and *Prenatal and Postpartum Care* (PPC). Providers were paid for encounters submitted with appropriate coding.

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

FHN was fully compliant with IS standard 2.0. **FHN** maintained the same process as the previous year for receiving and updating enrollment information from the State. The process during the measurement year did not change from the prior year. **FHN** continued to experience an increase in its Medicaid population, from 69,256 members at the end of 2011 to 83,195 members at the end of 2012. **FHN** has been growing its business and expanding into new areas for the last two years. The enrollment information was processed daily and monthly and was

processed consistent with the previous year. Daily files were reconciled against the monthly roster and the capitation file to ensure accuracy. Membership files were still housed in the Grandpa database, and there were no backlogs during the measurement year. The Grandpa database was to be retired in 2012 with the implementation of QNXT, but this did not occur until late January 2013. It was noted that following the conversion to QNXT, **FHN**'s historical enrollment data would be maintained in the data warehouse for use in 2013.

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

FHN was fully compliant with IS standard 3.0. **FHN** had an increase of 277 primary care physicians (PCPs) during 2012. **FHN** increased its PCP network by 20 percent and its specialist network by 50 percent due to increased contracting efforts. The provider data still resided in the provider maintenance (PM) database for the measurement year. With the continued effort to migrate its core system to QNXT, **FHN** was successful at cleaning up its National Provider Identifiers (NPIs) during 2012. The system walkthroughs conducted on-site showed how the data from the PM database matched the data in QNXT, and all provider information was accurate. **FHN** should experience no problems identifying and reporting on servicing providers for the measurement year.

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 Verisk hybrid tools. This was the first time **FHN** used Verisk hybrid tools to collect medical record data. HSAG reviewed the hybrid tools and corresponding instructions. Reviewer qualifications, training, and oversight were appropriate. Due to changes in hybrid tools, a convenience sample was required and subsequently passed. **FHN** passed the medical record review validation process for the following measure groups:

- Group A: Prenatal and Postpartum Care—Postpartum Care
- Group B: Well-Child Visits in the First 15 Months of Life (6+ Visits)
- Group D: Childhood Immunization Status—Combo 3
- Group F: No medical exclusions

Upon validation of the *Postpartum Care* indicator, one case was found noncompliant due to an abstraction error. According to the NCQA medical record review validation protocol, validation of a second sample was required and subsequently passed by **FHN**. Upon validation of the *Well-Child Visits in the First 15 Months of Life (W15) 6+Visits* measure, one case was found noncompliant; therefore, a second validation was required. During validation of the second W15 (6+ Visits) sample, HSAG noted that two cases were noncompliant due to abstraction errors. Following NCQA protocol, **FHN** re-abstracted all W15 (6+ Visits) numerator positive cases and removed

any cases that were found noncompliant for the numerator. A validation of a third sample was conducted and subsequently passed. **FHN** removed all cases containing abstraction errors from the W15 (6+Visits) positive numerator. HSAG suggests that for future HEDIS projects, **FHN** revise its in-house training program to include clarifications pertaining to documentation that meets the W15 numerator. In addition, HSAG suggests that **FHN** conduct a higher percent of over-read during future abstractions.

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

FHN was fully compliant with IS standard 5.0. **FHN** intended to use several external standard supplemental data sources for HEDIS reporting in 2013. However, it failed to include these sections in the HEDIS Roadmap. Subsequent to the on-site audit, the sections were completed and provided to the auditor. **FHN** planned on using data from the State immunization registry, the Healthy Kids registry, and Quest labs. Since these data were all external standard sources, primary source verification was not required. The processes in place to capture the data were discussed during the on-site audit. The files contained the membership identifier used by **FHN** and will be loaded and matched into the data warehouse using that identifier. All requirements discussed on-site were met for the use of external standard supplemental data. **FHN** also included any relevant historical medical record data for data integration. While this was considered supplemental data, it was not applicable to the three measures being audited since the measures under review require members to have the services during the measurement year and during a prior HEDIS season. **FHN** continued to use Cornerstone and Healthy Kids immunization data from the State. These data were received in standard formats from the State. **FHN** was instructed to include Roadmap sections for these data sources next year as well.

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

IS standard 6.0 was not applicable to the measures under the scope of the Illinois Medicaid audit for HEDIS 2013.

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

FHN was found to be partially compliant with IS standard 7.0. **FHN** converted to Verisk late in 2012 and will no longer produce its own source code. The Verisk software was fully certified in March 2013. **FHN** provided a copy of the certified software help screen to show that it is using the correct version. The three measures that Verisk produced for **FHN** were *W15*, *CIS* and *PPC*. **FHN** provided rate comparisons during the on-site review, showing side-by-side rates for the three measures under review. The rate comparison showed no significant changes from source code to certified software. **FHN** walked through the conversion process on-site and provided some mapping documents. There were no concerns with the processes in place for integrating all data sources for HEDIS reporting. **FHN** had adequate security and back-up procedures in place

to ensure all data are secure and at minimal risk for loss. **FHN** had a significant issue with processing some external encounter data that was discovered during the preliminary rate review process. After discovering this issue, the **FHN** staff requested an extension on reporting in order to properly resolve the issue. The State approved an extension of July 8, 2013, to submit its final rates. **FHN** successfully fixed the encounter data issue, and the rates improved significantly from the preliminary rate review. The measures were reviewed again and found to be fully reportable.

FHN Trended Results

Table 6.4 below provides the results of **FHN**'s trended performance measures. Only HEDIS measures reported for the current year and the previous two years are included in the table. The measures highlighted in green are the incentive measures.

Table 6.4—FHN Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Family Health Network			Difference From 2012
	2011	2012	2013	
Child and Adolescent Care				
Childhood Immunizations—Combo 2	75.7	72.0	78.70	6.7
Childhood Immunizations—Combo 3	70.4	69.9	72.92	3.02
Lead Screening in Children	81.9	82.9	82.41	-0.49
*Well-Child Visits in the First 15 Months (0 Visits)**	3.5	2.3	3.24	0.94
Well-Child Visits in the First 15 Months (6+ Visits)	53.8	50.1	50.23	0.13
Well-Child Visits (3–6 Years)	67.4	73.0	69.21	-3.79
Adolescent Well-Care Visits	43.9	44.1	45.60	1.5
Immunizations for Adolescents	40.5	44.8	50.23	5.43
Children's Access to PCPs (12–24 Months)	82.2	91.8	75.42	-16.38
Children's Access to PCPs (25 months–6 Years)	69.9	77.2	61.74	-15.46
Children's Access to PCPs (7–11 Years)	51.1	53.1	60.84	7.74
Adolescent's Access to PCPs (12–19 Years)	53.0	54.6	61.20	6.6
Adults' Access to Preventive/Ambulatory Care				
20–44 Years of Age	64.6	69.2	64.90	-4.3
45–64 Years of Age	67.4	74.1	67.54	-6.56
Preventive Screening for Women				
Breast Cancer Screening	47.7	48.9	49.04	0.14
Cervical Cancer Screening	69.4	71.5	72.85	1.35
Chlamydia Screening (16–20 Years of Age)	62.5	59.0	58.02	-0.98
Chlamydia Screening (21–24 Years of Age)	70.7	68.1	70.39	2.29
Chlamydia Screening (Combined Rate)	66.3	63.4	64.23	0.83

Table 6.4—FHN Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Family Health Network			Difference From 2012
	2011	2012	2013	
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	18.2	15.9	23.84	7.94
Frequency of Ongoing Prenatal Care (81–100% of Visits)	42.3	43.0	35.42	-7.58
Timeliness of Prenatal Care	62.4	69.8	62.96	-6.84
Postpartum Care	40.2	45.0	48.15	3.15
Chronic Conditions/Disease Management				
Controlling High Blood Pressure	45.6	43.4	46.02	2.62
Diabetes Care (HbA1C Testing)	79.2	79.5	77.43	-2.07
*Diabetes Care (Poor HbA1c Control)**	69.9	63.6	55.43	-8.17
Diabetes Care (Good HbA1c Control)	31.7	36.4	36.29	-0.11
Diabetes Care (Eye Exam)	31.7	44.7	36.00	-8.7
Diabetes Care (LDL-C Screening)	68.9	69.6	69.71	0.11
Diabetes Care (LDL-C Level <100 mg/dL)	29.5	27.7	26.86	-0.84
Diabetes Care (Nephropathy Monitoring)	84.7	85.8	71.71	-14.09
*Diabetes Care (BP < 140/80)***	NA	30.8	31.43	0.63
Diabetes Care (BP < 140/90)	54.6	52.6	54.29	1.69
Appropriate Medications for Asthma (Combined)	90.3	88.1	84.51	-3.59
Follow-up After Hospitalization for Mental Illness-7 Days	70.9	69.2	63.98	-5.22
Follow-up After Hospitalization for Mental Illness-30 Days	80.2	80.5	71.43	-9.07

***** 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 17 of the 36 trended measures, improved since HEDIS 2012, and five of these measures improved by more than 5.0 percentage points. These measures were *Childhood Immunizations—Combo 2, Immunizations for Adolescents, Children's Access to PCPs (7–11 Years), Adolescent's Access to PCPs (12–19 Years),* and *Diabetes Care (Poor HbA1c Control).* The rate for *Diabetes Care (Poor HbA1c Control)* improved significantly again, by more than percentage points.

The results also indicate that 19 of the 36 measures declined. The largest rate decreases (of approximately 15 percentage points) were seen in the *Children's Access to PCPs (12–24 Months), Children's Access to PCPs (25 months–6 Years),* and *Diabetes Care (Nephropathy Monitoring)* measures. The decline in these rates, coupled with the decline of other rates in the Access to Care and Diabetes Care groups indicate that focused attention needs to be given to these measures. Lastly, the two rates for *Follow-up After Hospitalization for Mental Illness* declined even though these rates remained above the 50th percentiles.

Harmony Health Plan of Illinois, Inc.

The Medicaid HEDIS 2013 rates for **Harmony** and the national Medicaid 2012 HEDIS 50th percentiles are presented in Table 6.5. 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 6.5—Harmony HEDIS 2013 Rates

	Harmony Rates for HEDIS 2013	2012 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	69.59	75.35
Childhood Immunizations—Combo 3	64.48	71.93
Lead Screening in Children	79.21	71.41
*Well-Child Visits in the First 15 Months (0 Visits)**	4.38	1.22
Well-Child Visits in the First 15 Months (6+ Visits)	56.20	62.95
Well-Child Visits (3–6 Years)	71.54	72.26
Adolescent Well-Care Visits	46.47	49.65
*Immunizations for Adolescents***	43.07	62.29
Children's Access to PCPs (12 - 24 Months)	88.89	97.02
Children's Access to PCPs (25 months – 6 Years)	76.47	89.19
Children's Access to PCPs (7 – 11 Years)	72.95	90.58
Adolescent's Access to PCPs (12 - 19 Years)	73.44	89.21
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	71.09	82.34
45–64 Years of Age	72.82	87.31
Preventive Screening for Women		
Breast Cancer Screening	36.86	50.46
Cervical Cancer Screening	72.81	69.10
Chlamydia Screening (16–20 Years of Age)	50.60	54.18
Chlamydia Screening (21–24 Years of Age)	62.68	64.36
Chlamydia Screening (Combined Rate)	55.73	58.40
Maternity-Related Measures		
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	14.11	6.58
Frequency of Ongoing Prenatal Care (81–100% of Visits)	43.55	64.65
Timeliness of Prenatal Care	74.70	86.13
Postpartum Care	49.39	64.98
Chronic Conditions/Disease Management		
Controlling High Blood Pressure	39.42	57.52
Diabetes Care (HbA1C Testing)	77.37	82.38
*Diabetes Care (Poor HbA1c Control)**	56.69	41.68

Table 6.5—Harmony HEDIS 2013 Rates

	Harmony Rates for HEDIS 2013	2012 HEDIS 50th Percentiles
Diabetes Care (Good HbA1c Control)	36.50	48.72
Diabetes Care (Eye Exam)	27.25	52.88
Diabetes Care (LDL-C Screening)	65.45	76.16
Diabetes Care (LDL-C Level <100 mg/dL)	25.55	35.86
Diabetes Care (Nephropathy Monitoring)	71.53	78.71
*Diabetes Care (BP < 140/80)***	30.90	NA
Diabetes Care (BP < 140/90)	48.42	63.50
Appropriate Medications for Asthma (Combined)	84.14	85.87
Follow-up After Hospitalization for Mental Illness-7 Days	50.44	46.06
Follow-up After Hospitalization for Mental Illness-30 Days	64.37	67.65

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

Harmony reported three measures with rates at or above the Medicaid 2012 HEDIS 50th percentiles: *Lead Screening in Children*, *Cervical Cancer Screening (CCS),* and *Follow-up After Hospitalization for Mental Illness—7 Days*. The *CCS* measure was also an incentive measure.

Compared to the 50th percentiles, **Harmony** generally scored the lowest on maternity-related measures, diabetes care measures, and access measures, whereby none of the measures exceeded the 50th percentiles.

Compliance Audit Results for Harmony

The HEDIS 2013 compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2012 Technical Specifications* (Table 6.6). 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 6.6—Harmony HEDIS 2013Compliance Audit Results

Main Information Systems			Selected 2013 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 standard 1.0 requirements. There were no major changes to the Xcelys claims system or the encounter processing system used by **Harmony** during the measurement year. **Harmony**'s claims system, Xcelys, used only industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) when processing claims, and these codes were updated quarterly and annually. **Harmony** ensured that code specificity was maintained, primary and secondary codes were identified, and non-standard codes were not present. **Harmony** used standard submission forms and captured all fields relevant to HEDIS reporting. Proprietary forms were not used during the measurement year. All paper claims submitted to **Harmony** were forwarded to the scanning and vertexing vendor, ImageNet, where they were transmitted back to **Harmony** in standard 837 and 5010 formats. **Harmony** did not manually process claims during the measurement year. Claims time to process reports showed timely claims filing and processing. Incurred but not paid reports were satisfactory and did not show much lag beyond 90 days. **Harmony**'s processes included sufficient edit checks to ensure data were accurately captured in the transaction systems. **Harmony** regularly monitored the vendor's performance against expected performance standards.

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

Harmony was fully compliant with the IS standard 2.0 requirements. There were no concerns with the processing of enrollment files received from the State. As in prior years, monthly files were received and loaded into **Harmony**'s data system. Processing of membership information complied with all IS 2.0 standards. There were sufficient edit checks in place to ensure that files loaded did not contain errors, and there was minimal manual data entry. In addition to the usual reconciliation process conducted daily and monthly, the enrollment files were reconciled against the capitation files from the State. This provided **Harmony** with additional validation checks to ensure all eligible members were being captured. **Harmony** had no issues with membership data during 2012. There were no backlogs of applications, and there was minimal retroactive enrollment during the measurement year.

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

Harmony was fully compliant with the IS standard 3.0 requirements. **Harmony** used Visual CACTUS for capturing its provider credentialing information in 2012. The plan credentialed providers using Visual CACTUS and then loaded those providers into Xcelys. Practitioners were required to be board certified or completed training in the specialty of practice, with exceptions on an individual basis for primary care. Monthly audits were conducted for accuracy of the provider

information entered into the CACTUS database. A sample of provider files were reviewed against verified information and data entry into CACTUS. **Harmony** audited a minimum of five files per credentialing specialist. The auditor observed the credentialing software and found it sufficient for HEDIS reporting. **Harmony** used several credentialing vendors during the measurement period. **Harmony** conducted a 100-percent over-read of all provider documents obtained from the credentialing vendors and conducted an annual on-site visit to each. **Harmony** used its core system, Xcelys, to produce its provider directory. **Harmony**'s Xcelys system was continuously reconciled against Visual CACTUS to ensure data were synchronized and complete. Specialties and sub-specialties were accounted for in both systems. The specialty mapping was reviewed, and no significant changes 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

Table 6.7—Harmony Selected HEDIS 2013 Measures for Medical Record Validation

HEDIS Measure	Product Line	Number of Records	Group	Pass/Fail
Postpartum Care	Medicaid	16	A	Pass
Well-Child Visits in the First 15 Months of Life (6+ Visits)	Medicaid	16	B	Pass
Childhood Immunization Status—Combo 3	Medicaid	16	D	Pass
Exclusions	Medicaid	3	F	Pass

Harmony was fully compliant with the IS 4.0 reporting requirements. 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. HSAG reviewed the Outcomes hybrid tools and corresponding instructions. **Harmony** validated all potential exclusions that were identified by the Outcomes review staff and 100 percent of the abstracted cases. Reviewer qualifications, training, IRR process, and vendor oversight were appropriate. Upon request by **Harmony**, a convenience sample was required and subsequently passed. **Harmony** passed medical record review validation for the following measure groups:

- Group A: Postpartum Care
- Group B: Well-Child Visits in the First 15 Months of Life (6+ Visits)
- Group D: Childhood Immunization Status—Combo 3
- Group F: Exclusions

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

Harmony was fully compliant with the IS standard 5.0 requirements. **Harmony** used six supplemental data sources for reporting its Medicaid measures. Only one data source, Pseudoclaims, was considered non-standard supplemental data. A sample of the Pseudoclaims data was conducted during the on-site review and found to be compliant with the supplemental data standards. The non-standard supplemental data source included exclusions from previous HEDIS seasons, such as hysterectomies, double mastectomies, and colonoscopies. The additional five supplemental data sources were external standard data or claims feeds from external vendors or State agencies. The external sources were monitored and trended monthly by the **Harmony** staff. Trending assisted **Harmony** in determining if data were missing from any particular file and served as a basis for reconciling capitation with external entities. These supplemental data sources were loaded into **Harmony**'s data warehouse where additional reconciliation occurred. Warehouse edit checks also determined if the supplemental data contained standard codes. For HEDIS 2013, the supplemental data sources provided significant numerator positive results.

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

IS standard 6.0 was not applicable to the measures under the scope of the Illinois Medicaid audit for HEDIS 2013.

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

Harmony was fully compliant with the IS standard 7.0 requirements. **Harmony** had a significant change in its reporting software during the measurement year. For HEDIS 2013, **Harmony** migrated from McKesson's CareEnhance Resource Management Software (CRMS) certified software to Inovalon. **Harmony** spent several months implementing the software and maintained testing documents and test cases to ensure all data were migrated appropriately. During the migration, **Harmony** noted defects and corrected them accordingly. Additionally, **Harmony** conducted side-by-side comparisons to its HEDIS 2012 results to determine accuracy of the data migration. **Harmony** indicated there were no significant differences in the data year over year in its side-by-side testing. **Harmony** did note that several denominators increased as a result of the remapping of certain data elements. The audit team reviewed several denominators for the three measures under review and found them to be compliant. As with many software migrations, data remapping often results in "cleaner" data, especially when data have not been examined in several years. As a result, the implementation helped to clean up any data issues that previously were potential issues under the McKesson software. The on-site primary source validation showed that source files matched target files, and no issues were detected. Preliminary and final rates validated that there were no significant negative impacts on the software migration. **Harmony** maintained sufficient processes to integrate these data sources for HEDIS reporting, and there were no issues

detected. **Harmony** provided sufficient documentation ensuring that appropriate fields were mapped. As notes in previous HEDIS seasons, access to **Harmony**'s data met Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards.

Harmony Trended Results

Table 6.8 provides the results of **Harmony**'s trended performance measures. Only HEDIS measures reported for the current year and the previous two years are included. The measures highlighted in green are the incentive measures.

Table 6.8—Harmony Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Harmony			Difference From 2012
	2011	2012	2013	
Child and Adolescent Care				
Childhood Immunizations—Combo 2	65.9	68.9	69.59	0.69
Childhood Immunizations—Combo 3	61.6	64.0	64.48	0.48
Lead Screening in Children	78.1	79.1	79.21	0.11
*Well-Child Visits in the First 15 Months (0 Visits)**	5.4	4.6	4.38	-0.22
Well-Child Visits in the First 15 Months (6+ Visits)	51.3	51.3	56.20	4.90
Well-Child Visits (3–6 Years)	71.8	65.2	71.54	6.34
Adolescent Well-Care Visits	38.9	35.5	46.47	10.97
*Immunizations for Adolescents***	29.9	38.7	43.07	4.37
Children's Access to PCPs (12–24 Months)	86.5	88.8	88.89	0.09
Children's Access to PCPs (25 months–6 Years)	73.3	74.2	76.47	2.27
Children's Access to PCPs (7–11 Years)	70.5	71.0	72.95	1.95
Adolescent's Access to PCPs (12–19 Years)	71.4	72.3	73.44	1.14
Adults' Access to Preventive/Ambulatory Care				
20–44 Years of Age	69.3	70.8	71.09	0.29
45–64 Years of Age	68.8	71.3	72.82	1.52
Preventive Screening for Women				
Breast Cancer Screening	30.7	34.4	36.86	2.46
Cervical Cancer Screening	69.8	71.5	72.81	1.31
Chlamydia Screening (16–20 Years of Age)	46.1	50.1	50.60	0.50
Chlamydia Screening (21–24 Years of Age)	57.2	59.7	62.68	2.98
Chlamydia Screening (Combined Rate)	50.9	54.0	55.73	1.73
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	16.5	14.8	14.11	-0.69
Frequency of Ongoing Prenatal Care (81–100% of Visits)	39.9	42.1	43.55	1.45
Timeliness of Prenatal Care	64.7	64.7	74.70	10.00
Postpartum Care	48.7	49.6	49.39	-0.21

Table 6.8—Harmony Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Harmony			Difference From 2012
	2011	2012	2013	
Chronic Conditions/Disease Management				
Controlling High Blood Pressure	42.6	37.2	39.42	2.22
Diabetes Care (HbA1C Testing)	69.6	71.1	77.37	6.27
*Diabetes Care (Poor HbA1c Control)**	65.9	62.5	56.69	-5.81
Diabetes Care (Good HbA1c Control)	29.4	29.4	36.50	7.10
Diabetes Care (Eye Exam)	18.2	27.5	27.25	-0.25
Diabetes Care (LDL-C Screening)	63.7	59.9	65.45	5.55
Diabetes Care (LDL-C Level <100 mg/dL)	17.5	22.4	25.55	3.15
Diabetes Care (Nephropathy Monitoring)	67.4	67.6	71.53	3.93
*Diabetes Care (BP < 140/80)***	NA	31.1	30.90	-0.20
Diabetes Care (BP < 140/90)	49.6	48.7	48.42	-0.28
Appropriate Medications for Asthma (Combined)	86.0	79.9	84.14	4.24
Follow-up After Hospitalization for Mental Illness-7 Days	42.7	41.8	50.44	8.64
Follow-up After Hospitalization for Mental Illness-30 Days	56.1	57.1	64.37	7.27

* 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 36 trended measures improved since HEDIS 2012, and the rates for nine measures improved by 5.0 or more percentage points. Two rates improved by at least 10.0 percentage points: *Adolescent Well-Care Visits* and *Timeliness of Prenatal Care*.

Four rates showed a small decline of less than 0.5 percentage points: *Postpartum Care, Diabetes Care (Eye Exam), Diabetes Care (BP < 140/80),* and *Diabetes Care (BP < 140/90)*. Nearly all of **Harmony**'s rates improved, but many are still low compared to national percentiles, indicating a need for **Harmony** to continue 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, the rates for these measures are not applicable (NA). Since the enrollment for **Meridian** was expected to still be low for 2013, the audited measures required for **Meridian** consisted of the following measures:

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

The Medicaid HEDIS 2013 rates for **Meridian** and the National Medicaid 2012 HEDIS 50th percentiles are presented below (Table 6.10). 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 6.9—Meridian HEDIS 2013 Rates

HEDIS Measures	Meridian Rates for HEDIS 2013	2012 HEDIS 50th Percentiles
Child and Adolescent Care		
Childhood Immunizations—Combo 2	84.89	75.35
Childhood Immunizations—Combo 3	82.73	71.93
Lead Screening in Children	85.97	71.41
*Well-Child Visits in the First 15 Months (0 Visits)**	0.58	1.22
Well-Child Visits in the First 15 Months (6+ Visits)	92.40	62.95
Well-Child Visits (3–6 Years)	88.90	72.26
Adolescent Well-Care Visits	79.65	49.65
*Immunizations for Adolescents***	68.57	62.29
Children's Access to PCPs (12 - 24 Months)	96.74	97.02
Children's Access to PCPs (25 months – 6 Years)	95.52	89.19
Children's Access to PCPs (7 – 11 Years)	95.28	90.58
Adolescent's Access to PCPs (12 - 19 Years)	94.93	89.21
Adults' Access to Preventive/Ambulatory Care		
20–44 Years of Age	88.21	82.34
45–64 Years of Age	90.55	87.31
Preventive Screening for Women		
Breast Cancer Screening	NA	50.46
Cervical Cancer Screening	80.56	69.10
Chlamydia Screening (16–20 Years of Age)	58.95	54.18

Table 6.9—Meridian HEDIS 2013 Rates

HEDIS Measures	Meridian Rates for HEDIS 2013	2012 HEDIS 50th Percentiles
Chlamydia Screening (21–24 Years of Age)	70.73	64.36
Chlamydia Screening (Combined Rate)	65.60	58.40
Maternity-Related Measures		
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	0.81	6.58
Frequency of Ongoing Prenatal Care (81–100% of Visits)	95.97	64.65
Timeliness of Prenatal Care	96.37	86.13
Postpartum Care	83.06	64.98
Chronic Conditions/Disease Management		
Controlling High Blood Pressure	NA	57.52
Diabetes Care (HbA1C Testing)	93.18	82.38
*Diabetes Care (Poor HbA1c Control)**	70.45	41.68
Diabetes Care (Good HbA1c Control)	22.73	48.72
Diabetes Care (Eye Exam)	75.00	52.88
Diabetes Care (LDL-C Screening)	84.09	76.16
Diabetes Care (LDL-C Level <100 mg/dL)	34.09	35.86
Diabetes Care (Nephropathy Monitoring)	75.00	78.71
*Diabetes Care (BP < 140/80)***	9.09	NA
Diabetes Care (BP < 140/90)	13.64	63.50
Appropriate Medications for Asthma (Combined)	NA	85.87
Follow-up After Hospitalization for Mental Illness-7 Days	NA	46.06
Follow-up After Hospitalization for Mental Illness-30 Days	NA	67.65

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

Meridian reported 24 out of 35 measures with rates above the Medicaid 2012 HEDIS 50th percentiles. An additional five measures had fewer than 30 eligible cases (indicated by *NA*). Only *Children's Access to PCPs (12–24 Months)*, *Diabetes Care (LDL-C Level <100 mg/dL), Diabetes Care (Nephropathy Monitoring), Diabetes Care (BP < 140/80),* and *Diabetes Care (BP < 140/90)* were below the HEDIS 2012 Medicaid 50th percentiles.

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 is 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 2013 Technical Specifications* (Table 6.10). 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 6.10—Meridian HEDIS 2013 Compliance Audit Results

Main Information Systems			Selected 2013 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 IS standard 1.0. No issues were identified with the claims processing system. As in the previous HEDIS year, **Meridian** used optical character recognition (OCR) 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. Five percent of each claim was audited by an internal claims inspector daily. This audit resulted in minimal errors for claims processing. All other claims were submitted through standard 837 formatting, either by direct submission or through partnered clearinghouses. The on-site review of the claims system confirmed that code specificity was captured, and primary and secondary codes were identified. Coding tables were updated each year as they were issued from the authorized entities. The internal claims system allowed unlimited ICD-9 and CPT-4 codes. This continued to be a best practice conducted by **Meridian**. **Meridian**'s internally developed system continued to impress the audit team. The system was capable of effortlessly handling the additional claims load resulting from the plan's expansion into new territories. During the on-site demonstrations, the plan showed the system's capabilities for toggling between electronic claims and imaged claims. **Meridian** was able to produce primary source documents with ease when requested by the auditor.

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

Meridian was fully compliant with IS standard 2.0. No issues were identified with enrollment data. **Meridian** had sufficient processes in place to ensure enrollment data were complete and accurate. The enrollment file from the State was reconciled both daily and monthly. Additional checks and balances were conducted against the encounter files submission to the State. During the daily file process, the enrollment file was downloaded from the State website and matched against the internal enrollment system. Any additions, deletions, or changes were conducted within 24–48 hours of file receipt. Once the files were reconciled, they were loaded into MCS. Members that were retroactively added were accompanied with encounter data from the State. New members were provided identification cards immediately. Changed membership information was logged into the system at the time of the file load. The files were also matched against any duplicates. When a duplicate was found, the system automatically created a report for manual review. Any discrepancies were resolved with the State, and true duplicates received the original identification number. A review of the duplicated process 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 **Meridian**. 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 standard 3.0. 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 completion was not an issue. The audit team reviewed all specialty mappings on-site and found no issues. All relevant information was captured for all specialties. Sub-specialties and midlevel specialties were also mapped appropriately. The credentialing system demonstration and the primary source verification proved to be flawless. The credentialing staff took great pride in maintaining provider records. The provider records reviewed during the on-site visit were well organized and contained the appropriate primary source documents. This continues to be a best practice among healthcare organizations.

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

Meridian reported its rates administratively; therefore, IS standard 4.0 was not applicable to the scope of the audit.

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

Meridian was fully compliant with IS standard 5.0. No issues were encountered during the review of supplemental data. **Meridian** used a new supplemental data source for the three measures under review. The supplemental data stemmed from an internal disease management program that captured information during telephonic contacts with both providers and members. The outreach program consisted of contacting members to ensure visits or services were kept during the time frame required by the disease management program. Any member-reported information was verified by the provider, and the provider must have followed up with a claim or other evidence that the visit or service occurred. The audit team listened in on several calls during the on-site visit and found no issues with the process. Additionally, **Meridian** staff conducted interrater reliability on a minimum of 5 percent of all calls for each staff member. Audits compared the recorded conversation between the member and **Meridian** staff with what was entered in the system. Each staff member must maintain 95 percent accuracy, or further training is required. All reported HEDIS data must be 100 percent accurate. Members that entered HEDIS-related information must meet this threshold; otherwise, it is considered a failure and re-training is required. In addition to listening in on several phone calls during the on-site review, the auditor randomly selected records to determine accuracy in the reporting system. Each record reviewed passed inspection without errors. The supplemental data were maintained in **Meridian**'s core system, which is considered a best practice.

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

IS 6.0, Member Call Center Data, was not applicable to the measures under the scope of the 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. There were no issues identified with data integration. **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 there were no issues identified with the final reported rates. Primary source verification was performed on all measures, and no issues were found.

Meridian Trended Results

Table 6.11 below provides the results of **Meridian**'s trended performance measures. Only HEDIS measures reported for both HEDIS 2012 and HEDIS 2013 are included in the table. In addition, due to the relatively small population for **Meridian**, 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 6.11—Meridian Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Meridian Health Plan			Difference From 2012
	2011	2012	2013	
Child and Adolescent Care				
Childhood Immunizations—Combo 2	NA	87.0	84.89 (N=278)	-2.21
Childhood Immunizations—Combo 3	NA	83.3	82.73 (N=278)	-0.57
Lead Screening in Children	NA	92.2	85.97 (N=278)	-6.23
*Well-Child Visits in the First 15 Months (0 Visits)**	NA	0.0	0.58 (N=171)	0.58
Well-Child Visits in the First 15 Months (6+ Visits)	NA	82.0	92.40 (N=171)	10.40
Well-Child Visits (3–6 Years)	NA	84.9	88.90 (N=1144)	4.00
Adolescent Well-Care Visits	NA	66.7	79.65 (N=1199)	12.95
Children's Access to PCPs (12–24 Months)	100.0 (N=78)	100.0 (N=118)	96.74 (N=460)	-3.26
Children's Access to PCPs (25 months–6 Years)	92.1 (N=101)	92.1 (N=239)	95.52 (N=1472)	3.42
Children's Access to PCPs (7–11 Years)	NA	81.3	95.28 (N=127)	13.98
Adolescent's Access to PCPs (12–19 Years)	NA	90.0	94.93 (N=138)	4.93
Adults' Access to Preventive/Ambulatory Care				
20–44 Years of Age	90.5 (N=148)	89.1 (N=313)	88.21 (N=789)	-0.89
45–64 Years of Age	NA	91.1	90.55 (N=127)	-0.55
Preventive Screening for Women				
Cervical Cancer Screening	NA	84.4	80.56 (N=576)	-3.84
Chlamydia Screening (21–24 Years of Age)	NA	67.4	70.73 (N=123)	3.33
Chlamydia Screening (Combined Rate)	NA	60.8	65.60 (N=218)	4.8

Table 6.11—Meridian Trended HEDIS Results

HEDIS Measures	HEDIS Rates for Meridian Health Plan			Difference From 2012
	2011	2012	2013	
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	NA	1.4	0.81 (N=248)	-0.59
Frequency of Ongoing Prenatal Care (81–100% of Visits)	NA	94.5	95.97 (N=248)	1.47
Timeliness of Prenatal Care	98.2 (N=55)	93.9 (N=147)	96.37 (N=248)	2.47
Postpartum Care	85.5 (N=55)	76.2 (N=147)	83.06 (N=248)	6.86

The rates for *Childhood Immunizations—Combo 2, Childhood Immunizations—Combo 3*, *Lead Screening in Children*, *Well-Child Visits in the First 15 Months (0 Visits)*, *Children's Access to PCPs (12–24 Months)*, *Adults' Access to Preventive/Ambulatory Care* (both indicators), and *Cervical Cancer Screening* declined; however, the 2013 rates were based on a much higher number of cases. Measures with fewer than 30 eligible cases in the denominator are designated as *NA*, following NCQA's guidelines.

All other rates improved, especially *Well-Child Visits in the First 15 Months (6+ Visits)*, *Adolescent Well-Care Visits*, and *Children's Access to PCPs (7–11 Years)*, which improved by at least 10.0 percentage points from the previous years.

Plan Comparisons and Recommendations

This section of the report compares the HEDIS and CHIPRA performance measure results for **FHN**, **Harmony**, and **Meridian** based on the performance measures listed in Table 6.12. The measures have been classified into related categories for discussion purposes.

Table 6.12—Classification of HEDIS 2013 Measures

Category	HEDIS 2013 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)
*** CHIPRA Measures**	*Annual Pediatric Hemoglobin (HbA1c) Testing*
	Developmental Screening in the First Three Years of Life
	Annual Number of Asthma Patients 2–20 Years of Age with an Asthma Related ED Visit

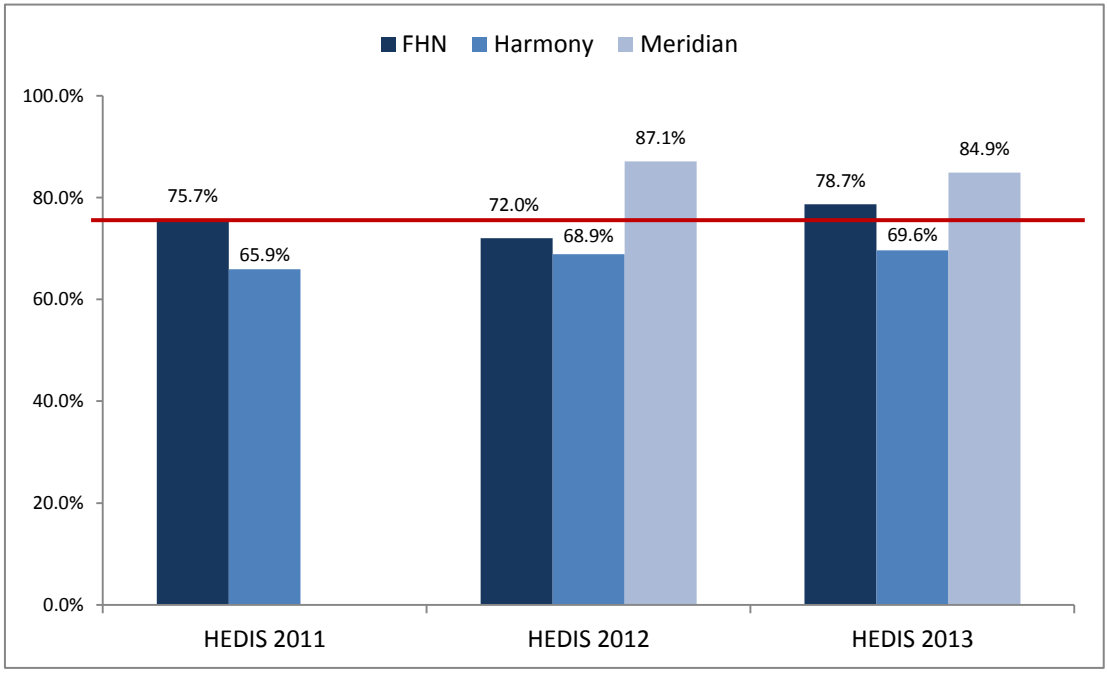
Child and Adolescent Care

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 three years.

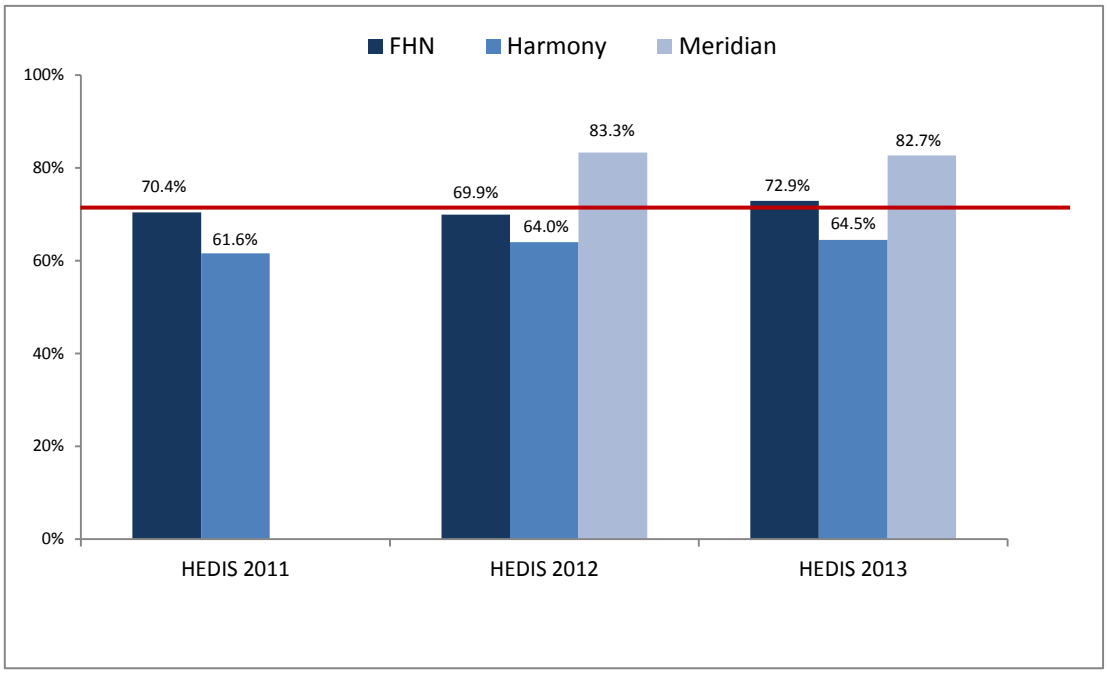
Figure 6.1—Comparison of HFS MCO Performance for *Childhood Immunizations—Combination 2*



FHN's rate of 78.7 percent represented an improvement of 6.7 percentage points from the previous year. This rate is above the National Medicaid HEDIS 2012 50th percentile. **Harmony**'s rate increased 0.7 percentage points over last year but was still more than 5 percentage points below the 50th percentile. Trending for both **FHN** and **Harmony** shows rates have remained about the same since HEDIS 2011. The rate for **Meridian**, at 84.9 percent, fell slightly more than 2 percentage points since last year but was well above the 50th percentile.

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]).

Figure 6.2—Comparison of HFS MCO Performance for *Childhood Immunizations—Combination 3*

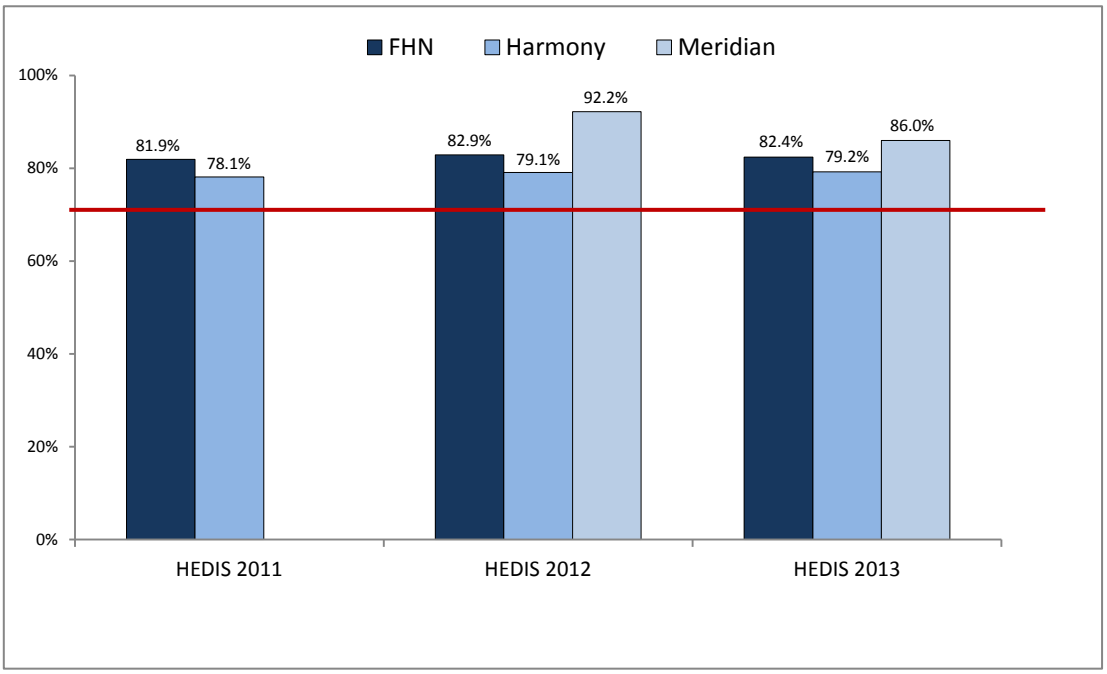


FHN's rate of 72.9 percent was 1 percentage point above the National Medicaid HEDIS 2012 50th percentile, and represented an improvement of 3 percentage points from last year. **Harmony**'s rate increased 0.5 percentage points over last year but is still more than 5 percentage points below the 50th percentile. The rate for **Meridian**, at 82.7 percent, was well above the 50th percentile.

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. **Meridian** reported on this measure for the first time in 2012.

Figure 6.3—Comparison of HFS MCO Performance for *Lead Screening in Children*

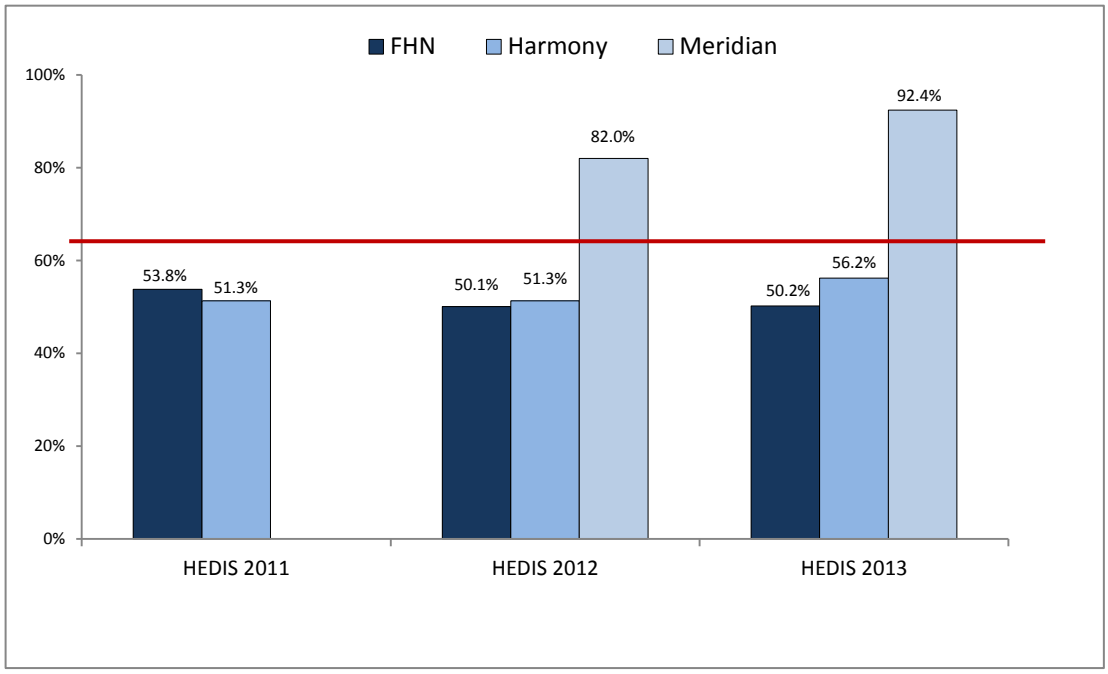


Both **FHN** and **Harmony** have continued to demonstrate good results for this measure. **FHN** reported a rate of 82.4 percent while **Harmony** reported a rate of 79.2 percent for HEDIS 2013. Overall, the HEDIS 2013 rate declined slightly from HEDIS 2012 by 0.5 percentage points for **FHN** and increased from HEDIS 2012 by 0.1 percentage points for **Harmony**. The rate for **Meridian** was the highest, at 86.0 percent. The HEDIS 2013 rates for all three MCOs exceeded the National Medicaid HEDIS 2012 50th percentile.

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*.

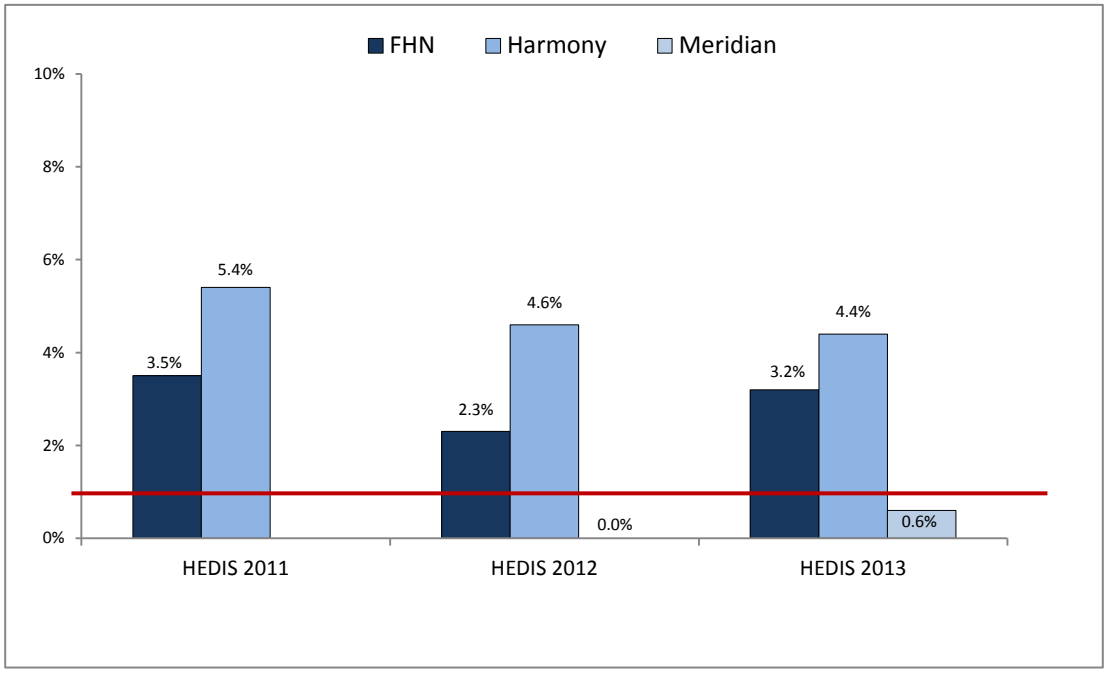
Figure 6.4—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—Six or More Visits*



Since HEDIS 2012, **FHN**'s rate improved by 0.10 percentage points and is currently at 50.20 percent, while **Harmony**'s rate improved by 4.90 percentage points and is at 56.20 percent. The HEDIS 2013 rates for both **FHN** and **Harmony** are below the National Medicaid HEDIS 2012 50th percentile, while **Meridian**'s rate of 92.40 percent is well above the 50th percentile.

For the Zero Visits numerator, lower rates indicate better performance. The results in Figure 6.5 indicate that approximately 95.00 percent of the eligible children enrolled in **FHN** or **Harmony** received at least one well-child visit in their first 15 months of life.

Figure 6.5—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—Zero Visits*

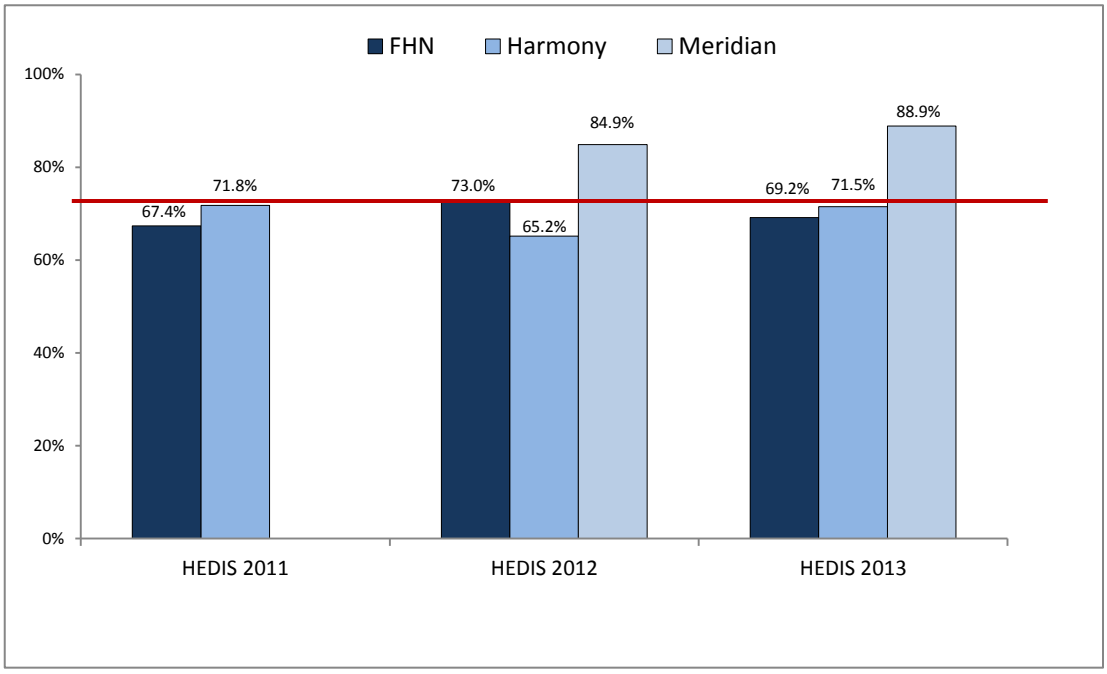


FHN's performance had a small decline in 2013 as the rate increased slightly to 3.2 percent from last year's rate of 2.3 percent. Overall, **Harmony**'s rate of 4.4 percent is an improvement over the previous years. **Meridian**'s rate of 0.6 percent is the only rate in this category to exceed the National Medicaid HEDIS 50th percentile.

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*.

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

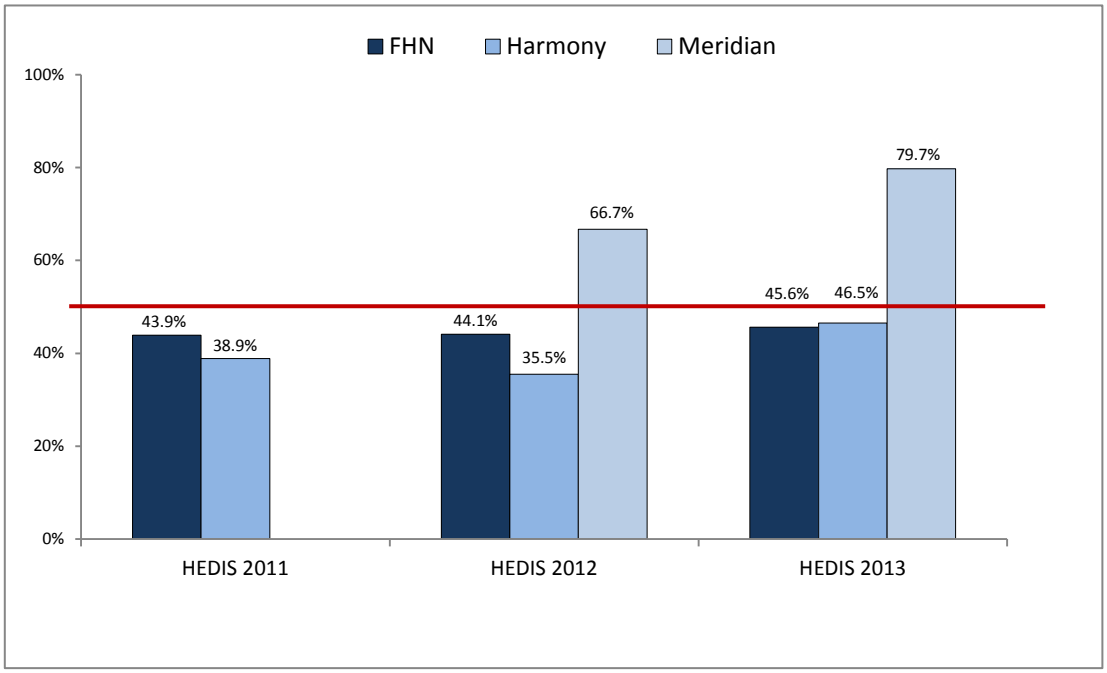


Meridian reported a rate of 88.9 percent and was the only MCO in 2013 to report a rate above the National Medicaid HEDIS 2012 50th percentile. Since HEDIS 2012, the rate for **FHN** has declined from 73.0 percent to 69.2 percent, putting it below the 50th percentile. The rate for **Harmony** improved by 6.3 percentage points since HEDIS 2012, increasing from 65.2 percent to 71.5 percent for HEDIS 2013. **Harmony**'s rate improved from last year but is still slightly below the National Medicaid HEDIS 2012 50th percentile for HEDIS 2013.

Adolescent Well-Care Visits

Figure 6.7 presents the comparative rates for *Adolescent Well-care Visits*. **Meridian** had fewer than 30 eligible cases in 2011 and therefore was presented for the first time in 2012.

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

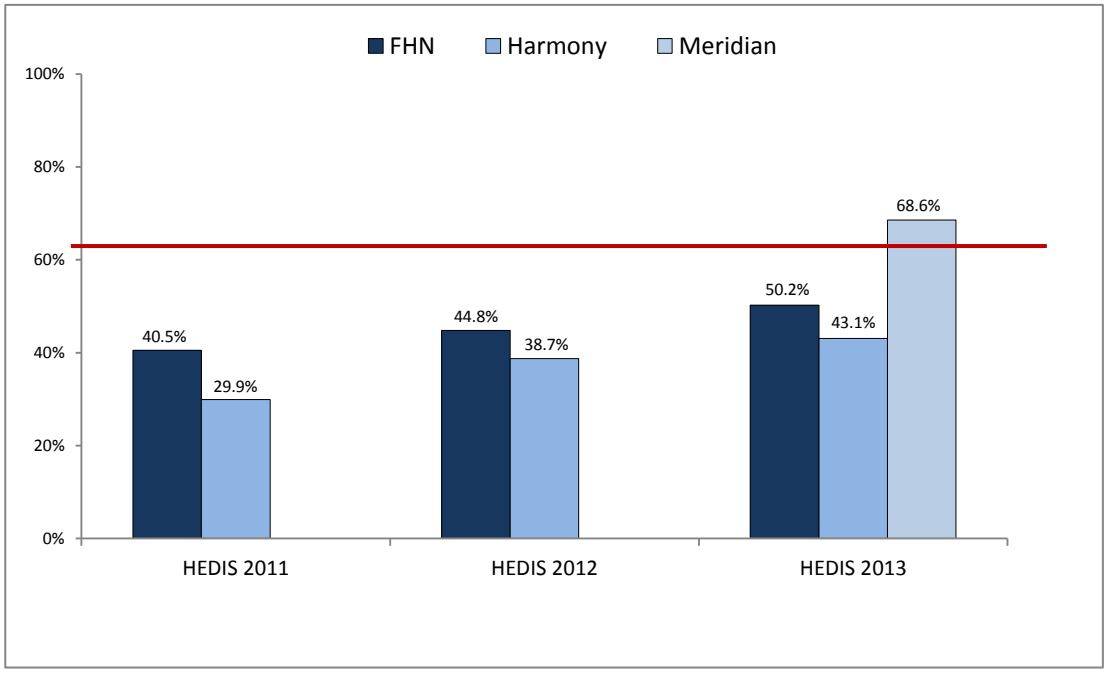


Meridian's rate of 79.7 percent for HEDIS 2013 was the only rate above the National Medicaid HEDIS 2012 50th percentile. The rate for **FHN** has remained about the same throughout recent years and is currently at 45.6 percent, which is less than 5 percentage points below the 50th percentile mark. **Harmony** has had similar difficulties with improving the rate for this measure. **Harmony**'s rate has actually improved significantly from 35.5 percent to 46.5 percent since HEDIS 2012, but **Harmony**'s rate continues to remain below the National Medicaid HEDIS 2012 50th percentile for HEDIS 2013.

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.

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



HEDIS 2010 was the first year for reporting this measure for both **FHN** and **Harmony**. **Meridian** had fewer than 30 eligible cases in 2012 and therefore is presented for the first time in 2013. **Meridian** has reported a rate of 68.6 percent and is well above the National Medicaid HEDIS 2012 50th percentile for HEDIS 2013.

Since HEDIS 2010, the rates for both **FHN** and **Harmony** have shown improvement. **FHN**'s rate increased by 5.4 percentage points since last year, while **Harmony**'s rate improved by 4.4 percentage points. The rates for both **FHN** and **Harmony** are below the 50th percentile.

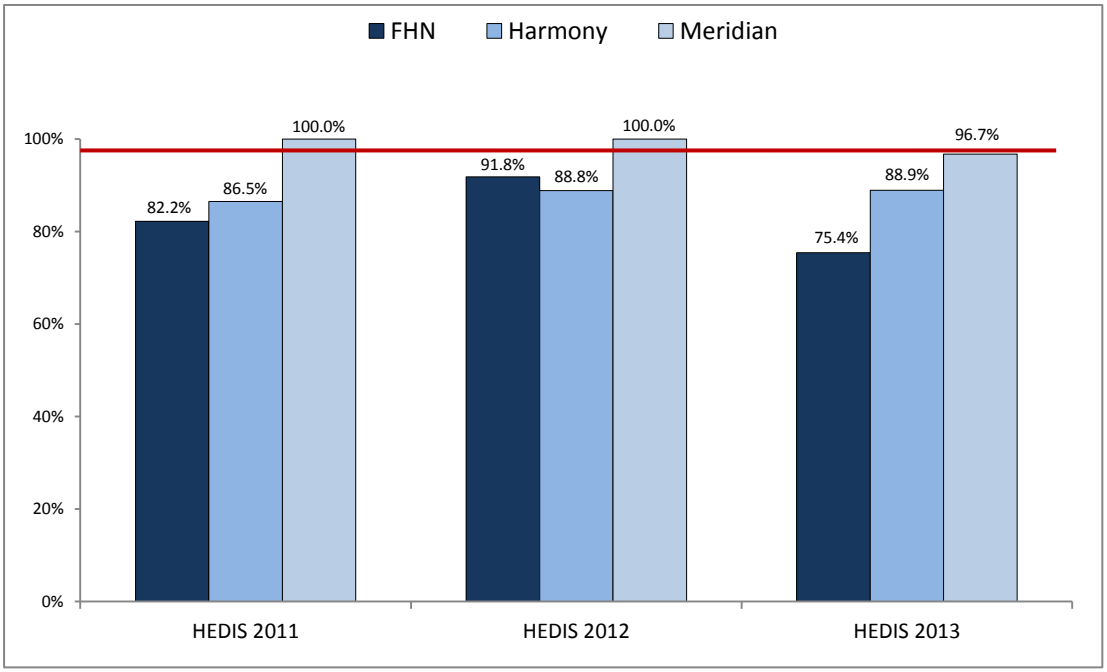
Access to Care

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 Adolescent's Access to PCPs (12–24 Months)*.

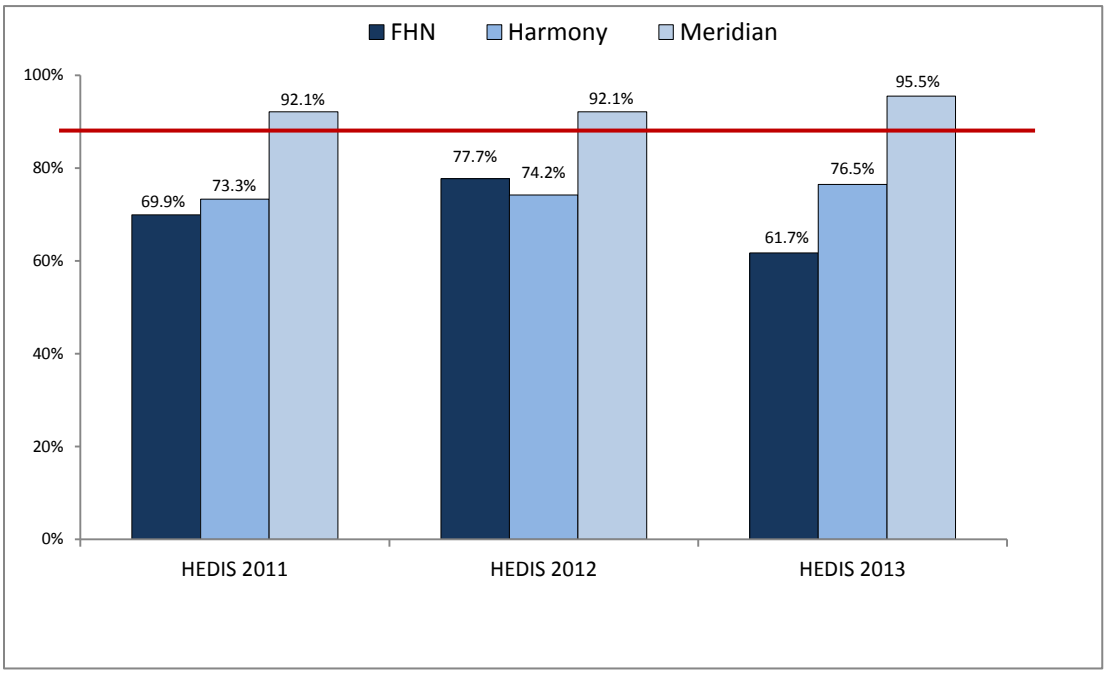
Figure 6.9—Comparison of HFS MCO Performance for *Children's and Adolescent's Access to PCPs (12–24 Months)*



For HEDIS 2011 and 2012, **Meridian** reported a rate of 100.0 percent. In 2013, **Meridian** reported a decreased rate of 96.7 percent, which was also slightly below the National Medicaid HEDIS 2012 50th percentile. The HEDIS 2013 rate for **FHN** decreased by 16.4 percentage points since HEDIS 2012. The HEDIS 2013 rate for **Harmony** improved by 0.1 percentage points over HEDIS 2012. The rates for both **FHN** and **Harmony** remained below the National Medicaid HEDIS 2012 50th percentile and were 75.4 and 88.9 percent, respectively.

Figure 6.10 presents the comparative rates for *Children's and Adolescent's Access to PCPs (25 Months–6 Years)*. **FHN** and **Harmony** first reported this measure beginning in HEDIS 2008 while HEDIS 2011 was the first year **Meridian** reported on the measure.

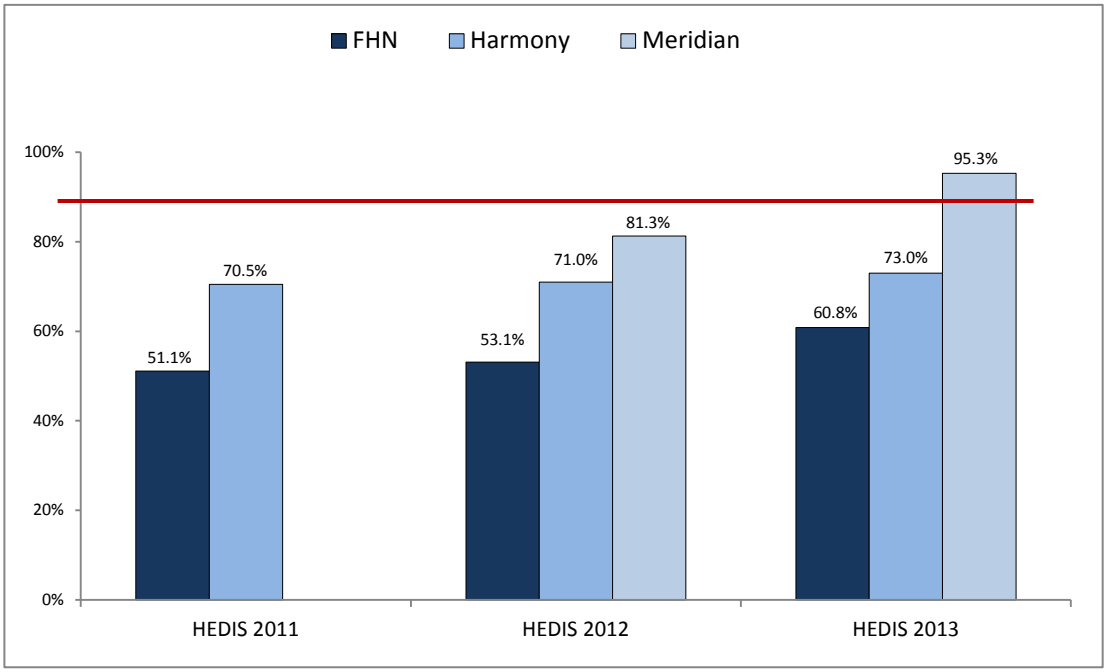
Figure 6.10—Comparison of HFS MCO Performance for *Children's and Adolescent's Access to PCPs (25 Months–6 Years)*



Meridian's rate of 95.5 percent was above the National Medicaid HEDIS 2012 50th percentile in 2013. Overall, the rate for **FHN** declined by 16.0 percentage points since HEDIS 2012 and is now at 61.7 percent. The rate for **Harmony** improved by 2.3 percentage points and is now at 76.5 percent. The rates for both **FHN** and **Harmony** remained below the National Medicaid HEDIS 2012 50th percentile.

Figure 6.11 presents the comparative rates for *Children's and Adolescent's Access to PCPs (7–11 Years).* **FHN** and **Harmony** first reported this measure beginning in HEDIS 2008, while HEDIS 2012 was the first year **Meridian** reported on the measure.

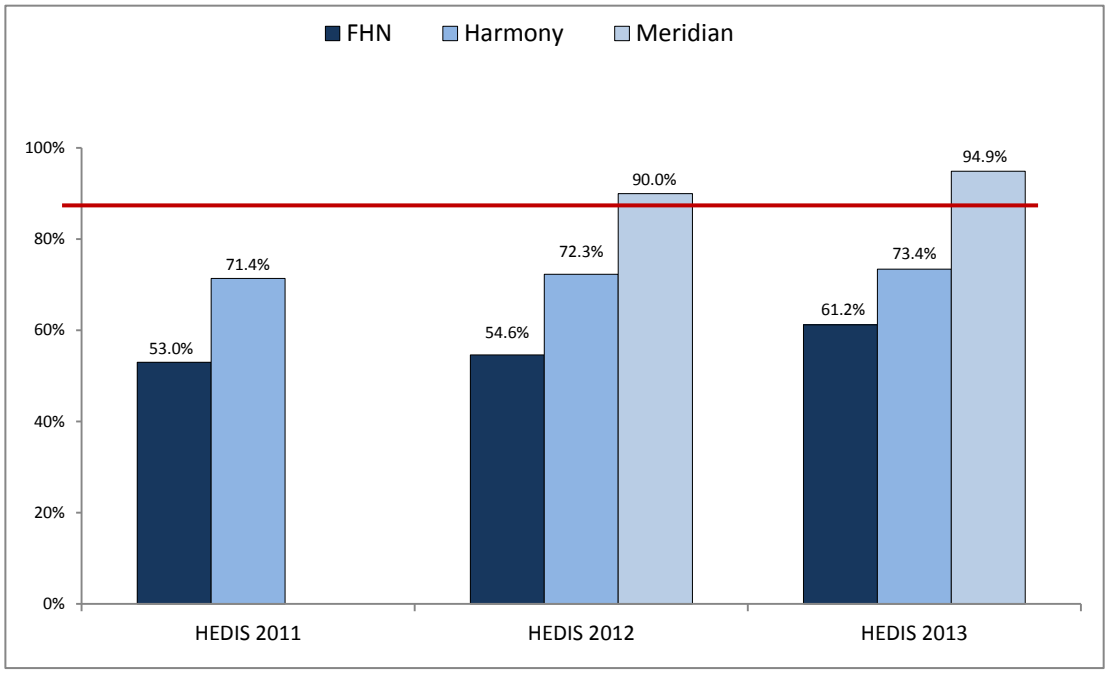
Figure 6.11—Comparison of HFS MCO Performance for *Children's and Adolescent's Access to PCPs (7–11 Years)*



FHN's rate significantly improved in 2013 by 7.7 percentage points, to 60.8 percent, but this rate remains well below the National Medicaid HEDIS 2012 50th percentile. The rate for **Harmony** improved by 2 percentage points since HEDIS 2012 to 73.0 percent, which is still under the 50th percentile. The rate for **Meridian**, at 95.3 percent, was the highest rate among the three MCOs and the only rate above the 50th percentile.

Figure 6.12 presents the comparative rates for *Children and Adolescent's Access to PCPs (12–19 Years).* **FHN** and **Harmony** first reported this measure beginning in HEDIS 2008, while HEDIS 2012 was the first year **Meridian** reported on the measure.

Figure 6.12—Comparison of HFS MCO Performance for *Children and Adolescent's Access to PCPs (12–19 Years)*

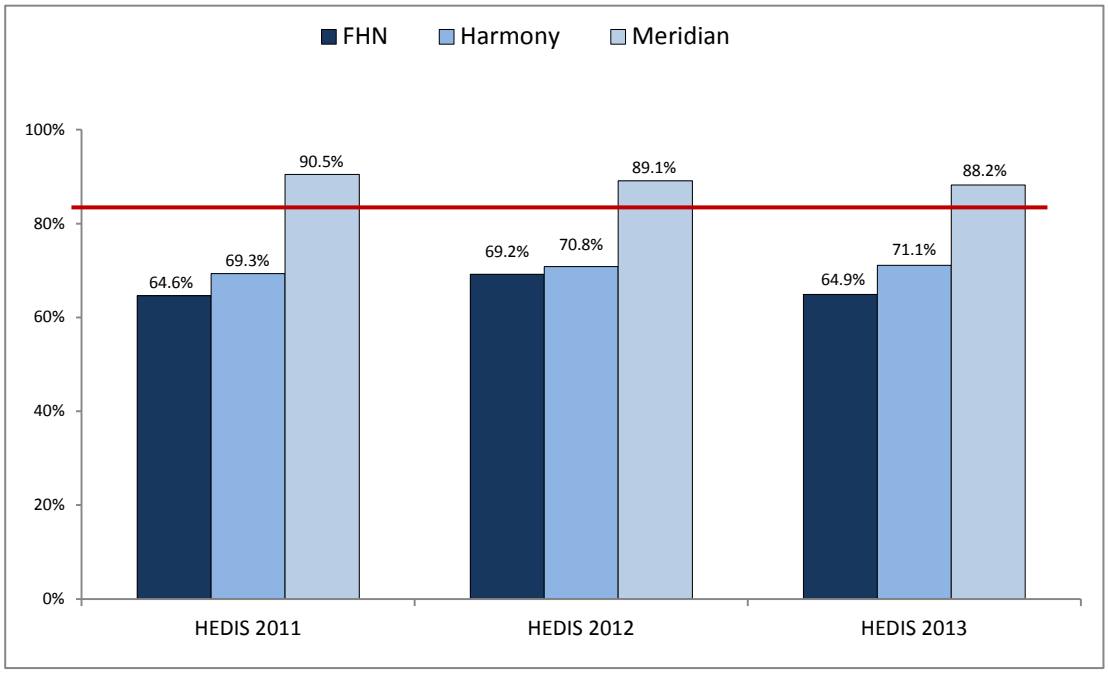


Meridian exceeded the National Medicaid HEDIS 2012 50th percentile with its rate of 94.9 percent. The rate for **FHN** improved by 6.6 percentage points since HEDIS 2012, to 61.2 percent, but it remains well below the 50th percentile. **Harmony**'s rate of 73.4percent is an improvement of 1.1 percentage points and is higher than **FHN**'s rate, but it remains below the 50th percentile again in 2013.

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 third year for reporting a rate for **Meridian**, which has exceeded the National Medicaid HEDIS 50th percentile again for the third year in a row.

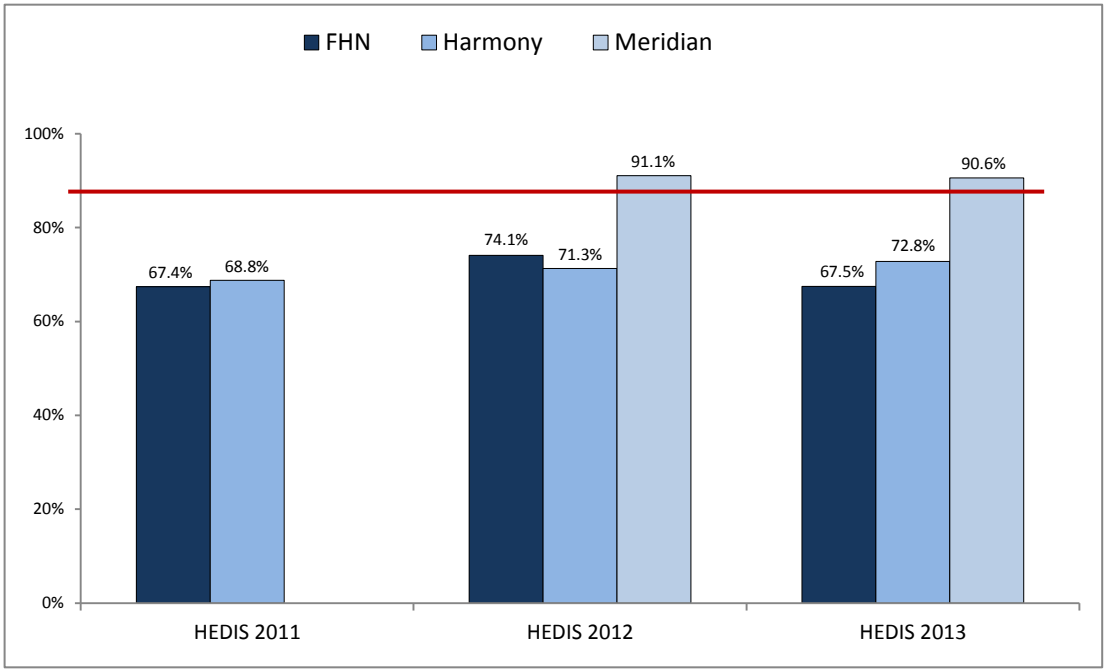
Figure 6.13—Comparison of HFS MCO Performance for *Adults' Access to Preventative/Ambulatory Care (Ages 20–44)*



The rate for **FHN** declined by 4.3 percentage points from the rate of 69.2 percent reported for HEDIS 2012. **Harmony**'s rate improved by 0.3 percentage points in 2013, and **Harmony** continued to outperform **FHN**. The rates for both **FHN** and **Harmony** were below the National Medicaid HEDIS 2012 50th percentile, and were 64.9 percent and 71.1 percent, respectively. **Meridian** was the only plan to exceed the 50th percentile with its rate of 88.2 percent.

Figure 6.14 presents the comparative rates for *Adults' Access to Preventive/Ambulatory Care (Ages 45–64)*.

Figure 6.14—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Care (Ages 45–64)*



For HEDIS 2013, **Meridian** reported a rate of 90.6 percent. This rate was the only one to exceed the HEDIS 2012 National Medicaid 50th percentile. The rate of 67.5 percent for **FHN** represents a significant decline of 6.6 percentage points. **Harmony**'s rate of 72.8 percent improved by 1.5 percentage points. Although **FHN**'s rate surpassed **Harmony**'s rate in HEDIS 2012, **Harmony**'s rate surpassed **FHN**'s rate for HEDIS 2013. The rates for both MCOs, however, were still below the 50th percentile.

The rates for measures related to access continued to improve, but still remain low and below the national 50th percentiles. This indicates that 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.

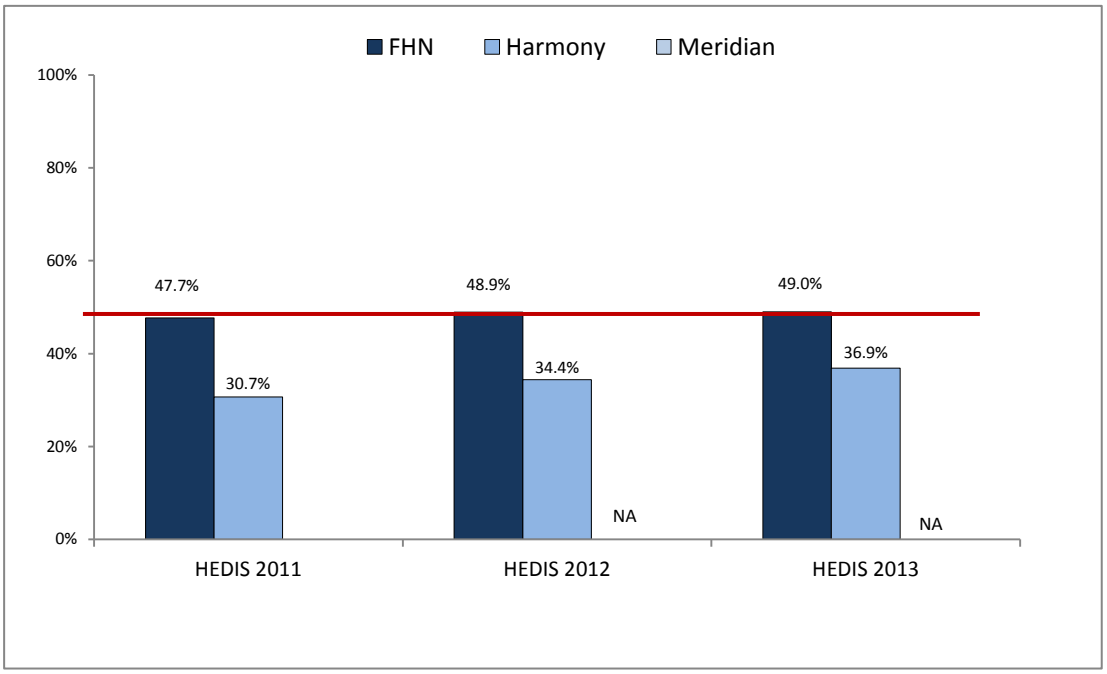
Preventive Screening for Women

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*.

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

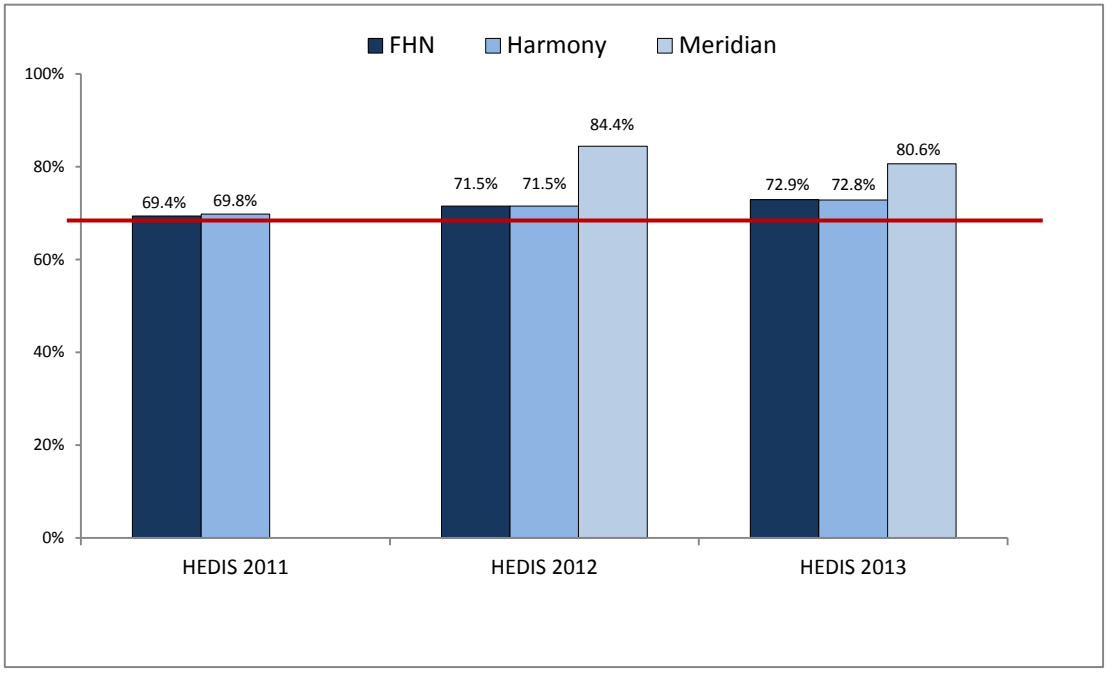


FHN continued to outperform **Harmony** in this area, but the rates for both MCOs were below the HEDIS 2012 National Medicaid 50th percentile. However, the rate for **FHN** of 49.00 percent improved 0.10 percentage points since HEDIS 2012, and the current rate is less than 2 percentage points below the 50th percentile. **Harmony**'s rate of 36.90 percent also improved slightly, by 2.50 percentage points since HEDIS 2012.

Cervical Cancer Screening

The rates for *Cervical Cancer Screening* are displayed in Figure 6.16.

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

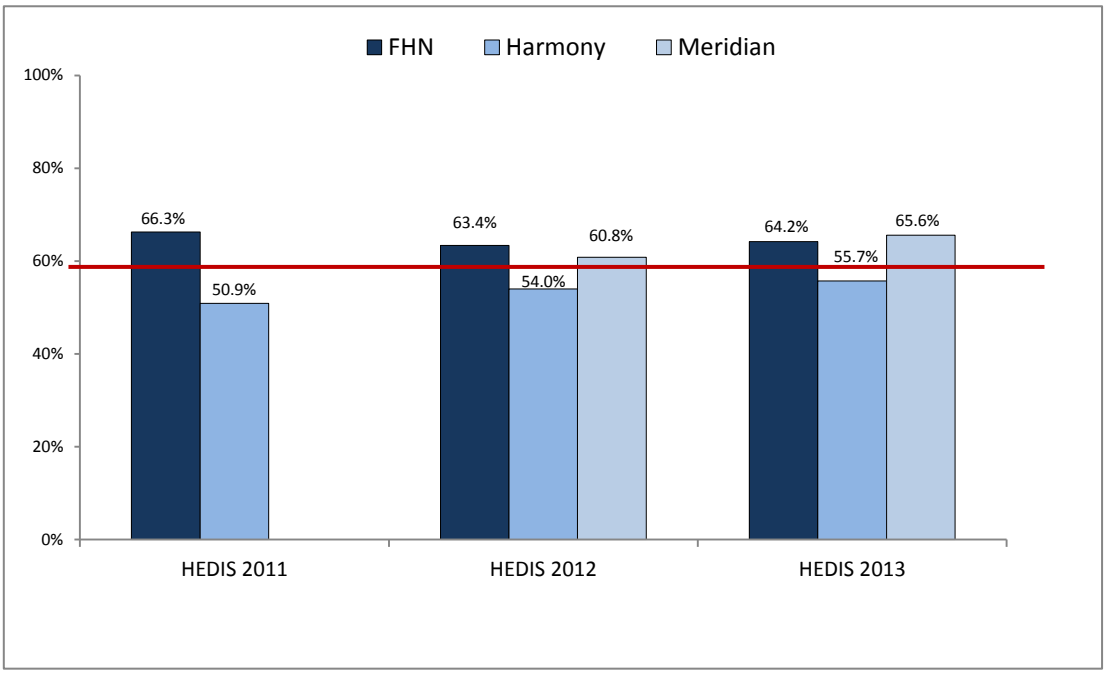


The rates for both **FHN** and **Harmony** were very similar, at 72.9 percent and 72.8 percent, respectively. **FHN**'s rate improved 1.4 percentage points since HEDIS 2012, and **Harmony**'s rate improved by 1.3 percentage points. All plans reported rates above the HEDIS 2012 National Medicaid 50th percentile for 2013. **Meridian**'s rate of 80.6 percent was the highest rate among the three MCOs.

Chlamydia Screening in Women

Figure 6.17 presents the comparative rates for *Chlamydia Screening in Women*. Given the relatively low population for this measure, caution should be used when comparing to the other MCOs.

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



Meridian's rate of 65.6 percent exceeded the National Medicaid HEDIS 2012 50th percentile again for 2013. **FHN**'s rate of 64.2 percent also exceeded the 50th percentile for the third year in a row, and demonstrated an improvement of 0.8 percentage points from HEDIS 2012. **Harmony**'s rate of 55.7 percent improved 1.7 percentage points since HEDIS 2012, but remains slightly below the 50th percentile.

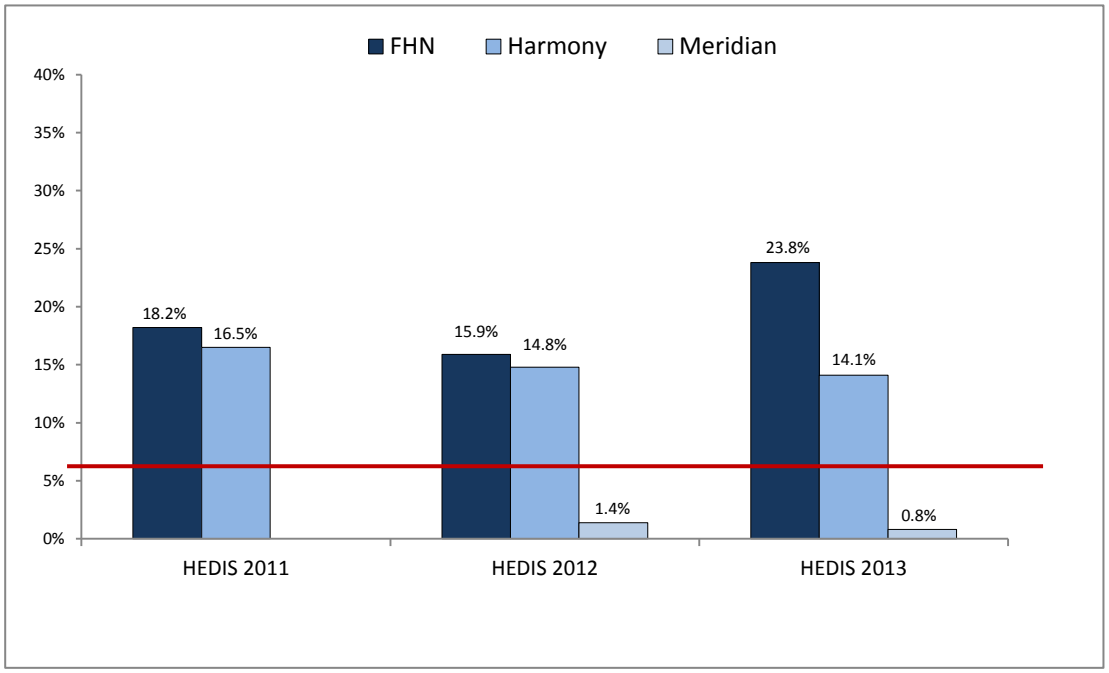
Maternity-Related Care

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.

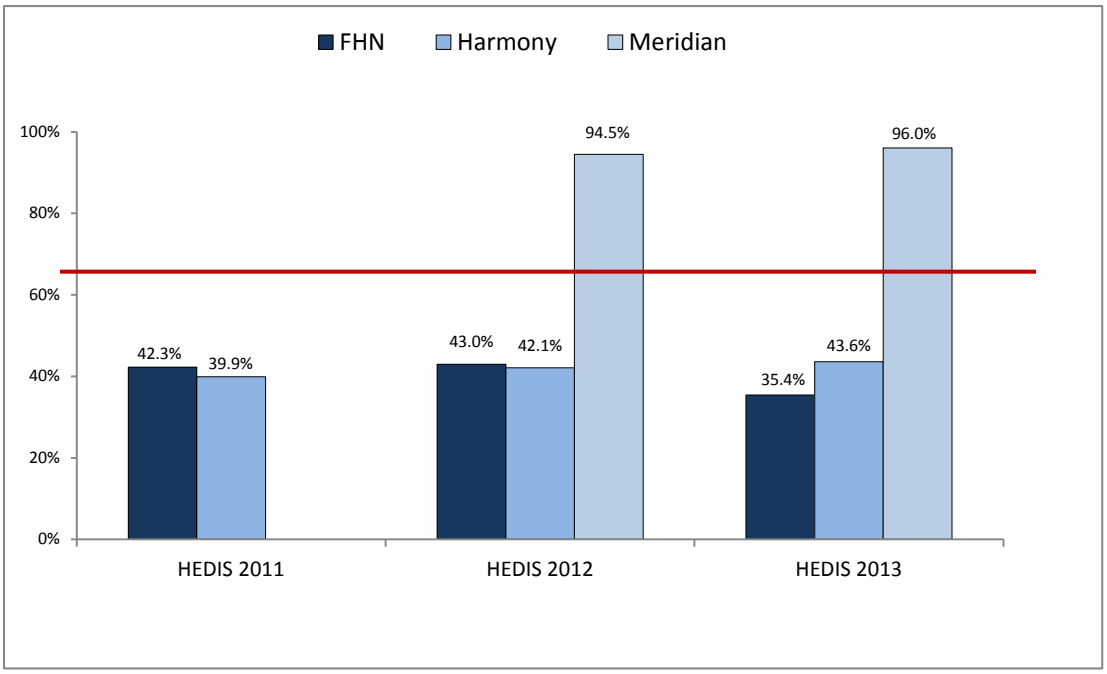
Figure 6.18—Comparison of HFS MCO Performance for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)*



Both **Harmony** and **Meridian** continued to demonstrate improvement with this measure since HEDIS 2011, but **FHN** actually regressed by 7.9 percentage points to a rate of 23.8 percent in 2013. **Harmony** reported a rate of 14.1 percent, which is an improvement of 0.7 percentage points since HEDIS 2012. **Meridian** was the only plan to report a rate better than the National Medicaid HEDIS 2012 50th percentile; its rate was 0.8 percent.

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)*.

Figure 6.19—Comparison of HFS MCO Performance for *Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)*



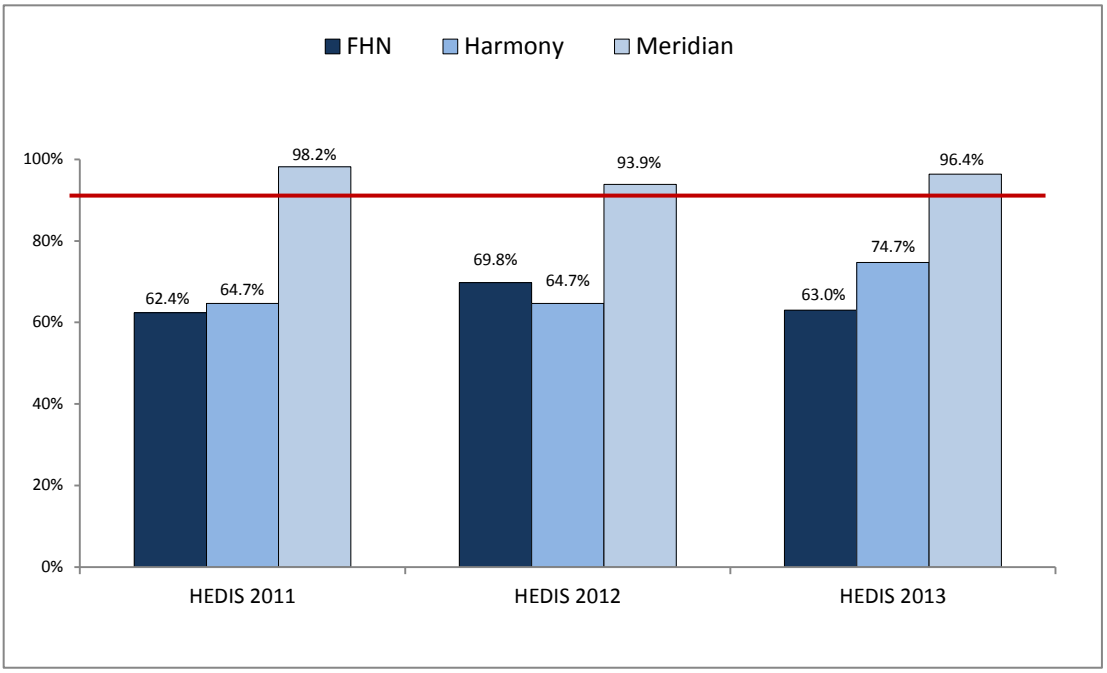
The HEDIS rates for **FHN** have remained low. Although there was a slight improvement from HEDIS 2011 to HEDIS 2012, the rate declined by 7.6 percentage points in 2013 to 35.4 percent. **Harmony**'s rate has shown steady improvement each year; **Harmony** reported a rate of 43.6 percent in 2013, which is an improvement of 1.5 percentage points over HEDIS 2012. The rates for both MCOs were still well below the National Medicaid HEDIS 2012 50th percentile. **Meridian**'s rate of 96.0 percent for HEDIS 2013 remained above the 50th percentile.

The measures related to access to care in this report show low rates, and 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, and/or a combination of any of these factors. The MCOs should continue, 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*.

Figure 6.20—Comparison of HFS MCO Performance for *Timeliness of Prenatal Care*

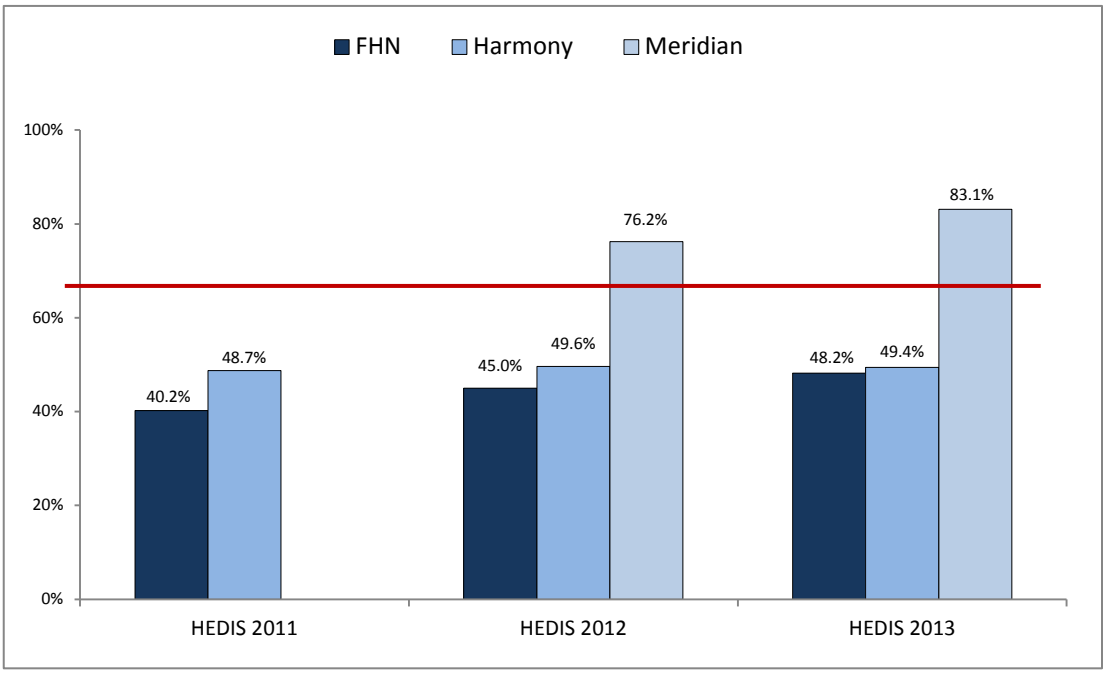


In 2013, **Meridian**'s rate of 96.4 percent was the highest rate reported and the only rate to exceed the HEDIS 2012 National Medicaid 50th percentile. **FHN**'s rate fell 6.8 percentage points to 63.0 percent, and **Harmony**'s rate improved by 10 percentage points to 74.7 percent since HEDIS 2012. Both **FHN** and **Harmony** were well below the National HEDIS 2011 Medicaid 50th percentile.

Timeliness of Postpartum Care

Figure 6.21 presents the comparative performance of the HFS MCOs for *Postpartum Care*.

Figure 6.21—Comparison of HFS MCO Performance for Postpartum Care



For HEDIS 2013, **Meridian**'s rate of 83.1 percent was the highest and only rate to exceed the HEDIS 2012 National Medicaid 50th percentile. **FHN**'s rate of 48.2 increased 3.2 percentage points since HEDIS 2012, while **Harmony**'s rate of 49.4 percent declined 0.2 percentage points. Both **FHN** and **Harmony** were well below the National HEDIS 2012 Medicaid 50th percentile.

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.

Chronic Conditions/Disease Management

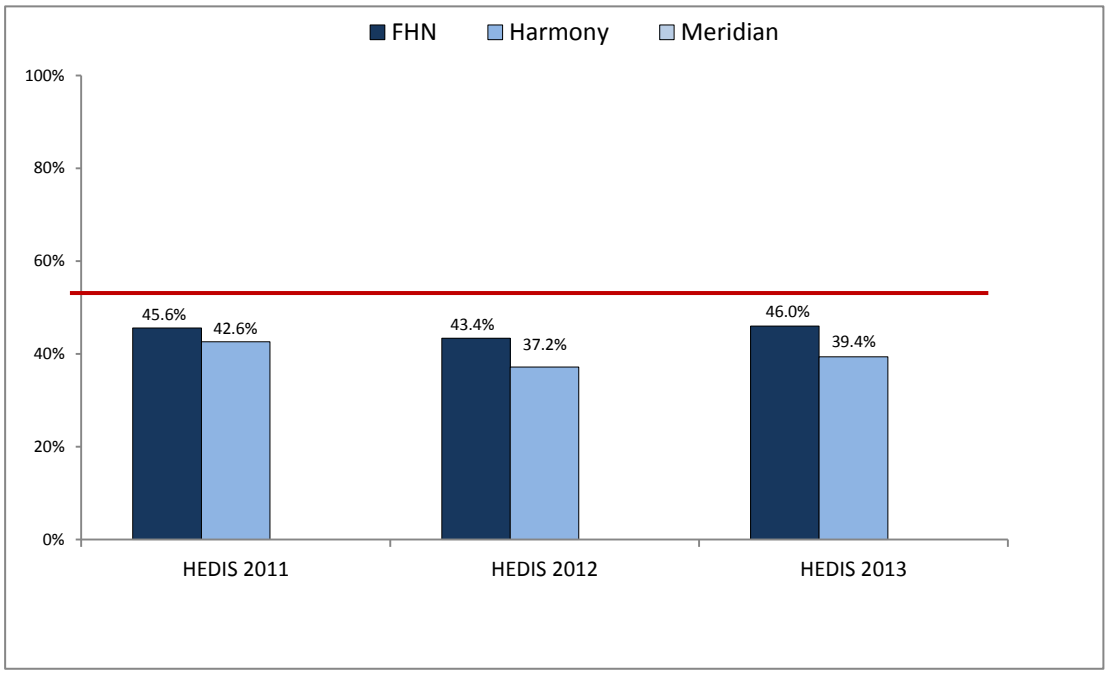
This section addresses HEDIS measures regarding chronic conditions/disease management. The HEDIS measures were *Controlling High Blood Pressure, Comprehensive Diabetes Care, Use of Appropriate Medications for People With Asthma,* and *Follow-up After Hospitalization for Mental Illness*.

Meridian had fewer than 30 eligible cases for many of the measures in this section. In accordance with NCQA, the results for **Meridian** are NA for measures with fewer than 30 cases, and the rates 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.

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



FHN's rate increased 2.6 percentage points since HEDIS 2012 to 46.0 percent. This measure has been very unpredictable for **FHN**, with rates increasing and decreasing over the years. **Harmony**'s rates have also shown fluctuation. At 39.4 percent, **Harmony**'s rate increased 2.2 percentage points since HEDIS 2012. Neither of the MCOs exceeded the National Medicaid HEDIS 2012 50th percentile.

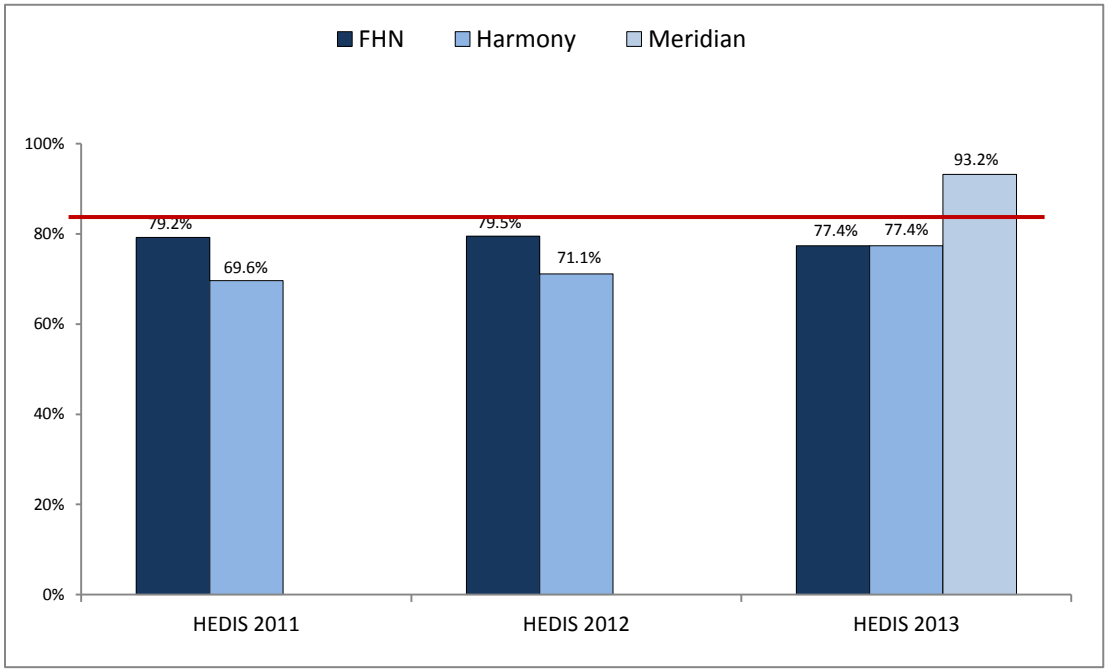
Comprehensive Diabetes Care

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*.

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

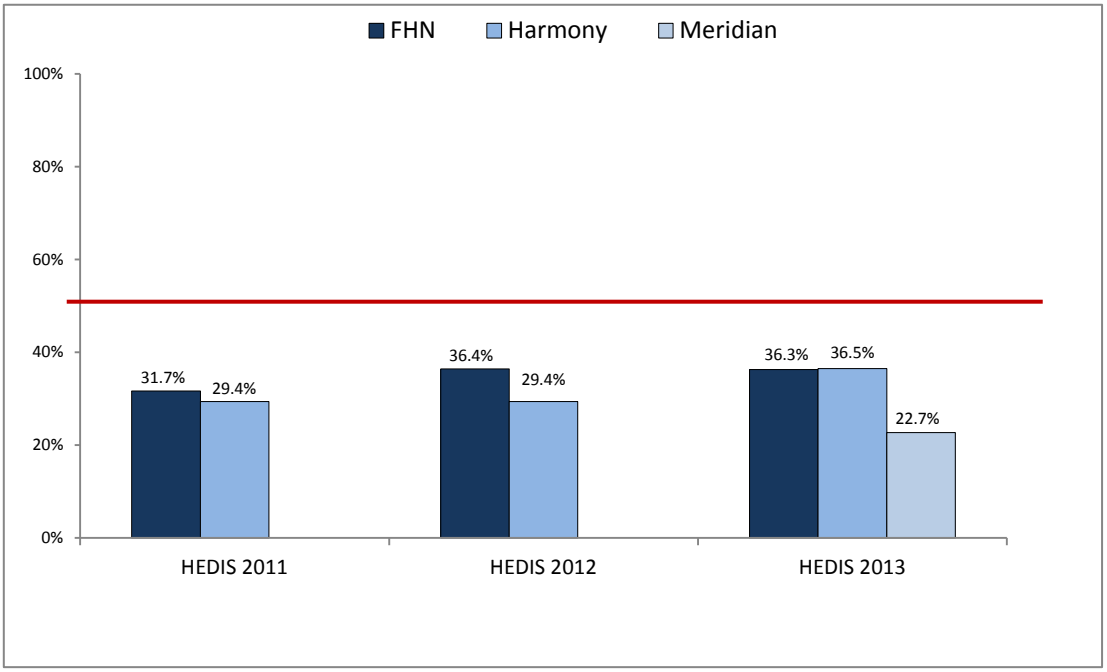


FHN's 2013 rate fell 2.1 percentage points since HEDIS 2012 while **Harmony**'s rate rose 6.3 percentage points. Both **FHN** and **Harmony** reported a rate of 77.4 percent. The only rate above the National Medicaid HEDIS 2012 50th percentile was **Meridian**'s 2013 rate of 93.2 percent.

Comprehensive Diabetes Care—Good HbA1c Control

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

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

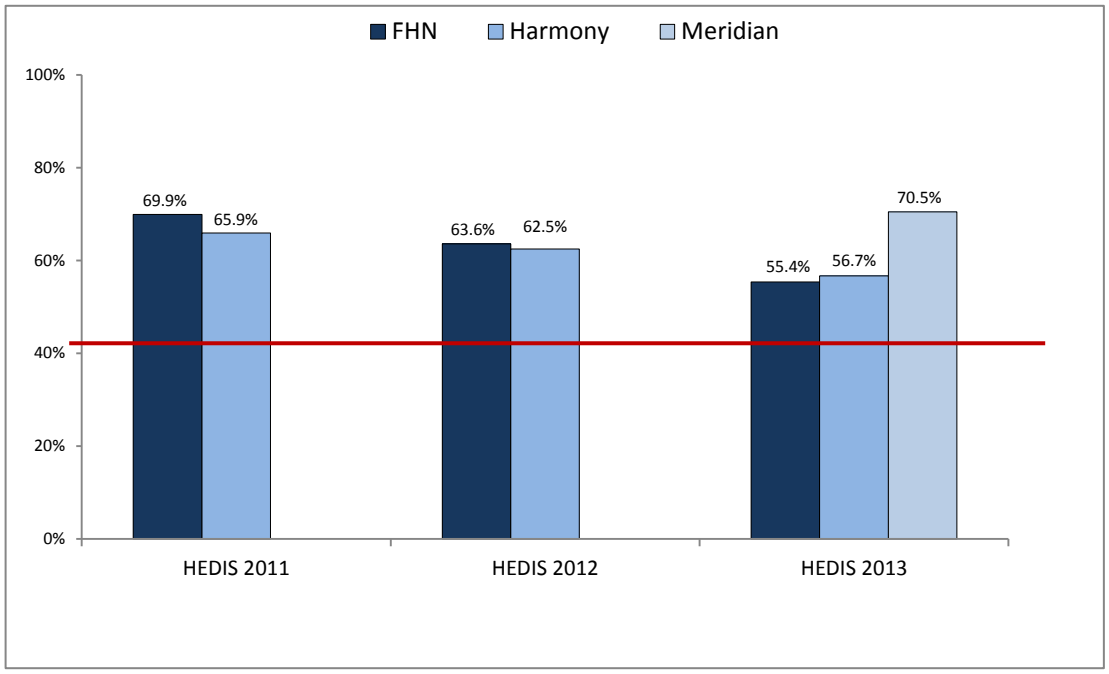


The rate for **FHN** fell by 0.1 percentage points since HEDIS 2012 to 36.3 percent. **Harmony**'s rate improved 7.1 percentage points since HEDIS 2012 to 36.5 percent. Although the rates for both MCOs continued to improve, the rates were well below the National Medicaid HEDIS 2012 50th percentile. 2013 was the first year **Meridian** reported a rate. Its rate, 22.7, was based on only 44 cases. None of these rates met the 50th percentile for HEDIS 2012.

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.

Figure 6.25—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Poor HbA1c Control*



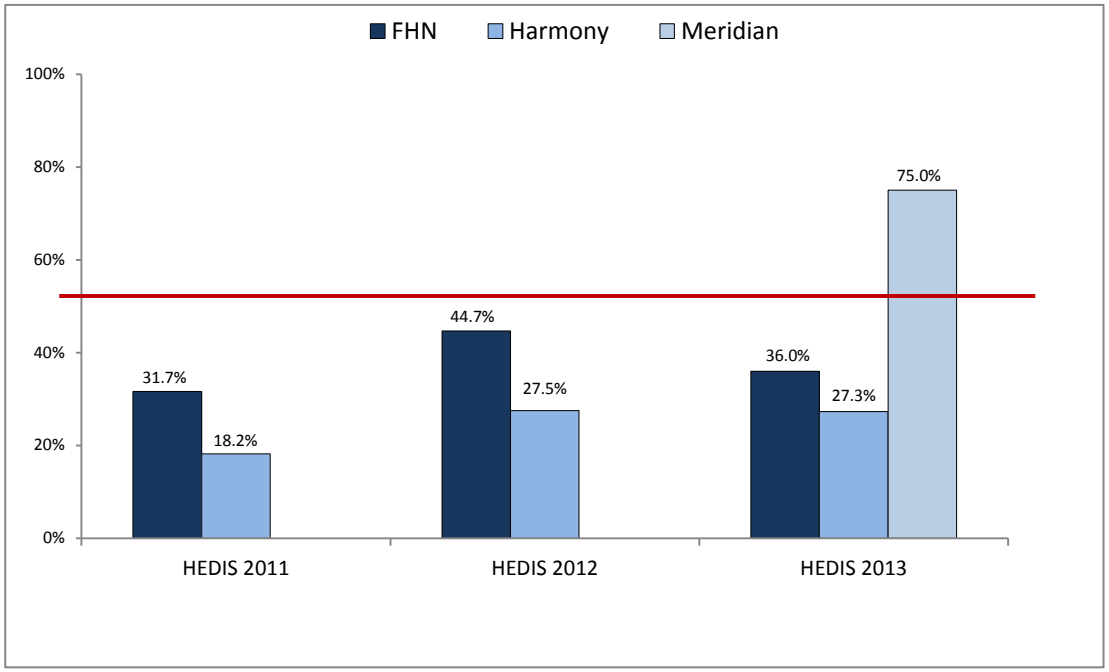
Overall, the performance for **FHN** and **Harmony** has continued to improve for this measure. **FHN**'s rate of 55.4 percent represents a total improvement of 14.5 percentage points since HEDIS 2011, and **Harmony**'s rate of 56.7 percent represents a total improvement of 9.2 percentage points since HEDIS 2011. However, both plans' rates are still above the National Medicaid HEDIS 2012 percentile, as is **Meridian**'s reported rate of 70.5. Since this is an inverse measure, lower rates represent better performance. 2013 was the first year that **Meridian** reported on this measure; however, the rate is based on only 44 cases.

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 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*.

Figure 6.26—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Eye Exam*

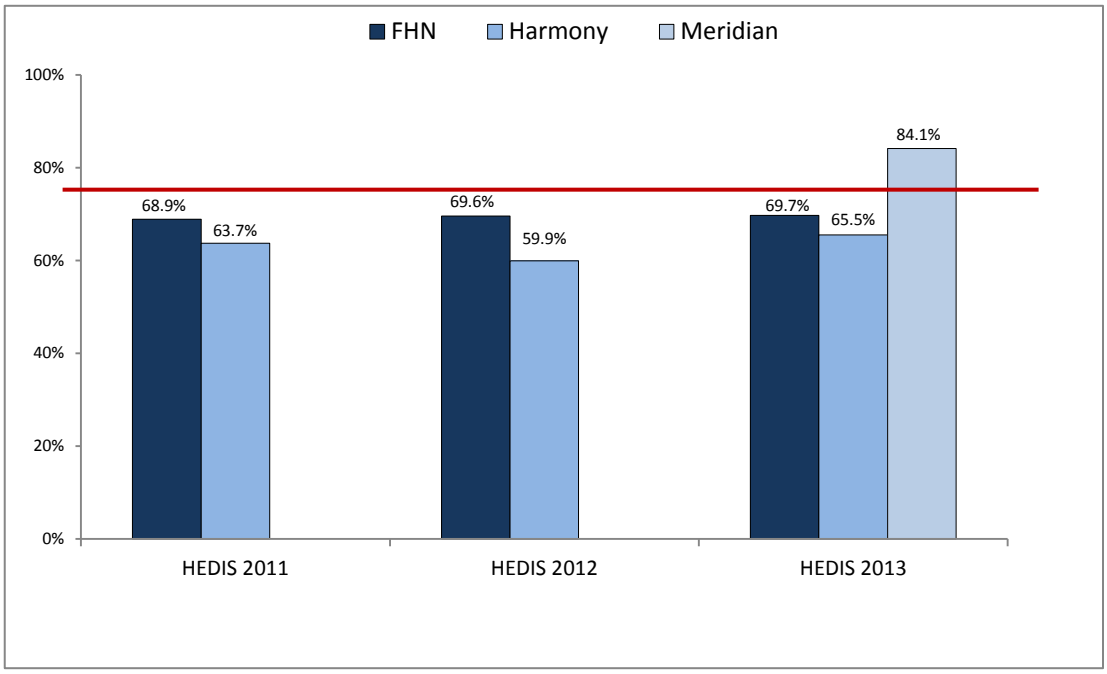


FHN's rate of 36.0 percent fell by 8.7 percentage points, while **Harmony**'s rate of 27.3 percent fell by 0.2 percentage points since HEDIS 2012. Both rates were below the HEDIS 2012 50th percentile. **Meridian**'s rate of 75.0 exceeded the National Medicaid HEDIS 2012 50th percentile by more than 20 percentage points.

Comprehensive Diabetes Care—LDL-C Screening

Figure 6.27 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Screening*.

Figure 6.27—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—LDL-C Screening*

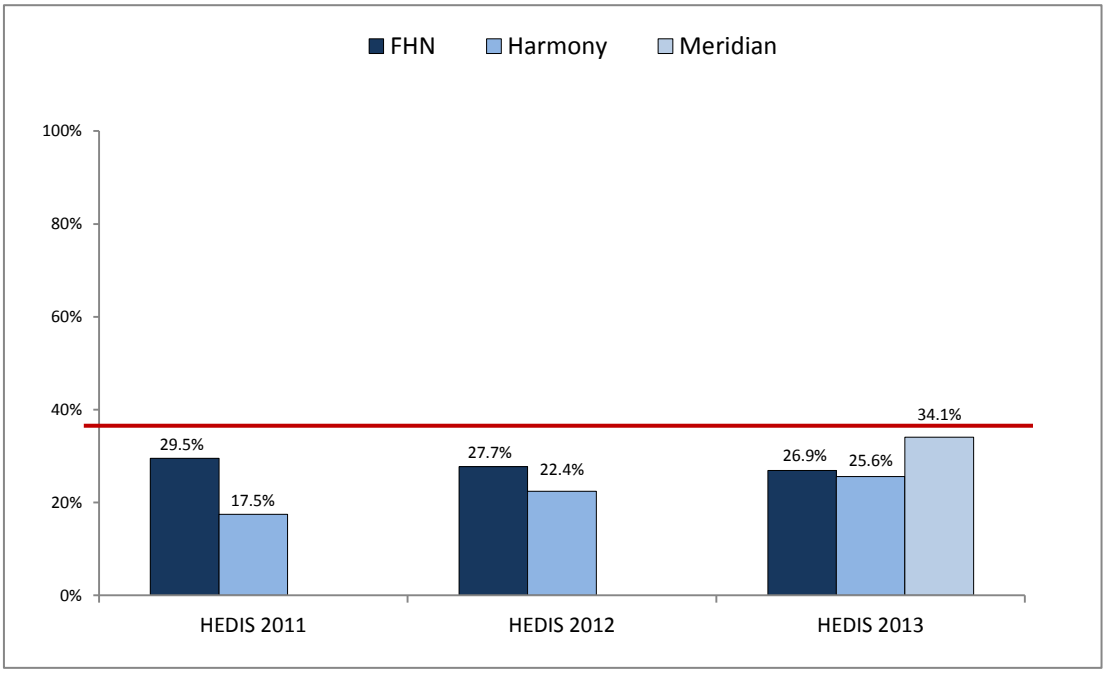


Since HEDIS 2012, the rate for **FHN** of 69.7 percent improved by 0.1 percentage points, while **Harmony**'s rate of 65.5 percent also improved, by 5.6 percentage points. Both MCOs' rates remained below the National Medicaid HEDIS 2012 50th percentile. **Meridian** was the only plan to perform above the 50th percentile, with a rate of 84.1 percent. This was the first year that **Meridian** reported a rate for this measure.

Comprehensive Diabetes Care—LDL-C Level < 100mg/DL

Figure 6.28 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Level <100mg/DL*.

Figure 6.28—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—LDL-C Level <100mg/DL*

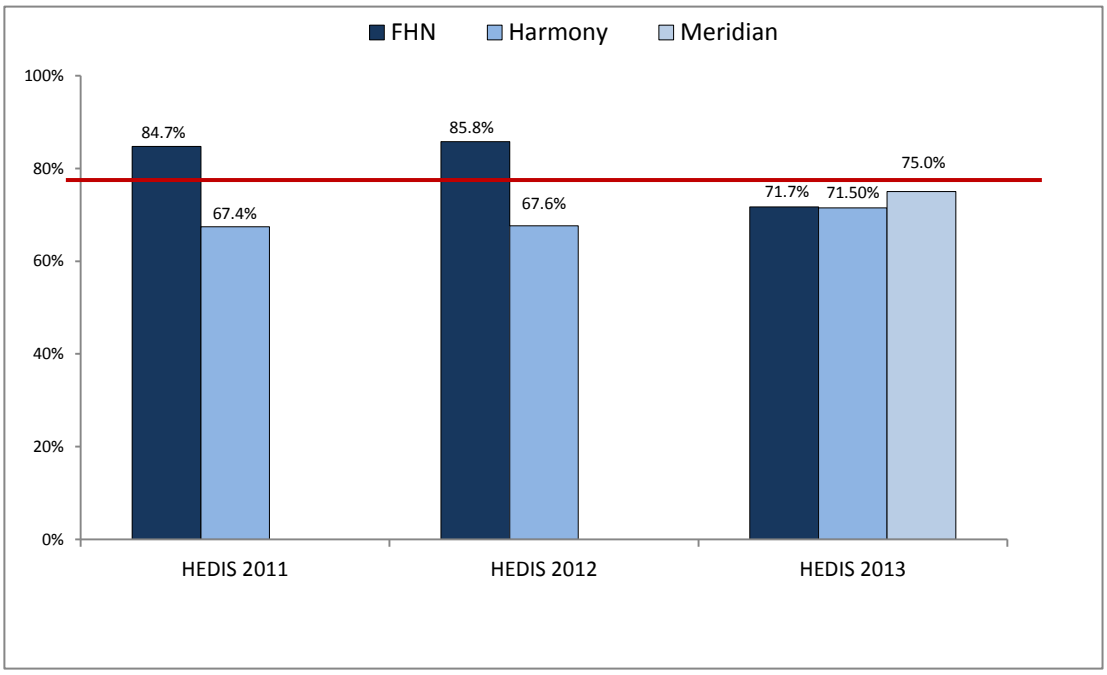


FHN's rate of 26.9 percent represents a slight decline of 2.6 percentage points since HEDIS 2011, while **Harmony**'s rate of 25.6 improved steadily by 8.1 percentage points since HEDIS 2011. **Meridian** reported a rate for the first time in 2013 (34.1 percent). Unfortunately, all three MCOs had rates below the National Medicaid HEDIS 2012 50th percentile. The fairly low rates for this measure may be due to lack of encounter data from the contracted laboratories.

Diabetes Care— Nephropathy Monitoring

Figure 6.29 presents the comparative rates for *Comprehensive Diabetes Care—Monitoring for Nephropathy*.

Figure 6.29—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Monitoring for Nephropathy*

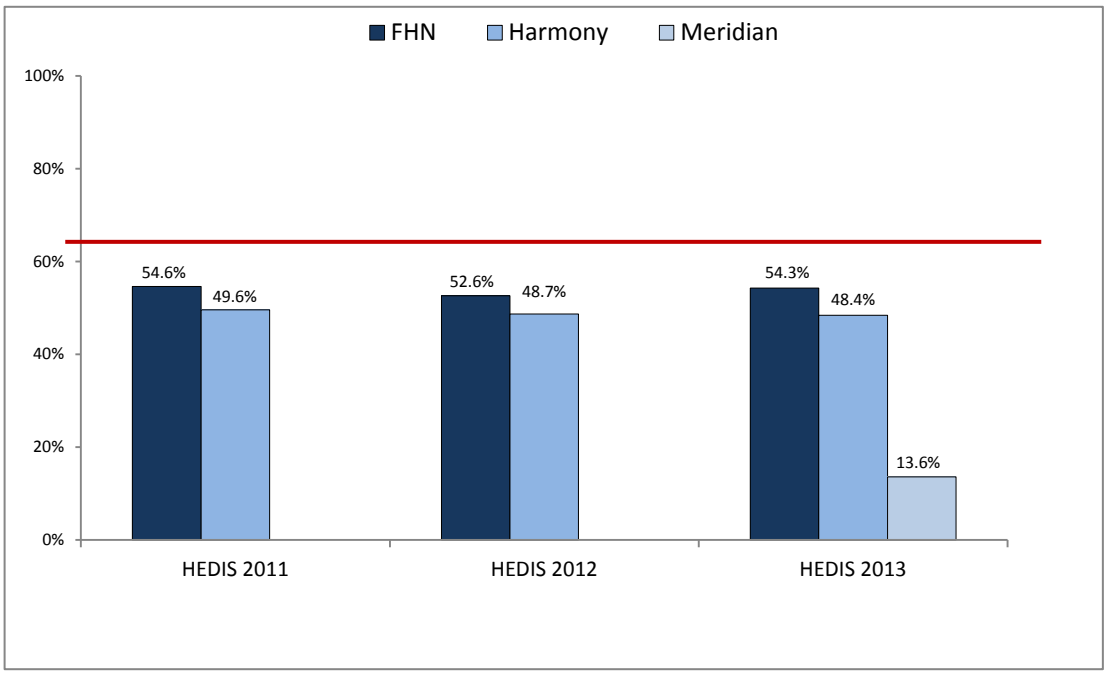


FHN's rate declined 14.1 percentage points since HEDIS 2012 to a 2013 rate of 71.7 percent, and has fallen below the National Medicaid HEDIS 50th percentile for the first time in four years. **Harmony**'s rate has increased 3.9 percentage points since HEDIS 2012 to a 2013 rate of 71.5 percent, and **Meridian** reported a rate for the first time in 2013 (75.0 percent). All three MCOs fell below the National Medicaid HEDIS 50th percentile for HEDIS 2012.

Comprehensive Diabetes Care—Blood Pressure < 140/90

Figure 6.30 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure (Less than 140/90 and 130/80)*.

Figure 6.30—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Blood Pressure <140/90*

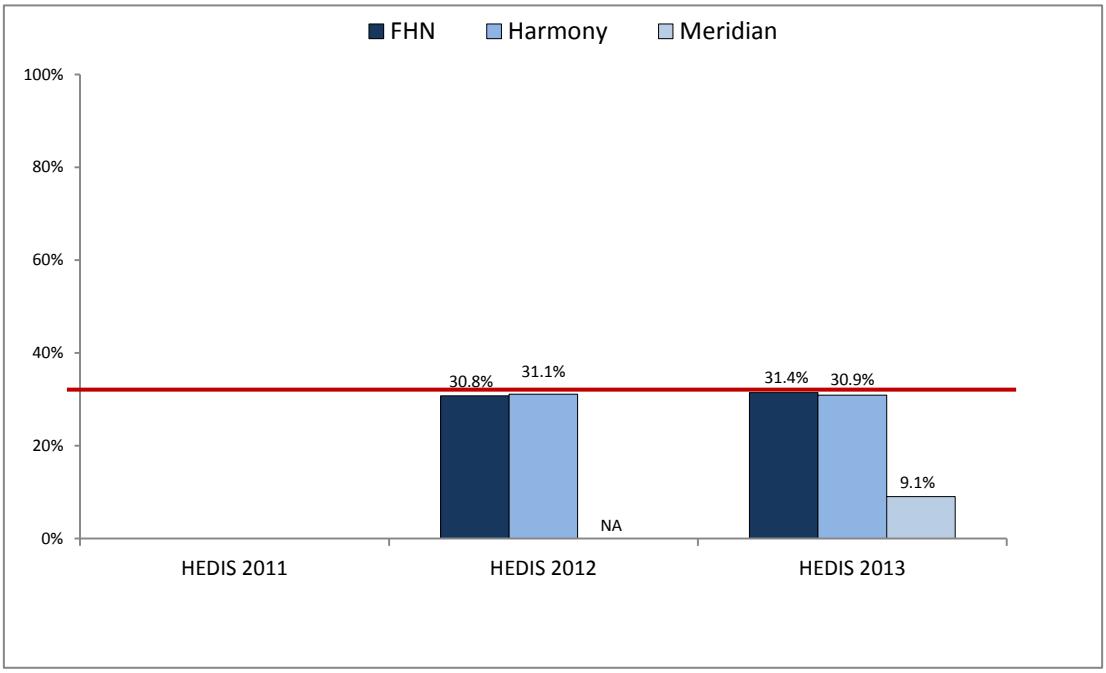


FHN's rate for this measure increased 1.7 percentage points to 54.3 percent since HEDIS 2012. **Harmony**'s rate, which has shown a slight but steady decline for the past three years, fell 0.3percentage points to 48.4 percent. **Meridian**'s first-time reported rate was 13.6 percent. All rates reported by the MCOs were below the National Medicaid HEDIS 2012 50th percentile.

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 (before HEDIS 2011) and the 50th percentile, should be viewed with caution. Direct comparisons between years and with percentiles are not appropriate.

Figure 6.31—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Blood Pressure <140/80*

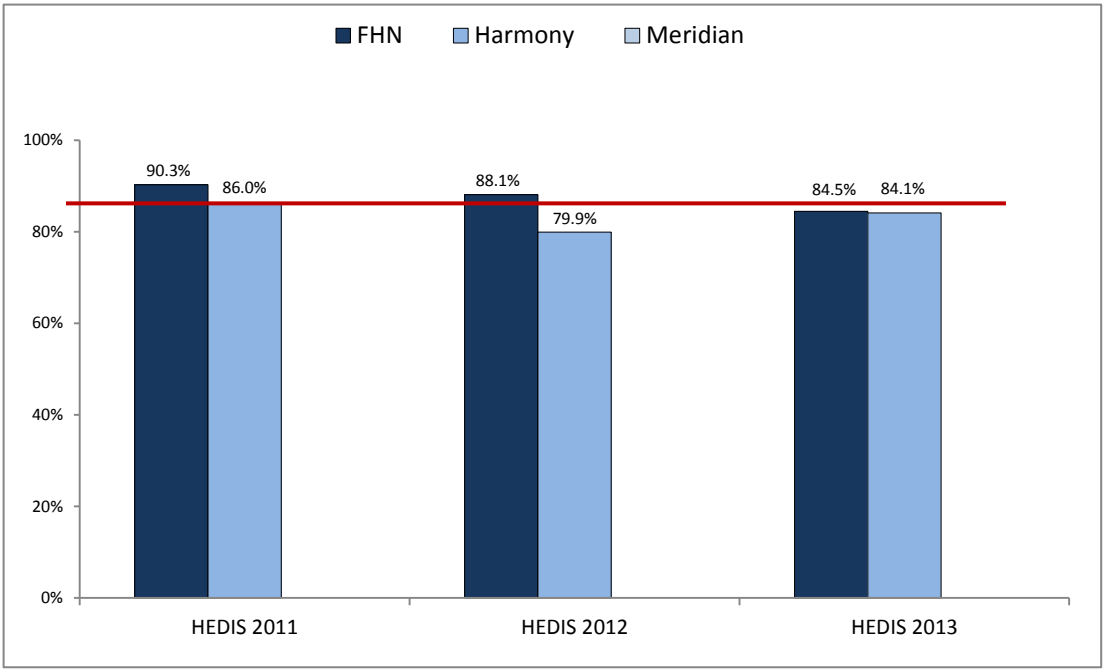


The rate for **FHN** increased by 0.6 percent but is still lower than the National Medicaid HEDIS 2012 50th percentile. The rate for **Harmony**, at 30.9 percent, is lower than the HEDIS 2012 rate by 0.2 percent and is also lower the National Medicaid HEDIS 2012 50th percentile. This is the first year that **Meridian** is reporting this measure, and at 9.1 percent, its rate is the lowest rate of the three MCOs.

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 had multiple changes in 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. In 2013, the age range was again modified to 5–64 years of age. For both **FHN** and **Harmony**, the change had an impact of less than 1 percentage point on the rates for this measure; therefore, this measure was still trended. However, due to the changes, there were no available percentiles. As mentioned at the start of this section, **Meridian** had less than 30 eligible cases for this measure; therefore, its rate is not presented.

Figure 6.32—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma (Combined)*

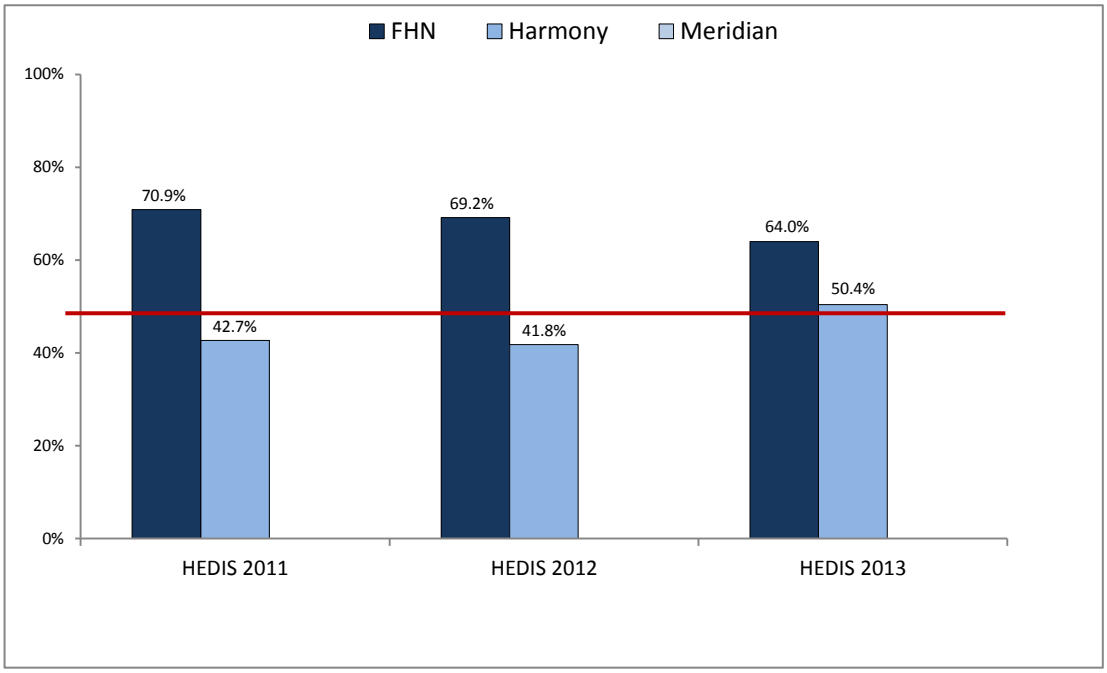


The rate for **FHN** fell 3.6 percentage points to 84.5 percent since HEDIS 2012, and has shown a slight decline in the rate each year. The rate for **Harmony** has increased 4.2 percentage points, with its 2013 rate at 84.1 percent.

Follow-up After Hospitalization for Mental Illness—7 Days

Figure 6.33 below presents the comparative rates for *Follow-up After Hospitalization for Mental Illness (7 Days)*.

Figure 6.33—Comparison of HFS MCO Performance for *Follow-up After Hospitalization for Mental Illness (7 Days)*

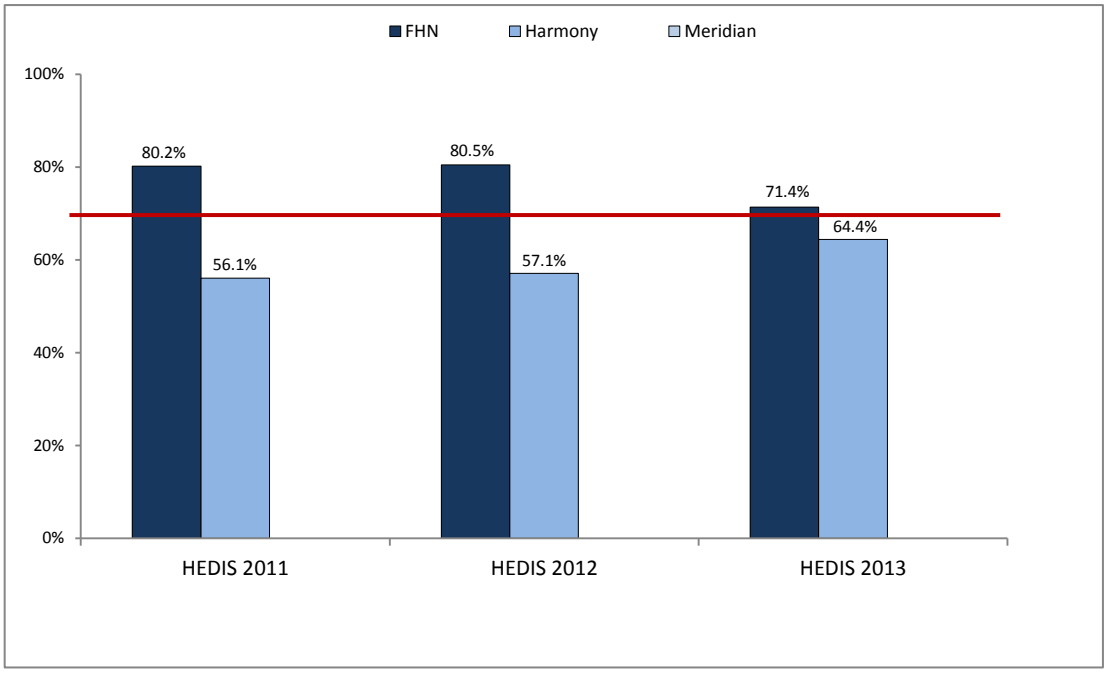


FHN's rate of 64.0 percent was well above the National Medicaid HEDIS 2012 50th percentile even though **FHN**'s performance has declined for HEDIS 2011 and 2012. **Harmony**'s rate improved 8.6 percentage points since HEDIS 2012, bringing it above the 50th percentile to 50.4 percent. **Meridian** had less than 30 eligible cases for this measure; therefore, the rate is not presented.

Follow-up After Hospitalization for Mental Illness—30 Days

Figure 6.34 below presents the comparative rates for *Follow-up After Hospitalization for Mental Illness (30 Days)*.

Figure 6.34—Comparison of HFS MCO Performance for *Follow-up After Hospitalization for Mental Illness (30 Days)*



For 30-day follow-up, **FHN**'s rate fell from 80.5 percent to 71.4 percent, but remained above the National Medicaid HEDIS 2012 50th percentile. This was the sixth consecutive year that **FHN** exceeded the 50th percentile. **Harmony**'s rate continued to improve, by 7.3 percentage points for 2013, to a rate of 64.4 percent. This rate is approximately 3.5 percentage points lower than the National Medicaid HEDIS 2012 50th percentile.

CHIPRA Results

This section addresses the CHIPRA measures reported by **FHN**, **Harmony**, and **Meridian**: *Annual Number of Asthma Patients Ages 2–20 with One or More Asthma-related ED Visits, Annual Pediatric A1c Testing,* and *Developmental Screening in First 3 Years of Life*. This was the first year the three MCOs reported these measures. The measures are not HEDIS measures and have no benchmarks for comparison. The CHIPRA measures listed in the table below were the measures validated by HSAG. The full set of CHIPRA measures can be found in Appendix C of this report.

Table 6.13—CHIPRA Measure Results

CHIPRA Measure	FHN Rate	Harmony Rate	Meridian Rate
Annual Number of Asthma Patients Ages 2–20 with One or More Asthma-related ED Visits*	15.25%	23.35%	9.15%
Annual Pediatric A1c Testing	25.81%	57.35%	NA
Developmental Screening in First 3 Years of Life—Year 1	25.00%	NR	70.91%
Developmental Screening in First 3 Years of Life—Year 2	39.58%	NR	65.37%
Developmental Screening in First 3 Years of Life—Year 3	38.89%	NR	69.42%
Developmental Screening in First 3 Years of Life—Total	34.49%	46.72%	68.07%
*Lower rates represent better performance for this measure			

All three MCOs reported rates below 25 percent for the *Annual Number of Asthma Patients Ages 2–20 with One or More Asthma-related ED Visits*. **Meridian** reported the lowest rate, at 9.15 percent.

For *Annual Pediatric A1c Testing*, **Harmony**'s rate of 57.35 percent was more than twice as high as **FHN**'s rate of 25.81 percent. **Meridian** had only nine cases; therefore, the result is reported as *NA*.

The overall rate for *Developmental Screening in First 3 Years of Life* ranged from 34.49 percent for **FHN** to 68.07 percent of **Meridian**. **Harmony** reported only the total rate and was assigned *NR* for the individual age groups.

Of all the MCOs, **Meridian** performed best on every measure, followed by **Harmony**. Although this was the first year for reporting these measures, none of the rates appeared to be representative of superior performance. HSAG recommends that the MCOs begin monitoring these measures and implement quality improvement initiatives, as needed.

Encounter Data Completeness

Table 6.14 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. Note that **Meridian** used only administrative data.

Table 6.14—Estimated Encounter Data Completeness for Hybrid Measures

HEDIS Measure	Percentage of Numerator Positive Cases Determined by Administrative Data								
	FHN			Meridian			Harmony		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Childhood Immunizations—Combo 2	10.4	6.4	59.4		100	100	76.0	78.3	72.0
Childhood Immunizations—Combo 3	10.5	6.0	49.5		100	100	74.7	69.6	67.9
Lead Screening in Children	75.7	77.1	80.1		100	100	28.3	96.3	92.3
Well-Child Visits in the First 15 Months (6+ Visits)	43.3	48.8	41.9		100	100	70.6	79.6	85.3
Well-Child Visits (3–6 Years)	73.3	84.8	68.6		100	100	91.2	92.5	96.7
Adolescent Well-Care Visits	67.4	83.8	65.0		100	100	86.3	91.8	93.7
Cervical Cancer Screening	57.7	80.4	73.9		100	100	91.3	95.9	95.6
Frequency of Ongoing Prenatal Care (81–100%)	31.7	52.2	35.3		100	100	82.9	82.1	81.6
Timeliness of Prenatal Care	26.7	34.1	55.9		100	100	49.6	54.5	90.2
Postpartum Care	25.3	28.2	67.3		100	100	75.0	67.6	88.7
Diabetes Care (HbA1c Testing)	10.3	8.5	42.8		100	100	78.7	92.8	93.7
Diabetes Care (Eye Exam)	39.7	62.8	83.3		100	100	45.3	90.3	70.5
Diabetes Care (LDL-C Screening)	8.7	12.5	57.0		100	100	77.5	90.2	90.0
Diabetes Care (Nephropathy Monitoring)	37.4	34.6	88.8		100	100	63.5	95.3	98.0

Note: The measures highlighted in blue are the seven hybrid incentive measures. Rates with more than 75% data completeness are highlighted in green; rates with less than 50% data completeness are highlighted in red.

No encounter data were more than 90.0 percent complete for **FHN**. Three measures had encounter data completeness rates greater than 80.0 percent, one additional measure had an encounter data completeness rate above 70 percent, and six measures had data completeness rates between 50.0 and 70.0 percent. The remaining four measures had data completeness rates below 50 percent. Although some encounter data completeness has improved, these results indicate that **FHN** continues to have difficulty obtaining complete encounter data for all measures. **FHN** is strongly encouraged to continue its efforts to improve encounter data submission.

Harmony's encounter data submission rates exceeded **FHN**'s rates for every measure except one. **Harmony** had eight measures with encounter data completeness levels of 90.0 percent or greater (compared to two measures for HEDIS 2011). No 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.

Integrated Care Plan Findings—SFY 2012–2013

Background

The Integrated Care Program (ICP) operates in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake, and Will counties. The State implemented the managed care delivery system under the State plan authority (Section 1932[a]), approved effective May 1, 2011. Select long-term care services, including several 1915 (c) Home and Community Based Services Waiver Programs (HCBS) waivers, are being added under Service Package II of the ICP.

The Illinois Department of Healthcare and Family Services (HFS) implemented the ICP program on May 1, 2011, for seniors and persons with disabilities (SPD), who are eligible for Medicaid but not eligible for Medicare. The ICP program was expanded to four additional regions of the State in 2013. This expansion aligns with the State's mission to comply with Public Act 96-1501, which requires 50 percent of Medicaid clients to be enrolled in a form of care coordination by January 2015.

Aetna and **IlliniCare** have participated in the Integrated Care Program since 2011. HFS worked collaboratively with HSAG and the ICP plans 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 ICP plans are a mix of HEDIS, HEDIS-like, and State-defined measures.

Calendar year 2010 was considered the initial baseline year, meaning that 2010 baseline data were used to set the baseline for 2012. In consultation with the ICP plans, HFS used the rates reported for members who were previously enrolled in the fee-for-service (FFS) 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 FFS program. This baseline rate was then used to calculate a Quality Improvement System for Managed Care (QISMC) goal for 2013. The method used the same numerator specifications for the measures, and then aggregated the available members who subsequently were enrolled in **Aetna** or **IlliniCare**. This provided aggregated baseline rates for 2012 for comparison to the rates reported by **Aetna** and **IlliniCare** 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. The ICP plans' 2013 baseline rates were used to calculate future QISMC target goals.

SFY 2013 is the second year of reporting the performance measures for **Aetna** and **IlliniCare**. Both plans were required to report on a set of 29 performance measures. An additional set of 22 bonus incentive measures (or pay-for-performance) were required for reporting.

ICP Findings

SFY 2013 was the first year for reporting for the ICP measures. HFS calculated the baselines for the ICP measures using FFS claims data. The utilization measures, with the exception of ED visits, are presented for information purposes but are not included when comparing the 2013 reported rates to the 2012 baseline rates.

The ICP 2013 rates for **Aetna** and **IlliniCare** are presented in Table 6.15 and Table 6.16 below. Table 6.15 displays the results for the 29 non-incentive measures. Rates highlighted in red indicate that performance declined from the baseline rate.

Table 6.15—ICP Rates for the Non-Incentive Measures

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2013 Rate	Change From Baseline	IlliniCare 2013 Rate	Change From Baseline
Access to Care Measures (Percentages)					
Annual Dental Visit	23.92%	23.15%	-0.77%	20.47%	-3.46%
Inpatient Hospital 30-Day Readmission Rate*	8.31%	7.91%	-0.40%	12.82%	4.51%
Inpatient Mental Hospital 30-Day Readmission Rate*	24.20%	23.34%	-0.86%	27.61%	3.41%
Preventive Care Measures (Percentages)					
Influenza Immunization	9.92%	13.08%	3.16%	10.72%	0.79%
Cervical Cancer Screening	40.81%	31.87%	-8.94%	37.55%	-3.26%
Appropriate Care Measures (Percentages)					
Annual Monitoring for Patients on Persistent Medications ACE Inhibitors or ARBs	86.00%	89.59%	3.59%	89.21%	3.21%
Annual Monitoring for Patients on Persistent Medications Digoxin	81.46%	94.04%	12.58%	91.61%	10.15%
Annual Monitoring for Patients on Persistent Medications Diuretics	86.60%	89.38%	2.79%	89.66%	3.06%
Annual Monitoring for Patients on Persistent Medications Anticonvulsants	74.49%	80.72%	6.23%	78.77%	4.29%
Annual Monitoring for Patients on Persistent Medications Total	84.12%	87.84%	3.71%	87.67%	3.54%
Comprehensive Diabetes Care—HbA1c Testing (DD Population Only)	79.05%	80.26%	1.21%	79.03%	-0.02%

Table 6.15—ICP Rates for the Non-Incentive Measures

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2013 Rate	Change From Baseline	IlliniCare 2013 Rate	Change From Baseline
Behavioral Health Measures (Percentages)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia**	NA	80.89%	NA	70.97%	NA
Behavioral Health Risk Assessment (BHRA) and Completed within 60 Days of Enrollment**	NA	24.89%	NA	27.70%	NA
Follow-up Completed within 30 Days of Positive BHRA **	NA	29.41%	NA	38.77%	NA
Initiation and Engagement of AOD Dependence Treatment 18+ years—Initiation of AOD treatment	45.71%	51.53%	5.82%	53.56%	7.85%
Initiation and Engagement of AOD Dependence Treatment 18+ years—Engagement of AOD Treatment	8.97%	6.12%	-2.85%	5.00%	-3.97%
Follow-Up After Hospitalization for Mental Illness, 7-Day follow-up	34.67%	25.93%	-8.74%	23.03%	-11.64%
Utilization Measures (Per 1,000 Member Months)					
Ambulatory Care—ED Visits Per 1,000 MM (DD Population Only)*	112.06	46.36	-65.70	NR	NR
Dental ED Visits Per 1,000 MM*	11.37	0.80	-10.57	0.73	-10.64
Inpatient Utilization (Per 1,000 Member Months)					
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient Discharges (Per 1,000 MM)	40.35	27.65	-12.71	27.32	-13.03
Inpatient Utilization—General Hospital/Acute Care: Total Medicine Discharges (Per 1,000 MM)	28.95	19.34	-9.61	19.29	-9.66
Inpatient Utilization—General Hospital/Acute Care: Total Surgery Discharges (Per 1,000 MM)	10.78	7.79	-3.00	7.61	-3.17
Inpatient Utilization—General Hospital/Acute Care: Total Maternity Discharges (Per 1,000 MM)	0.62	0.66	0.04	0.57	-0.06
Mental Health Utilization Inpatient and Outpatient (Percentages)					
Mental Health Utilization—Any Services Total	25.04%	22.92%	-2.11%	16.84%	-8.20%
Mental Health Utilization—Inpatient Total	6.11%	5.62%	-0.48%	4.20%	-1.91%
Mental Health Utilization—Intensive outpatient/partial Hospitalization Total	2.74%	0.24%	-2.50%	0.12%	-2.62%
Mental Health Utilization—Outpatient Total	23.32%	21.03%	-2.29%	15.19%	-8.12%
Long Term Care (Per 1,000 Member Months)					
Long Term Care Urinary Tract Infection Admission Rate*	2.17	0.42	-1.74	0.48	-1.69
Long Term Care Bacterial Pneumonia Admission Rate*	2.42	0.76	-1.66	0.83	-1.59

* Lower rates represent better performance for these measures.
**There were no baseline rates established for these measures. The rates for this reporting period will be used to establish baseline rates. Rates with fewer than 30 eligible cases are reported as NA.

Aetna's rates for four measures represented a decline from the baseline rates. Overall, 14 rates improved, with five rates improving by more than 5.0 percentage points. The rates for **IlliniCare** showed that five measures represented a decline from the baseline rates, although the rate for *Comprehensive Diabetes Care—HbA1c Testing (DD Population Only)* was only 0.02 percentage points lower than the baseline rate. One additional rate received an *NR* designation, as **IlliniCare** inadvertently did not calculate the measure for this reporting period. Overall, **IlliniCare** showed that 12 rates improved, with three rates improving by more than 5.0 percentage points.

Both plans performed similarly to each other for most rates. Including the utilization measures, *Cervical Cancer Screening, Follow-up Completed within 30 Days of Positive BHRA, Mental Health Utilization (Outpatient),* and *Mental Health Utilization (Any Services)* had rates that were more than 5.0 percentage points apart. The denominators for three measures had less than 30 eligible cases for both **Aetna** and **IlliniCare**; therefore, those rates were reported as *NA*.

ICP Pay-for-Performance Results

Table 6.16 displays the results for the 22 pay-for-performance measures. The target goals were established using the baseline rate, along with minimum expected improvement. In addition, to achieve an overall *Met* status, several of the performance measures were grouped together and had specific requirements for the group of rates. For example, congestive heart failure consisted of three measures, with a minimum requirement that two of the three rates achieve the target goal in order to achieve an overall result of met. One performance measure was reported as *NA* due to the enrollment criteria for the measure. Rates highlighted in red indicate that performance declined from the baseline rate.

Table 6.16—ICP Pay-for-Performance Results for 2013 Contracted Goals and Results

Measure	Baseline Rate	Target Goal	Aetna		IlliniCare	
			2013 Rate	Overall Result	2013 Rate	Overall Result
Follow-up After Hospitalization for Mental Illness, 30 day follow-up	55.42%	59.88%	44.03%	NOT MET	40.90%	NOT MET
Annual Dental Visit—DD Population	36.01%	42.41%	38.94%	NOT MET	28.12%	NOT MET
Ambulatory Care Follow- up with a Provider within 14 Days of Emergency Department Visit	40.25%	46.23%	40.92%	NOT MET	40.11%	NOT MET
Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge	46.85%	52.17%	54.10%	**MET**	50.96%	NOT MET
Antidepressant Medication Management Effective Acute Phase Treatment	52.05%	56.85%	55.44%	NOT MET	49.31%	NOT MET

Table 6.16—ICP Pay-for-Performance Results for 2013 Contracted Goals and Results

Measure	Baseline Rate	Target Goal	Aetna		IlliniCare	
			2013 Rate	Overall Result	2013 Rate	Overall Result
Antidepressant Medication Management Effective Continuation Phase Treatment	41.52%	47.37%	47.67%	**MET**	36.11%	NOT MET
Ambulatory Care—ED Visits per 1000 Member Months	178.23	160.41	76.93	**MET**	80.55	**MET**
Comprehensive Diabetes Care (CDC)	**The CDC measure requires a Met Target Goal for 2 of #1–3, and 1 of #4–5**					
1. HbA1c Testing	77.13%	79.42%	83.39%	NOT MET	79.69%	NOT MET
2. Nephropathy Monitoring	75.42%	77.88%	80.47%		82.78%	
3. LDL-C Screening	75.63%	78.07%	80.84%		75.50%	
4. Statin Therapy (80% of Eligible days)	40.85%	46.77%	41.21%		38.32%	
5. ACEI / ARB Therapy (80% of Eligible days)	38.38%	44.54%	40.40%		38.10%	
Congestive Heart Failure (CHF)	**The CHF measure requires a Met Target Goal for 2 of #1–3**					
1. ACEI/ARB Therapy 80% of the Time	32.40%	39.16%	44.61%	**MET**	36.48%	**MET**
2. Beta Blockers 80% of the Time	30.40%	37.36%	68.90%		78.70%	
3. Diuretics 80% of the Time	34.47%	41.02%	42.65%		42.86%	
Coronary Artery Disease (CAD)	**The CAD measure requires a Met Target Goal for 2 of #1–4**					
1. Cholesterol Testing	76.01%	78.41%	77.52%	NOT MET	74.72%	NOT MET
2. Statin Therapy 80% of the Time	42.74%	48.47%	45.75%		43.38%	
3. ACEI/ARB Therapy 80% of the Time	36.59%	42.93%	40.88%		37.69%	
4. Persistence of Beta-Blocker Treatment After a Heart Attack	35.00%	41.50%	86.00%		87.80%	
Pharmacotherapy Management of COPD Exacerbation (PCE)	**The PCE measure requires a Met Target Goal for 2 of #1–3**					
1. Systemic corticosteroid dispensed within of 14 days of the event	62.08%	65.87%	69.97%	**MET**	72.37%	**MET**
2. Bronchodilator dispensed within 30 days of the event	78.13%	80.32%	89.47%		90.79%	
3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*	29.67%	36.70%	NA*	NA	NA*	NA
* The SPR measure required two years of continuous enrollment for members; therefore, it was not applicable for 2013.						

This was the first year for reporting these pay-for-performance measures for **Aetna** and **IlliniCare**. Consequently, rates may be low due to the relative newness of the program, and members not fully using the services provided by the plans. However, both plans showed good improvement for a number of measures.

Overall, **Aetna** achieved a *Met* status for five measures, which included meeting the target goals for 12 of the individual rates. Nine rates did not meet the target goals. **IlliniCare** achieved a *Met* status for three measures, including eight individual rates; the other 13 rates did not meet the target goals. Both plans achieved a *Met* status for CHF and PCE, and showed good performance for reducing ambulatory care ED visits.

Aetna and **IlliniCare** both failed to meet the overall goals for CDC and CAD. In addition, neither plan met the target goals for *Follow-up After Hospitalization for Mental Illness, Annual Dental Visit, Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department Visit,* and *Antidepressant Medication Management Effective Acute Phase Treatment.*

Validation of Performance Improvement Projects

Objectives

As part of its quality assessment and performance improvement program, HFS requires each VMCO to conduct performance improvement projects (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 Balanced Budget Act of 1997 (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 implement PIPs was based on the Centers for Medicare & Medicaid Services (CMS) guidelines as outlined in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September

2012.[7-1] 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' 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. Select the Study Topic
- Activity II. Define the Study Question(s)
- Activity III. Select the Study Indicator(s)
- Activity IV. Use a Representative and Generalizable Study Population
- Activity V. Use Sound Sampling Techniques (if Sampling Was Used)
- Activity VI. Reliably Collect Data
- Activity VII. Analyze and Interpret Study Results
- Activity VIII. Implement Intervention and Improvement Strategies
- Activity IX. Assess for Real Improvement
- Activity X. Assess for Sustained Improvement

HSAG calculated the percentage score of evaluation elements met for each MCO and Integrated Care Plan (ICP plan) 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.

[7-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

Findings

Table 7.1 displays the overall validation results for each activity and each stage of the *EPSDT* [Early and Periodic Screening, Diagnosis, and Treatment] *Screening* PIP across all PIPs validated by HSAG.

Table 7.1—Validation Results Across All VMCOs for the *EPSDT Screening* PIP (N=3 PIPs)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic	100% 6/6	0% 0/6	0% 0/6
	II. Define the Study Question(s)	100% 3/3	0% 0/3	0% 0/3
	III. Select the Study Indicator(s)	100% 6/6	0% 0/6	0% 0/6
	IV. Use a Representative and Generalizable Study Population	100% 3/3	0% 0/3	0% 0/3
	V. Use Sound Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Reliable Collect Data	100% 15/15	0% 0/15	0% 0/15
Design Total		**100% 45/45**	**0% 0/45**	**0% 0/45**
Implementation	VII. Analyze Data and Interpret Study Results	100% 14/14	0% 0/14	0% 0/14
	VIII. Implement Intervention and Improvement Strategies	*Not Assessed*		
Implementation Total		**100% 14/14**	**0% 0/14**	**0% 0/14**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Overall PIP Results		**100% 59/59**	**0% 0/59**	**0% 0/59**

Table 7.2 displays the overall validation results for each activity and each stage of the *Perinatal Care and Depression Screening* PIP across all PIPs validated by HSAG.

Table 7.2—Validation Results Across All VMCOs for the *Perinatal Care and Depression Screening* PIP (N=3 PIPs)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic	100% 18/18	0% 0/18	0% 0/18
	II. Define the Study Question(s)	100% 6/6	0% 0/6	0% 0/6
	III. Select the Study Indicator(s)	100% 21/21	0% 0/21	0% 0/21
	IV. Use a Representative and Generalizable Study Population	100% 9/9	0% 0/9	0% 0/9
Design Total		**100% 54/54**	**0% 0/54**	**0% 0/54**
Implementation	V. Use Sound Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Reliably Collect Data	100% 33/33	0% 0/33	0% 0/33
	VII. Implement Intervention and Improvement Strategies	92% 11/12	8% 1/12	0% 0/12
Implementation Total		**98% 56/57**	**2% 1/57**	**0% 0/57**
Outcomes	VIII. Analyze Data and Interpret Study Results	88% 23/26	12% 3/26	0% 0/26
	IX. Assess for Real Improvement Achieved	25% 3/12	75% 9/12	0% 0/12
	X. Assess for Sustained Improvement Achieved	0% 0/3	100% 3/3	0% 0/3
Outcomes Total		**63% 26/41**	**37% 15/41**	**0% 0/41**
Overall PIP Results		**89% 136/152**	**11% 16/152**	**0% 0/152**

Table 7.3 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 7.3—Percent of All Elements *Met*

PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	100%	100%	100%
Perinatal Care and Depression Screening	87%	92%	89%

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 VMCOs in achieving real and sustained improvement across all study indicators for the *Perinatal Care and Depression Screening* PIP.

During SFY 2012–2013, HSAG conducted a validation and analysis of the *EPSDT Screening* and *Perinatal Care and Depression Screening* 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 EPSDT. This year's EPSDT PIP was redesigned to focus on improving performance related to well-child visits and developmental screenings. These visits help 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 well-child visits and developmental 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.

Table 7.4 provides a list of the *EPSDT Screening* PIP study indicators validated for FY 2012–2013.

Table 7.4—*EPSDT Screening* PIP Study Indicators

Indicator	Description of Indicator
1	The percentage of children who received six or more well-child visits in the first 15 months of life
2	The percentage of children who received zero well-child visits in the first 15 months of life
3	The percentage of children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday
4	The percentage of children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their first birthday and on or before their second birthday
5	The percentage of children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their second birthday and on or before their third birthday
6	The percentage of children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented in the 12 months preceding their first, second, or third birthday
7	The percentage of children 3–6 years of age who received one or more well-child visits during the measurement year

Results

With the redesign of the *EPSDT Screening* PIP, all three VMCOs reported baseline data. Indicator performance were evaluated in SFY 2014 when first remeasurement data are reported.

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 new *EPSDT Screening* PIP, two of the three VMCOs implemented interventions. Both **FHN** and **Meridian** identified member, provider, and system barriers, and similar barriers were identified for both plans. These barriers were lack of provider knowledge about EPSDT criteria and medical record review guidelines, the lack of standardized EPSDT documentation, and lack of member knowledge and compliance for EPSDT well-child visits. To address and overcome these barriers, the following interventions were implemented:

- Conducted EPSDT chart reviews on noncompliant providers.

- Provider representatives conducted one-on-one provider education about the EPSDT audit tool.
- Distributed EPSDT Tool Kits to all primary care providers.
- Provided online EPSDT resources to all primary care providers.
- Used alerts in the Managed Care System (MCS) to remind members of the need for regular developmental screenings.
- Implemented care coordination to assist members with scheduling appointments.
- Implemented a member incentive program.
- Held community outreach events.

The VMCOs continued to participate 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 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 healthcare and accessing their medical home for preventive healthcare, including well-child screening services. Barriers to accessing healthcare 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.

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 healthcare and accessing their medical home for preventive healthcare, including well-child screening services. Barriers to accessing healthcare 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.

Perinatal Care and Depression Screening PIP

Background

HFS identified improving birth outcomes as one of its healthcare 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. The secondary purpose of this PIP is 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 Treatment or 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 Treatment or 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 Treatment or Follow-up Within 30 Days for a Positive Depression Screen

Table 7.6—SFY 2012 Performance Improvement Project Outcomes

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	Unchanged*	
Family Health Network, Inc.	13	5	2	8	1	0	6
Harmony Health Plan of Illinois, Inc.	16	1	0	14	1	1	12
Meridian Health Plan, Inc.	16	5	2	5	4	6	7
Overall Totals	**45**	**11**	**4**	**27**	**6**	**7**	**25**

[1] The number of study indicators that demonstrated sustained improvement.
* The rates did not change between the prior measurement period and the current measurement period.

Results

Table 7.5 displays the outcomes for the *Perinatal Care and Depression Screening* study indicators for each VMCO.

Overall, for the most recent measurement period, **Harmony** demonstrated the best performance with 14 of its 16 study indicators (87.5 percent) achieving improvement; and for one of those indicators, the improvement was statistically significant (women who were screened for depression within 56 days after delivery). Rates ranged from 15 percent for frequency of ongoing prenatal care < 21 percent to 64.7 percent for members receiving timely prenatal care.

Eight of **FHN**'s 13 reported study indicators demonstrated improvement, with one indicator's improvement being statistically significant (timeliness of prenatal care). Five study indicators showed declines in performance, and two of these declines were statistically significant during the most recent measurement period. Although **FHN**'s performance was not optimal, more than half of the 13 indicators demonstrated improvement, and six of these indicators sustained the improvement over comparable time periods. The lowest reported rate was 1.9 percent for women who had a referral within 30 days of a positive depression screening, and the highest reported rate was 69.7 percent for timeliness of prenatal care.

Meridian progressed to reporting Remeasurement 2 data with mixed results. Of its 16 study indicators, only five indicators improved; however, four of these indicators' improvement was statistically significant. Five study indicators demonstrated declines in performance, with two of the declines statistically significant (women who were screened for depression during the pregnancy and prior to delivery or within 56 days after delivery, and women screened for depression within 56 days after delivery). Rates for six study indicators were unchanged between Remeasurement 1 and Remeasurement 2. Rates ranged from 63.2 percent for women who were screened for depression during the pregnancy and prior to delivery or within 56 days after delivery, to 100 percent for women who had a referral, follow-up, and treatment within 7, 14, and 30 days of a positive depression screening.

With the progression of this PIP, 60 percent of all study indicators across all three VMCOs achieved improvement, and 93 percent of the indicators have sustained the improvement over baseline without a statistically significant decline.

Barriers/Interventions

Based on the barriers identified and discussed for the *Perinatal Care and Depression Screening* PIP, **FHN** continued most of its ongoing interventions, as well as implemented some new strategies such as the Text4Baby Program. Through this program, mothers receive information pertinent to the gestational age and for the age of the baby up to 1 year. **FHN** also implemented routine reviews of emergency room (ER) claims to identify women who were diagnosed in the ER as being pregnant. These women were referred to the prenatal case manager. **FHN** also implemented a new provider incentive program designed to pay providers $25 for notifying **FHN** of female members who were diagnosed as pregnant. The payments are sent out quarterly to providers. **FHN** is currently tracking the success of this program.

Harmony documented that lack of member knowledge regarding prenatal care and screenings and poor member contact rates continue to be barriers that need to be addressed. To address these identified barriers, **Harmony** continues to have its member services staff update member contact information each time contact is made with a member. Hospital discharge follow-up telephone calls are made to members to assist with scheduling the postpartum visit and arrange transportation, if needed. **Harmony** also continues its "Harmony Hugs" program. The program provides all members with a packet that includes a booklet containing articles about prenatal care, postpartum care, and depression screening.

The VMCO also identified that the Independent Physicians Association's (IPA's) and providers' lack of knowledge continues to be a barrier. To overcome this barrier, **Harmony**'s executive staff members conduct one-on-one education with the IPAs. During these educational meetings, the IPAs are educated on IPA and physician report cards, member noncompliant lists, how to use

correct billing codes, the importance of submitting encounters, the importance of screening members for depression, and how to document these screenings in the medical record.

To address its identified system-based barriers, **Meridian** automated the encounter data file provided by the State of Illinois to capture the maximum amount of pregnant members so that outreach and coordination of care services could be conducted. Weekly reporting of prenatal claims based on HEDIS specifications was also implemented to identify existing pregnant women enrolled with the health plan and execute outreach to members to assist in the management of their care. **Meridian** hired a behavioral health professional and a licensed clinical professional counselor to conduct the high-risk prenatal and depression screenings. To overcome some of the member-based barriers, **Meridian** developed additional educational materials and incentive programs to meet its members' needs, including Spanish versions of all existing prenatal/postpartum information, and raffles to promote timely prenatal and postpartum care. Lastly, **Meridian** established a Maternity Care Coordination Program through which prenatal and postpartum members are contacted by a representative and provided coordinated care during their perinatal period.

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 ICP plan 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 ICP plans with assistance from HSAG developed the study question, indicators, and data sources. The PIP focused on the 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 Community Based Care Coordination PIP had three study indicators that are outlined in Table 7.7.

Table 7.7—Community Based Care Coordination PIP Study Indicators

Indicator	Description of Indicator
1	The percentage of high to moderate risk members who do not have a readmission within 30 days of an acute care hospitalization.
2	The percentage 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	The percentage of high to moderate risk members accessing community resources within 14 days of discharge.

Table 7.8 displays the validation results for each activity and each stage of the *Community Based Care Coordination* PIP for both ICP plans. Both ICP plans did not progress to the point of reporting data during this validation period; therefore, only Activities I through VI were validated.

Table 7.8—PIP Validation Results Across All ICP PIPs (N=2)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic	100% 4/4	0% 0/4	0% 0/4
	II. Define the Study Question(s)	100% 2/2	0% 0/2	0% 0/2
	III. Select the Study Indicator(s)	100% 6/6	0% 0/6	0% 0/6
	IV. Use a Representative and Generalizable Study Population	100% 2/2	0% 0/2	0% 0/2
	V. Use Sound Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Reliably Collect Data	100% 11/11	0% 0/11	0% 0/11
Design Total		**100% 37/37**	**0% 0/37**	**0% 0/37**
Implementation	VII. Analyze Data and Interpret Study Results	100% 10/10	0% 0/10	0% 0/10
	VIII. Implement Intervention and Improvement Strategies	*Not Assessed*		
Implementation Total		**100% 10/10**	**0% 0/10**	**0% 0/10**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Overall PIP Results		**100% 47/47**	**0% 0/47**	**0% 0/47**

Table 7.9 displays the overall validation percentage for each individual ICP plan.

Table 7.9—PIP Validation Results Across All ICP PIPs (N=2)

PIP Topics	Aetna	IlliniCare
Community Based Care Coordination	100%	100%

The validation scores for **Aetna** and **IlliniCare** demonstrate that both plans developed methodologically sound PIP foundations that were designed to appropriately measure outcomes and improvement. The ICP plan's study indicator performance were evaluated in SFY 2014 when first remeasurement data are reported.

Overall Recommendations for VMCOs and ICP Plans

- Conduct causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science such as Plan-Do-Study-Act (PDSA) cycles into their improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the PIP documentation.
- Have a process for identifying high-priority barriers or ranking barriers in order of priority. The prioritization process and results should be documented in the PIP Summary Form.
- Identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the PIP Summary Form.
- Target interventions at high-priority barriers, rather than trying to address every identified priority with limited resources.
- Ensure that each intervention is directly linked to an identified barrier and to the study indicators. All interventions should directly impact the study indicator.
- Evaluate the efficacy of each intervention to determine if it is being successfully implemented and achieving the desired goal. The results of each intervention's evaluation for each remeasurement period should be included in the PIP.
- Design small-scale tests coupled with analysis of results to determine the success of the intervention. If the small-scale test results suggest that the intervention has been unsuccessful, the VMCO/ICP plan should determine: (1) if the true root cause was identified—if not, the VMCO/ICP plan should conduct another causal/barrier analysis to isolate the true root cause or issue that is impacting improvement; and (2) if the interventions need to be revised because a new root cause was identified or the intervention was unsuccessful.
- Synthesize the results of intervention-specific evaluations with regular causal/barrier analyses to develop a complete picture of each PIP's progress toward improvement goals. If evaluation results suggest that individual interventions are successful but the study indicator rate(s) did not improve, the VMCO/ICP plan should incorporate this information into further drill-down analyses to identify the true root causes of the lack of improvement.

Objectives

The CAHPS®[8-1] surveys ask members to report on and evaluate their experiences with healthcare. 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 MCOs (VMCOs), and **Aetna** and **IlliniCare** included under Integrated Care Plans (ICPs).

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 healthcare 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 healthcare 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 MCOs (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**.

[8-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Survey to the adult population and the CAHPS 5.0H 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 5.0H Adult Medicaid Survey to the adult population. **Aetna** and **IlliniCare** 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. **IlliniCare** did not indicate if it offered surveys in 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 2013 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." 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, **Harmony**'s, **Aetna**'s, and **IlliniCare**'s plan-specific findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points from 2012 to 2013. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points from 2012 to 2013. 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 2013 NCQA CAHPS top-box average.[8-2]

It is important to note that the CAHPS 5.0 Medicaid Health Plan Surveys were released by AHRQ in 2012. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the adult and child CAHPS Health Plan Surveys in August 2012. The following is a summary of the changes resulting from the transition to the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys.

With the transition from the CAHPS 4.0 to 5.0 Surveys, no changes were made to the four CAHPS global ratings: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. The question language, response options, and placement of the global ratings remained the same; therefore, comparisons to national data and prior year's rates were performed for all four global ratings.

For three of the five composite measures (*Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), minor to no changes were made to the question language; therefore, comparisons to national data and prior year's rates were performed for these composite measures. For the *Getting Needed Care* composite measure, changes were made to the question language and placement of questions included in the composite. While comparisons to national data and prior year's rates were performed for this composite measure, the changes to the question language and reordering of questions may impact survey results; therefore, caution should be exercised when interpreting the results of the *Getting Needed Care* composite measure. For the *Shared Decision Making* composite measure, changes were made to the question language, response options, and number of questions. All items in the composite measure were reworded to ask about "starting or stopping a prescription medicine," whereas previously the items asked about "choices for your treatment of health care." Response options for these questions were revised to accommodate the new question language. Also, one question was added to the composite. Due to these changes,

[8-2] Quality Compass® 2013 data serve as the source for the NCQA national averages contained in this publication and are used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2013 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

comparisons to national data and prior year's rates could not be performed for the *Shared Decision Making* composite measure.

Measures that could not be compared to the prior year's rates or NCQA CAHPS national averages are denoted as Not Comparable (NC).

Program-Specific Findings

VMCOs

Family Health Network

Adult Medicaid

The Myers Group collected 395 valid surveys from the eligible **FHN** adult Medicaid population from January through May 2013, yielding a response rate of 18.7 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2012 and 2013 adult Medicaid CAHPS top-box percentages are presented in Table 8.1.

Table 8.1—FHN Adult Medicaid CAHPS Results

	2012 Top-Box Percentages	2013 Top-Box Percentages
Composite Measures		
Getting Needed Care	63.8%*	78.0%
Getting Care Quickly	80.6%*	74.8%
How Well Doctors Communicate	89.6%	90.0%
Customer Service	75.6%*	89.8%*
Shared Decision Making	NC	50.7%*
Global Ratings		
Rating of All Health Care	44.5%	48.3%
Rating of Personal Doctor	64.1%	58.6%
Rating of Specialist Seen Most Often	48.0%*	60.4%*
Rating of Health Plan	54.3%	47.8%

* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC indicates that comparisons could not be performed for this measure.
Indicates the 2013 top-box rate is substantially above the 2013 NCQA CAHPS national average.
Indicates the 2013 top-box rate is substantially below the 2013 NCQA CAHPS national average.

A comparison of **FHN**'s 2012 results to its 2013 results revealed that **FHN**'s rates increased for five measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health*

Care, and *Rating of Specialist Seen Most Often*. The rate increases were substantial for *Getting Needed Care*, *Customer Service*, and *Rating of Specialist Seen Most Often*. However, a comparison of **FHN**'s 2012 to its 2013 results revealed that **FHN**'s rates decreased for three measures: *Getting Care Quickly*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The decrease in rates was substantial for all three of these measures. **FHN** scored more than 5 percentage points below the 2013 NCQA CAHPS top-box national average on two measures: *Getting Care Quickly* and *Rating of Health Plan*.

Child Medicaid

The Myers Group collected 515 valid surveys from the eligible **FHN** child Medicaid population from January through May 2013, yielding a response rate of 19.8 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2012 and 2013 child Medicaid CAHPS top-box percentages are presented in Table 8.2.

Table 8.2—FHN Child Medicaid CAHPS Results

	2012 Top-Box Percentages	2013 Top-Box Percentages
Composite Measures		
Getting Needed Care	61.8%*	73.8%
Getting Care Quickly	82.4%	77.8%
How Well Doctors Communicate	85.9%	88.7%
Customer Service	74.0%*	85.1%
Shared Decision Making	NC	55.9%*
Global Ratings		
Rating of All Health Care	53.3%	55.8%
Rating of Personal Doctor	63.4%	70.9%
Rating of Specialist Seen Most Often	50.0%*	58.1%*
Rating of Health Plan	56.8%	57.3%

* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC indicates that comparisons could not be performed for this measure.
Indicates the 2013 top-box rate is substantially above the 2013 NCQA CAHPS national average.
Indicates the 2013 top-box rate is substantially below the 2013 NCQA CAHPS national average.

A comparison of **FHN**'s 2012 results to its 2013 results revealed that **FHN**'s rates increased for seven measures: *Getting Needed Care*, *How Well Doctor's Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. The increases were substantial for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* One measure decreased from 2012—*Getting Care Quickly*. In comparison to NCQA national averages, **FHN** scored substantially below the 2013

NCQA CAHPS top-box national average on five measures, including *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Harmony Health Plan

Adult Medicaid

The Myers Group collected 487 valid surveys from the eligible **Harmony** adult Medicaid population from January through May 2013, yielding a response rate of 18.2 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2012 and 2013 adult Medicaid CAHPS top-box percentages are presented in Table 8.3.

Table 8.3—Harmony Adult Medicaid CAHPS Results

	2012 Top-Box Percentages	2013 Top-Box Percentages
Composite Measures		
Getting Needed Care	62.7%	71.3%
Getting Care Quickly	77.9%	73.8%
How Well Doctors Communicate	90.1%	87.2%
Customer Service	74.3%*	83.5%
Shared Decision Making	NC	54.0%
Global Ratings		
Rating of All Health Care	44.0%	43.1%
Rating of Personal Doctor	64.0%	51.3%
Rating of Specialist Seen Most Often	53.8%*	52.0%*
Rating of Health Plan	45.2%	37.2%

* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC indicates that comparisons could not be performed for this measure.
Indicates the 2013 top-box rate is substantially above the 2013 NCQA CAHPS national average.
Indicates the 2013 top-box rate is substantially below the 2013 NCQA CAHPS national average.

A comparison of **Harmony**'s 2012 results to its 2013 results showed an increase in rates for only two measures: *Getting Needed Care* and *Customer Service*. Both of these measures displayed a substantial increase. Six measures showed a decrease in rates from 2012 to 2013: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Two measures, *Rating of Personal Doctor* and *Rating of Health Plan*, showed a substantial decrease from 2012 to 2013. **Harmony** scored substantially below the 2013 NCQA CAHPS top-box national averages on six measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Child Medicaid

The Myers Group collected 441 valid surveys from the eligible **Harmony** child Medicaid population from January through May 2013, yielding a response rate of 15.0 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2012 and 2013 child Medicaid CAHPS top-box percentages are presented in Table 8.4.

Table 8.4—Harmony Child Medicaid CAHPS Results

	2012 Top-Box Percentages	2013 Top-Box Percentages
Composite Measures		
Getting Needed Care	63.8%*	73.6%
Getting Care Quickly	73.6%	79.5%
How Well Doctors Communicate	87.7%	89.4%
Customer Service	77.9%*	86.5%
Shared Decision Making	NC	54.7%*
Global Ratings		
Rating of All Health Care	49.2%	55.8%
Rating of Personal Doctor	61.3%	69.7%
Rating of Specialist Seen Most Often	60.9%*	70.7%*
Rating of Health Plan	48.2%	43.6%

* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC indicates that comparisons could not be performed for this measure.
Indicates the 2013 top-box rate is substantially above the 2013 NCQA CAHPS national average.
Indicates the 2013 top-box rate is substantially below the 2013 NCQA CAHPS national average.

A comparison of **Harmony**'s 2012 results to its 2013 results showed an increase in rates for seven measures: *Getting Needed Care, Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. All of these measures except *How Well Doctors Communicate* displayed a substantial increase. **Harmony**'s rate decreased from 2012 to 2013 for one measure, *Rating of Health Plan*, with this rate showing a substantial decrease. **Harmony** scored substantially below the 2013 NCQA CAHPS top-box national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*.

Plan Comparisons

Due to its small size, **Meridian** was allowed to conduct its own survey. Because of 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 2013 adult Medicaid CAHPS results for **FHN** and **Harmony**.

Table 8.5—2013 Adult Medicaid CAHPS Results

	FHN	Harmony
Composite Measures		
Getting Needed Care	78.0%	71.3%
Getting Care Quickly	74.8%	73.8%
How Well Doctors Communicate	90.0%	87.2%
Customer Service	89.8%*	83.5%
Shared Decision Making	50.7%*	54.0%
Global Ratings		
Rating of All Health Care	48.3%	43.1%
Rating of Personal Doctor	58.6%	51.3%
Rating of Specialist Seen Most Often	60.4%*	52.0%*
Rating of Health Plan	47.8%	37.2%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

A comparison of the health plans' results to one another showed that **FHN** outperformed **Harmony** on eight of the nine measures. For *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*, **FHN** scored substantially higher than **Harmony**. For 2013, **Harmony** only showed higher rates for one measure, *Shared Decision Making*.

Child Medicaid

Table 8.6 presents the 2013 child Medicaid CAHPS results for **FHN** and **Harmony**.

Table 8.6—2013 Child Medicaid CAHPS Results

	FHN	Harmony
Composite Measures		
Getting Needed Care	73.8%	73.6%
Getting Care Quickly	77.8%	79.5%
How Well Doctors Communicate	88.7%	89.4%
Customer Service	85.1%	86.5%
Shared Decision Making	55.9%*	54.7%*
Global Ratings		
Rating of All Health Care	55.8%	55.8%
Rating of Personal Doctor	70.9%	69.7%
Rating of Specialist Seen Most Often	58.1%*	70.7%*
Rating of Health Plan	57.3%	43.6%
* Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

A comparison of **FHN**'s and **Harmony**'s results to one another show that **Harmony** outperformed **FHN** on four of the CAHPS measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Specialist Seen Most Often*. **FHN** scored substantially higher than **Harmony** on *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 3,664 adult and child members combined from the eligible population. At the time the sample was selected, the eligible population criteria were 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.

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 5.0H 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 2012 and 2013 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	2012 Results	2013 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 its 2012 or 2013 Member Satisfaction Survey summary report.		

A comparison of **Meridian**'s 2012 results to its 2013 results reveal that **Meridian** improved on seven of the 13 reportable measures. These measures include:

- *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 2012 to 87.7 percent in 2013.

Meridian showed a decrease in rates from 2012 to 2013 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 2012 to 54.9 percent in 2013 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 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 2013 **Meridian** report.

ICPs

Aetna Better Health

Adult Medicaid

CSS collected 468 valid surveys from the eligible **Aetna** adult Medicaid population from February through May 2013, yielding a response rate of 37.4 percent. The overall NCQA target number of valid surveys is 411. It is important to note that 2013 represents the second year **Aetna** participated in the CAHPS surveys. Because the first-year baseline measurement occurred after launch of a new program, the 2012 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 and 2013 Adult Medicaid CAHPS top-box percentages are presented in Table 8.8.

Table 8.8—Aetna Adult Medicaid CAHPS Results

	2012 Top-Box Percentages	2013 Top Box Percentages
Composite Measures		
Getting Needed Care	63.2%	75.6%
Getting Care Quickly	71.2%	76.8%
How Well Doctors Communicate	85.0%	89.7%
Customer Service	78.0%	80.2%
Shared Decision Making	NC	48.2%
Global Ratings		
Rating of All Health Care	40.8%†	46.4%
Rating of Personal Doctor	55.5%†	57.1%
Rating of Specialist Seen Most Often	59.8%†	63.1%
Rating of Health Plan	41.4%†	42.1%

† For the global ratings, **Aetna**'s rates were calculated based on the Appendix Cross Tabulation of Survey Results.
NC indicates that comparisons could not be performed for this measure.
Indicates the 2013 top-box rate is substantially above the 2013 NCQA CAHPS national average.
Indicates the 2013 top-box rate is substantially below the 2013 NCQA CAHPS national average.

From 2012 to 2013, **Aetna** showed increases in eight of the nine measures, including *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.* Three measures displayed a substantial increase: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of All Health Care.* **Aetna** scored more than 5 percentage points below the 2013 NCQA CAHPS top-box

national average for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

IlliniCare Health Plan

Adult Medicaid

The Myers Group collected 562 valid surveys from the eligible **IlliniCare** adult Medicaid population from January through May 2013, yielding a response rate of 32.5 percent. The overall NCQA target number of valid surveys is 411. It is important to note that 2012 represented the first year **IlliniCare** participated in the CAHPS surveys. **IlliniCare**'s 2012 and 2013 Adult Medicaid CAHPS top-box percentages are presented in Table 8.9.

Table 8.9—IlliniCare Adult Medicaid CAHPS Results

	2012 Top-Box Percentages	2013 Top Box Percentages
Composite Measures		
Getting Needed Care	66.2%	76.3%
Getting Care Quickly	79.2%	80.7%
How Well Doctors Communicate	89.8%	90.2%
Customer Service	83.8%	84.3%
Shared Decision Making	NC	49.5%
Global Ratings		
Rating of All Health Care	47.5%	48.3%
Rating of Personal Doctor	65.1%	62.3%
Rating of Specialist Seen Most Often	56.5%	61.4%
Rating of Health Plan	45.4%	46.1%

NC indicates that comparisons could not be performed for this measure.
Indicates the 2013 top-box rate is substantially above the 2013 NCQA CAHPS national average.
Indicates the 2013 top-box rate is substantially below the 2013 NCQA CAHPS national average.

Seven out of nine measures for **IlliniCare** showed an increase in rates from 2012 to 2013: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* One measure showed a substantial increase—*Getting Needed Care.* One measure showed a decline—*Rating of Personal Doctor.* **IlliniCare** scored more than 5 percentage points below the 2012 NCQA CAHPS top-box average on one measure, *Rating of Health Plan.*

Plan Comparisons

Adult Medicaid

Table 8.10 presents the 2013 adult Medicaid CAHPS results for **Aetna** and **IlliniCare**.

Table 8.10—2013 Adult Medicaid CAHPS Results

	Aetna	IlliniCare
Composite Measures		
Getting Needed Care	75.6%	76.3%
Getting Care Quickly	76.8%	80.7%
How Well Doctors Communicate	89.7%	90.2%
Customer Service	80.2%	84.3%
Shared Decision Making	48.2%	49.5%
Global Ratings		
Rating of All Health Care	46.4%	48.3%
Rating of Personal Doctor	57.1%	62.3%
Rating of Specialist Seen Most Often	63.1%	61.4%
Rating of Health Plan	42.1%	46.1%

Aetna scored higher than **IlliniCare** in only one area, *Rating of Specialist Seen Most Often*. **IlliniCare** scored higher than **Aetna** for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **IlliniCare** scored substantially higher than **Aetna** for *Rating of Personal Doctor*.

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—VMCOs

Family Health Network

Based on **FHN**'s 2013 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 decreased from 2012 to 2013.

For the adult Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

For the child Medicaid population, **FHN** should focus on improving performance in the area of *Getting Care Quickly*.

Harmony Health Plan

Based on **Harmony**'s 2013 adult and child Medicaid CAHPS results, **Harmony** should focus on those areas where rates were both below CAHPS national averages and decreased from 2012 to 2013.

For the adult Medicaid population, **Harmony** decreased substantially for *Rating of Personal Doctor* 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 on improving performance in the area of *Rating of Health Plan*.

Meridian Member Satisfaction Survey

Meridian Health Plan

A comparison of **Meridian**'s 2012 results to 2013 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 2012 to 2013. For **Meridian**, rates fell in the area of office wait time from 2012 to 2013; approximately half of respondents reported having waited more than 30 minutes to see their doctor. From 2012 to 2013, rates slightly decreased in the areas of patients reporting that their doctor listened and explained things in an understandable way, and office staff was courteous and helpful. A decrease in the percentage of patients reporting that it was always or usually easy to get care, tests, or treatment, or behavioral health care or substance abuse services through their health plan was noted from 2012 to 2013; however, **Meridian**'s 2013 rates for these measures remained above 90 percent. 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 2013 rates for the customer service measure.

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. For **Aetna** and **IlliniCare**, 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.

CAHPS Survey—ICPs

Aetna Better Health

For the adult Medicaid population, **Aetna** should focus on the measures which showed the least improvement from 2012 to 2013: *Getting Needed Care, Rating of Personal Doctor* and *Rating of Health Plan.*

IlliniCare

For the adult Medicaid population, **IlliniCare** showed a decrease in rate for *Rating of Personal Doctor.* **IlliniCare** should focus on improving the rate for this 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 the two health plans. Each health plan should evaluate these general recommendations in the context of its own operational and quality improvement (QI) activities.

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.

Shared Decision Making

- Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their healthcare. 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' healthcare experience, health plans should identify and eliminate patient challenges when receiving healthcare. 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 healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare 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 healthcare 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 healthcare "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 healthcare 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 who 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.

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 medications they can recommend to help patients stop smoking. **Meridian** also could explore the option of creating similar smoking cessation educational materials for members.

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.

Getting Needed Care

- Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate healthcare providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate healthcare providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive timely care.
- Health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist health plans in promoting patient health awareness and preventive healthcare efforts.

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 healthcare "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 healthcare 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 2011–2012 are compiled by MCO, and by categories of care and activities in the tables below. Each recommendation is followed by the health plan's response in SFY 2012–2013 (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 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. However, **FHN** continued the following interventions to improve EPSDT rates:

FHN Response:

- 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.
- Continued to emphasize importance of well-child care in the member newsletter.
- Continued to remind members that transportation to and from well-child care is a covered benefit.
- Continued with semiannual reminder letters to case holders identifying missing services for their children.
- Continued provider education about coding, using standardized forms, appropriate completion of standardized forms, importance of submission encounter/claims data, appropriate content of well-child visits, and periodicity schedule.
- Continued quarterly submissions to medical groups of children with incomplete preventive services based on claims/encounter data.
- Continued collaborative outreach with Project LAUNCH.

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. The MCOs and the State should also consider a PIP around these measures.

FHN Response:

- Continued member education via member handbook and member newsletter articles.
- Continued with semiannual notification to members of missing preventive services.
- Continued with quarterly notification of members missing services to medical groups.

Maternity-Related Care

Previous Recommendations: FHN continues to report rates well below the HEDIS Medicaid 25th percentile for maternity-related measures. In response to these low rates, the State and the VMCOs began a collaborative perinatal depression screening PIP in 2007. As a result, In SFY 2012–2013, **FHN** reported improved rates for *Frequency of Ongoing Prenatal Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*. **FHN** should begin evaluating the effectiveness of its interventions for these PIPs, which may lead to improvement in its HEDIS rates.

FHN Response:

- Brighter Beginnings program for pregnant members and their babies continued. The incentive for keeping prenatal appointments will remain a $10 Target gift card. A diaper bag with sample sizes of several baby products and educational materials is given to each member who delivers at her in-network hospital and misses no more than one prenatal visit.
- Enhanced the postpartum incentive of the Brighter Beginnings Program to $25, and continued providing the Baby Photo Album for keeping the postpartum visit within the HEDIS time frame (21 to 56 days after delivery) and for completing an Edinburgh Postnatal Depression Screening (EPDS) tool.
- **FHN** hired, March 2013, a second Brighter Beginnings care manager who has been aggressive in contacting members. However, with the increase in overall enrollment, the number of pregnant members has also increased, so a third maternity care manager position has been approved.
- Continued with free pregnancy tests to members on request.
- Increased visits to obstetric care providers to educate on the Brighter Beginnings program.
- Continued with provider incentive of $25 for initial notification of pregnant members. **FHN** will increase marketing of this incentive through the provider newsletter, QA meetings, and provider visits.
- Continued partnership with the CMS program "text4baby." The program sends text messages three times a week to pregnant women. **FHN** is unable to determine the number of members using this service; however, anecdotally, members comment that the text messages are useful and informational.
- Established program with hospitals and medical groups to identify women who go to the ED with a diagnosis of pregnancy. Initiated efforts to contact the women immediately to initiate prenatal care.

Preventive Screening for Women

Previous Recommendation: The rates for **FHN** for measures in the Preventive Screening for Women category improved over 2011–2012, but they remained fairly low. The measures examine whether female members are screened for breast and cervical cancer and chlamydia.

FHN Response:

- Continued mammography incentive. **FHN**'s mammography incentive of a $25 gift card from Payless ShoeSource 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 statistically significant increase in the HEDIS breast cancer screening measure over the years, though the 2013 rate of 49 percent remains below the 50th percentile. In 2012, 2445 letters were mailed to all women over age 40, and 170 gift cards were mailed (7 percent).

Chronic Conditions/Disease Management

Previous Recommendation: FHN had three measures with rates that exceeded the 2011 HEDIS Medicaid 50th percentiles in the Chronic Conditions/Disease Management category. However, 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** continued to struggle to improve its rates for the *Comprehensive Diabetes Care—Eye Exam* measure. **FHN** has shown significant improvement in this measure; however, needs to conduct an analysis to determine the reason the rate continues to be so low. The MCOs and the State should also consider a PIP around this measure.

FHN Response:

- Continued to educate providers on case/disease management program in general via provider newsletter and on-site office visits.
- Continued to educate providers one-on-one about case/disease management as members are enrolled in the program.
- Developed reports with all data elements as required for internal and external submission.
- Developed tool and time frame for assessing member satisfaction with case/disease management program.
- Developed new partnerships with Centers of Excellence in the areas of prevention and management of chronic diseases.
- Provided care management staff with educational information on health literacy and motivational interviewing/coaching.

Chronic Conditions/Disease Management
◆ Completed the installation and implementation of McKesson VITAL Platform and Disease Monitor. ◆ Continued comprehensive case/disease management for asthmatic and diabetic members. Case management is also in place for members with obesity and hypertension and children with special healthcare needs. ◆ Continued diabetes care management. Identified members are contacted, assessed, risk stratified, and enrolled into the program. Educational material is sent to all. A diabetes action 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 identified and established; and both members and PCPs receive copies. 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. ◆ Continued diabetes member incentive. All diabetic members in case management are mailed details on the incentive and a monthly reminder about follow-up care. The member is awarded a $50 gift card for submitting proof of annual PCP visit and all required screenings for effective management of diabetes. ◆ In March 2013, **FHN** invited members with the diagnosis of diabetes to participate in a focus group to assess the educational needs of members with this disease. **FHN** will use this information to enhance its health education program and to provide additional support and services to this targeted population, including various providers and resources to address gaps in care and member knowledge. ◆ In addition, in April 2013 **FHN** provided transportation and guided members with diabetes through the ADA-sponsored Diabetes Expo at McCormick Place. This free annual event included health screenings, cooking demonstrations, product and service exhibitors, and lectures about diabetes management and prevention.

Behavioral Health
Previous Recommendation: 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. **FHN Response:** **FHN**'s behavioral health vendor, PsycHealth, worked with **FHN** to continue and/or implement the

Behavioral Health
following QI initiatives: ◆ The continuation of the Close the Loop process sent out letters to individuals who requested information regarding in-network providers for possible request for referral. Letters are sent out every two weeks and within one month of contact with PsycHealth regarding possible referral. ◆ The Readmission Outreach Project continued. This program is based on (1) the observations of cyclical stresses and rehospitalizations of members during certain seasons, time frames, or annually, and (2) research that once a member is hospitalized the likelihood and risk of rehospitalization is significantly higher than for a member who has never had a psychiatric inpatient admission. PsycHealth targeted those members hospitalized in the past year for both outreach and calls to contact to review triggers or warning symptoms, services offered, and methods for reaching PsycHealth in case of an emergency. ◆ 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. Thirty-one total new ICM cases were identified and invited to enroll in the program in 2012. Of these cases, 28 did not respond, refused to enroll, or switched/terminated their benefits. Fifteen of these cases were enrolled in Virtual Helping Hands. ◆ To address the low number of members accepting ICM invitation, Virtual Helping Hands (VHH) was developed for implementation in 2012 to promote follow-up and engagement in treatment. In 2012–2013, there were 120 members identified who failed post-inpatient appointments or refused ICM and failed to engage in follow-up care coordination communications with the clinical care team. ◆ Continued the Transitional Care Program (TCP targeted at improving mental health follow-up rates and decreasing readmissions rates. TCP provides an in-home visit within 7 days to members who have been discharged for inpatient psychiatric admissions. In 2012, PsycHealth coordinated 394 TCP referrals. This reflected a 17.61 percent increase over the prior year. In addition, there were 116 inpatient follow-up call logs, 256 TCP call logs, and 1,528 transitional care follow-up call logs which provided outreach, support, and explanation of discharge plans to members. ◆ PsycHealth's Home Intervention Program (HIP) is a URAC Gold Award Winner for Best Practice in Healthcare. This program commenced in 1999 to reach high risk patients whose hospital readmission rates were significant and outpatient follow-up rate was low to nonexistent. PsycHealth policies and procedures as well as ongoing review of call logs, admission patterns, and case complexities determine recommendations for members to this program. During SFY 2012–2013, 264 HIP referrals and 175 HIP services were provided. PsycHealth expanded the service area for HIP and added a team of providers to the roster for provision of services in this outstanding program in 2012. ◆ Continued Bridges to Health, an integrative and collaborative program which uses a health risk survey to identify members who may be in need of behavioral health services. In 2012, 96 members

Behavioral Health
were identified as potentially needing behavioral health assessment and or services. Attempts to contact all members by phone were made for outreach and communication. Members reached were offered mental health referrals. Those who could not be contacted by phone were sent letters with information regarding contacting PsycHealth and behavioral health services. ◆ PsycHealth continued procedures described in previous annual reports such as daily inpatient status checks, daily meetings that focus on inpatient members with pending post-discharge status, and standardized discharge note format in the clinical care department documentation. ◆ In 2012–2013, PsycHealth and **FHN** received two URAC Best Practice Awards. Additionally, PsycHealth received a Platinum Award for the "Prevent Psychiatric Anniversary Readmissions" Initiative.

Encounter Data
Previous Recommendation: No encounter data were more than 90 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 measures and is strongly encouraged to focus efforts on improving encounter data submission. **FHN Response:** ◆ Significant progress was made in improving and aligning the data management infrastructure at **FHN**. This occurred through the implementation of two new software systems—one for the management of member and provider data and the other for calculation and oversight of HEDIS scoring based on encounters. These systems maintain strict thresholds for encounter data accuracy and support critical workflow in member and provider management, encounter data and HEDIS scoring, and disease/care management. While the implementation of multiple systems is seen as a critical organizational advancement, significant optimization and report development efforts are still underway to allow access and analysis to meaningful concurrent metrics for provider reporting and quality/outcomes improvement. ◆ The sources of encounter variability are multifactorial and diverse, especially in light of multiple technology advancements put in place in 2012 and 2013. **FHN** analysis and group reporting of encounter data metrics (i.e., compliance with regulatory and system requirements, coding accuracy, etc.) are underway to validate root causes, barriers, and implement corrective actions that will efficiently mitigate inconsistency. ◆ Continued with provider education on preventive care guidelines, appropriate coding, importance of encounter/claims data submission via group sessions, one-on-one session, and through the provider newsletter. Increased emphasis on appropriate coding.

Focused Administrative Review Recommendations

Previous Recommendation: 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 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.

FHN Response:

- In 2013 **FHN** established the Delegation Oversight Committee with direct reporting responsibility to the **FHN** Administrative QA Committee. The Delegation Oversight Committee is charged with managing oversight and monitoring activities to ensure that delegated entities maintain compliance with regulatory and contractual obligations.

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.
- 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 healthcare 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.

FHN Response:

- All medical groups are delegated for utilization management and quality activities, and most are delegated for provider credentialing. The medical groups were originally delegated peer review when **FHN** had no process or Peer Review Committee in place; however, the case review and quality oversight elements of peer review were de-delegated after **FHN** established a fully functioning peer review committee, as discussed in the 2012 Annual Report. Other routine elements of peer review and credentialing are still a delegated responsibility of most groups and remain subject to annual audit. The behavioral health vendor is also delegated for quality.
- In calendar year 2012 all groups were audited in the domains noted above. The results were shared with the QM/UM Committee. Mean compliance to the delegated functions within utilization and quality management exceeded 90 percent across the delegated groups. Opportunities for

Focused Administrative Review Recommendations
improvement were identified in the structure and documentation of group/provider peer review activities in many delegated groups where mean compliance was 77 percent as well as in ensuring that recredentialing files contained all required documentation (mean compliance = 74 percent). In response to these findings, groups were required to submit corrective action plans, and all complied in a timely manner. Implementation and follow-up to these corrective action plans will be tracked and monitored through local quality management activities. This will also be included in the ongoing oversight and annual site audits which are a function of the Delegation Oversight Committee discussed previously.

Harmony Health Plan of Illinois, Inc.

Child and Adolescent Care
Previous Recommendation: Harmony demonstrated improvement for all 10 of its EPSDT PIP 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. **Harmony Response:** ◆ 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 in scheduling a 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. ◆ Continued HEDIS Education and Screening Program (ESP) which educates members who have care gap and provides education regarding the care gap and the disease process. ◆ Provided newborn packets that contained information on the recommended well-child visits, immunizations, and lab testing schedule. ◆ Sent to over 50,000 new members preventive care booklets which listed the recommended well-child visits and immunization schedule and highlighted the importance of preventive healthcare services. ◆ Continued to educate providers on WellCare's Secure Provider Portal, which allows real-time online review of a member's current care gap status. ◆ Continued collaborative outreach with Project LAUNCH.

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. The MCOs and the State should also consider a PIP around these measures.

Access to Care

Harmony Response:

- Access and availability standards are forwarded to providers and independent physician associations who are asked for assistance to mitigate issues. Ongoing education with providers and independent physician organizations, including assistance to help them better understand and implement access and availability standards, is conducted by the local market network management team.
- Intervention is conducted by the local network management team to monitor compliance with access and availability audit outcomes. Follow-up with providers who submit a corrective action plan takes place to verify that the required corrections are in place and functional, where possible.
- Continued the HEDIS Inbound Care Gap program. This intervention involves members who call inbound to Customer Service and are identified as having a childhood immunization HEDIS Care Gap. Customer Service educates the member about the importance of scheduling and receiving preventive care services and offers to assist in scheduling a doctor appointment via a three-way phone call to the member's physician office.

Maternity-Related Care

Previous Recommendation: Harmony continues to report rates well below the HEDIS Medicaid 25th percentile for maternity-related measures. In response to these low rates, the State and the VMCOs began a collaborative *Perinatal Depression Screening PIP* in 2007. As a result, in SFY 2012–2013, 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. **Harmony** should begin evaluating the effectiveness of its interventions for these PIPs, which may lead to improvement in HEDIS rates.

Harmony Response:

- Continued Harmony Hugs. All pregnant **Harmony** members receive an initial Hugs enrollment call. This call describes the benefits of the Hugs program and services and incentives provided.
- Harmony Hugs program had a higher rate of compliance in all three measures (timeliness of prenatal care, frequency of ongoing prenatal care, and postpartum care) compared to non-Harmony Hugs members.
- In 2012 there was a significant increase in the number of Harmony Hugs members who had a compliant prenatal visit—66 members in 2012 compared to 12 members in 2011. Frequency of ongoing prenatal care also had a significant increase in the number of compliant Harmony Hugs members—44 members in 2012 compared to 9 in 2011.
- Continued distribution of the maternity booklets which provide prenatal, postpartum, and newborn care education to all known pregnant members.
- Continued Maternity Education and Reward Program (MERP) to distribute educational materials,

Maternity-Related Care
strollers, "pack and plays," and diapers upon completion of the requirements. (1,675 MERP booklets were mailed, and 61 strollers and 36 "Pack and Plays" were distributed to members during the reporting period.) ◆ The field case manager coordinates efforts with the FQHC groups, collaborating with family case managers, and the Centering Pregnancy programs if available. The field case manager also refers as appropriate to Magellan Behavioral Heath especially if member is having depression issues or has an addiction.

Preventive Screening for Women
Previous Recommendation: 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. **Harmony Response:** ◆ Continue the HEDIS Inbound Care Gap program. This intervention involves members who call inbound to Customer Service and are identified as having a (breast cancer screening) HEDIS Care Gap. Customer Service educates the member on the importance of scheduling and receiving preventive care services and offers to assist in scheduling a doctor appointment via a three-way phone call to the member's physician office. ◆ Preventive Care booklets, which highlight the importance of receiving preventive services, sent to 46,842 new members. ◆ Continued centralized telephonic outreach regarding the importance of scheduling a Pap smear and sent periodicity letters.

Chronic Conditions/Disease Management
Previous Recommendation: 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. **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

Chronic Conditions/Disease Management
continue member education, 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) ▪ Improved member education and aligned program to improve quality/HEDIS measures for members with diabetes and asthma. ◆ The number of cases identified and referred to Case Management substantially increased in contract year 2012. In contract year 2011 there were 632 members referred. In 2012, system reporting was upgraded and numbers can be identified for members referred to Short Term Case Management (SCM) and Complex Case Management (CCM) programs. ◆ The Case Management program includes short term and complex case management. The Welcome Home program, (previously called Transitional Care Management or TCM) was moved to the Member Engagement Unit in March 2012. A screening is completed on members recently discharged from the hospital to identify those with complex discharge needs and barriers and gaps in care. Referral made to the short-term or complex case management programs as appropriate. ◆ Developed and implemented the ICT (Interdisciplinary Care Team) process for Complex Case Management. Case managers were trained on identification of the member's ICT which includes the member and/or designated representative, PCP, and other specialty providers. The ICT includes members and providers input into the development of care plan goals. ◆ Added a Care Gaps database link to the case management platform; Educated CMs on care gap identification and facilitation of care gaps closure. ◆ Reviewed the process for the identification of members for case management through case and disease management claims/encounters algorithm; changed the Welcome Home hierarchy to increase the identification of Illinois members for post-discharge outreach. ◆ Staffing has been enhanced and now incorporates a multidiscipline structure including RN, LCSW, BSW, and BH specialists in the staffing matrix. ◆ Staff received extensive retraining for enhanced assessments, care plans, and NCQA quality standards. ◆ Staff trained on motivational interviewing to enhance engagement and retention of members. ◆ The Case Management Program continues to focus efforts on coordinating care for members to ensure that they have a follow-up visit with their PCP after the initial admission. Care managers have been educated on the importance of ensuring that aftercare appointments are scheduled within 7 days after discharge and that barriers to attending these appointments, including lack of access to transportation, are identified and coordinated on behalf of the enrolled CM members. **Previous Recommendation:** Continue to strengthen the case management and care coordination program.

Chronic Conditions/Disease Management

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 composed of short-term case management and complex case management differentiation. Short-term case management's (SCM's) 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 healthcare needs by creating a specific flag in the current medical management platform for Children with Special Health Care Needs (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.
- 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).

Behavioral Health

Previous Recommendation: Though **Harmony**'s overall trend is still up from HEDIS 2008, this marked the second year of decline for the *Follow-up After Hospitalization for Mental Illness—7 Days* and showed little to no real improvement in the 30-day measure.

Harmony Response:

- In 2012, coordination of care/medical integration activities was reported quarterly in the SE CMC QIC as well as to the **Harmony** quarterly meetings. Additionally, a quarterly medical/behavioral integration workgroup to promote enhanced integration was continued between Magellan and **Harmony**.
- Medical integration interventions focused on a number of projects this year including:

Behavioral Health

- PCP Communication
  - The 2012 chart reviews measured the 5 Magellan treatment record review indicators related to PCP communication and evaluated communications to the PCP for accuracy, timeliness, sufficiency, frequency, and clarity. For these elements, 2012 is the fourth remeasurement period. Areas of improvement were indicated in Frequency—communication after change in treatment/medication/risk status and after termination of treatment.
  - Provided member medication adherence tip sheets for use with PCPs.
  - Educated psychiatrists on the importance of communication with PCPs regarding medication prescribed.
  - Discussed PCP communication and expectations through feedback provided from treatment record review activities.
  - Provided PCP communication tool template to providers along with treatment record review activity results.
- Ensuring Appropriate Use of Medications
  - Collaborated with **Harmony** to address anti-depression medication management.
  - Practitioner educational interventions continued through 2012 regarding second generation antipsychotic monitoring expectations.
  - Medical director provided consultation as requested on a case-by-case basis concerning appropriate use of psychotropic medications in children and adolescents.
- Coordination of Timely Access for Appropriate Treatment and Follow-up of Patients with Co-existing Medical and Behavioral Disorders
  - Conducted individual case management discussions with **Harmony**, as requested.
  - Improved identification of members and expanded criteria for inclusion in the ICM program, use of ambulatory follow-up results, enhanced assessment and treatment planning, outcomes assessment, and collaborative case review.
  - Screened members for co-occurring depression through **Harmony** disease management programs, then referred to Magellan for further assessment and follow-up.
- Implementation of Collaborative Primary or Secondary Preventive Health Program
  - Conducted a minimum of two preventive health programs with each health plan partner during 2012.
  - CSTARS is a program that WC has for pregnant women using drugs or alcohol, and Magellan accepts and works the referral.
  - HUGS is for pregnant women who have depression, and Magellan receives the referrals and helps coordinate care.

Behavioral Health

- Collaborative Activities with **Harmony**
  - Magellan medical director participated with **Harmony** utilization management committees and other committees/workgroups, as requested.
  - Magellan medical director and director of Quality & Compliance participated on customer quality and/or medical/behavioral coordination committees as requested.
  - Collaborated with **Harmony** on implementation of interventions related to:
    - Appropriate monitoring of second generation antipsychotic medications.
    - Improving intensive case management referrals/outcomes.
    - Improving provider/member collaboration.
    - PCP toolkit materials related to behavioral health.

Encounter Data

Previous Recommendations: The rates indicate that **Harmony** has reasonably good encounter data completeness. Two measures had more than a 90 percent data completion rate, two were above 80 percent, seven were above 70 percent, and one measure was above 60 percent. However, five of the measures had a data completion rate of less than 50 percent. **Harmony** should continue to reinforce efforts to improve submission of encounter data, concentrating efforts toward obtaining complete lab data.

Harmony Response:

- The largest Health Plan data issues continue to be inbound encounters and receiving claims/encounters as if **Harmony** was a commercial insurance company. Currently **Harmony** is re-contracting with all FQHCs to accommodate the change from the State paying wrap payments to the MCOs paying wrap payments. Within the contract changes, Harmony is also including more specific language around submission of claims/encounters to encourage submissions that will be accepted by the State. In the first quarter of 2013, **Harmony** set up a cross-functional task force to determine the issues, create provider education materials, and educate the providers on how to correctly submit claims/encounters. The cross functional team is also reviewing how to implement State requirements to rejecting/denying claims/encounters.
- Another issue faced by the Health Plan and providers was the conversion from 4010 to 5010. Providers experienced issues converting and testing 5010. There were many changes in the implementation date, which caused confusion among providers. There was also confusion about required fields, which has led to continued detailed conversation on claims/encounters with specific providers. **Harmony** implemented a new encounter processing system (EPS), which coincided with the 5010 conversion. This year has been devoted to fine-tuning the system and increasing automated processing.

Encounter Data
◆ With the new EPS system, new reporting will be available to track claim and encounter submissions going forward. The new system will be able to track actual submission of encounter data versus the target number of encounters specific to each direct submitting IPA dependent on contract type. We will be able to filter using both date of submission and date of service. ◆ Providers also use the noncompliant HEDIS report we issue quarterly to determine if they are submitting all encounters or if there are any data issues. Harmony issues the noncompliant lists quarterly to both the individual physicians and their medical groups so that everyone is aware of the data **Harmony** does not have. Harmony encourages providers to either send in their claims or encounters for the services already provided, or if not already provided, to call members to schedule visits.

Focused Administrative Review Recommendations
Previous Recommendations: 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. **Harmony Response:** During the contract year, there were several process improvements in the case management program. Major process improvement activities include: ◆ The case management program includes short term and complex case management. The Welcome Home program (previously called Transitional Care Management or TCM) was moved to the Member Engagement Unit in March 2012. A screening is completed on members recently discharged from the hospital to identify those with complex discharge needs and barriers and gaps in care. Referral made to the short-term or complex case management programs as appropriate. ◆ Short-term case management focuses on addressing the member's immediate, short term, event-driven needs that may result in a negative impact on the member's healthcare status. Short-term case management referrals include multiple readmissions, high ED utilization, immediate needs identified by discharge screening, and complex inpatient discharges (including LOS>7 days). Complex case management oversees members who have multiple, co-morbid conditions which are complex in nature and will require ongoing assistance with health management. Complex case management referrals include frequent hospital admissions, high ED utilization, members identified by an algorithm, utilization management referrals, provider and member self-referrals, medication non-compliance, and transition from short term case management.

Focused Administrative Review Recommendations

- Developed and implemented the ICT (Interdisciplinary Care Team) process for complex case management. Case managers were trained on identification of the member's ICT, which includes the member and/or designated representative, PCP, and other specialty providers. The ICT includes members and providers input into the development of care plan goals.
- Added a Care Gaps database link to the case management platform and educated CMs on care gap identification and facilitation of care gaps closure.
- Reviewed the process for the identification of members for case management through case and disease management claims/encounters algorithm, changed the Welcome Home hierarchy to increase the identification of Illinois members for post-discharge outreach.
- Staffing has been enhanced and now incorporates a multidiscipline structure including RN, LCSW, BSW, and BH specialists in the staffing matrix.
- Staff received extensive retraining for enhanced assessments, care plans, and NCQA quality standards.
- Staff trained on motivational interviewing to enhance engagement and retention of members.
- The Case Management Program continues to focus efforts on coordinating care for members to ensure that they have follow-up visits with their PCPs after the initial admission. Care managers have been educated on the importance of ensuring that aftercare appointments are scheduled within 7 days after discharge and that barriers to attending these appointments, including lack of access to transportation, are identified and coordinated on behalf of the enrolled CM members.

Previous Recommendations: 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.

Harmony Response:

- During this contract year, **Harmony** invested in hiring a new medical director with both extensive QI expertise and the communication and collaboration skills to increase **Harmony**'s joint efforts with providers, provider groups, and community organizations servicing our members. **Harmony**

Focused Administrative Review Recommendations
transitioned a senior manager with multiple years of experience in the Medicaid QI arena and one with extensive experience with our population into the director of QI role. **Harmony** hired a QI specialist who has multiple years of experience working in the field with Medicaid members. Last, the QI Department hired a QI coordinator who has experience with HEDIS. ◆ Other challenges have come from departments which support QI. There were staff challenges in the Utilization Management department. This department has hired additional resources and is now in the process of streamlining all processing within the department. The QI Analytics department has also experienced staffing challenges during the contract year. Even with the challenges, the department was able to make enhancements to provider reporting. ◆ Implemented functional scorecards for all markets/LOBs for ongoing compliance monitoring of all delegates. ◆ Developed and implemented the C360 Third Party Risk Management module to enhance the methodology used to deliver and track the delegation audits and corrective action plans (CAPs) of the delegated entities. ◆ Established a new model of clinical delegation oversight of nontraditional delegates. ◆ Coordinated all pre-delegation audits for current and expansion markets. ◆ Ensured that all Medicaid/Medicare reports were submitted timely and in compliance. ◆ Established linkage and communication for regulatory updates with internal compliance and market regulatory affairs. ◆ Received recognition by NCQA as "Best Practice". ◆ Received recognition during EQRO state audits as "Best Practice". ◆ Continued weekly vendor management/delegation coordination meetings. ◆ Continued monitoring of Medicare/Medicaid compliance through the focused reviews. ◆ Established automated database for tracking, trending, and reporting of delegated entity performance. ◆ Refined the end-to-end audit process with delegated entities; the audit is administered jointly with the contract owner, delegated entity, and delegation auditor.

Consumer Satisfaction—FHN and Harmony

Consumer Satisfaction

Previous Recommendation: Overall recommendations for **FHN** and **Harmony** to improve CAHPS results include:

- Identify potential barriers for patients receiving appropriate access to care.
- Identify and eliminate patient challenges when receiving healthcare.
- 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 healthcare 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 healthcare 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 that physicians are properly trained to facilitate the shared decision making process with patients.

FHN Response:

- The ad hoc committee for the CAHPS surveys met in January 2013 to review data and develop improvement strategies. Feedback from this group led to the increase in contracted specialists with **FHN**. This effort correlates with a significant increase (66.4 percent to 77.2 percent) in member satisfaction related to obtaining appointments with specialists in the 2013 CAHPS survey.

Consumer Satisfaction

Harmony Response:

- Implemented the following interventions to increase the percentage of members who respond that they usually or always for obtain information/help from customer service and/or respond that they usually or always receive necessary care, tests, or treatments.

Plan Interventions:

- Conduct access and availability surveys.
- Monitor referral process via customer service stats to determine the IPAs/PCPs with the greatest issues and educate.
- Increase plan network of hospitals, PCPs, and specialists—even though no GeoAccess issues exist in Northern Illinois. This will improve access and availability.
- Reviewed current training at call center and made script changes.
- Ongoing monitoring of member services by local staff. Listened to existing customer service calls to identify if process was followed and/or areas of opportunities.
- Implementation of Member Escalation Team. Eight reps 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. Hired two additional relations reps to only work issues identified through Customer Service, Sales, and the retention channels.
- Monthly membership retention meetings and customer service workgroups.
- Outbound calls to disenrolling members. Two retention specialists located in the Chicago office make calls to case holders of members that were disenrolling to speak directly to the decision maker in hopes of better understanding the reasons that members are disenrolling. Both retention specialists speak Spanish and English.
- Welcome calls are made to newly enrolled members. From July 1, 2012, to June 30, 2013, a total of 65,453 calls were made through a vendor. Within the call the members' demographic information, intended PCP, and receipt of ID card is confirmed, along with a review of Harmony's benefits. During the call, the representative also goes over the health risk assessment with the member. Within the welcome call, the member is offered assistance in setting up appointments with the PCP. These calls have been scripted in both English and Spanish to improve the ability to relay the information to the members.

Provider Interventions

- Monitor provider access and availability via survey, and put providers on corrective action plans, as appropriate.
- Educate medical groups and physicians about the quality initiative and HEDIS measures.

Consumer Satisfaction
◆ Online access to Care Gap list through WellCare website. *Member Interventions* ◆ Welcome calls to newly enrolled members. Within the calls, the member's demographic information, intended PCP, and receipt of ID card are confirmed, along with a review of Harmony's benefits. A Health Risk Assessment is also performed while the member is on the phone. During the welcome calls, the member is offered assistance in setting up appointments with the PCP. These calls have been scripted in both English and Spanish to improve the ability to relay the information to the members. ◆ Outbound calls to disenrolling members. Two retention specialists in the Chicago office began making calls in April to case holders of members that 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 so that Harmony has a better understanding of how competitors and eligibility are impacting disenrollment. ◆ Members educated via newsletters and member handbook about plan benefits including, but not limited to: ▪ Covered benefits and service. ▪ Exclusions from coverage. ▪ Out-of-network and out-of-service area benefit restrictions. ▪ After hours care, primary care services. ▪ Case management and disease management. ▪ Utilization management programs. ▪ Nurse hotline availability—24 hours/365 days-a-year.

Meridian Health Plan, Inc.

Child and Adolescent Care

Previous Recommendation: 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, this is only the second year of reporting for relatively low populations for many of the measures.

Meridian Response:

- Conducted drill-down data analysis of medical record documentation to reveal that routine two-year-old visits are more focused on immunizations/routine lab tests than on full and comprehensive EPSDT visits, despite the opportunity that these routine preventive healthcare visits offer. This presents an educational opportunity for both members and providers.
- Additional drill-down analysis of the total population identified a trend among our pediatric providers on the west side of the State that offer same day appointments. It appears that same-day appointments result in lower developmental screening rates. **Meridian** will work with these providers to establish office flows to ensure EPSDT visits that include consistent developmental screenings.
- Created an EPSDT toolkit for providers to have access to tools and subjective developmental screenings in an effort to promote each aspect of the EPSDT program.
- 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 Meridian's website.
- Developmental screening promotion and education with appropriate billing for providers.
- Member education on the importance of developmental screenings in children for early identification and referral for developmental delays.

Access to Care

Previous Recommendation: For HEDIS 2012, **Meridian** had 118 eligible cases and reported a rate of 100 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.

Meridian Response:

- Expanded provider HEDIS fax program to include additional providers in new counties.

Maternity-Related Care

Previous Recommendation: Meridian achieved improvement for nine of its 16 indicators for the *Perinatal Care and Depression Screening* PIP 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 insignificant and could not be assessed for improvement or sustained improvement.

Meridian Response:

- Maternity program transitioned to a Maternity Care Coordination program where a team manages all pregnant members throughout the postpartum period.
- Hired and trained a community health outreach specialist to work with difficult-to-reach members in the community setting.
- Created an outreach campaign utilizing the automatic dialer software to reach more members in an efficient manner. These calls are made on Tuesdays and Thursdays at rotating times. All staff members working this campaign are trained to administer high-risk prenatal assessments and EPDS screening tools.
- Updates to the process flows for prenatal/postpartum member outreach to include faxing of all prenatal and postpartum EPDS to the OB provider and the PCP.
- Weekly reports in MCS to identify members with inconsistencies in prenatal and postpartum authorization data.
- Provider fax templates to obtain prenatal authorization information timely.
- Implementing the program option for prenatal and postpartum members to receive texts from text4baby; this program offers education throughout the member's pregnancy and into the postpartum period.

Preventive Screening for Women

Previous Recommendation: Meridian's rates for *Cervical Cancer Screening* were above the HEDIS 2011 National Medicaid 50th percentile of 69.7 percent. **Meridian**'s rate of 60.8 percent for *Chlamydia Screening in Women* was based on 74 cases. Meridian had fewer than 30 eligible cases for the *Breast Cancer Screening* measure, and in accordance with NCQA, the rate was reported as NA.

Meridian Response:

- **Meridian** continues to increase provider awareness of members with needed preventive health services. Progress reports are distributed monthly to the provider offices, with achieved and missed amounts clearly indicated both in aggregate and by individual member.
- A "hot list" was added to the monthly report to identify members due for services with time-

Preventive Screening for Women
sensitive preventive care needs. ◆ Flyers and other educational pieces for providers were reformatted. The front page is focused on office staff, and the other side is provider-focused. ◆ PCP HEDIS performance monitoring was made available on the Provider Portal.

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 this section. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **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 this section. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, **Meridian**'s rates were not presented for this year. **Meridian Response:** NA

Consumer Satisfaction
Previous Recommendation: 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. **Meridian Response:** ◆ Created and revised scripts for use in outreach campaigns. ◆ Restructured the outbound dialer system to create maximum efficiency and improve reach rates to members. There are now two key campaigns: ▪ Welcome calls

Consumer Satisfaction
▪ Priority HEDIS (includes members with all outstanding HEDIS needs) ◆ Created an Overflow Queue for unanswered calls for 15 seconds or more and calls placed on hold for a longer time than desired. These calls are sent to the Overflow Queue and answered by senior representatives in Member Services. ◆ Member Services hours expanded to 7 a.m. to 7 p.m. in an effort to allow improved access times for members to call. ◆ Added information on benefits of member portal to increase member access to plan. ◆ Created a new To-Do Queue for State file changes, and dedicated staff to use the queue to ensure accurate member contact information. ◆ Hired and trained a dedicated UM nurse. ◆ Updated job aide for denials/appeals based on feedback during the 2011 annual site visit review. ◆ Trained Member Advisory Committee members about their role in Grievance Committee participation to ensure understanding. ◆ Revised Grievance Policy to ensure proper tracking and reporting of informal and formal grievances.

Integrated Care Plans

Performance Measures
◆ The ICP plans 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 program, through input from HFS, identified the PIP topic, Community Based Care Coordination, which was designed to focus on medically high-risk members with a recent hospital discharge who were actively receiving care coordination with linkage to community resources. During the third quarter of 2011, the ICP plans began developing the study question and indicators and identifying data sources. The baseline measurement period for this study was from January 1, 2012, through December 31, 2012. Remeasurement periods are Period 1—January 1, 2013, through December 31, 2013; and Period 2—January 1, 2014, through December 31, 2014.
◆ Both **Aetna** and **IlliniCare** demonstrated strong performance in the Design stage, meeting 100 percent of the evaluation elements in Activities I through V. Neither plan had 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 ICP plans have laid the foundation for the successful progression to the next stages of the PIP process.
Previous Recommendation: Overall recommendations for the PIP:
◆ As the ICP plans 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, and implementing active interventions that are logically linked to the barriers and that will directly impact study indicator outcomes.
Aetna Response:
◆ **Aetna** has initiated the following interventions, anticipating significant impact on readmission rates: ▪ CM staff monitor daily inpatient census for all members with readmit risk score > 60 and/or CORE score of 4, 5, and 6 for initiation of targeted interventions. ▪ Members identified with readmit risk score > 60 and/or CORE score of 4, 5, and 6 are targeted for Integrated Care (UM/CM/BH staff) case rounds. ▪ Discharge calls are made to targeted members within 24 hours post-acute care discharge. ▪ Pilot telemonitoring project initiated with a sample of members identified as high risk.

Performance Improvement Project (PIP)

IlliniCare Response:

- **IlliniCare** reported that the PIP plan document, data abstraction tool, and instructions as well as the measurement strategy were validated by HSAG. In April 2013 **IlliniCare** submitted the PIP summary document and all related documents of support for analysis. After review of the initial submission, several action items/adjustments were recommended in May. **IlliniCare** completed the suggested changes, resubmitted the documents, and are awaiting the final analysis of baseline data.

Consumer Satisfaction

Previous Recommendation: 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 healthcare.
- 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 healthcare 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 healthcare 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.

Consumer Satisfaction

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

Aetna Response:

- **Aetna**'s dedicated outreach strategy includes a multi-tiered approach via our Member Advisory Council, community engagement, and member newsletters. Dedicated outreach efforts have been made in a variety of forums in order to disseminate information in the broadest means possible. Indirectly, work has been done with advocates to provide the opportunity to educate the community about the details of the program and the benefit coverage associated with Aetna Better Health. This information flow is effective as many advocates work directly with our members and their caregivers. Community engagement has been underway in the Rockford region with plans for ongoing efforts to address the recent expansion into the counties of Winnebago, Boone, and McHenry.

IlliniCare Response:

- **IlliniCare** plans to review 2013 CAHPS results and compare with 2012 data in order to develop an action plan for areas in need of improvement and to implement appropriate interventions.

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. The purpose of the review was to determine the ICP plans' 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).
- Through this ongoing process, the ICP plans addressed many recommendations in order to meet the necessary requirements to participate in the ICP program. The formal readiness review reports were not published until after the release of the ICP plans' annual reports; therefore, the ICP plans' responses to the recommendations made in the readiness review will be reflected in the SFY 2013-2014 EQR Technical Report.
- Listed below are the recommendations made as a result of the entire readiness review process.

Previous Recommendation: Aetna did not meet the 30-mile distance requirement in Kane County for specialists, including orthopedics, endocrinologists, oncologists, and otolaryngologists. **Aetna** will need to continue strengthening the provider network by contracting with additional specialty and subspecialty providers including optometrists, skilled nursing facility physicians (SNFists), and providers willing to provide services to homebound enrollees.

Previous Recommendation: The findings of the review identified that **Aetna** was compliant with most components of the Integrated Care Management (ICM) Program. Areas identified for improvement

Readiness Reviews
included: ◆ Improving coordination of follow-up care with the PCP and other healthcare providers for members with chronic conditions. ◆ Including 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, at the point of contact, enrollees who need referral for a health risk assessment. **Previous Recommendation: Aetna**'s 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. **Previous Recommendation: Aetna** will also be required to ensure that its affiliated providers are advised of substantive changes to the grievances and appeals policies and procedures. **Previous Recommendation:** The following 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 **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). **Previous Recommendation: 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. **Previous Recommendation: Aetna** was required to revise its policies and procedures to include handling and reporting requirements in case of breach of confidentiality. **Previous Recommendation: 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). **Previous Recommendation:** Increasing the frequency of oversight and monitoring of grievances from monthly to weekly during the early implementation phase of the integrated care program was recommended. More frequent oversight could assist **Aetna** with early identification and resolution of issues unique to the enrollees of this program. **Previous Recommendation: Aetna** will need to continue to develop, then adopt and implement,

Readiness Reviews
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 were revised to include an annual update of the practice guidelines as required by contract. **Previous Recommendation:** 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. **Previous Recommendation:** 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 healthcare; hospitals; and speech, occupational, and physical therapy. (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. **Previous Recommendation: IlliniCare** should continue its efforts to expand the provider network to ensure that 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. **Previous Recommendation: 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. **Previous Recommendation:** The findings of the review identified that **IlliniCare** was compliant with most 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

Readiness Reviews

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.
- Referring enrollees identified with chronic care conditions to the disease management program and/or having in place a chronic care management plan.
- Revising 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.
- Having written procedures in place to include provision of coordination of care for prospective enrollees upon request.

Previous Recommendation: A corrective action was initiated and 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.

Previous Recommendation: 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.

Previous Recommendation: 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.

Previous Recommendation: 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.
- 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.

Previous Recommendation: IlliniCare will need to revise its policies and procedures to include handling

Readiness Reviews
and reporting requirements in case of breach of confidentiality. **Previous Recommendation: 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). **Previous Recommendation: IlliniCare**'s 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. **Previous Recommendation:** 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. **Previous Recommendation:** 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 that providers are informed and trained on the signs of suspected abuse and neglect and how to report alleged abuse or neglect.

Technical Assistance to HFS and MCOs

Technical assistance is one of the activities identified by the Centers for Medicare & Medicaid Services (CMS) that EQROs can provide to state clients.

HSAG has provided a variety of technical assistance to HFS that has led to quality outcomes. This includes technical assistance in the following areas: Performance Improvement Plan (PIP), grievance and appeals process, care management programs, CAHPS sampling and development of CAHPS supplemental questions, 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, HCBS Waiver program requirements, and much more.

HSAG has worked with HFS and the MCOs to develop models of stakeholder collaboration for quality improvement projects which are essential for identifying and implementing sustainable activities that lead to improved preventive and developmental services. The Illinois collaborative PIPs have improved. Topics include EPSDT screening services for children; perinatal care, postpartum care, and depression screening for women; and 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).

Specific examples of technical assistance topics conducted in SFY 2012–2013 are listed below.

Conducting PIPs

- Selecting PIP Topics
- Development of Study Question(s)
- Selection of Study Indicator(s)

- Selection of Study Population
- Sampling Methods
- Data Collection/Analyses
- Assessment of Quality Improvement Strategies
- Sustained Improvement

Technical Assistance to HFS and MCOs in Monthly and Quarterly Managed Care 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 associate director 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, readiness reviews, 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 worksheets, PowerPoint presentations, slide handouts, or technical demonstrations. Subject matter experts, including clinical and analytical staff as required, are involved in the development of meeting content; and appropriate staff 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.

Technical Assistance to HFS—Development of Performance Measures

Throughout SFY 2012–2013, HSAG continued to assist HFS in developing performance measures that would meet the unique demands of the Integrated Care Program, and began discussions on performance measures for the CCE, MMAI, and ACE programs. HSAG completed a literature review to determine if there were existing measures that could be adapted

for use or if there were any applicable measures currently being developed. HSAG worked collaboratively with HFS to identify and develop performance measures specific to each of the programs and the populations they currently and will serve as part of the care coordination expansion.

HSAG continued to work with HFS to refine the 30 performance measures identified for the ICP plans, including revising data specifications for any performance measures that changed from the original set of measures established in the prior year. The 30 ICP performance measures that were developed by HFS and the ICP plans continue to include a mix of HEDIS, HEDIS-like, and State-defined measures. Each year HSAG updates the ICP technical specifications document which provides instructions on data collection for each measure and general guidelines for calculations and sampling.

In additional HSAG has provided technical assistance for performance measures to HFS in the following areas:

- HEDIS and HEDIS-like measure recommendations
- Selection of P4P measures
- Methodologies for establishing performance improvement benchmarks for the HEDIS and non-HEDIS performance measures

Technical Assistance—ICP Care Coordination Reporting

Throughout SFY 2012–2013, at the request of HFS, HSAG worked extensively with the ICP plans to provide guidance in development of reporting guidelines and specifications for the Care Management/Care Coordination program reporting to ensure all ICP plans were collecting and reporting the information in a consistent manner to allow HFS to compare ICP performance on outreach, risk stratification, engagement, and care and disease management activities. The reports included the following:

- Active Participant Report
- Outreach Summary Report
- Risk Stratification Report
- Case Management/Disease Management Report

Home and Community-Based Waivers Training for ICP Care Coordinators

Throughout SFY 2012–2013 HSAG worked with HFS and the State Waiver agencies to provide technical assistance and training to the ICP care coordination staff on the requirements of the waiver programs. Technical assistance provided by HSAG included development of crosswalks between the ICP contract and waiver requirements and participation in meetings between HFS,

Waiver agencies, and ICP plans to assist with coordination and communication of HFS expectations for ICP plan management of the HCBS Waiver enrollees. Topics for the review sessions included service and care planning; critical incidents; abuse, neglect, and exploitation; qualifications and training of care coordination staff; expectations for caseloads; and frequency of contacts for waiver enrollees.

Home and Community-Based Waivers—Staffing, Qualifications, and Training

Since the implementation of Service Package II and the associated specific HCBS Waiver program requirements for qualifications and training of the ICP staff working with waiver enrollees (such as Persons with Physical Disabilities (PD), Persons with HIV/AIDS, Persons with Brain Injury, Persons who are Elderly, and Persons in a Supportive Living Facility), it became necessary for HFS to monitor how the ICP plans were complying with the waiver and ICP contract requirements. HSAG developed a data collection worksheet which was forwarded to the ICP plans for completion. Following receipt of the data collection worksheet from each ICP plan, HSAG conducted an analysis of the Care Management/Care Coordination staff by position, FTE count, and qualifications. In addition, HSAG conducted a review of the training documented within the worksheet to determine if staff had completed the required training and completed the HCBS Waiver training curriculum. ICP plans are also required to submit an organizational chart that identifies the structure and hierarchy of authority for the Care Management/Care Coordination department.

At the end of SFY 2013, HFS contracted with HSAG to continue the review of the ICP plans' Care Coordination/Care Management staffing, qualifications, and training to ensure compliance with the requirements as outlined in Attachment XVI of the ICP contract.

Care Coordination Entities—Technical Assistance to HFS and CCEs

At the direction of HFS, HSAG provided ongoing technical assistance to HFS and the CCEs to assist in the implementation of the CCE program. Technical assistance to HFS included review of the *Draft Coordination of Services under the Innovations Project for Seniors and Persons with Disabilities Contract* to review contract language *specific to* provider contracting, care coordination requirements including caseloads and staffing, quality improvement program structure, and monthly and quarterly reporting. HSAG also assisted HFS in developing the content and outline for the CCE annual report. The CCEs are required to conduct an annual evaluation of their care coordination program and present the results in the CCE annual report.

Technical assistance provided by HSAG to the CCEs included on-site consultation, conference calls, and webinars to review the requirements of the CCE contract and guide the CCEs in the development of policies and procedures, care management/care coordination model program

description, quality program structure and reporting, grievances and complaints, and network provider agreement language. Technical assistance continued following the pre-implementation readiness reviews to assist the CCEs with revisions of documents to comply with contract requirements.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys Sampling Methodology

As an ad hoc request to the EQRO contract, HFS requested that HSAG develop a proposed sampling methodology for conducting Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys of adult Medicaid beneficiaries enrolled in ICPs.

The sampling methodology was developed for purposes of meeting CMS' reporting requirement of CAHPS surveys for Physical Disability and Elderly waivers. The ICP populations covered under the State of Illinois' Physical Disability and Elderly waivers include the following: nursing facility residents, AIDS/HIV members, physically disabled members, brain injury members, supportive living facilities members, and aging members. For further information, please reference the Illinois Integrated Care Plans—CAHPS Sampling Plan methodologies document which provides an overview of the proposed sampling option for the ICP population in Illinois.

CAHPS Supplemental Questions

HFS requested that HSAG assist with development of the CAHPS supplemental questions for purposes of meeting CMS' reporting requirement of CAHPS surveys for Physical Disability and Elderly waivers. HSAG worked with NCQA to obtain approval of the supplemental questions which subsequently were forwarded to the ICP plans for inclusion in their CAHPS surveys.

University of Illinois at Chicago (UIC)—Independent Evaluation of the Integrated Care Program

HFS contracted with UIC to conduct an independent evaluation of the Integrated Care Program. The first report was released by UIC in March 2013 which covered Service Package I (acute healthcare). The ICP plans began covering Services Package II (long-term services and supports [LTSS] enrollees in February 2013. The 2014 UIC report will include the transition period to Service Package II services covered by the ICP plans. HSAG has worked extensively with UIC and HFS to assist UIC with the evaluation process. HSAG conducted meetings with HFS throughout SFY 2012–2013 to discuss the information requests from UIC and worked cooperatively with UIC to deliver reports and data to support the evaluation. HSAG provided information to UIC for the **Aetna** and **IlliniCare** pre-implementation readiness reviews, provider

network data, and performance measures. HSAG will continue to support the UIC evaluation process through the provision of reports and data as requested by HFS.

Table A.1—Child and Adolescent Care and Adults' Access to Preventive/Ambulatory Care Measures

HEDIS Measures	MER	FHN	HAR	All MCOs	National Medicaid HEDIS 2012 Percentiles				
					10th	25th	50th	75th	90th
Child and Adolescent Care									
Childhood Immunizations—Combo 2	84.89%	78.70%	69.59%	76.90%	64.23%	69.10%	75.35%	80.79%	84.18%
Childhood Immunizations—Combo 3	82.73%	72.92%	64.48%	72.26%	58.88%	64.72%	71.93%	77.49%	82.48%
Lead Screening in Children	85.97%	82.41%	79.21%	82.51%	39.23%	57.52%	71.41%	81.86%	86.56%
*Well-Child Visits in the First 15 Months (0 Visits)**	0.58%	3.24%	4.38%	3.25%	0.46%	0.72%	1.22%	2.43%	3.89%
Well-Child Visits in the First 15 Months (6+ Visits)	92.40%	50.23%	56.20%	59.76%	43.80%	54.31%	62.95%	70.70%	77.31%
Well-Child Visits (3–6 Years)	88.90%	69.21%	71.54%	81.20%	61.07%	65.51%	72.26%	79.32%	83.04%
Adolescent Well-Care Visits	79.65%	45.60%	46.47%	65.77%	35.52%	42.11%	49.65%	57.61%	64.72%
Immunizations for Adolescents	68.57%	50.23%	43.07%	49.85%	39.77%	50.36%	62.29%	70.83%	80.91%
Children's Access to PCPs (12–24 Months)	96.74%	75.42%	88.89%	83.80%	93.06%	95.56%	97.02%	97.88%	98.39%
Children's Access to PCPs (25 months–6 Years)	95.52%	61.74%	76.47%	72.57%	83.16%	86.62%	89.19%	91.40%	92.63%
Children's Access to PCPs (7–11 Years)	95.28%	60.84%	72.95%	70.01%	83.37%	87.56%	90.58%	92.88%	94.51%
Adolescents' Access to PCPs (12–19 Years)	94.93%	61.20%	73.44%	70.71%	81.78%	86.04%	89.21%	91.59%	93.01%
Adults' Access to Preventive/Ambulatory Care									
20–44 Years of Age	88.21%	64.90%	71.09%	69.72%	67.40%	77.96%	82.34%	85.43%	88.52%
45–64 Years of Age	90.55%	67.54%	72.82%	71.87%	78.26%	84.09%	87.31%	89.94%	90.96%
* Lower rates indicate better performance for this measure.									

	National Medicaid HEDIS 2012 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	MER	FHN	HAR	All MCOs	National Medicaid HEDIS 2012 Percentiles				
					10th	25th	50th	75th	90th
Preventive Screening for Women									
Breast Cancer Screening	NA	49.04%	36.86%	39.93%	36.80%	44.82%	50.46%	56.58%	62.76%
Cervical Cancer Screening	80.56%	72.85%	72.81%	76.13%	51.85%	61.81%	69.10%	73.24%	78.51%
Chlamydia Screening (16–20 Years of Age)	58.95%	58.02%	50.60%	52.76%	42.94%	48.80%	54.18%	61.21%	67.38%
Chlamydia Screening (21–24 Years of Age)	70.73%	70.39%	62.68%	65.48%	52.45%	59.09%	64.36%	69.86%	72.67%
Chlamydia Screening (Combined Rate)	65.60%	64.23%	55.73%	58.50%	47.62%	52.70%	58.40%	63.89%	68.83%
Maternity-Related Measures									
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	0.81%	23.84%	14.11%	14.94%	2.43%	4.57%	6.58%	10.71%	19.11%
Frequency of Ongoing Prenatal Care (81–100% of Visits)	95.97%	35.42%	43.55%	52.25%	39.42%	52.55%	64.65%	72.99%	82.75%
Timeliness of Prenatal Care	96.37%	62.96%	74.70%	74.98%	72.02%	80.54%	86.13%	90.39%	93.33%
Postpartum Care	83.06%	48.15%	49.39%	56.55%	52.43%	58.70%	64.98%	71.05%	74.73%

***** Lower rates indicate better performance for this measure.

	National Medicaid HEDIS 2012 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	MER	FHN	HAR	All MCOs	National Medicaid HEDIS 2012 Percentiles				
					10th	25th	50th	75th	90th
Chronic Conditions/Disease Management									
Controlling High Blood Pressure	NA	46.02%	39.42%	42.40%	42.22%	50.00%	57.52%	63.65%	69.11%
Diabetes Care (HbA1C Testing)	93.18%	77.43%	77.37%	78.26%	74.90%	78.54%	82.38%	87.01%	91.13%
*Diabetes Care (Poor HbA1c Control)**	70.45%	55.43%	56.69%	56.89%	28.95%	34.33%	41.68%	50.31%	58.24%
Diabetes Care (Good HbA1c Control)	22.73%	36.29%	36.50%	35.65%	35.04%	42.09%	48.72%	55.70%	59.37%
Diabetes Care (Eye Exam)	75.00%	36.00%	27.25%	33.66%	36.25%	45.03%	52.88%	61.75%	69.72%
Diabetes Care (LDL-C Screening)	84.09%	69.71%	65.45%	68.32%	64.38%	70.34%	76.16%	80.88%	83.45%
Diabetes Care (LDL-C Level <100 mg/dL)	34.09%	26.86%	25.55%	26.58%	23.06%	28.47%	35.86%	41.02%	46.44%
Diabetes Care (Nephropathy Monitoring)	75.00%	71.71%	71.53%	71.80%	68.43%	73.48%	78.71%	83.03%	86.93%
Diabetes Care (BP < 140/90)	13.64%	54.29%	48.42%	49.07%	47.02%	54.48%	63.50%	69.82%	75.44%
Appropriate Medications for Asthma (Combined)	NA	84.51%	84.14%	84.22%	79.72%	82.54%	85.87%	88.19%	90.56%
Follow-up After Hospitalization for Mental Illness—7 Days	NA	63.98%	50.44%	55.10%	24.03%	32.20%	46.06%	57.68%	69.57%
Follow-up After Hospitalization for Mental Illness—30 Days	NA	71.43%	64.37%	66.74%	36.04%	57.29%	67.65%	77.47%	84.28%
* Lower rates indicate better performance for this measure.									

	National Medicaid HEDIS 2012 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Table B.1—Trending for HEDIS 2011–2013
for Family Health Network, Inc.

HEDIS Measures	HEDIS Rates for FHN			HEDIS 2012 National Medicaid Percentiles				
	2011	2012	2013	10th	25th	50th	75th	90th
Child and Adolescent Care								
Childhood Immunizations—Combo 2	75.70	72.00	78.70	64.23	69.10	75.35	80.79	84.18
Childhood Immunizations—Combo 3	70.40	69.90	72.92	58.88	64.72	71.93	77.49	82.48
Lead Screening in Children	81.90	82.90	82.41	39.23	57.52	71.41	81.86	86.56
*Well-Child Visits in the First 15 Months (0 Visits)**	3.50	2.30	3.24	0.46	0.72	1.22	2.43	3.89
Well-Child Visits in the First 15 Months (6+ Visits)	53.80	50.10	50.23	43.80	54.31	62.95	70.70	77.31
Well-Child Visits (3–6 Years)	67.40	73.00	69.21	61.07	65.51	72.26	79.32	83.04
Adolescent Well-Care Visits	43.90	44.10	45.60	35.52	42.11	49.65	57.61	64.72
*Immunizations for Adolescents***	40.50	44.80	50.23	39.77	50.36	62.29	70.83	80.91
Children's Access to PCPs (12–24 Months)	82.20	91.80	75.42	93.06	95.56	97.02	97.88	98.39
Children's Access to PCPs (25 months–6 Years)	69.90	77.20	61.74	83.16	86.62	89.19	91.40	92.63
Children's Access to PCPs (7–11 Years)	51.10	53.10	60.84	83.37	87.56	90.58	92.88	94.51
Adolescents' Access to PCPs (12–19 Years)	53.00	54.60	61.20	81.78	86.04	89.21	91.59	93.01
Adults' Access to Preventive/Ambulatory Care								
20–44 Years of Age	64.60	69.20	64.90	67.40	77.96	82.34	85.43	88.52
45–64 Years of Age	67.40	74.10	67.54	78.26	84.09	87.31	89.94	90.96
Preventive Screening for Women								
Breast Cancer Screening	47.70	48.90	49.04	36.80	44.82	50.46	56.58	62.76
Cervical Cancer Screening	69.40	71.50	72.85	51.85	61.81	69.10	73.24	78.51
Chlamydia Screening (16–20 Years of Age)	62.50	59.00	58.02	42.94	48.80	54.18	61.21	67.38
Chlamydia Screening (21–24 Years of Age)	70.70	68.10	70.39	52.45	59.09	64.36	69.86	72.67
Chlamydia Screening (Combined Rate)	66.30	63.40	64.23	47.62	52.70	58.40	63.89	68.83

Table B.1—Trending for HEDIS 2011–2013
for Family Health Network, Inc.

HEDIS Measures	HEDIS Rates for FHN			HEDIS 2012 National Medicaid Percentiles				
	2011	2012	2013	10th	25th	50th	75th	90th
Maternity-Related Measures								
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	18.20	15.90	23.84	2.43	4.57	6.58	10.71	19.11
Frequency of Ongoing Prenatal Care (81–100% of Visits)	42.30	43.00	35.42	39.42	52.55	64.65	72.99	82.75
Timeliness of Prenatal Care	62.40	69.80	62.96	72.02	80.54	86.13	90.39	93.33
Postpartum Care	40.20	45.00	48.15	52.43	58.70	64.98	71.05	74.73
Chronic Conditions/Disease Management								
Controlling High Blood Pressure	45.60	43.40	46.02	42.22	50.00	57.52	63.65	69.11
Diabetes Care (HbA1C Testing)	79.20	79.50	77.43	74.90	78.54	82.38	87.01	91.13
*Diabetes Care (Poor HbA1c Control)**	69.90	63.60	55.43	28.95	34.33	41.68	50.31	58.24
Diabetes Care (Good HbA1c Control)	31.70	36.40	36.29	35.04	42.09	48.72	55.70	59.37
Diabetes Care (Eye Exam)	31.70	44.70	36.00	36.25	45.03	52.88	61.75	69.72
Diabetes Care (LDL-C Screening)	68.90	69.60	69.71	64.38	70.34	76.16	80.88	83.45
Diabetes Care (LDL-C Level <100 mg/dL)	29.50	27.70	26.86	23.06	28.47	35.86	41.02	46.44
Diabetes Care (Nephropathy Monitoring)	84.70	85.80	71.71	68.43	73.48	78.71	83.03	86.93
*Diabetes Care (BP < 140/80)***	NA	30.80	31.43	27.31	33.09	39.10	46.20	54.99
Diabetes Care (BP < 140/90)	54.60	52.60	54.29	47.02	54.48	63.50	69.82	75.44
Appropriate Medications for Asthma (Combined)	90.30	88.10	84.51	79.72	82.54	85.87	88.19	90.56
Follow-up After Hospitalization for Mental Illness—7 Days	70.90	69.20	63.98	24.03	32.20	46.06	57.68	69.57
Follow-up After Hospitalization for Mental Illness—30 Days	80.20	80.50	71.43	36.04	57.29	67.65	77.47	84.28

* Lower rates indicate better performance for these measures.

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

	Quality Performance Program Measures

Table B.2—Trending for HEDIS 2011–2013
for Harmony Health Plan of Illinois, Inc.

HEDIS Measures	HEDIS Rates for Harmony			HEDIS 2012 National Medicaid Percentiles				
	2011	2012	2013	10th	25th	50th	75th	90th
Child and Adolescent Care								
Childhood Immunizations—Combo 2	65.9	68.86	69.59	64.23	69.10	75.35	80.79	84.18
Childhood Immunizations—Combo 3	61.6	63.99	64.48	58.88	64.72	71.93	77.49	82.48
Lead Screening in Children	78.1	79.08	79.21	39.23	57.52	71.41	81.86	86.56
*Well-Child Visits in the First 15 Months (0 Visits)**	5.4	4.62	4.38	0.46	0.72	1.22	2.43	3.89
Well-Child Visits in the First 15 Months (6+ Visits)	51.3	51.34	56.20	43.80	54.31	62.95	70.70	77.31
Well-Child Visits (3–6 Years)	71.8	65.21	71.54	61.07	65.51	72.26	79.32	83.04
Adolescent Well-Care Visits	38.9	35.52	46.47	35.52	42.11	49.65	57.61	64.72
*Immunizations for Adolescents***	29.9	38.69	43.07	39.77	50.36	62.29	70.83	80.91
Children's Access to PCPs (12–24 Months)	86.5	88.82	88.89	93.06	95.56	97.02	97.88	98.39
Children's Access to PCPs (25 months–6 Years)	73.3	74.20	76.47	83.16	86.62	89.19	91.40	92.63
Children's Access to PCPs (7–11 Years)	70.5	70.95	72.95	83.37	87.56	90.58	92.88	94.51
Adolescents' Access to PCPs (12–19 Years)	71.4	72.32	73.44	81.78	86.04	89.21	91.59	93.01
Adults' Access to Preventive/Ambulatory Care								
20–44 Years of Age	69.3	70.81	71.09	67.40	77.96	82.34	85.43	88.52
45–64 Years of Age	68.8	71.33	72.82	78.26	84.09	87.31	89.94	90.96
Preventive Screening for Women								
Breast Cancer Screening	30.7	34.37	36.86	36.80	44.82	50.46	56.58	62.76
Cervical Cancer Screening	69.8	71.53	72.81	51.85	61.81	69.10	73.24	78.51
Chlamydia Screening (16–20 Years of Age)	46.1	50.06	50.60	42.94	48.80	54.18	61.21	67.38
Chlamydia Screening (21–24 Years of Age)	57.2	59.73	62.68	52.45	59.09	64.36	69.86	72.67
Chlamydia Screening (Combined Rate)	50.9	54.02	55.73	47.62	52.70	58.40	63.89	68.83

Table B.2—Trending for HEDIS 2011–2013
for Harmony Health Plan of Illinois, Inc.

HEDIS Measures	HEDIS Rates for Harmony			HEDIS 2012 National Medicaid Percentiles				
	2011	2012	2013	10th	25th	50th	75th	90th
Maternity-Related Measures								
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	16.5	14.84	14.11	2.43	4.57	6.58	10.71	19.11
Frequency of Ongoing Prenatal Care (81–100% of Visits)	39.9	42.09	43.55	39.42	52.55	64.65	72.99	82.75
Timeliness of Prenatal Care	64.7	64.72	74.70	72.02	80.54	86.13	90.39	93.33
Postpartum Care	48.7	49.64	49.39	52.43	58.70	64.98	71.05	74.73
Chronic Conditions/Disease Management								
Controlling High Blood Pressure	42.6	37.23	39.42	42.22	50.00	57.52	63.65	69.11
Diabetes Care (HbA1C Testing)	69.6	71.05	77.37	74.90	78.54	82.38	87.01	91.13
*Diabetes Care (Poor HbA1c Control)**	65.9	62.53	56.69	28.95	34.33	41.68	50.31	58.24
Diabetes Care (Good HbA1c Control)	29.4	29.44	36.50	35.04	42.09	48.72	55.70	59.37
Diabetes Care (Eye Exam)	18.2	27.49	27.25	36.25	45.03	52.88	61.75	69.72
Diabetes Care (LDL-C Screening)	63.7	59.85	65.45	64.38	70.34	76.16	80.88	83.45
Diabetes Care (LDL-C Level <100 mg/dL)	17.5	22.38	25.55	23.06	28.47	35.86	41.02	46.44
Diabetes Care (Nephropathy Monitoring)	67.4	67.64	71.53	68.43	73.48	78.71	83.03	86.93
*Diabetes Care (BP < 140/80)***	NA	31.14	30.90	27.31	33.09	39.10	46.20	54.99
Diabetes Care (BP < 140/90)	49.6	48.66	48.42	47.02	54.48	63.50	69.82	75.44
Appropriate Medications for Asthma (Combined)	86.0	79.89	84.14	79.72	82.54	85.87	88.19	90.56
Follow-up After Hospitalization for Mental Illness—7 Days	42.7	41.81	50.44	24.03	32.20	46.06	57.68	69.57
Follow-up After Hospitalization for Mental Illness—30 Days	56.1	57.10	64.37	36.04	57.29	67.65	77.47	84.28

* Lower rates indicate better performance for these measures.

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

	Quality Performance Program Measures

Table B.3—Trending for HEDIS 2011–2013
for Meridian Health Plan, Inc.

HEDIS Measures	HEDIS Rates for Meridian			HEDIS 2012 National Medicaid Percentiles				
	2011	2012	2013	10th	25th	50th	75th	90th
Child and Adolescent Care								
Childhood Immunizations—Combo 2		87.0%	84.89%	64.23	69.10	75.35	80.79	84.18
Childhood Immunizations—Combo 3		83.3%	82.73%	58.88	64.72	71.93	77.49	82.48
Lead Screening in Children		92.2%	85.97%	39.23	57.52	71.41	81.86	86.56
*Well-Child Visits in the First 15 Months (0 Visits)**		0.00%	0.58%	0.46	0.72	1.22	2.43	3.89
Well-Child Visits in the First 15 Months (6+ Visits)		82.0%	92.40%	43.80	54.31	62.95	70.70	77.31
Well-Child Visits (3–6 Years)		84.9%	88.90%	61.07	65.51	72.26	79.32	83.04
Adolescent Well-Care Visits		66.7%	79.65%	35.52	42.11	49.65	57.61	64.72
*Immunizations for Adolescents***		NA	68.57%	39.77	50.36	62.29	70.83	80.91
Children's Access to PCPs (12–24 Months)	100%	100%	96.74%	93.06	95.56	97.02	97.88	98.39
Children's Access to PCPs (25 months–6 Years)	92.1%	92.1%	95.52%	83.16	86.62	89.19	91.40	92.63
Children's Access to PCPs (7–11 Years)		81.3%	95.28%	83.37	87.56	90.58	92.88	94.51
Adolescents' Access to PCPs (12–19 Years)		90.0%	94.93%	81.78	86.04	89.21	91.59	93.01
Adults' Access to Preventive/Ambulatory Care								
20–44 Years of Age	90.5%	89.1%	88.21%	67.40	77.96	82.34	85.43	88.52
45–64 Years of Age		91.1	90.55%	78.26	84.09	87.31	89.94	90.96
Preventive Screening for Women								
Breast Cancer Screening		NA	65.52%	36.80	44.82	50.46	56.58	62.76
Cervical Cancer Screening		84.4%	80.56%	51.85	61.81	69.10	73.24	78.51
Chlamydia Screening (16–20 Years of Age)		NA	58.95%	42.94	48.80	54.18	61.21	67.38
Chlamydia Screening (21–24 Years of Age)		67.4%	70.73%	52.45	59.09	64.36	69.86	72.67
Chlamydia Screening (Combined Rate)		60.8%	65.60%	47.62	52.70	58.40	63.89	68.83

Table B.3—Trending for HEDIS 2011–2013
for Meridian Health Plan, Inc.

HEDIS Measures	HEDIS Rates for Meridian			HEDIS 2012 National Medicaid Percentiles				
	2011	2012	2013	10th	25th	50th	75th	90th
Maternity-Related Measures								
*Frequency of Ongoing Prenatal Care (<21% of Visits)**		1.4%	0.81%	2.43	4.57	6.58	10.71	19.11
Frequency of Ongoing Prenatal Care (81–100% of Visits)		94.5%	95.97%	39.42	52.55	64.65	72.99	82.75
Timeliness of Prenatal Care	98.2%	93.9%	96.37%	72.02	80.54	86.13	90.39	93.33
Postpartum Care	85.5%	76.2%	83.06%	52.43	58.70	64.98	71.05	74.73
Chronic Conditions/Disease Management								
Controlling High Blood Pressure		NA	NA	42.22	50.00	57.52	63.65	69.11
Diabetes Care (HbA1C Testing)		NA	93.18%***	74.90	78.54	82.38	87.01	91.13
*Diabetes Care (Poor HbA1c Control)**		NA	70.45%***	28.95	34.33	41.68	50.31	58.24
Diabetes Care (Good HbA1c Control)		NA	22.73%***	35.04	42.09	48.72	55.70	59.37
Diabetes Care (Eye Exam)		NA	75.00%***	36.25	45.03	52.88	61.75	69.72
Diabetes Care (LDL-C Screening)		NA	84.09%***	64.38	70.34	76.16	80.88	83.45
Diabetes Care (LDL-C Level <100 mg/dL)		NA	34.09%***	23.06	28.47	35.86	41.02	46.44
Diabetes Care (Nephropathy Monitoring)		NA	75.00%***	68.43	73.48	78.71	83.03	86.93
*Diabetes Care (BP < 140/80)***		NA	9.09%***	27.31	33.09	39.10	46.20	54.99
Diabetes Care (BP < 140/90)		NA	13.64%***	47.02	54.48	63.50	69.82	75.44
Appropriate Medications for Asthma (Combined)		NA	NA	79.72	82.54	85.87	88.19	90.56
Follow-up After Hospitalization for Mental Illness–7 Days		NA	NA	24.03	32.20	46.06	57.68	69.57
Follow-up After Hospitalization for Mental Illness–30 Days		NA	NA	36.04	57.29	67.65	77.47	84.28

* Lower rates indicate better performance for these measures.

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

*** Denominator = 44

NA: Denominator less than 30

Quality Performance Program Measures

Table C.1—Voluntary Managed Care Organizations
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Performance Measures

Beginning Contract Year	Indicator	Methodology
Year 1	Effectiveness of Care: Childhood Immunization Status—Combo 3	HEDIS
Year 1	Effectiveness of Care: Breast Cancer Screening	HEDIS
Year 1	Effectiveness of Care: Cervical Cancer Screening	HEDIS
Year 1	Effectiveness of Care: Use of Appropriate Medications for Enrollees with Asthma	HEDIS
Year 1	Effectiveness of Care: Comprehensive Diabetes Care	HEDIS
Year 1	Effectiveness of Care: Controlling High Blood Pressure—Rates for <140/90	HEDIS
Year 1	Effectiveness of Care: Chlamydia Screening in Women	HEDIS
Year 1	Effectiveness of Care: Follow-up after Hospitalization for Mental Illness; 7-day and 30-day Follow-up	HEDIS
Year 1	Access/Availability of Care: Prenatal and Postpartum Care	HEDIS
Year 1	Frequency of Ongoing Prenatal Care	HEDIS
Year 1	Access/Availability of Care: Adults' Access to Preventive/Ambulatory Health Services—Total Rate	HEDIS
Year 1	Access/Availability of Care: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Combined Rate	HEDIS
Year 1	Use of Services: Well-Child Visits During the First 15 Months of Life—Six or more visits	HEDIS
Year 1	Use of Services: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	HEDIS
Year 1	Effectiveness of Care: Antidepressant Medication Management	HEDIS
Year 1	Access/Availability of Care: Children's and Adolescents' Access to Primary Care Providers	HEDIS
Year 1	Effectiveness of Care: Childhood Lead Screening	HEDIS
Year 1	Use of Services: Ambulatory Care	HEDIS
Year 1	CAHPS 4.0	HEDIS
Year 2	Use of Services: Adolescent Well-Care Visits	HEDIS
Year 2	Effectiveness of Care: Adolescent Immunization Status	HEDIS
Year 3	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment for Children/Adolescents	HEDIS

Table C.1—Voluntary Managed Care Organizations
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Performance Measures

Beginning Contract Year	Indicator	Methodology
Year 3	Developmental Screening in the First Three Years of Life	CAHMI & NCQA
Year 3	Appropriate Testing for Children with Pharyngitis	HEDIS
Year 3	Ambulatory Care: Emergency Department Visits	HEDIS
Year 3	Annual Number of Asthma Patients Ages 2–20 with ≥1 Asthma-related ER Visit	Alabama Medicaid
Year 3	Follow-up Care for Children Prescribed ADHD Medication	HEDIS
Year 3	Annual Pediatric Hemoglobin A1C Testing	NCQA
Year 3	Effectiveness of Care: Childhood Immunization Status—Combos 2–10	HEDIS
1/1/2014	Human Papillomavirus (HPV) Vaccines for Females	NCQA
1/1/2014	Medication Management for People with Asthma	NCQA
1/1/2014	Behavioral Health Risk Assessment (for Pregnant Women)	AMA-convened Physician Consortium for Performance Improvement