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 2014

(July 1, 2013-June 30, 2014)

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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) 2014 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.

Purpose of Report

The SFY 2014 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 health plans for the SFY 2014 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the State requirements.

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

Federal regulations at 42 CFR 438.364 call for the production by each state of a detailed technical report on EQR results. 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 HFS-contracted health plans. 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 health plan'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 health plan, makes comparisons of plan performance, and describes performance improvement efforts.

Report Organization

The EQR technical report is organized as follows:

- **Section 1—Executive Summary** describes the purpose of this report and its organization, the scope of the report (mandatory and optional EQR activities), and a summary of overall conclusions and recommendations.
- **Section 2—Introduction and Background** provides the history of State Medicaid and describes its eligibility requirements, enrollment, and programs. Section 2 also 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 3—Mandatory Regulatory Requirements** includes an assessment of each health plan's strengths and weaknesses in regard to quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries. This includes a description of activities, initiatives, and priority measures that support the Quality Strategy goals.
- **Section 4—Performance Improvement Projects** (PIPs) describes the validation process and conclusions for PIPs and describes the PIP interventions and outcomes for each PIP conducted by health plans during the report period.
- **Section 5—Performance Measures** describes the validation process and conclusions for the reporting year, including a description of the assessment of the health plans' information systems (IS). It also provides an evaluation of the health plans' ability to collect and accurately report on the performance measures and presents performance measure results for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] 2013 and trended HEDIS measures from 2011–2014.
- **Section 6—Administrative Compliance Reviews** describes the administrative assessment activities, including readiness activities, conducted for each health plan. For each of the activities, the report presents the objectives, technical methods of data collection and analysis, description of data obtained, findings for each health plan, and conclusions drawn from the data. The care management/care coordination staffing review process, the methods and findings of the CMS Home and Community-Based Services (HCBS) Waiver record reviews,

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

and the provider network capacity validation activities conducted by HSAG during the reporting year are also presented.

- **Section 7—Additional EQR Activities** describes additional activities conducted by the EQRO including validation of encounter data, validation of State measures for Primary Care Case Management/Children's Health Insurance Program Reauthorization Act (PCCM/CHIPRA), and a description of focused reviews conducted during the reporting year. The section also describes monthly and quarterly managed care meetings and technical assistance to HFS and the health plans.
- **Section 8—Consumer Quality of Care Surveys** presents the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys and other member satisfaction surveys conducted by health plans and HFS during the report period.
- **Appendix A**—displays the voluntary managed care organization (VMCO) HEDIS 2014 Medicaid rates for voluntary managed care (VMC).
- **Appendix B**—displays the Illinois Performance Measure 2013 Medicaid rates for the Integrated Care Program (ICP).
- **Appendix C**—displays a list of acronyms that are used throughout this report.

Overview of the SFY 2014 External Quality Review

Mandatory EQR Activities

The SFY 2014 EQR Technical Report focuses on the three federally mandated EQR activities that HSAG performed over a 12-month period (July 1, 2013, to June 30, 2014). As set forth in 42 CFR 438.352, these mandatory activities were:

- **Validation of PIPs.** As part of the SFY 2014 review, HSAG validated PIPs conducted by the health plans regarding compliance with requirements set forth in 42 CFR 438.240(b)(1). In SFY 2014 the health plans continued their PIPs on the topics of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening and perinatal care and depression screening. In addition, the ICP continued the *Community Based Care Coordination* PIP.
- **Validation of performance measures.** The State contracted with HSAG to conduct a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit[1-3] of 2013 data for the health plans. The process of validating performance measures includes two elements: (1) validation of a health plan's data collection process and (2) a review of performance measure results compared with other health plans and national benchmarks. This report presents the performance measure results for the health plans.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-3] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

- **Review, within the previous three-year period, to determine health plan compliance with State standards for access to care, structure and operations, and quality measurement and improvement.** HSAG spent SFY 2014 working with HFS to develop and conduct the operational readiness review process for the Family Health Plan/Accountable Care Act (FHP/ACA) program, ICP, Care Coordination Entities (CCEs), Accountable Care Entities (ACEs), and the Medicare-Medicaid Alignment Initiative (MMAI) as part of the expansion of managed care. During this reporting period, HSAG did not conduct a review of the health plans' compliance with State standards.
- **Staffing and qualifications reviews.** HFS contracted with HSAG to conduct reviews to ensure health plans had adequate staffing to serve members and that staff members were appropriately qualified by assessing compliance with qualifications, related experience, full-time equivalent (FTE) allocation, caseload assignments, annual training, and training curriculum.
- **CMS HCBS Waiver record reviews.** HFS contracted HSAG to review compliance with the HCBS Waiver measures for each ICP health plan to monitor the quality of services and supports provided to the HCBS waiver program enrollees.
- **Validation of provider network capacity.** HSAG was contracted to conduct a provider network validation of the health plans' provider networks as a key component of the pre-implementation readiness reviews. The network analysis and validation allows HFS to evaluate the provider networks across the health plans using a consistent and standardized approach.

Additional and Optional EQR Activities

Other EQR activities conducted by HSAG included:

- **Validation of encounter data.** HSAG was contracted to conduct an encounter data validation (EDV) study. The goal of the study was to assess the degree of data file completeness, accuracy, and timeliness across two health plans in order to provide insight into the quality of HFS' overall encounter data system.
- **Validation of State performance measures.** HSAG conducts annual validation of performance measures for the PCCM Program, the ICP, and the Children's Health Insurance Program (CHIP) using the CHIPRA measures.
- **Focused reviews.** At the request of HFS, HSAG conducts focused reviews and special projects as necessary.
- **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, including on-site quarterly meetings with the health plans as well as monthly teleconference meetings.

- **Provision of technical assistance.** HSAG provides ongoing technical assistance to HFS and the health plans throughout the reporting year at the request of HFS.
- **Assessment of consumer quality of care surveys.** Each year, the health plans are required to independently administer a consumer satisfaction survey. As part of its SFY 2014 review, HSAG evaluated the results of Adult and Child CAHPS® surveys conducted in 2013 and 2014 by The Myers Group and the Center for the Study of Services (CSS) to identify trends, strengths, and opportunities for improvement.[1-4]

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 health plan.

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

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

- Performance measure audits using NCQA's standardized audit methodology (as described in Section 5 of this report).
- PIP results (as described in Section 4 of this report).
- Member satisfaction survey results (as described in Section 8 of this report).
- Operational readiness reviews findings (as described in Section 6 of this report).
- Technical assistance to HFS and health plans (as described in Section 7 of this report).

Summary of Mandatory Activities

PIPs

VMC 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

[1-4] The Myers Group administered the CAHPS surveys on behalf of **FHN**, **Harmony**, and **IlliniCare**. The CSS administered the CAHPS survey on behalf of **Aetna**.

regulations, HFS' EQRO validates PIPs to determine if the PIPs were designed to achieve improvement in clinical and/or 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 health 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 health 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 health 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 health plans' improvement strategies.

HFS required the three VMC health plans—**Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**)—to participate in a mandatory statewide PIP focused on the following two topics:

- *EPSDT Screening*
- *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 Screening* PIP is *total number of children who received six or more well-child visits in the first 15 months of life.*

During SFY 2014, all three VMC health plans progressed to implementing interventions for the *EPSDT Screening* PIP. Overall, out of 21 study indicators across the health plans, 20 demonstrated improvement. Of those, 11 demonstrated statistically significant improvement. **FHN** had one study indicator that demonstrated a decline for this measurement period; however, the decline was not statistically significant.

The primary purpose of the *Perinatal Care and Depression Screening* collaborative PIP was to determine if health plan 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. Eleven of **Harmony**'s 15 study indicators (73 percent) achieved improvement; and for six of those, the improvement was statistically significant. Six of **FHN**'s 13 reported study indicators demonstrated improvement for this measurement period, with four being statistically significant. **Meridian** had seven study indicators that demonstrated improvement for Remeasurement 3, with three demonstrating statistically significant improvement.

Section 4 of this report details the validation process for PIPs and the results of and recommendations for the PIPs conducted during the report period.

ICP PIPs

HFS required health plans delivering ICP services to participate in a mandatory, statewide PIP, *Community Based Care Coordination*. The statewide PIP focused on improving care coordination and the linkage of the member/client to ambulatory care and community services. 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 Better Health** (**Aetna**) and **IlliniCare Health Plan, Inc.** (**IlliniCare**) progressed to reporting first remeasurement data for the three study indicators and implemented interventions for the SFY 2014 validation cycle. Both **Aetna** and **IlliniCare** achieved statistically significant improvement in all three study indicators for the first remeasurement.

Performance Measures

Voluntary Managed Care

For ease of review, this report organizes performance reporting by classifying performance measures into the following measure sets, which are aligned with those included in the Quality Strategy. Measures in these sets provide information on the quality of, timeliness of, and access to healthcare services furnished to HFS beneficiaries.

- Access to Care
- Child and Adolescent Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health

Access to Care

The measures identified below fall into the HEDIS Access to Care domain. These measures examine how members access healthcare services offered by the health plan. The measures cover preventive and ambulatory services for adult, child, and adolescent members, as well as alcohol and drug dependence treatment. The following table presents HEDIS measures regarding access to care.

Table 1.1—HEDIS Measures for Access to Care

Category	HEDIS Measure
Access to Care	*Children and Adolescents' Access to Primary Care Practitioners* ◆ *12–24 Months* ◆ *25 Months–6 Years* ◆ *7–11 Years* ◆ *12–19 Years*
	Adults' Access to Preventive/Ambulatory Health Services ◆ *20–44 Years* ◆ *45–64 Years* ◆ *Total*
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ◆ *Initiation of AOD Treatment—13–17 Years* ◆ *Initiation of AOD Treatment—18+ Years* ◆ *Initiation of AOD Treatment—Total* ◆ *Engagement of AOD Treatment—13–17 Years* ◆ *Engagement of AOD Treatment—18+ Years* ◆ *Engagement of AOD Treatment—Total*

For this measure set, when compared to last year's results, **FHN**'s rates declined for six out of 13 measures and improved for seven measures. **Harmony**'s rates improved for seven measures, declined for five measures, and remained the same for one measure relative to the previous year. However, even with this improvement, both **FHN** and **Harmony** performed well below the 2013 Quality Compass 50th percentiles for most measures, particularly for measures related to children's, adolescents', and adults' access to care. Therefore, internal policies regarding member and provider education should be evaluated.

When compared to last year's results, **Meridian**'s rates declined for six measures and increased for five measures. Two measures were reported as "NA." However, even with these mixed results, **Meridian** continued to outperform the other two health plans for all measures and performed at or above the 2013 Quality Compass 50th percentiles for all but one measure (*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment–18+ Years*) in this measure set.

Child and Adolescent Care

The measures identified below fall into the Child and Adolescent Care 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 management and on how the health plan uses available health services and resources to manage chronic diseases. The following table summarizes the HEDIS measures regarding care for children and adolescents.

Table 1.2—HEDIS Measures for Child and Adolescent Care

Category	HEDIS Measure
Child and Adolescent Care	*Childhood Immunization Status (Combinations 2 and 3)* ◆ *Combination 2* ◆ *Combination 3*
	◆ *Lead Screening in Children*
	Immunizations for Adolescents ◆ *Combination 1 (Meningococcal, Tdap/Td)*
	◆ *Human Papillomavirus Vaccine for Female Adolescents*
	Well-Child Visits in the First 15 Months of Life ◆ *No Well-Child Visits* ◆ *Six or More Well-Child Visits*
	◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
	◆ *Adolescent Well-Care Visits*
	◆ *Appropriate Testing for Children With Pharyngitis*
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents ◆ *BMI Percentile Documentation—Total* ◆ *Counseling for Nutrition—Total* ◆ *Counseling for Physical Activity—Total*

Of the 13 measures in the Child and Adolescent Care category, rates for **FHN** improved for eight measures and declined for four measures. One measure could not be compared to last year because no rate was reported.

Harmony showed improvement for eight measures and declined for four measures. One measure could not be compared to the prior year. **Meridian** achieved rates at or above the 2013 Quality Compass 50th percentiles on 11 of the 13 measures/indicators in this measure set, with eight measures improving and five measures declining. **FHN** and **Harmony** met or exceeded the 2013 Quality Compass 50th percentile for five and four measures, respectively.

FHN, **Harmony**, and **Meridian** all exceeded the 2013 Quality Compass 50th percentiles for the following three measures—*Lead Screening in Children*, *Adolescent Well-Care Visits*, and indicators under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition–Total.*

The overall results for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure signified that approximately 95.0 percent of the eligible children received at least one well-child visit in their first 15 months of life for the 2014 measurement year. However, only **Meridian** reported a rate above the 2013 Quality Compass 50th percentile. Though **FHN** and **Harmony** did not achieve rates above the 2013 Quality Compass 50th percentiles for this measure, both health plans displayed an overall rate improvement since the 2012 reporting year.

None of the health plans met the 2013 Quality Compass 50th percentile for *Appropriate Testing for Children With Pharyngitis*. For **Harmony** and **FHN**, the *Human Papillomavirus Vaccine for Female Adolescents* measure demonstrated the greatest possibility for improvement when compared to 2013 Quality Compass 50th percentiles.

Women's Health

The Women's Health measures fall into the Effectiveness of Care, and Utilization and Relative Resource Use HEDIS domains. The measures examine how well the health plan provides timely prenatal care and care to women following delivery. The measures also consider the frequency of prenatal care, which may provide information about how the stage of a woman's pregnancy when she enrolls in the health plan impacts the health plan's ability to provide effective pregnancy-related care. In addition to maternity-related care, the measures cover preventive screenings performed for breast cancer, cervical cancer, and chlamydia. The following table presents HEDIS measures related to women's health.

Table 1.3—HEDIS Measures for Women's Health

Category	HEDIS Measure
Women's Health	◆ *Breast Cancer Screening*
	◆ *Cervical Cancer Screening*
	Chlamydia Screening in Women ◆ *16–20 Years* ◆ *21–24 Years* ◆ *Total*
	Prenatal and Postpartum Care ◆ *Timeliness of Prenatal Care* ◆ *Postpartum Care*
	Frequency of Ongoing Prenatal Care ◆ *<21 Percent of Expected Visits* ◆ *>81 Percent of Expected Visits*

FHN improved rates for the *Breast Cancer Screening* and *Chlamydia Screening in Women—16–20 Years* measures by 3.63 percentage points and 1.33 percentage points, respectively, but saw rate declines for the other seven measure indicators. As with the last reporting year, the rates reported by **FHN** continued to fall below 2013 results for six of eight measures, and were below the 2013 Quality Compass 50th percentiles for half of the measures in the Women's Health measure set.

Similar to **FHN**, **Harmony** displayed a slight rate increase for only two of the nine measures in this measure set (*Breast Cancer Screening* and *Frequency of Ongoing Prenatal Care–<21 Percent of Expected Visits). Breast Cancer Screening* improved by 6.13 percentage points and *Frequency of Ongoing Prenatal Care–<21 Percent of Expected Visits* improved by 1.32 percentage points. The health plan showed lower rates for the other seven measures. Additionally, none of the women's health measures reported by **Harmony** met the 2013 Quality Compass 50th percentiles.

Meridian demonstrated rate improvements for only two measures in this measure set: *Cervical Cancer Screening* and *Chlamydia Screening in Women—21–24 Years*. However, **Meridian** exceeded the 2013 Quality Compass 50th percentiles for six out of the seven measures in this measure set with available benchmarks, and outperformed the other two health plans.

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 have been identified in prior years, and **FHN** and **Harmony** have initiated improvements to their processes. The improvements realized, however, have been marginal. To determine the reason for the low compliance, the health plans should continue to conduct root-cause analysis and develop interventions to improve the rates in this measure set.

Care for Chronic Conditions

The Care for Chronic Conditions measures fall into the Effectiveness of Care HEDIS domain. The measures examine how well care is delivered to members with chronic disease and how well the health plans' healthcare delivery system helps members cope with their illness. The following table presents HEDIS measures regarding care for chronic conditions.

Table 1.4—HEDIS Measures for Care for Chronic Conditions

Category	HEDIS Measure
Care for Chronic Conditions	*Comprehensive Diabetes Care* ◆ *Hemoglobin A1c (HbA1c) Testing* ◆ *HbA1c Poor Control (>9.0%)1* ◆ *HbA1c Control (<8.0%)* ◆ *Eye Exam (Retinal) Performed* ◆ *LDL-C Screening* ◆ *LDL-C Control (<100 mg/dL)* ◆ *Medical Attention for Nephropathy* ◆ *BP Control (<140/90 mm Hg)* ◆ *BP Control (<140/80 mm Hg)*
	◆ *Controlling High Blood Pressure*
	Use of Appropriate Medications for People With Asthma ◆ *5–11 Years* ◆ *12–18 Years* ◆ *19–50 Years* ◆ *51–64 Years* ◆ *Total*
	Medication Management for People With Asthma ◆ *Medication Compliance 50%—5–11 Years* ◆ *Medication Compliance 50%—12–18 Years* ◆ *Medication Compliance 50%—19–50 Years* ◆ *Medication Compliance 50%—51–64 Years* ◆ *Medication Compliance 50%—Total* ◆ *Medication Compliance 75%—5–11 Years* ◆ *Medication Compliance 75%—12–18 Years* ◆ *Medication Compliance 75%—19–50 Years* ◆ *Medication Compliance 75%—51–64 Years* ◆ *Medication Compliance 75%—Total*

Rates for three measures in this measure set were not displayed due to low denominators in 2014 (i.e., less than 30 eligible cases). **FHN** improved its performance for six out of 14 measures with reported rates in both 2013 and 2014. **FHN**'s rates declined for eight measures in this measure set. **FHN** met or exceeded the 2013 Quality Compass 50th percentiles for 10 measures in the Care for Chronic Conditions measure set and fell below the 2013 Quality Compass 50th percentiles for 12 measures.

Harmony demonstrated improved rates from 2013 to 2014 for 13 measures in this measure set. **Harmony** had nine measures for which reported rates fell slightly below last year's rates. **Harmony** met or exceeded the 2013 Quality Compass 50th percentiles for two of its 22 measures with reportable or available rates in 2014 in this measure set.

For nine of the 25 measures it reported, **Meridian** had less than 30 eligible cases; therefore, the rates are not presented. Health plan comparison for this measure set should be used with caution since **Meridian** is reporting its rates based on small population size. However, 13 of the measures reported exceeded the 2013 Quality Compass 50th percentiles, including all reported indicators under *Use of Appropriate Medications for People With Asthma* and *Medication Management for People With Asthma.*

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 1.5—HEDIS Measure for Behavioral Health

Category	HEDIS Measure
Behavioral Health	*Follow-up After Hospitalization for Mental Illness (7 Days and 30 Days)* ◆ *7-Day Follow-Up* ◆ *30-Day Follow-Up*
	Antidepressant Medication Management ◆ *Effective Acute Phase Treatment* ◆ *Effective Continuation Phase Treatment*

Compared to the previous year, **FHN**'s rates for both *Follow-Up After Hospitalization for Mental Illness* measures fell—by 9.78 percentage points for the *7-Day Follow-Up* measure and by 9.85 percentage points for the *30-Day Follow Up* measure. However, even with the decline in rates, **FHN** still exceeded the 2013 Quality Compass 50th percentile for the *7-Day Follow-Up* measure.

Harmony demonstrated a rate increase compared to last year for two of the four Behavioral Health measures. Both rates for *Follow-Up After Hospitalization for Mental Illness* increased, while both the *Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measures for *Antidepressant Medication Management* decreased by 7.76 percentage points and 1.47 percentage points, respectively. In addition, **Harmony** exceeded the 2013 Quality Compass 50th percentile for the *7-Day Follow-Up* and *30-Day Follow-Up* rates.

FHN and **Harmony** both outperformed **Meridian**, for which performance for two out of the four measures declined and no measures in the Behavioral Health measure set exceeded the 2013 Quality Compass 50th percentiles.

Integrated Care Program

Aetna and **IlliniCare** have participated in the ICP since 2011. SFY 2014 was the second year reporting the ICP measures.

Aetna's rates for four measures represented a decline from the baseline rates. Overall, rates for 13 measures improved from the baseline rates. The rates for **IlliniCare** showed that rates for four measures declined and rates for 13 measures improved from the baseline rates.

Overall, **Aetna** achieved a *Met* status for five pay-for-performance (P4P) measures, which included meeting the target goals for 12 of the individual rates. Eight individual rates did not meet the target goals. **Aetna** achieved a *Met* status for *Congestive Heart Failure (CHF)* for a second consecutive year and improved performance for both *Comprehensive Diabetes Care (CDC)* and *Coronary Artery Disease (CAD)* to meet the overall goals. **Aetna** also continued to show good performance for reducing ambulatory care emergency department visits and effectively monitoring antidepressant medication management.

IlliniCare achieved a *Met* status for one measure and seven individual rates; the remaining 13 individual rates reported did not meet the target goals. **IlliniCare** improved performance for CAD to meet the overall measure goal, after previously failing to meet the overall goal, and continued to show good performance for reducing ambulatory care ED visits.

Aetna and **IlliniCare** both failed to meet the target goals for the *Pharmacotherapy Management of COPD Exacerbation* measure category. In addition, neither ICP health plan met the target goals for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up; Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit*; *Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge*; *Ambulatory Care—ED Visits per 1,000 Member Months;* and *Bronchodilator Dispensed within 30 Days of the Event.*

Encounter Data Completeness

The health plans 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 able to reach at least 90.0 percent encounter data completeness for four measures. Eleven measures showed data completeness less than 50.0 percent. Although 13 measures demonstrated an 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 are strongly encouraged.

Harmony exceeded 90.0 percent data completeness for five out of 26 measures. In addition, **Harmony** continued to outperform **FHN** in data completeness for all but four measures. Seven

of the 26 measures had data completeness less than 50.0 percent. However, when compared to last year's results, **Harmony**'s data completeness improved for 11 measures. **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, except for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Comprehensive Diabetes Care* measures. **Meridian** had five measures with encounter data completeness levels of 100.0 percent and three measures with encounter data completeness rates below 50.0 percent. **Meridian** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission for the select measures that are not solely determined through administrative data.

Administrative Compliance Reviews

During SFY 2014, HSAG focused on working with HFS to develop and conduct the readiness review process for FHP/ACA, ICP, and MMAI health plans as well as the CCEs and ACEs, as part of the expansion of managed care. Readiness review activities occurred for some health plans even though they did not implement the program until the following fiscal year as noted by the "go live" dates listed in this section. 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 readiness review tool included requirements that addressed operational areas necessary to service the targeted population and ensure that health plans had the system capacity needed to enroll recipients in their designated service areas.

HSAG conducted five readiness reviews to ensure the health plans that would serve the FHP/ACA population were prepared for the rollout from voluntary to mandatory managed care. New health plans joined the ICP so that there were nine participating during the reporting period. Some health plans began servicing this population at a later date than others, so the ICP health plan reviews were staggered as necessary to ensure each health plan had the system capacity needed to enroll recipients in the designated service areas. Three ICP health plan readiness reviews were conducted during the reporting period. Eight MMAI health plans were reviewed to evaluate their readiness to provide services. The primary objective of the CCE and ACE readiness reviews was to evaluate implementation of care coordination programs and readiness to provide services. HSAG conducted six CCE and seven ACE reviews during the reporting period.

HSAG and HFS used a standardized monitoring tool to document follow-up on any elements that required corrective action and monitored corrective actions until successfully completed. HSAG and HFS determined, prior to client enrollment, whether each health plan's internal organizational structure, health information systems, and staffing and oversight were sufficient to ensure ongoing compliance with contract requirements, quality oversight, and monitoring. Once enrollment

began, health plans, CCEs and ACEs were required to submit monthly reports monitoring care coordination, provider network development and capacity, and staffing. Detailed results of all readiness review activities can be found in Section 6, as well as a description of other compliance review activities such as staff and qualifications reviews and provider network capacity validation activities.

Additional EQR Activities

Throughout the reporting year, HSAG conducts additional EQR activities at the request of HFS such as validation of encounter data, validation of State measures for PCCM/CHIPRA, focused reviews, special projects, monthly and quarterly managed care meetings, and technical assistance to HFS and the health plans. Many of these activities are ongoing or require continued monitoring. They are presented in detail in Section 7 of this report.

Member Satisfaction Surveys

Member satisfaction surveys are designed to capture accurate and reliable information from consumers about their experiences with healthcare. The CAHPS 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**, **IlliniCare**, and **Meridian** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf.

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 healthcare. 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). The following tables present the CAHPS measures regarding member satisfaction.

Table 1.6—CAHPS Measures for Adult and Child Medicaid

CAHPS Measure
Composite Measures
Getting Needed Care
Getting Care Quickly
How Well Doctors Communicate
Customer Service
Shared Decision Making

CAHPS Measure
Global Ratings
Rating of All Health Care
Rating of Personal Doctor
Rating of Specialist Seen Most Often
Rating of Health Plan

VMC CAHPS

A comparison of **FHN**'s 2013 results to its 2014 results revealed that **FHN**'s Adult CAHPS rates increased for four measures but decreased for five measures, including scoring substantially below the 2014 NCQA CAHPS top-box national average on two measures: *Getting Needed Care* and *Getting Care Quickly*. **FHN**'s rates increased for six of the Child CAHPS measures; however, rates for three measures decreased from 2013 and the health plan scored substantially below the 2014 NCQA CAHPS top-box national average on four measures.

Harmony's 2013 to 2014 results showed an increase in rates for six Adult CAHPS measures and a decrease in three measures. For six of the measures, **Harmony** scored substantially below the 2014 NCQA CAHPS top-box national averages. For its Child CAHPS surveys, **Harmony** showed increases in rates for two measures but its rates decreased from 2013 to 2014 for seven measures.

Meridian scored substantially above the 2014 NCQA CAHPS top-box national averages on three Adult CAHPS measures (*Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*) and two Child CAHPS measures (*Customer Service and Rating of Health Plan*).

A comparison of the health plans' results showed that **Meridian** outperformed **FHN** and **Harmony** on eight of the nine Adult CAHPS measures. For 2014, **FHN** had the lowest rates among the three health plans for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. **FHN** also had the highest rate among the three health plans on one measure. For 2014, **Harmony** did not outperform **FHN** or **Meridian** on any of the measures and showed the lowest rates for five measures.

A comparison of **FHN**'s, **Harmony**'s, and **Meridian**'s Child CAHPS results show that **Meridian** outperformed **FHN** and **Harmony** on seven of the measures, scoring substantially higher than the other health plans on five of these seven measures. **FHN** scored lowest among the health plans on three measures (*Customer Service*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*) and did not score highest on any of the CAHPS measures. **Harmony** scored lowest among the three health plans on six measures and outperformed **FHN** and/or **Meridian** on two measures: *Shared Decision Making* and *Rating of Specialist Seen Most Often*.

ICP CAHPS

The ICP health plans collected valid surveys from their eligible adult Medicaid population. Both **IlliniCare** and **Aetna** showed rate increases for five of the nine Adult CAHPS measures. **Aetna** scored substantially higher than **IlliniCare** on one measure (*Shared Decision Making),* but **IlliniCare** scored higher than **Aetna** on seven measures.

CAHPS Recommendations

HSAG provided general recommendations based on the information found in the CAHPS literature which are intended to address those areas for which CAHPS measure performance was low and opportunities for improvement exist for health plans. These recommendations are detailed in Section 8 of this report.

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' Division of Medical Programs is responsible for administering the State of Illinois' Medical Assistance Programs under the provisions of the Illinois Public Aid Code (305 ILCS 5/5 et seq.), the Illinois Children's Health Insurance Program Reauthorization Act (CHIPRA) (215 ILCS 106/1 et seq.), Covering All Kids Health Insurance Act (215 ILCS 170/1 et seq.), and Titles XIX and XXI of the federal Social Security Act 1932(a). 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 managed care organizations (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 managed care. 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 Children's Health Insurance Program (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 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 through a variety of managed care programs.

Care coordination is the centerpiece of Illinois' Medicaid reform. It's aligned with Illinois' Medicaid reform law and the Affordable Care Act (ACA). 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 State Fiscal Year (SFY) 2014:

- Phased in the Family Health Plan/Accountable Care Act (FHP/ACA) program in July 2014, as part of the rollout to mandatory managed care to replace the former VMC. FHP/ACA is a mandatory program for children and their families as well as the newly eligible ACA adults. During the reporting period, HFS' External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), conducted readiness reviews for those health plans that would serve the FHP/ACA population as detailed in Table 2.1.

Table 2.1—Readiness Review Activities for FHP/ACA Health Plans and Regions to Be Served

FHP/ACA Health Plans	Regions/Counties Served
CountyCare Health Plan (CountyCare)	Cook
Family Health Network (FHN)	Greater Chicago, Rockford
Harmony Health Plan of Illinois, Inc. (Harmony)	Greater Chicago, Metro East, Jackson, Perry, Randolph, Washington, Williamson
Meridian Health Plan, Inc. (Meridian)	Greater Chicago, Central Illinois (N), Metro East, Quad Cities, Rockford, Adams, Brown, DeKalb, Henderson, Lee, Livingston, McLean, Pike, Scott, Warren, Woodford
Molina Healthcare of Illinois, Inc. (Molina)	Central Illinois (N), Central Illinois (S), Metro East

- Continued expansion of the ICP. HFS contracted HSAG to conduct a pre- and post-implementation operational readiness review for additional health plans contracted to implement the ICP. The purpose of the review was to determine the ICP health plans' capacity to participate in the ICP. The operational readiness review consisted of four phases: pre-implementation activities, an on-site readiness review, post-readiness review activities, and post-implementation monitoring. During SFY 2014, HSAG conducted the readiness review activities for the regions and ICP health plans shown in Table 2.2 below.

Table 2.2—Readiness Review Activities for ICP Health Plans and Regions Served

ICP Health Plans	Regions Served
Blue Cross Blue Shield of Illinois (BCBSIL)	Greater Chicago
Cigna-HealthSpring of Illinois (Cigna)	Greater Chicago
Community Care Alliance of Illinois (CCAI)	Greater Chicago, Rockford
Humana Health Plan, Inc. (Humana)	Greater Chicago

- Continued 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 and serving children with complex medical needs. These provider-based networks are organized as Care Coordination Entities (CCEs). During the reporting period, readiness review activities were conducted for the counties and CCEs shown in Table 2.3 below.

Table 2.3—Readiness Review Activities for CCEs and Regions Served

CCEs	Counties Served
Be Well Partners in Health (Be Well)	Cook (certain zip codes)
La Rabida Children's Hospital (La Rabida)	Cook
Lurie Children's Hospital of Chicago, CCE (Lurie)	Cook, DuPage, Kane, Kendall, Lake, McHenry, Will
NextLevel Health (NextLevel)	Cook (certain zip codes)
Order of St. Francis (OSF) HealthCare System	OSF opted out of participation in the CCE program prior to implementation
Together4Health (T4H)	Cook

- Began the implementation process for the Accountable Care Entities (ACEs). This new model of care coordination was created under SB26, passed by the Illinois General Assembly in May 2013, and signed into law on July 22, 2013 (Public Act 98-104). The model coordinates a network of Medicaid services for children and their family members (initially), as well as ACA Medicaid adults. Eleven ACE proposals were received for evaluation in January 2014, and nine were selected for participation. In the reporting period, readiness review activities were conducted for the counties and ACEs shown in Table 2.4 below.

Table 2.4—Readiness Review Activities for ACEs and Regions Served

ACEs	Counties Served
Advocate Accountable Care (Advocate)	Cook, DuPage, Kane, Lake, McLean, McHenry, Will, Woodford
Better Health Network (Better Health)	Cook (certain zip codes)
HealthCura	Cook, DuPage
Illinois Partnership for Health, Inc. (IPH)	Central Illinois (N), Central Illinois (S), Rockford, Quad Cities, Adams, Brown, Cass, Clark, Coles, Crawford, Cumberland, DeKalb, Douglas, DuPage, Edgar, Effingham, Fulton, Grundy, Hancock, Henderson, Iroquois, Jasper, Kane, Kankakee, Kendall, Lake, LaSalle, Lee, Livingston, Macoupin, Marshall, Mason, McDonough, Montgomery, Morgan, Moultrie, Ogle, Pike, Putnam, Richland, Schuyler, Scott, Shelby, Stephenson, Warren, Whiteside, Will, Woodford
Loyola University Health System (Loyola)	Cook, DuPage, Will (certain zip codes)
MyCare Chicago (MyCare)	Cook (certain zip codes)
SmartPlan Choice	Champaign, Cook, Ford, Iroquois, Kane, Kankakee, Vermilion, Will

- Began the implementation process for the Medicare-Medicaid Alignment Initiative (MMAI) program. The MMAI program is 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. During the reporting year, the Centers for Medicare & Medicaid Services (CMS) and HSAG conducted operational readiness activities for the regions and MMAI health plans shown in Table 2.5 below.

Table 2.5—Readiness Review Activities for MMAI Health Plans and Regions Served

MMAI Health Plans	Regions Served
Aetna Better Health (Aetna)	Greater Chicago (excluding Lake)
Blue Cross Blue Shield of Illinois (BCBSIL)	Greater Chicago
Cigna-HealthSpring of Illinois (Cigna)	Greater Chicago (excluding Kankakee)
Health Alliance Connect, Inc. (Health Alliance)	Central Illinois (N), Central Illinois (S)
Humana Health Plan, Inc. (Humana)	Greater Chicago
IlliniCare Health Plan, Inc. (IlliniCare)	Greater Chicago
Meridian Health Plan, Inc. (Meridian)	Greater Chicago (excluding Kankakee)
Molina Healthcare of Illinois, Inc. (Molina)	Central Illinois (N), Central Illinois (S)

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.

Medicaid Managed Care

HFS' 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 health plans, 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 reporting 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. In SFY 2014, all three health plans operated in Cook County. **Harmony** also operated in Jackson, Kane, Madison, Perry, Randolph, St. Clair, Washington, and Williamson counties. **Meridian** also operated in Adams, Brown, Cook, DeKalb, Henderson, Henry, Knox, Lee, Livingston, McHenry, Mercer, Peoria, Pike, Rock, Island, Scott, Tazewell, Warren, Winnebago, and Woodford counties. *All Kids, Moms & Babies,* and *FamilyCare* recipients living in certain counties can voluntarily enroll in an MCO. The program recipients who enroll in an MCO receive most of their medical services including doctor visits, hospital stays, prescription drugs, vision care, dental care, and medical devices (e.g., eyeglasses and asthma inhalers) from those doctors and hospitals within the VMC network unless they gain approval to obtain outside services.

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.

As part of Illinois' care ccoordination expansion, Illinois Health Connect members in the five mandatory managed care regions will join a managed care entity beginning in July 2014. 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 MCOs, ACEs, or CCEs. Counties not included in the five managed care regions will continue to include IHC as a plan choice for most individuals enrolled in the HFS Medical program.

Integrated Care Program

The ICP is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of chronic health conditions, and coordination and continuity of care. A mandatory program for older adults and adults with disabilities who are eligible for Medicaid but not Medicare, the ICP operated in the regions of Central Illinois North, Central Illinois South, Quad Cities, and Metro East during the reporting year.

The ICP 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.

ICP 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 ICP was initiated in 2012 and continued in 2014, with new health plans undergoing readiness and implementation reviews in anticipation of expanding the ICP to additional counties.

The ICP health plans are responsible for all covered services currently funded by Medicaid through the State plan or waivers. Covered services were phased in as follows.

Service Package I: The ICP 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 HCBS waivers, are being added under Service Package II of the ICP. After Service Package II went into effective, all ICP health plan members in these areas had their waiver services administered through their health plan to more effectively coordinate and meet the total needs of the participant. The plans 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 ICP 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 ICP. The ICP health plans are responsible for the medical care services of nursing facility residents and also for all waiver participants otherwise eligible for the ICP.

Service Package II: Effective February 1, 2013, Service Package II of the ICP delivers care coordination and waiver services through a mandatory managed care delivery system for participants in several 1915(c) HCBS waivers who are enrolled in the ICP. Service Package II included 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).

During the reporting period, ICP participants in Illinois could choose between nine health plans—**Aetna**, **BCBSIL**, **Cigna**, **CCAI**, **Health Alliance**, **Humana**, **IlliniCare**, **Meridian**, and **Molina**. HFS' contracts with ICP health plans 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 2014, Medicaid, and the associated means-tested medical programs, provided comprehensive healthcare coverage to approximately 3 million Illinoisans and partial benefits to over 60,000 Illinoisans.

On average, each month, HFS programs cover over 1.5 million children; nearly 200,000 seniors; over 250,000 adults with disabilities; more than 650,000 other (nondisabled, nonsenior) adults as well as over 450,000 newly eligible ACA adults. Enrollment figures for SFY 2014 are displayed in Table 2.6.

Table 2.6—Illinois Medicaid Enrollment SFY 2014

Type of Benefits	Enrollment
Comprehensive Benefits	
Children	1,572,082
Adults With Disabilities	254,091
ACA Newly Eligible Adults	468,523
Other Adults	657,578
Seniors	190,575
Total Comprehensive	3,142,849
Partial Benefits	
Members With Partial Benefits	67,651
Total Members	
Total Members	3,210,500

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

Quality Strategy

The Code of Federal Regulations (CFR) at 42 438.200 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 2014, HFS continued to focus on measuring progress and outcomes, and establishing thresholds for improved performance. In addition, HFS continued 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 ACA. HFS' approach is to initially focus on the most complex, expensive clients and develop an integrated approach to care which brings together local PCPs, specialists, hospitals, nursing homes, behavioral health, and other providers to organize care around a patient's needs.

HFS is focused on continuous quality improvement by collaborating with its partners and stakeholders in support of HFS' mission. HFS is committed to ensuring quality healthcare coverage at sustainable costs, empowering people to make sound decisions about their well-being, and maintaining the highest standards of program integrity on behalf of the citizens of Illinois. Through the review process outlined in this section, HFS used the *Centers for Medicare & Medicaid Services State Quality Strategy Tool Kit for States* (updated April 1, 2013) to update 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 reflect expansion efforts and programming 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 health plans to establish objectives, priorities, and achievable timelines. The Quality Strategy is viewed as a "work in progress" as the state of

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

The process HFS uses to refine the Quality Strategy includes stakeholder involvement, including collaboration between the health plans and HFS through ongoing monthly telephonic and quarterly face-to-face meetings. The Medicaid Advisory Committee (MAC), which consists of up to 15 members, advises HFS with respect to policy and planning related to the health and medical services provided under the department's medical programs pursuant to Medicaid requirements established at 42 CFR 431.12.

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 has five subcommittees (Care Coordination, Long-Term Care, Public Education, Access, and Pharmacy).

The goal of the Quality Strategy is to continue to measure quality and health outcomes while working closely with stakeholders and sister agencies on the most effective way to deliver care under the expanded healthcare delivery systems in Illinois. HFS uses feedback from MAC members and other stakeholders to make necessary revisions to the Quality Strategy. HFS updates the Quality Strategy as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program.

To ensure the effectiveness of the Quality Strategy, HFS reviews the Quality Strategy 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 health plans are in contract compliance and commit adequate resources to perform internal monitoring and ongoing quality improvement toward the Quality Strategy goals.

A review of the Quality Strategy includes an assessment of:

- Access to care and network adequacy.
- Organizational structure and operations of the MCOs.
- Annual Healthcare Effectiveness Data and Information Set (HEDIS), HEDIS-like, and State-defined performance measures scores.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results.
- Audit reports.
- Quality assurance processes, including peer review and utilization review.

- Recipient complaints, grievances, and appeals, as well as provider complaints and issues.
- Preventing, detecting, and remediating critical incidents, at a minimum, on the State requirements for home and community-based programs.
- Collaborative performance improvement project (PIP) findings.
- Success in improving health outcomes for the priority performance measures.
- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvement in care and services) and trending indicator data.
- Identification of program barriers and limitations.
- Feedback obtained from HFS leadership, health plans, the provider community, advocacy groups, Medicaid recipients, and other internal and external stakeholders that can impact recipient access to high-quality, timely care and services.
- Recommendations for the upcoming year.
- Other relevant documentation.

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

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

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

Quality Strategy Objectives

HFS' goal is to measure both quality and health outcomes while continuing to work closely with stakeholders as well as sister agencies to ensure a comprehensive Quality Strategy that spans across all care coordination programs. HFS worked with stakeholders 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: Integrated Care Delivery—the right care, right time, right setting, right provider.

Goal 4: Ensure consumer safety, satisfaction, access to, and quality of care and services delivered to Illinois Medicaid recipients in select Care Coordination and 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 health plans focus their quality improvement efforts. It is HFS' expectation that by targeting specific priorities, more consistent improvement in these areas can be achieved. 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 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 health plans, and health plan medical directors and quality program staff. The meetings include discussion of compliance with the Quality Strategy, ongoing monitoring of performance of the health plans program changes or additions, and future initiatives. As new programs and initiatives are implemented, such as the ICP, 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 health plan 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 health plan's annual evaluation of their QAPI programs, and results of this evaluation are used to help develop the strategic direction for HFS and the plans. The results of this review are used in annual meetings between HFS and the plans to review the results of the External Quality Review (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 health plans.

Each year, HFS requires its EQRO to provide a written review of health plan performance in comparison to the Quality Strategy goals. This review is to include specific recommendations regarding any compliance deficits that may exist, as well as any revisions that might help the health plans 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 pay-for-performance (P4P) measures

HFS continues to update the Quality Strategy as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program.

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 [CIS]) 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 DPH 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.

Strengths and Weaknesses With Respect to Quality, Timeliness, and Access

Performance Standards

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

Access to Care Standards

The contracts between HFS and the health plans detail Illinois Medicaid standards for access to care, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. HFS' standards for access to care are as rigorous as those in 42 Code of Federal Regulations (CFR) 438.206–438.210. Health plans are required to implement the following standards for access to care:

- Availability and accessibility of all covered services (42 CFR 438.206)
- Assurances of adequate capacity and services (42 CFR 438.207)
- Coordination and continuity of care (42 CFR 438.208)
- Coverage and authorization of services (42 CFR 438.210)
- Credentialing and recredentialing (42CFR 438.214)

Structure and Operations Standards

State standards for structure and operations are as rigorous as those in 42 CFR 438.214–438.230, as detailed below:

- Provider selection and retention (42 CFR 438.214)
- Enrollee information (42 CFR 438.218)

- Enrollee rights (42 CFR 438.100)
- Confidentiality (42 CFR 438.224)
- Enrollment and disenrollment (42 CFR 438.226)
- Enrollment and disenrollment (Family Health Plan/Accountable Care Act (FHP/ACA) Contract 2015-24-002, Section 4.8)
- Grievance systems (42 CFR 438.228)
- Appeals process (42CFR 438.406)
- Subcontractual relations and delegation (42 CFR 438.230)
- Health and safety monitoring (FHP/ACA Contract 2015-24-002, Section 5.20)

Quality Measurement and Improvement Standards

Standards for quality measurement and improvement are as rigorous as those in 42 CFR 438.236–438.242, as detailed below:

- Practical/clinical guidelines (42 CFR 438.236)
- Quality assessment and performance improvement (QAPI) program (42 CFR 438.240)
- Required minimum standards of care (FHP/ACA Contract 2015-24-002—Attachment XXI)
- Health information system (42 CFR 438.242)

Measurement of Recipient Satisfaction

HFS also uses consumer satisfaction surveys to monitor health plan and provider performance, measure recipient satisfaction with services and access to care, and evaluate program characteristics. Each year, the health plans are required to independently administer a consumer satisfaction survey. Health plans administer Adult and Child (if applicable) Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H surveys. The primary objective is to obtain information effectively and efficiently about the level of satisfaction Medicaid Illinois recipients have with their healthcare experiences. The surveys ask recipients to report on and evaluate their experiences with healthcare on topics important to recipients, such as the communication skills of providers, accessibility of services, and satisfaction with the health plan.

Performance Measures

HFS requires health plans to monitor and evaluate the quality of care through the use of Healthcare Effectiveness Data and Information Set (HEDIS) and Department-defined performance measures.

This report organizes performance reporting by classifying performance measures into the following measure sets, which are aligned with those included in the Quality Strategy. Measures in these sets provide information on the quality of, timeliness of, and access to healthcare services furnished to HFS beneficiaries.

- Access to Care
- Child and Adolescent Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health

Summary of Voluntary Managed Care Requirements

Family Health Network, Inc. (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**) participated in the Voluntary Managed Care (VMC) program during the reporting year. With implementation of mandatory managed care, the VMC program was to be phased out in July 2014 and replaced with the Family Health Program/Affordable Care Act (FHP/ACA). FHP/ACA is a mandatory program for children and their families as well as the newly eligible ACA adults. Readiness review activities for the new program were conducted during the reporting year with these five health plans to begin participation in the FHP/ACA program: **CountyCare Health Plan** (**CountyCare**), **Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), **Meridian Health Plan, Inc.** (**Meridian**), and **Molina Healthcare of Illinois, Inc.** (**Molina**). Table 3.1 identifies the priority measures identified for the FHP/ACA program.

Table 3.1—Priority Measures for FHP/ACA

Measure Focus	Key Measure Name/Description	Quality	Timeliness	Access
Access to Care	*Adults' Access to Preventive/Ambulatory Health Services (Ages 20–65) (AAP)*		√	√
	Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge (All Ages)(IAPI)		√	√
	Well-Child Visits			
	1) Well-Child Visits in the First 15 Months of Life (W15)		√	√
	2) Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)		√	√
Women's Health	**Prenatal and Postpartum Care**			
	1) Timeliness of Prenatal Care		√	√
	2) Postpartum Care		√	√

Measure Focus	Key Measure Name/Description	Quality	Timeliness	Access
Child and Adolescent Care	*Childhood Immunization Status (calculates a rate for each vaccine and combos 2–10)—Combo 3 (CIS)*	√	√	√
	Developmental Screening in the First Three Years of Life (SDEV)	√	√	√

Summary of Primary Care Case Management (PCCM) Requirements

The PCCM program was HFS' first step toward implementing managed care throughout the State. Under the expansion of managed care pursuant to Medicaid Reform law (P.A. 96-1501) during State Fiscal Year (SFY) 2014, the Illinois Health Connect clients in the five mandatory managed care regions began to transition from the Illinois Health Connect program into new managed care health plans.

Illinois Health Connect will continue to be an essential medical home program that is available for individuals in the non-mandatory counties. In addition, it will be the primary access to care resource for individuals who are currently excluded (Third Party Liability (TPL)/Private Insurance, Supplemental Security Income (SSI), Division of Specialized Care for Children (DSCC), etc.) from mandatory participation in a managed care program. Below, Table 3.2 outlines the pay-for-performance (P4P) performance measures for the PCCM Program in calendar year 2014.

Table 3.2—Priority Measures for PCCM

Measure Focus	Key Measure Name/Description	Quality	Timeliness	Access
Care for Chronic Conditions	*Asthma Management: Ages 5–11, 12–18, 19–50, 51–64*	√		√
	Diabetes Management (Ages 18–75) (HbA1c test)	√		√
	Breast Cancer Screening (total for all ages 50–74)	√		√
	Childhood Immunization Combo	√		√
	Child Lead Screening	√		√
	Developmental Screening in the First Three Years of Life		√	√

Summary of Integrated Care Program (ICP) Requirements

The ICP contracts with **Aetna** and **IlliniCare** contain 54 performance measures. Of the measures, 21 are P4P measures, which are outlined in Table 3.3 below.

Table 3.3—Priority Measures for ICP

Measure Focus	Key Measure Name/Description	Quality	Timeliness	Access
Behavioral Health	*Follow-Up After Hospitalization for Mental Illness—30 Days*	√	√	√
	Antidepressant Medication Management—Effective Continuation Phase Treatment	√		
	Antidepressant Medication Management—Effective Acute Phase Treatment	√		
Access to Care	*Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit*		√	√
	Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge		√	√
	Ambulatory Care—ED Visits per 1,000 Member Months		√	√
Care for Chronic Conditions	**Comprehensive Diabetes Care**			
	1) HbA1c testing	√		
	2) Nephropathy Monitoring	√		
	3) LDL-C Screening	√		
	4) Statin Therapy (80% of Eligible Days)	√		
	5) ACEI/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 (CAD)			
	1) Cholesterol Testing	√		
	2) Statin Therapy 80% of the Time	√		
	3) ACEI/ARB 80% of the Time	√		
	4) Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	√		
	Pharmacotherapy Management of COPD Exacerbation (PCE)			
	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)	√		

Summary of Care Coordination Entities (CCE) Requirements

The contracts with CCEs contain 41 performance measures. Of the measures, five are P4P measures, as displayed in the table below.

Table 3.4—Priority Measures for CCE

Measure Focus	Key Measure Name/Description	Quality	Timeliness	Access
Access to Care	*Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge*	√	√	√
Utilization	*Ambulatory Care*	√		√
	Inpatient Utilization—General Hospital/Acute Care	√		
Risk-Adjusted Utilization	*Inpatient Hospital 30-day Readmission Rate*	√		
Behavioral Health	*Follow-Up after Hospitalization for Mental Illness*	√	√	√

Summary of Accountable Care Entities (ACE) Requirements

The contracts with ACEs contain 30 performance measures. Of the measures, four are P4P measures, as displayed in the table below.

Table 3.5—Priority Measures for ACE

Measure Focus	Key Measure Name/Description	Quality	Timeliness	Access
Access to Care	*Ambulatory Care Follow-Up with a Provider within 14 days after Emergency Department (ED) Visit*	√		√
Care for Chronic Conditions	**Comprehensive Diabetes Care**			
	1) *HbA1c testing*	√		
	2) *Nephropathy Monitoring*	√		
	3) *LDL-C Screening*	√		
Prevention/ Screening Services	*Childhood Immunization Status*	√	√	√
Behavioral Health	*Follow-Up Care for Children Prescribed ADHD Medication*	√		

HFS and Health Plan Progress Toward Quality Strategy Goals

Consistent with its mission, HFS has identified five goals for its Quality Strategy. This section compares health plan performance on the activities, initiatives, and priority measures that support these goals.

Goal 1

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

Activities, initiatives, and priority measures that support Goal 1:

- Validation and Monitoring of the Provider Network—Federal Medicaid regulations, CFR 438.207 do not describe 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 managed care organization network." HFS has contracted with Health Services Advisory Group, Inc. (HSAG), to conduct ongoing monitoring of the development and maintenance of health plan provider networks. The network analysis conducted by HSAG allows HFS to evaluate the provider network capacity across the health plans using a multifaceted, iterative, standardized approach. This process ensures that every health plan is analyzed on a consistent basis, resulting in fair comparisons across all health plans. The health plan-specific analysis allows each plan to understand its network deficiencies based on established requirements. Health plans are provided the opportunity to correct the deficiencies identified in the provider network validation before a final determination of readiness to implement their specific programs. The validation process ensures that each health plan has a broad range of specialties and services to provide access to care and services to its enrollees.
- Appointment Availability Monitoring—HFS requires that Medicaid providers are required to schedule appointments for eligible Medicaid members in accordance with the minimum appointment availability standards, and based on the acuity and severity of the presenting condition in conjunction with the members' past and current medical history. HFS requires the plans to conduct monitoring activities to determine participant access and availability for specific appointment standards, including routine appointments, nonurgent appointments, sick appointments, and after-hours accessibility.
- 24/7 Nurse Advice Line Access—As part of the contractual requirements, HFS requires health plans to have a toll-free 24/7 nurse line. This allows members to call 24 hours a day, seven days a week to get answers to general health questions, and advice to call a doctor or emergency services if necessary.
- HEDIS, HEDIS-like Performance Measures, and State-defined Measures—Section 5 of this report describes the evaluation of the health plans' ability to collect and report on the performance measures accurately and compares HEDIS and Children's Health Insurance Program Reauthorization Act (CHIPRA) performance measure results for each measure set.

- Cultural Considerations and Americans with Disabilities Act (ADA) Accessibility—HFS requires the health plans to participate in Illinois' efforts to promote the delivery of service in a culturally competent manner to all enrollees. This includes those with limited English proficiency and diverse cultural and ethnic backgrounds. HFS identifies the race, ethnicity, and primary language spoken for each Medicaid enrollee and provides this information to the health plans at the time of enrollment as Section 438.204 of federal regulations requires. In addition, HFS requires health plans to be compliant with the ADA to ensure physical access to buildings, services, and equipment.

Goal 2

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

Activities, initiatives, and priority measures that support Goal 2:

- Clinical Quality Focused Studies—The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of health plan members. HFS may use the contracted External Quality Review Organization (EQRO) to assist in defining the study and then compiling the results and creating a report of the study findings. An agreed-upon managed care intervention to improve an aspect of care is then implemented. The areas of focus may differ among the covered populations.
- Age-Appropriate Preventive Care Clinical Practice and Preventive Care Guidelines (Evidenced-Based Care); Preconception and Interconception Care; and HEDIS, HEDIS-like, and State-defined Performance Measures—HFS requires health plans to monitor and evaluate the quality of care using HEDIS and Department-defined performance measures. The health plans must establish methods to determine if the administrative data are accurate for each measure. In addition, the health plans 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 health plans meet the performance goal. Section 5 of this report describes the evaluation of the health plans' ability to collect and report on the performance measures accurately and compares HEDIS and CHIPRA performance measure results for each measure set.
- Care Coordination and Behavioral Health Collaborative Performance Improvement Projects—As part of its QAPI program, HFS requires health plans 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 PIP processes can have a favorable effect on health outcomes and member satisfaction. PIP results are detailed in Section 4 of this report.

- Incentive Programs—P4P measures create an incentive for health plans to spend money on care that produces valued outcomes. The health plans are rewarded for meeting pre-established targets for delivering quality healthcare services that result in (1) better health for the member, (2) better quality of life for the member, and (3) reduction in the cost of the service over time. Health plan performance on P4P measures is discussed in Section 5 of this report.

Goal 3

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

Activities, initiatives, and priority measures that support Goal 3:

- Care Management/Care Coordination Program (Intensive Case Management for Chronically Ill Recipients)—In line with the goal of serving at least 50 percent of Illinois Medicaid recipients in a care coordination/managed care program by January 2015, the State's contracts require health plans to offer the same comprehensive set of services to HFS clients that are available to the fee-for-service (FFS) population.
- Medical/Behavioral Care Coordination and Disease Management Program—HFS requires health plans to collect HEDIS and Department-defined performance measures related to chronic conditions and disease management. Results for these measures are reported in Section 5 of this report.
- Special Health Care Needs (SHCNs)—HFS identifies SHCNs using 3M™ clinical risk grouping (CRG) software. The CRG software uses data from Medicaid Management Information System (MMIS) claims, including age, sex, diagnosis, procedures, pharmaceuticals, site of service, and date of service to assign each client to a single CRG. CRGs are aggregated in succession of health statuses from Status 1 (Healthy) through Status 9 (Catastrophic), with clients in the lower statuses identified as having fewer healthcare needs. Each status is further adjusted for severity of illness. For example, Status 6 (Significant Chronic Disease in Multiple Organ Systems) includes six levels of increasing severity of illness (from 6.1 through 6.6). Clients assigned to Status 6.1 through Status 6.6 as identified through the CRG software tend to have chronic conditions affecting multiple organ systems. Currently, approximately 70,000 children have been identified through this model. Those identified are indicated to all health plans so that they can be targeted for care coordination purposes. HFS reserves the right to amend its method for identifying and defining this population.

Goal 4

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

Activities, initiatives, and priority measures that support Goal 4:

- CAHPS Consumer Satisfaction Survey (Adult, Child, and Children with Chronic Conditions)—Each year, health plans are required to independently administer a consumer satisfaction survey for both adults and children as applicable to the programs they cover. The EQRO evaluates the results of adult and child CAHPS surveys conducted by the health plans to identify trends, strengths, and opportunities for improvement. Health plan comparison results for CAHPS surveys are presented in Section 8.
- Participant Outcomes and Status Measures (POSM) Survey for the Elderly—This survey measures a member's perception of quality of life with the following purposes: (1) help determine quality of life measures that should be considered in developing service plans; (2) determine if quality of life improvements are reported by participants over time; and (3) assist in identifying areas in need of quality improvement. HFS requires health plans to conduct this survey for its elderly member population, and results are reported in the health plans' annual reports.
- Member Grievances/Complaints and Appeals/State Fair Hearings—HFS requires health plans to have a formally structured grievance system that is compliant with Sections 45 of the Managed Care Reform and Patient Rights Act, 215 ILCS 134, and 42 CFR to handle all grievances and appeals subject to the provisions of such sections of the Act and regulations. This includes establishing and maintaining a procedure for reviewing appeals by a member or a member's authorized representative.
- Health and Safety Monitoring for Waiver Participants—HFS reviews the waiver providers for each health plan to monitor the quality of services and supports provided to the Home and Community-Based Services (HCBS) waiver program enrollees and requires the health plans to report on HCBS Centers for Medicare & Medicaid Services (CMS) waiver performance measures. The results of the HCBS CMS performance measures can be found in Section 6 of this report.

Goal 5

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

Activities, initiatives, and priority measures that support Goal 5:

- QAPI Program—HFS conducts monthly QAPI committee meetings to evaluate health plan performance and whether the goals and objectives of the Quality Strategy are being met, as well as to establish goals and objectives. The EQRO evaluates the health plans' annual evaluation of their QAPI programs, and results of this evaluation are used to help develop the strategic direction for HFS and the health plans.

- PIPs, Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs)—As part of its QAPI program, HFS requires health plans to conduct PIPs in accordance with 42 CFR 438.240. PIP results are detailed in Section 4 of this report.
- Monitoring of Performance Measures—HEDIS, HEDIS-like, State defined, and CHIPRA performance measure results are presented in Section 5 of this report.
- Comprehensive Administrative Review/Readiness Review—HFS' EQRO conducts comprehensive, on-site, administrative compliance reviews of the health plans at least once in a three-year period. HFS' EQRO reviews health plans' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards are as rigorous as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards. In addition, HFS's EQRO conducts operational readiness reviews as needed. The health plan results of these review processes are discussed in Section 6 of this report.
- State Oversight and Monitoring—HFS has established a rigorous data collection and reporting schedule for routine monitoring and oversight to ensure health plan compliance with contract requirements and to evaluate performance. Reporting is required on a monthly, quarterly, and annual basis. HFS holds monthly conference calls and quarterly, face-to-face meetings with health plans to review performance. HFS contracts with its EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. The EQRO performs services in accordance with 42 CFR, parts 430, 433, 434, and 438, and the Balanced Budget Act (BBA) of 1997.
- Health Information Systems—HFS' robust information system is key to monitoring the goals and objectives of the Quality Strategy and provides essential information for the ongoing operation and review of the Quality Strategy. The State's Bureau Division of Information Systems (DIS) maintains the MMIS, which includes all functional areas (recipient information, eligibility, demographics, provider enrollment, health plan enrollment, claims and encounter data, payment information, third-party liability, and reporting). HFS' enterprise data warehouse (EDW) and its executive information system (EIS) track key indicators for comparison (state, county, fee-for-service, and health plan [specific and aggregate]) for tracking and trending of utilization and health outcomes. Data are imported from other state agencies' data systems to determine utilization, and to report findings to health plans to drive improvement.
- Complete, Accurate, and Timely Encounter Data—During SFY 2014, HFS contracted with its EQRO to conduct an encounter data validation (EDV) study. The goal of the study was to assess the degree of data file completeness, accuracy, and timeliness across two health plans in order to provide insight into the quality of HFS' overall data system. The results of this study are detailed in Section 7of this section.

Validation of Performance Improvement Projects

Objectives

As part of its quality assessment and performance improvement program, the Illinois Department of Healthcare and Family Services (HFS) requires each health plan to conduct performance improvement projects (PIPs) in accordance with the Code of Federal Regulations (CFR), at 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 health plan processes can have a favorable effect on health outcomes and member satisfaction. Additionally, as one of the mandatory external quality review (EQR) activities under the Balanced Budget Act of 1997 (BBA), the State is required to validate the PIPs conducted by its contracted managed care organization (MCO), Integrated Care Program (ICP) health plans, and prepaid inpatient health plans. HFS contracted with Health Services Advisory Group, Inc. (HSAG), to meet this validation requirement.

The primary objective of PIP validation is 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. Each PIP at a minimum must report a baseline and two annual remeasurement periods. The remeasurement study indicator results are compared to the baseline to determine if real and sustained improvement were attained.

Table 4.1—Baseline and Remeasurement Years for Each PIP

PIP Topics	FHN	Harmony	Meridian
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening	CY 2011 CY 2012 CY 2013	CY 2011 CY 2012 CY 2013	CY 2011 CY 2012 CY 2013
Perinatal Care and Depression Screening	11/06/04 to 11/05/05 11/06/05 to 11/05/06 11/06/06 to 11/05/07 11/06/07 to 11/05/08 11/06/08 to 11/05/09 11/06/09 to 11/05/10 11/06/10 to 11/05/11 11/06/11 to 11/05/12	11/06/04 to 11/05/05 11/06/05 to 11/05/06 11/06/06 to 11/05/07 11/06/07 to 11/05/08 11/06/08 to 11/05/09 11/06/09 to 11/05/10 11/06/10 to 11/05/11 11/06/11 to 11/05/12	11/06/08 to 11/05/09 11/06/09 to 11/05/10 11/06/10 to 11/05/11 11/06/11 to 11/05/12

Technical Methods of Data Collection and Analysis

The methodology used to implement PIPs is 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.[4-1] Using this protocol, HSAG, in collaboration with HFS, developed the PIP Summary Form, which each health plan 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

[4-1] 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.

- 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 health 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. If one critical evaluation element receives a *Partially Met* score, the overall PIP validation status will be *Partially Met*. Similarly, if one critical evaluation element receives a *Not Met* score, the overall PIP validation status will be *Not Met*. HSAG's PIP Validation Tool also provides, for informational purposes, the percentage of critical elements met, which is calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*.

Voluntary Managed Care

Findings

Table 4.2 displays the overall validation results for each activity and each stage of the *EPSDT Screening* PIP across all PIPs validated by HSAG.

Table 4.2—Combined Validation Results Across All MCOs 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% 26/26	0% 0/26	0% 0/26
	VIII. Implement Intervention and Improvement Strategies	100% 11/11	0% 0/11	0% 0/11
Implementation Total		**100% 37/37**	**0% 0/37**	**0% 0/37**
Outcomes	IX. Assess for Real Improvement Achieved	58% 7/12	42% 5/12	0% 0/12
	X. Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total		**58% 7/12**	**42% 5/12**	**0% 0/12**
Overall PIP Results		**95% 89/94**	**5% 5/94**	**0% 0/94**

Table 4.3 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 4.3—Validation Results Across All MCOs 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	100% 12/12	0% 0/12	0% 0/12
Implementation Total		**100% 57/57**	**0% 0/57**	**0% 0/57**
Outcomes	VIII. Analyze Data and Interpret Study Results	100% 26/26	0% 0/26	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		**71% 29/41**	**29% 12/41**	**0% 0/41**
Overall PIP Results		**92% 140/152**	**8% 12/152**	**0% 0/152**

Table 4.5 shows the percentage of applicable evaluation elements *Met* in the Outcomes stage for **Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**) individually, and all three MCOs' combined performance on the PIPs.

Table 4.4—Percent of All Elements *Met*

PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	91%	97%	96%
Perinatal Care and Depression Screening	92%	92%	91%

The validation scores of **FHN**, **Harmony**, and **Meridian** demonstrate strong performance in the Design and Implementation stages for all three MCOs, indicating that each PIP was designed and implemented appropriately to measure outcomes and improvement. Opportunities for improvement exist for all three MCOs in achieving real and sustained improvement as shown in Table 4.5, which indicates weaker performance in these areas.

Table 4.5—Percentage of Elements *Met* in the Outcomes Stage—Combined and by MCO

PIP Topics	Combined-All 3 MCOs	FHN	Harmony	Meridian
EPSDT Screening	58% 7/12	25% 1/4	75% 3/4	75% 3/4
Perinatal Care and Depression Screening	71% 29/41	71% 10/14	71% 10/14	69% 9/13

During state fiscal year (SFY) 2014, HSAG conducted a validation and analysis of the *EPSDT Screening* and *Perinatal Care and Depression Screening* PIPs to evaluate the MCOs' performance on the PIP indicators. The following is a result of that analysis.

Outcomes and Interventions

EPSDT Screening PIP

Background

HFS required each MCO to participate in a mandatory statewide PIP focused on EPSDT. The PIP focused 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 first remeasurement 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 4.6 provides a list of the EPSDT Screening PIP study indicators validated for SFY 2014.

Table 4.6—*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 (inverse measure—higher values indicate worse performance)
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

For the 2013–2014 validation, all three MCOs reported Remeasurement 1 data for the *EPSDT Screening* PIP. Table 4.7 displays outcomes for the *EPSDT Screening* PIP study indicators for each MCO.

Table 4.7—SFY 2014 Performance Improvement Project Outcomes for *EPSDT Screening*

Comparison to Study Indicator Results From Prior Measurement Period			
MCO	**Number of Study Indicators**	**Improved**	**Statistically Significant Improvement (p<.05)**
FHN	7	6	4
Harmony	7	7	2
Meridian	7	7	5
Overall Totals	**21**	**20**	**11**

Overall, for the *EPSDT Screening* PIP, out of 21 study indicators across the MCOs, 20 demonstrated improvement. Of those, 11 demonstrated statistically significant improvement. **FHN** had one study indicator that demonstrated a decline for this measurement period; however, the decline was not statistically significant.

Barriers/Interventions

For the *EPSDT Screening* PIP, all three MCOs progressed to implementing interventions. **FHN** focused on three provider barriers which were all related to improperly completed forms and screening tools. **FHN**'s interventions included chart audits and follow-up provider office visits, provider education, distribution of order forms and sample forms to providers, and an encounter data incentive plan.

Harmony and **Meridian** identified member, provider, and system barriers. Similar barriers included providers not completing screening and/or documentation of all required components for an EPSDT visit, MCOs unable to reach members, and members' lack of knowledge and compliance with timely EPSDT well-child visits.

To address and overcome barriers, **Harmony** implemented improvement strategies that included member, provider, and system-focused interventions. **Harmony** conducted telephonic outreach to over 24,000 members during the reporting period and made improvements to its Healthcare Effectiveness Data and Information Set (HEDIS) Inbound Care Gap program, such as revising the scripting and adding Spanish translation to better communicate with more members. To educate providers, **Harmony** conducted office visits, distributed educational materials, and sent provider fax blasts. **Harmony** also developed a point of contact to address provider issues and

streamlined the documentation process for the HEDIS Education and Screening Program (ESP). **Harmony**'s system-focused interventions include partnering with Planned Parenthood, improving data collection tools, and sending monthly outcome reports to providers.

Meridian implemented member-focused interventions such as mailing age-specific flyers with gift card incentive information and conducting targeted outreach with parents to educate and promote preventive care for their children. For providers, **Meridian** created a HEDIS secure mobile application to automatically upload screenshots of member records as supplemental/hybrid data so that provider network development representatives are able to collect medical record documentation to meet HEDIS measures. To make system improvements, **Meridian** provided weekly employee HEDIS education to all staff and used managed care system (MCS) alerts to prompt representatives to remind members of the need for regular developmental screenings.

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 MCOs chose to determine the percentage of women who were enrolled in an Illinois Medicaid MCO and were screened for depression during the prenatal and/or postpartum period. The primary purpose of this collaborative PIP was to determine if MCO 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 4.8—*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

Indicator	Description of Indicator
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 4.9—SFY 2014 Performance Improvement Project Outcomes

MCO	Comparison to Study Indicator Results From Prior Measurement Period			
	Number of Study Indicators	Improved	Statistically Significant Improvement (p<.05)	Sustained Improvement
FHN	13¥	6	4	7
Harmony	15§	11	6	12
Meridian	15§	7	3	5
Overall Totals	**43**	**24**	**13**	**24**

¥ The MCO did not report data on Study Indicators 8, 9, and 10.
§ According to the SFY 2014 PIP validation tools for these MCOs, 15 study indicators were evaluated.

Results

Table 4.9 displays the outcomes for the *Perinatal Care and Depression Screening* study indicators for each MCO. With the progression of this PIP, 30 percent of study indicators evaluated across all three MCOs achieved statistically significant improvement and 56 percent demonstrated sustained improvement over the duration of the PIP.

Harmony demonstrated the best performance with 11 out of 15 study indicators (73 percent) achieving improvement; and for six of those indicators, the improvement was statistically significant. **Harmony** achieved sustained improvement in 12 study indicators. **Harmony**'s prenatal and postpartum care rates reported in the PIP for this measurement period were 74.7 percent and 49.4 percent, respectively.

Six of **FHN**'s 13 reported study indicators demonstrated improvement for this measurement period, with four being statistically significant improvements. **FHN** achieved sustained improvement in seven study indicators. **FHN** reported its prenatal and postpartum care rates for this measurement period as 63.0 percent and 48.2 percent, respectively.

Meridian had seven study indicators that demonstrated improvement for Remeasurement 3, with three demonstrating statistically significant improvement. **Meridian** achieved sustained improvement in five of the study indicators. **Meridian** reported the highest prenatal and postpartum care rates out of the three MCOs: 96.4 percent and 83.1 percent, respectively.

Barriers/Interventions

For the SFY 2014 validation, **FHN**'s barriers for the *Perinatal Care and Depression Screening* PIP included quality of physician documentation in medical records, quality and amount of encounter data received, and member education. **FHN** reported that its maternity care coordinators complete a telephonic screening tool as part of the comprehensive assessment for maternity care management and as part of the postpartum phone calls. For positive screenings, the behavioral health vendor conducts a same-day follow-up. The behavioral health vendor also continued its intensive care management and home intervention programs, and conducts direct postpartum follow-up with patients to assist with completion of both the postpartum office visit and postpartum depression screening. The Brighter Beginnings program for pregnant members and their babies continued, as well as most of **FHN**'s ongoing interventions such as provider education, partnering with "Text4Baby," and member and provider incentives. Additionally, **FHN** reviewed physician records for errors in documentation, moved to a claims database system, called members to schedule postpartum visits, and met with providers to discuss HEDIS results.

Harmony reported barriers that included difficulty reaching members, members declining assistance with scheduling appointments, lack of member knowledge regarding prenatal care and screenings, provider lack of knowledge regarding the Harmony Hugs program, and provider and office staff time constraints. To address barriers, **Harmony** continued to implement member, provider, and system interventions. Member-focused interventions included outreach and education in addition to enrolling members in the Harmony Hugs program. Provider-focused interventions included provider outreach and education, audits, and corrective action plans for noncompliant providers. **Harmony** continued focused, clinical provider visits to the top 13 independent physician associations (IPAs). System interventions included collaborating with physician groups, partnering with Planned Parenthood, conducting a reevaluation of the Harmony Hugs program, and developing a postpartum outreach initiative process improvement plan.

Meridian continued to address barriers related to coordination of care, member and provider knowledge, identifying pregnancy risk factors, and ensuring timely prenatal and postpartum visits. Ongoing interventions included incentives for members and providers, member outreach, the use of standardized screening and assessment tools, and collaboration with network providers to

schedule visits. **Meridian** established a Maternity Care Coordination program that includes frequent contact and coordinated care for members during the perinatal period. In 2013, the MCO documented that it provided additional educational material in the prenatal packet, assigned dedicated quality improvement staff to follow up on prenatal and postpartum members who were identified as no-shows, utilized a community health outreach worker to conduct home visits, and provided lists of members due for visits to the care coordination team.

Recommendations for MCOs

The MCOs had some success with the *EPSDT Screening* and *Perinatal Care and Depression Screening* PIPs for the SFY 2014 validation. Of the 21 total study indicators across the three MCOs for the *EPSDT Screening* PIP, 20 study indicators demonstrated improvement, with 11 of those demonstrating statistically significant improvement. For the *Perinatal Care and Depression Screening* PIP, there were a total of 43 study indicators, and 24 of those demonstrated improvement. The MCOs' choice of interventions, the combination of intervention types, and sequence of implementing interventions are essential to the performance improvement project's overall success. HSAG recommends the MCOs:

- Evaluate the effectiveness of each intervention implemented. If the intervention is not having the desired effect, the MCO should determine how it will address these deficiencies by modifying or discontinuing current interventions and/or implementing new improvement strategies.
- Conduct a causal/barrier analysis at least annually using quality improvement tools. The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes.
- Conduct drill-down analysis to identify subgroups with lower performance, in addition to periodic analyses of the MCO's most recent data.
- Consider testing interventions on a small scale using a quality improvement method such as Plan-Do-Study-Act (PDSA). Testing interventions on a small scale reduces risk and allows the MCO to maximize its resources. Changes that are successful when tested on a small scale should be considered for spread and eventually full implementation. The MCO should abandon changes that are not successful when tested on a small scale and develop new changes for testing.

Integrated Care Program

Community Based Care Coordination PIP

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 health plan (**Aetna Better Health** [**Aetna**] and **IlliniCare Health Plan, Inc.** [**IlliniCare**]) 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 health plans developed the study question, indicators, and data sources with assistance from HSAG. The PIP focused on the relationship between care coordination, timely ambulatory care services, and readmission rates < 30 days post discharge. The study population included 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 the 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 4.10.

Table 4.10—*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.

Outcomes and Interventions

Table 4.11—PIP Outcomes for *Community Based Care Coordination*

Comparison to Study Indicator Results From Prior Measurement Period		
ICP Health Plan	**Number of Study Indicators**	**Statistically Significant Improvement (p<.05)**
Aetna	3	3
IlliniCare	3	3
Overall Totals	**6**	**6**

Table 4.11 displays outcomes for the *Community Based Care Coordination* PIP. The PIPs had three study indicators. Both ICP health plans achieved statistically significant improvement in all three study indicators for the first remeasurement.

Results

Table 4.12 displays the validation results for each activity and each stage of the *Community Based Care Coordination* PIP.

Table 4.12—PIP Validation Results Across All ICP Health Plan 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% 18/18	0% 0/18	0% 0/18
	VIII. Implement Intervention and Improvement Strategies	100% 6/6	0% 0/6	0% 0/6
Implementation Total		**100% 24/24**	**0% 0/24**	**0% 0/24**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% 8/8	0% 0/8	0% 0/8
	X. Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total		**100% 8/8**	**0% 0/8**	**0% 0/8**
Overall PIP Results		**100% 69/69**	**0% 0/69**	**0% 0/69**

Table 4.13 displays the overall validation percentage for each individual ICP health plan.

Table 4.13—PIP Validation Results Across All ICP Health Plan PIPs (N=2)

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

Baseline and Remeasurement 1 Results

The following figures display the baseline and first remeasurement results for **Aetna** and **IlliniCare** for each study indicator.

Figure 4.1—Aetna Care Coordination PIP Results for Study Indicator 1

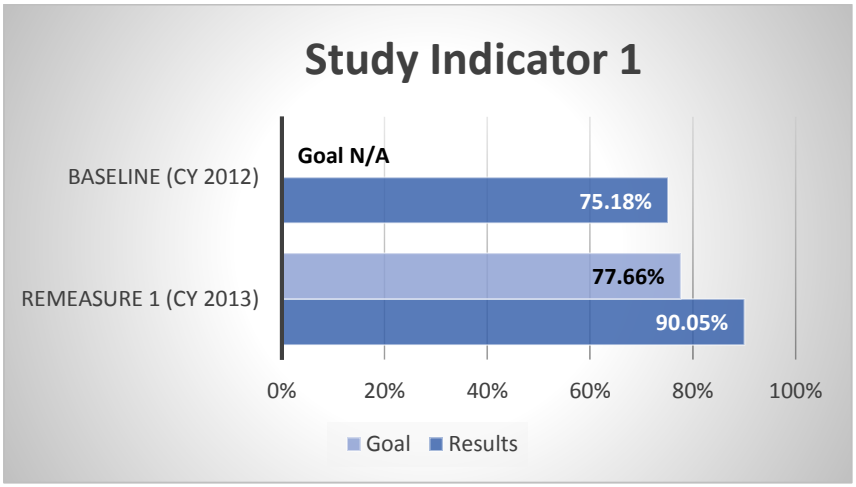


Figure 4.2—Aetna Care Coordination PIP Results for Study Indicator 2

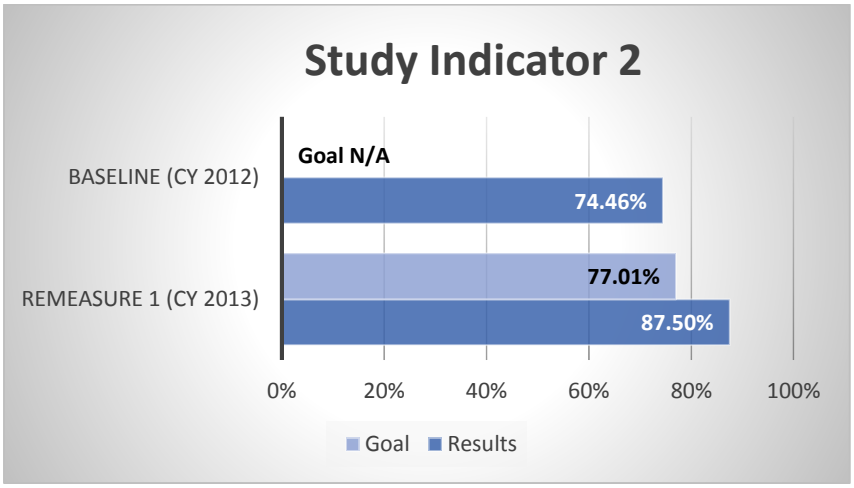


Figure 4.3—Aetna Care Coordination PIP Results for Study Indicator 3

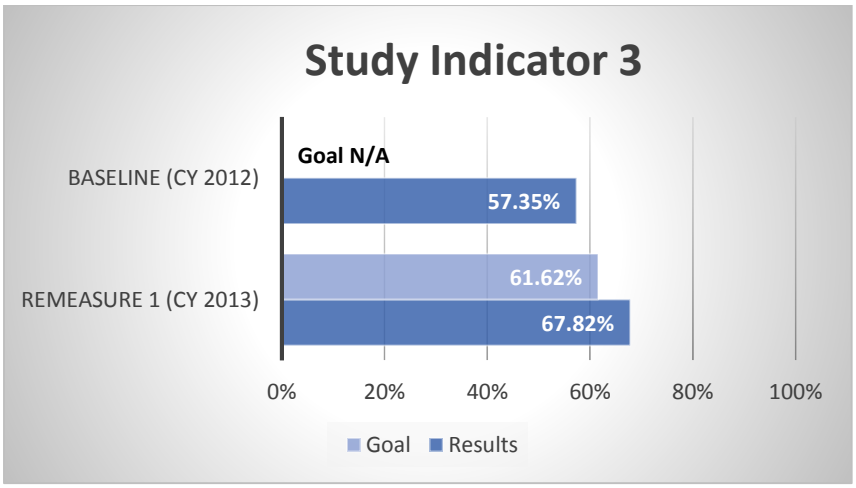


Figure 4.4—IlliniCare Care Coordination PIP Results for Study Indicator 1

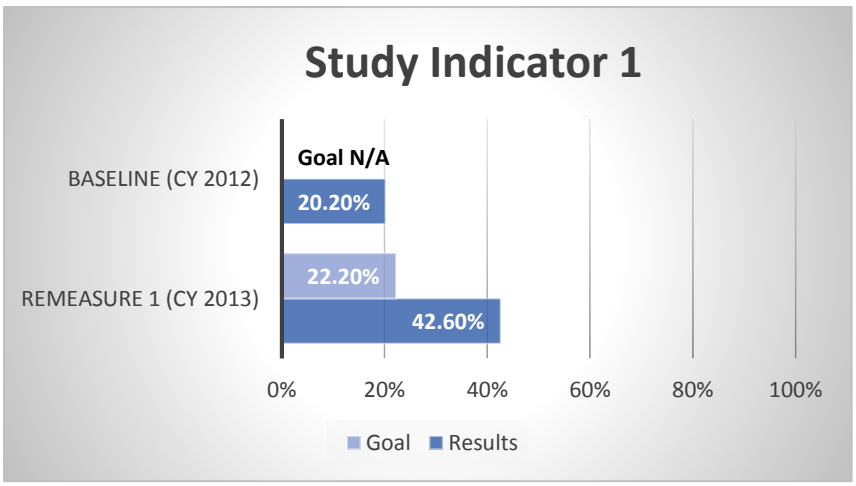


Figure 4.5—IlliniCare Care Coordination PIP Results for Study Indicator 2

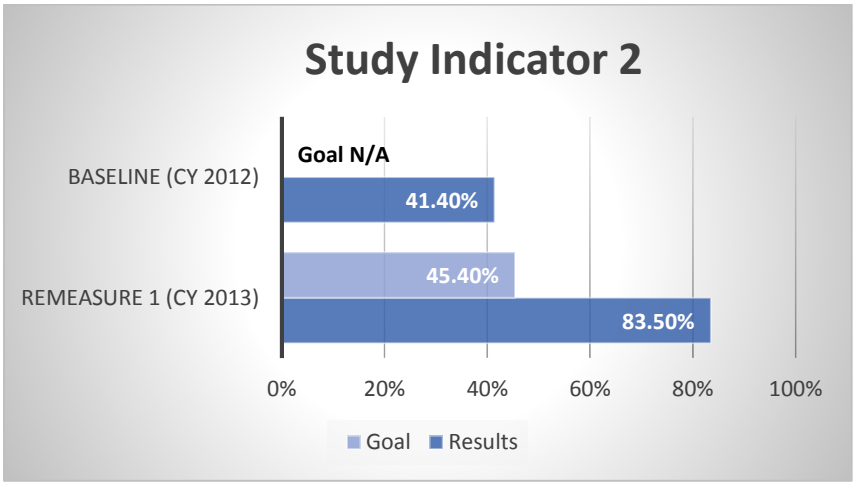
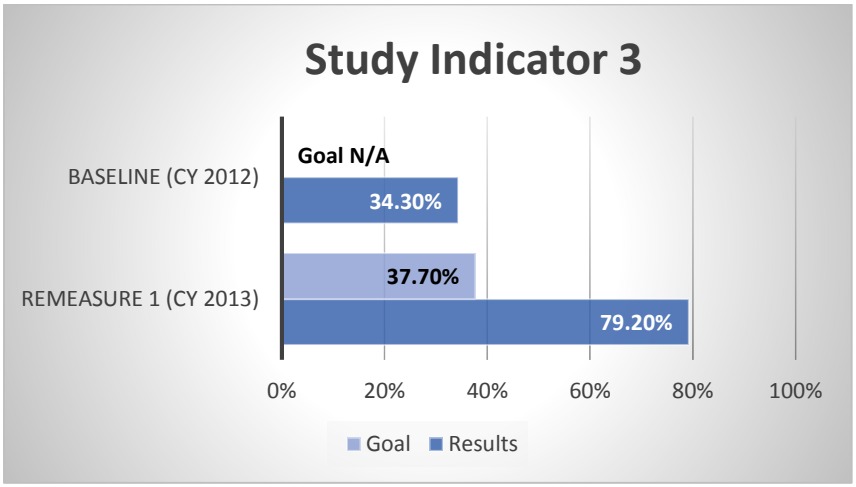


Figure 4.6—IlliniCare Care Coordination PIP Results for Study Indicator 3



Barriers/Interventions

For the *Community Based Care Coordination* PIP, both ICP health plans progressed to implementing interventions. **Aetna** identified barriers that included lack of timely identification of hospital discharges, subjective prioritization of cases for follow-up, lack of timely follow-up following discharge, and inadequate time to assist members with discharge plans due to caseload size. **IlliniCare** also focused on barriers that included lack of timely notification of authorization requests and member admissions, in addition to inconsistent application of the discharge planning process, inaccurate member demographics, inconsistencies in provider contact information, and members' lack of adherence to the treatment plan.

Both **Aetna** and **IlliniCare** identified a similar barrier related to timely notification of hospital discharges. To address and overcome this barrier, **Aetna** initiated a process which involved the utilization manager contacting members or hospital discharge planners to discuss care needed

while the member is still in the hospital, as well as daily monitoring of an inpatient census for all members with readmit or Consolidated Outreach and Risk Evaluation (CORE)scores above established thresholds. **IlliniCare** revised its concurrent review nurse workflow and utilization management reviewer assignments. Both included telephonic outreach to members after discharge which involved a follow-up component for members who could not be reached initially. **IlliniCare** also completed educational visits to high-volume facilities.

Recommendations for ICP Health Plans

Overall, the ICP health plans performed well for the SFY 2014 validation, achieving statistically significant improvement in all study indicators and a 100 percent (*Met*) validation status. The PIPs were methodologically sound, and quality improvement processes were used in the identification of barriers and interventions. HSAG recommends that the ICP health plans:

- Build on existing momentum for study indicators demonstrating statistically significant improvement and implement new and/or enhanced interventions.
- Continue conducting causal/barrier analyses at least annually using quality improvement tools and prioritize barriers based on analysis results.
- Consider testing interventions on a small scale using a quality improvement method such as PDSA. Testing interventions on a small scale reduces risk and allows the ICP health plan to maximize its resources. Changes that are successful when tested on a small scale should be considered for spread and eventually full implementation. Changes that are not successful when tested on a small scale should be abandoned and new changes developed for testing.

Validation of Performance Measures—NCQA HEDIS Compliance Audit Findings for Voluntary Managed Care—SFY 2014

Objectives

This section describes the evaluation of the health plans' ability to collect and report on the performance measures accurately. The Healthcare Effectiveness Data and Information Set (HEDIS) performance measures are a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (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 managed care organizations (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 of Healthcare and Family Services (HFS) requires the health plans to monitor and evaluate the quality of care through the use of HEDIS and HFS-defined performance measures. The MCOs must establish methods 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, and analytic file production.

Technical Methods of Data Collection and Analysis

HFS required that an NCQA-licensed audit organization conduct an independent audit of each MCO's measurement year (MY) 2013 data. HFS contracted with HSAG to audit **Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**). The audits were conducted in a manner consistent with the 2014 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. The audit incorporated two main components:

- A detailed assessment of the MCO's information systems (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.
  - Any manual processes employed for MY 2013 HEDIS data production and reporting.

The audit included 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 based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. The measures selected for validation through the NCQA HEDIS compliance audits were the following:

- *Childhood Immunization Status—Combo 3*
- *Human Papillomavirus Vaccines for Female Adolescents*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*
- *Developmental Screening in the First Three Years of Life* (for the Children's Health Insurance Program Act [CHIPRA])

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

- *Children and Adolescent's Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment—Initiation of AOD Treatment—13–17 Years, 18+ Years, and Total; and Engagement of AOD Treatment—13–17 Years, 18+ Years, and Total*
- *Childhood Immunization Status—Combo 2*
- *Lead Screening in Children*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Appropriate Testing for Children With Pharyngitis*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Percentile Documentation, Counseling for Nutrition, and Counseling for Physical Activity Totals*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—16–20 Years, 21–24 Years, and Total*
- *Frequency of Ongoing Prenatal Care—<21 Percent and ≥81 Percent of Expected Visits*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, LDL-C Screening, LDL-C Control (<100 mg/dL), Medical Attention for Nephropathy, BP Control (<140/90 mm Hg), and BP Control (<140/80 mm Hg)*
- *Controlling High Blood Pressure*
- *Use of Appropriate Medications for People With Asthma—5–11 Years, 12–18 Years, 19–50 Years, 51–64 Years, and Total*
- *Medication Management for People With Asthma—Medication Compliance 50% and 75%—5–11 Years, 12–18 Years, 19–50 Years, 51–64 Years, and Total*
- *Follow-up After Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up*
- *Antidepressant Medication Management—Effective Acute and Effective Continuation Phase Treatment*

HSAG used a number of different methods and information sources to conduct audits and reviews 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, an abstraction of a sample of medical records selected by the auditors was compared to the results of the MCO's review determinations for the same records.
- If supplemental data were used, primary source verification of a sample of records was conducted from any nonstandard and member-reported databases.
- 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.
- A variety of interviews with 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 2014 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

Each of the audited measures reviewed by HSAG received a final audit result that was applicable to the HEDIS measures consistent with the NCQA categories listed below in Table 5.1.

Table 5.1—HEDIS Measure Audit Findings

Rate/Result	Definition
0–XXX	A rate or numeric result: The organization followed the specifications and produced a reportable rate or result for the measure.
Not Reportable (NR)	Not Reportable: 1. The calculated rate was materially biased, or 2. The organization chose not to report the measure, or 3. The organization was not required to report the measure.
Not Applicable (NA)	Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate.
No Benefit (NB)	Benefit Not Offered: The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).

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

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

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

For the discussions 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 *No Visits* and *Six 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 *<21 Percent of Expected Visits* and *≥81 Percent of Expected 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 reviewed the processes in place at each MCO for performance of MRR for all measures reported using the hybrid method. HSAG reviewed data collection tools and training materials to verify that all key HEDIS data elements were captured. Feedback was provided to each MCO if the data collection tools appeared to be missing necessary data elements.

HSAG also performed a re-abstraction of records selected for MRR 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 16 records from each numerator-positive member list for each selected measure from appropriate measure groups and from the exclusions group (as 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. If fewer than 16 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).

MCO-Specific Findings

The following Medicaid HEDIS 2014 results tables show the current year's performance for each HEDIS measure relative to the 2013 Quality Compass® percentiles.[5-1] Please note that the 2013 Quality Compass did not contain benchmarks for select measures (i.e., *Human Papillomavirus Vaccine for Female Adolescents* and *Medication Management for People with Asthma—Medication Compliance 50%* measure indicators); therefore, the 2013 HEDIS Audit Means and Percentile 50th percentile values were used for this analysis. The 2014 performance level column illustrated in the tables rates the MCO's performance as follows:

Table 5.2—Star Ratings

Stars	Quality Compass Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	From the 75th percentile to the 89th percentile
★★★ Good	From the 50th percentile to the 74th percentile
★★ Fair	From the 25th percentile to the 49th percentile
★ Poor	Below the 25th percentile

Green shading within the tables below indicates the measure is an incentive measure.

[5-1] 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 NCQA. Quality Compass 2013 includes certain HEDIS performance measure 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.

FHN

The Medicaid HEDIS 2014 rates for **FHN** are presented in Table 5.3.

Table 5.3—FHN's HEDIS 2014 Rates

	HEDIS 2014 Rate	2014 Performance Level
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	85.91%	★
25 Months–6 Years	71.52%	★
7–11 Years	74.34%	★
12–19 Years	74.25%	★
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	63.85%	★
45–64 Years	65.66%	★
Total	64.08%	★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	52.38%	★★★★★
Initiation of AOD Treatment—18+ Years	39.39%	★★★
Initiation of AOD Treatment—Total	41.07%	★★★
Engagement of AOD Treatment—13–17 Years	31.75%	★★★★★
Engagement of AOD Treatment—18+ Years	11.79%	★★★
Engagement of AOD Treatment—Total	14.37%	★★★
Child and Adolescent Care		
Childhood Immunization Status		
Combination 2	71.06%	★★
Combination 3	65.97%	★
Lead Screening in Children		
Lead Screening in Children	78.24%	★★★
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	53.47%	★
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	16.90%	★★
Well-Child Visits in the First 15 Months of Life		
No Well-Child Visits[1]	1.62%	★★
Six or More Well-Child Visits	51.39%	★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.06%	★★

	HEDIS 2014 Rate	2014 Performance Level
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	48.61%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	20.20%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	60.65%	★★★
Counseling for Nutrition—Total	59.72%	★★★
Counseling for Physical Activity—Total	52.31%	★★★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening[2]	52.67%	NB
Cervical Cancer Screening		
Cervical Cancer Screening[2]	64.50%	NB
Chlamydia Screening in Women		
16–20 Years	59.35%	★★★
21–24 Years	67.71%	★★★
Total	63.78%	★★★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	57.64%	★
Postpartum Care	44.44%	★
Frequency of Ongoing Prenatal Care		
<21 Percent of Expected Visits[1]	29.63%	★
≥81 Percent of Expected Visits	29.17%	★
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	74.29%	★
HbA1c Poor Control (>9.0%)[1]	62.26%	★
HbA1c Control (<8.0%)	29.48%	★
Eye Exam (Retinal) Performed	72.88%	★★★★★
LDL-C Screening	58.96%	★
LDL-C Control (<100 mg/dL)	17.22%	★
Medical Attention for Nephropathy	67.45%	★
BP Control (<140/90 mm Hg)	54.48%	★★
BP Control (<140/80 mm Hg)	34.20%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	42.58%	★
Use of Appropriate Medications for People With Asthma		
5–11 Years	87.65%	★★
12–18 Years	85.51%	★★

	HEDIS 2014 Rate	2014 Performance Level
19–50 Years	82.51%	★★★★
51–64 Years	NA	NA
Total	85.59%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—5–11 Years	50.23%	★★★
Medication Compliance 50%—12–18 Years	52.54%	★★★
Medication Compliance 50%—19–50 Years	54.30%	★★
Medication Compliance 50%—51–64 Years	NA	NA
Medication Compliance 50%—Total	52.13%	★★★
Medication Compliance 75%—5–11 Years	27.23%	★★★
Medication Compliance 75%—12–18 Years	27.12%	★★★
Medication Compliance 75%—19–50 Years	33.77%	★★★
Medication Compliance 75%—51–64 Years	NA	NA
Medication Compliance 75%—Total	29.41%	★★★
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	54.20%	★★★
30-Day Follow-Up	61.58%	★★
Antidepressant Medication Management		
Effective Acute Phase Treatment[2]	46.82%	NB
Effective Continuation Phase Treatment[2]	29.48%	NB

[1] For this measure, a lower rate indicates better performance. When comparing the rates to the 2013 Quality Compass National Percentiles, percentiles were reversed (e.g., the 90th percentile became the 10th percentile)

[2] Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

NA Indicates the rate was withheld because the denominator was less than 30.

NB Comparisons to 2013 Quality Compass National Percentiles were not performed either because percentiles did not exist or comparisons were inappropriate.

FHN had 25 measure indicators with rates that met or exceeded the 2013 Quality Compass or HEDIS Audit Means and Percentiles 50th percentiles, including six measure indicators in the Access to Care measure set, five in the Child and Adolescent Care measure set, three in the Women's Health measure set, ten in the Care for Chronic Conditions measure set, and one in the Behavioral Health measure set. Three measure indicators had fewer than 30 eligible cases (indicated by NA). Additionally, only one of the eight incentive measures met or exceeded the 50th percentile.

FHN performed lower than the 2013 Quality Compass or HEDIS Audit Means and Percentiles 50th percentiles on 32 measure indicators, including seven measure indicators in the Access to Care measure set, eight in the Child and Adolescent Care measure set, four in the Women's Health

measure set, 12 in the Care for Chronic Conditions measure set, and one in the Behavioral Health measure set.

NCQA HEDIS Compliance Audit Results for FHN

The 2014 NCQA HEDIS compliance audit indicated that **FHN** was in compliance with the *HEDIS 2014 Technical Specifications* (Table 5.4). Membership data supported all necessary HEDIS calculations, medical data were partially compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 5.4—FHN 2014 NCQA 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	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

FHN was fully compliant with IS standard 1.0 for medical services data. **FHN** fully converted to QNXT during the measurement year; however, the conversion was finally completed in late January 2013. For the first month of the measurement year, claims and encounters were processed in the Proclaim system, similar to the previous year. The Proclaim system contained sufficient edits to ensure claims were processed appropriately. Coding schemes were verified during the system walkthrough and nonstandard 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/nonparticipating 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 had minimal impact on the measures under review. Encounters, in contrast, 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* measure, which is gender-specific. Since Proclaim accounted for only one month of claims processing, HSAG did not expect there to be any overall issues. **FHN** continued its efforts to increase encounter data submission.

For the remaining months of 2013, **FHN** used the new claims processing system, QNXT. The QNXT system contained all of the appropriate edits for approving and denying claims and also contained all of the relevant fields required to process claims. **FHN** was not using QNXT for adjudicating claims; QNXT was only being used as a conduit for moving data from its external vendors for benefit counting and storage. **FHN** needs to spend more time ensuring its external vendors are supplying appropriate levels of claims each month.

FHN's incentive programs did not change during the measurement year. As in the past, **FHN** targeted many of the key HEDIS measures, including *Well-Child Visits in the First 15 Months of Life*, *Childhood Immunization Status*, and *Prenatal and Postpartum Care.* Providers were paid for encounters submitted with appropriate coding. HSAG did not identify any issues or concerns.

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

FHN was fully compliant with IS standard 2.0. **FHN** began housing all member enrollment files in the QNXT system beginning in February 2013. When QNXT went live, all enrollment strings were carried over from the legacy system for consistency. HSAG verified through primary source verification that all members were converted correctly. **FHN** still maintained the same process for receiving and updating enrollment information from the State. The process during the measurement year did not change from the previous year. **FHN** continued to see an increase in its Medicaid population and has been growing its business in the counties it serves. The enrollment information was processed daily and monthly and was processed in the same manner as in 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.

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

FHN was fully compliant with IS standard 3.0. **FHN** did not undergo any major changes to its provider credentialing process during the measurement year. All specialties were documented and adequate oversight was conducted on external entities. **FHN** migrated all of its providers to QNXT in February 2013. HSAG reviewed the mappings and QNXT system for accuracy of provider migration. There were no issues found during the inspection of the QNXT system against the legacy PM database. **FHN** had minimal changes in providers during the year and conducted network adequacy reviews as required by the State to ensure members had appropriate

opportunities to access care. **FHN** did not report any issues with provider processing of claims during 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. **FHN** staff conducted medical record pursuit and data collection. Medical record data were collected into the Verisk hybrid tools. The Verisk hybrid tools and corresponding instructions were reviewed by HSAG and feedback was provided to **FHN**. The custom Developmental Screening hybrid tool and instructions were reviewed, and there were no concerns. Reviewer qualifications, training, and oversight were appropriate. A convenience sample was required due to abstraction errors noted during the 2013 MRR and due to the new State-required measure. There were no issues noted during the convenience sample process.

FHN passed the MRR 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*
- Group D: *Human Papillomavirus Vaccines for Female Adolescents*
- Group F: No exclusions
- *Developmental Screening in the First Three Years of Life*

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

FHN was fully compliant with IS standard 5.0. **FHN** used only three supplemental databases for HEDIS reporting. Each of the supplemental databases were external standard databases. HSAG reviewed and approved each database based on manual inspection of the files, as well as historical evidence from prior years' audits.

FHN's external standard databases included:

1. LabCorp
2. Healthy Kids
3. State Historical Encounters

The impact the supplemental data had on rates was considered to be minimal for the measures under review; however, the databases were approved and will account for some numerator compliance for records. None of the supplemental databases will impact the issue found by NCQA where denominators were identified through supplemental data.

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 2014.

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

FHN was found to be fully compliant with IS standard 7.0. **FHN** converted to Verisk late in 2012 and has maintained a good relationship with the vendor. The HEDIS measures generated by Verisk were fully certified in March 2014. **FHN** provided a snapshot of the certified software help screen to show that it is using the correct version as well as provided the globally unique identifier numbers (GUIDs) for each measure. **FHN** provided preliminary rate comparisons showing side-by-side rates for the measures under review. Verisk produced the non-HEDIS CHIPRA measure, *Developmental Screening in the First Three Years of Life* for **FHN** this year. **FHN** walked through the conversion process on-site and provided 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 were secure and at minimal risk for loss; however, the disaster recovery documentation needs additional work.

Harmony

The Medicaid HEDIS 2014 rates for **Harmony** are presented in Table 5.5.

Table 5.5—Harmony's HEDIS 2014 Rates

	HEDIS 2014 Rate	2014 Performance Level
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	89.98%	★
25 Months–6 Years	76.47%	★
7–11 Years	75.63%	★
12–19 Years	77.70%	★
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	70.38%	★
45–64 Years	71.23%	★
Total	70.48%	★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	40.00%	★★★
Initiation of AOD Treatment—18+ Years	31.62%	★
Initiation of AOD Treatment—Total	32.89%	★
Engagement of AOD Treatment—13–17 Years	7.06%	★
Engagement of AOD Treatment—18+ Years	7.02%	★★
Engagement of AOD Treatment—Total	7.02%	★★
Child and Adolescent Care		
Childhood Immunization Status		
Combination 2	70.60%	★★
Combination 3	66.44%	★★
Lead Screening in Children		
Lead Screening in Children	78.84%	★★★
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	58.33%	★★
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	14.81%	★★
Well-Child Visits in the First 15 Months of Life		
No Well-Child Visits1	3.76%	★
Six or More Well-Child Visits	56.57%	★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	68.06%	★★

	HEDIS 2014 Rate	2014 Performance Level
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	49.77%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	34.15%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	38.19%	★★
Counseling for Nutrition—Total	59.49%	★★★
Counseling for Physical Activity—Total	54.86%	★★★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening[2]	42.99%	NB
Cervical Cancer Screening		
Cervical Cancer Screening[2]	72.73%	NB
Chlamydia Screening in Women		
16–20 Years	44.13%	★
21–24 Years	56.60%	★
Total	50.15%	★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	70.00%	★
Postpartum Care	48.37%	★
Frequency of Ongoing Prenatal Care		
<21 Percent of Expected Visits[1]	12.79%	★★
≥81 Percent of Expected Visits	42.09%	★
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	75.61%	★
HbA1c Poor Control (>9.0%)[1]	56.76%	★
HbA1c Control (<8.0%)	34.59%	★
Eye Exam (Retinal) Performed	25.50%	★
LDL-C Screening	59.20%	★
LDL-C Control (<100 mg/dL)	20.62%	★
Medical Attention for Nephropathy	72.73%	★
BP Control (<140/90 mm Hg)	58.54%	★★
BP Control (<140/80 mm Hg)	36.36%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	50.00%	★
Use of Appropriate Medications for People With Asthma		
5–11 Years	84.41%	★
12–18 Years	83.90%	★★

	HEDIS 2014 Rate	2014 Performance Level
19–50 Years	86.30%	★★★★
51–64 Years	NA	NA
Total	84.73%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—5–11 Years	44.27%	★★
Medication Compliance 50%—12–18 Years	39.01%	★
Medication Compliance 50%—19–50 Years	48.03%	★
Medication Compliance 50%—51–64 Years	NA	NA
Medication Compliance 50%—Total	44.32%	★
Medication Compliance 75%—5–11 Years	22.29%	★★
Medication Compliance 75%—12–18 Years	17.49%	★
Medication Compliance 75%—19–50 Years	22.71%	★
Medication Compliance 75%—51–64 Years	NA	NA
Medication Compliance 75%—Total	21.46%	★
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	61.68%	★★★★
30-Day Follow-Up	69.80%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment[2]	39.50%	NB
Effective Continuation Phase Treatment[2]	25.97%	NB

[1] For this measure, a lower rate indicates better performance. When comparing the rates to the 2013 Quality Compass National Percentiles, percentiles were reversed (e.g., the 90th percentile became the 10th percentile).

[2] Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

NA Indicates the rate was withheld because the denominator was less than 30.

NB Comparisons to 2013 Quality Compass National Percentiles were not performed either because percentiles did not exist or comparisons were inappropriate.

Harmony reported nine measure indicators with rates at or above the 2013 Quality Compass 50th percentiles, including one in the Access to Care measure set, four in the Child and Adolescent Care measure set, two in the Care for Chronic Conditions measure set, and two in the Behavioral Health measure set. Only one of the nine measure indicators was an incentive measure. Additionally, three measure indicators had fewer than 30 eligible cases (indicated by NA).

Compared to the 2013 Quality Compass and HEDIS Audit Means and Percentiles 50th percentiles, **Harmony** scored the lowest on the Access to Care and Care for Chronic Conditions measures, whereby only three out of 35 measure indicators with reported rates from these two categories exceeded the 50th percentiles.

NCQA HEDIS Compliance Audit Results for Harmony

The 2014 NCQA HEDIS compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2014 Technical Specifications*. 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 5.6—Harmony 2014 NCQA 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	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 changes to the Xcelys claims system or the encounter processing system used by **Harmony** during the measurement year. **Harmony**'s claims system, Xcelys, continued to use only industry standard codes (e.g., International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM], Current Procedure Terminology, 4th Edition [CPT-4], Diagnosis-related Group [DRG], Healthcare Common Procedure Coding System [HCPCS]) when processing claims. HSAG confirmed with **Harmony** staff that all code sets were updated quarterly, annually, and whenever released. The Xcelys claims system maintained code specificity, appropriate number of bytes to capture codes, and appropriate edits to deny invalid codes. Xcelys also allowed for an unlimited number of codes to be submitted and captured. HSAG's walkthrough of the system ensured that primary and secondary codes were identified and nonstandard 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, which is consistent with the previous 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.

HSAG also confirmed with the MCO staff that when a member was retroactively enrolled, the MCO contacted the State to request all services that were paid during the period of retroactivity for inclusion in its HEDIS rates.

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

Harmony was fully compliant with the IS standard 2.0 requirements. **Harmony** has maintained the same process for member enrollment for several years. There were no changes to the process for HEDIS 2014, measurement year 2013. As in prior years, monthly files were received and loaded into **Harmony**'s Xcelys system. Processing of membership information complied with standards, and appropriate fields were captured as outlined in the Roadmap. HSAG verified on-site that there were sufficient edit checks in place to ensure files loaded did not contain errors. Daily and monthly, **Harmony** verified all of its Medicaid enrollment files from the State. All enrollment files were reconciled against the capitation payment files in addition to the daily and monthly State reconciliation. HSAG confirmed that there were no backlogs in processing during the measurement year, and retroactivity was at a minimum.

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

Harmony was fully compliant with the IS standard 3.0 requirements. **Harmony** continued to use Visual CACTUS to process its credentialing information during the 2013 measurement year. **Harmony** used Visual CACTUS, as it has in the past, to credential providers. HSAG's review of the credentialing process did not reveal any issues. HSAG verified that once a provider met all of the credentialing criteria, the provider information was transferred to Xcelys. **Harmony** required all practitioners to be board certified, or at a minimum, complete training for the specialty in which they practice.

Harmony continued to conduct monthly audits against both the Visual CACTUS and Xcelys systems to determine if there were any gaps in information and maintained quality assurance reports for the measurement year. **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 subspecialties 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.

Harmony has good oversight of its provider process, and HSAG did not find any deficiencies in provider processing.

HSAG conducted primary source verification during the on-site audit and reviewed a sample of provider records during the session. All files were found to be accurate.

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

Harmony was fully compliant with the IS 4.0 reporting requirements. **Harmony** contracted with Outcomes Health, a medical record vendor, for medical record pursuit and abstraction. **Harmony** staff procured medical records and forwarded the records to the medical record vendor for abstraction. Medical record data were collected into the Outcomes Health hybrid tools. HSAG reviewed the Outcomes Health hybrid tools and instructions and did not have any concerns. **Harmony** validated all potential exclusions that were identified by the Outcomes Health review staff and 100 percent of the abstracted cases.

Reviewer qualifications, training, IRR process, and vendor oversight were appropriate. Due to the new State-required custom measure, *Developmental Screening in the First Three Years of Life,* and *Human Papillomavirus Vaccine for Female Adolescents* measure, a convenience sample was required and subsequently passed.

Harmony passed MRRV for the following measure groups:

- Group A: *Timeliness of Prenatal Care*
- Group A: *Postpartum Care*
- Group B: *Well-Child Visits in the First 15 Months of Life*
- Group D: *Human Papillomavirus Vaccines for Female Adolescents*
- Group F: No exclusions
- *Developmental Screening in the First Three Years of Life*

Upon MRR of the *Timeliness of Prenatal Care* measure, an abstraction error was noted. HSAG reviewed the remaining nine prenatal cases and noted two abstraction errors. Due to the errors noted during the *Timeliness of Prenatal Care* review, HSAG extrapolated the findings to the *Postpartum Care* measure. No errors were noted during the *Postpartum Care* review. No other measures were being reported in measure Group A.

During MRR of the *Well-Child Visits in the First 15 Months of Life* measure, one abstraction error was noted. According to the NCQA MRRV protocol, validation of a second sample was required. During the second sample validation, one abstraction error was noted. HSAG validated the remaining 21 *Well-Child Visits in the First 15 Months of Life* numerator positive cases, and no errors were detected.

HSAG validated the new State-required measure, *Developmental Screening in the First Three Years of Life*. Upon validation of this measure, three abstraction errors were noted. Since there were less than 16 cases, **Harmony** removed the associated three cases from the numerator positive category.

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

Harmony was fully compliant with the IS standard 5.0 requirements. **Harmony** continued to use several standard supplemental data sources for reporting its Medicaid measures and did not use any nonstandard supplemental data. The supplemental data sources were external standard data that were State organized immunization and encounter data. These supplemental systems have been reviewed and approved in the past and, upon HSAG's review, did not differ materially from the previous year. The external sources were monitored monthly by **Harmony** analysts through trending and data validation. HSAG confirmed that the supplemental data sources were used only for numerator compliance and not for determining denominators. Additionally, the supplemental data were used to enhance rates for the hybrid measures under the scope of the Illinois Medicaid audit.

All supplemental data sources were loaded into **Harmony**'s data warehouse where they were scrutinized for member identification, appropriate coding, and appropriate provider identification (including specialty identification).

For HEDIS 2014, the supplemental data sources are expected to provide significant numerator positive results, reducing the burden on medical record review.

HSAG reviewed and approved **Harmony**'s supplemental data sources during March 2014.

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 2014.

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

Harmony was fully compliant with the IS standard 7.0 requirements. **Harmony** had a significant change in its reporting software in late 2012 and early 2013, and this revised software was first

used in HEDIS 2013. **Harmony** was very successful in its conversion to the new software vendor during that time and continued to use the same vendor during 2014. **Harmony** continued to update the software vendor with provider and member records as required by ongoing maintenance. Inspection of the Roadmap documents and interviews during the on-site provided sufficient evidence that **Harmony** was appropriately maintaining the certified software.

Harmony continued to conduct side-by-side analyses and trended rates to determine gaps in mapping or claims data, as well as to determine accuracy of software. **Harmony** indicated there were no significant differences in the data from year to year in its side-by-side analyses.

HSAG conducted primary source verification of several records for each measure under review and found no errors. HSAG reviewed records in the certified software, as well as the Xcelys (claims/member/provider) system to determine that all records were being mapped appropriately.

HSAG reviewed **Harmony**'s rates based on a three year trend and found no anomalies. **Harmony** maintained sufficient processes to integrate all internal and external data sources for HEDIS reporting.

Meridian

The Medicaid HEDIS 2014 rates for **Meridian** are presented in Table 5.7.

Table 5.7—Meridian's HEDIS 2014 Rates

	HEDIS 2014 Rate	2014 Performance Level
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	98.50%	★★★★★
25 Months–6 Years	95.36%	★★★★★
7–11 Years	97.00%	★★★★★
12–19 Years	97.24%	★★★★★
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	87.08%	★★★★
45–64 Years	87.98%	★★★
Total	87.20%	★★★★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	NA	NA
Initiation of AOD Treatment—18+ Years	43.75%	★★★★
Initiation of AOD Treatment—Total	43.93%	★★★★
Engagement of AOD Treatment—13–17 Years	NA	NA
Engagement of AOD Treatment—18+ Years	8.33%	★★
Engagement of AOD Treatment—Total	10.28%	★★★
Child and Adolescent Care		
Childhood Immunization Status		
Combination 2	85.68%	★★★★★
Combination 3	83.37%	★★★★★
Lead Screening in Children		
Lead Screening in Children	88.45%	★★★★★
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	70.26%	★★★
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	48.60%	★★★★★
Well-Child Visits in the First 15 Months of Life		
No Well-Child Visits[1]	0.00%	★★★★★
Six or More Well-Child Visits	90.46%	★★★★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	88.44%	★★★★★

	HEDIS 2014 Rate	2014 Performance Level
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	74.58%	★★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	52.23%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	58.33%	★★★
Counseling for Nutrition—Total	64.35%	★★★
Counseling for Physical Activity—Total	37.73%	★★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening[2]	NA	NB
Cervical Cancer Screening		
Cervical Cancer Screening[2]	80.65%	NB
Chlamydia Screening in Women		
16–20 Years	46.90%	★
21–24 Years	71.28%	★★★★
Total	62.13%	★★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	94.03%	★★★★★
Postpartum Care	78.46%	★★★★★
Frequency of Ongoing Prenatal Care		
<21 Percent of Expected Visits[1]	0.86%	★★★★★
≥81 Percent of Expected Visits	92.72%	★★★★★
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	94.37%	★★★★★
HbA1c Poor Control (>9.0%)[1]	73.24%	★
HbA1c Control (<8.0%)	23.94%	★
Eye Exam (Retinal) Performed	63.38%	★★★★
LDL-C Screening	91.55%	★★★★★
LDL-C Control (<100 mg/dL)	29.58%	★★
Medical Attention for Nephropathy	88.73%	★★★★★
BP Control (<140/90 mm Hg)	67.61%	★★★
BP Control (<140/80 mm Hg)	43.66%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	78.50%	★★★★★
Use of Appropriate Medications for People With Asthma		
5–11 Years	95.74%	★★★★★
12–18 Years	NA	NA

	HEDIS 2014 Rate	2014 Performance Level
19–50 Years	NA	NA
51–64 Years	NA	NA
Total	92.86%	★★★★★
Medication Management for People With Asthma		
Medication Compliance 50%—5–11 Years	96.47%	★★★★★
Medication Compliance 50%—12–18 Years	NA	NA
Medication Compliance 50%—19–50 Years	NA	NA
Medication Compliance 50%—51–64 Years	NA	NA
Medication Compliance 50%—Total	94.31%	★★★★★
Medication Compliance 75%—5–11 Years	88.24%	★★★★★
Medication Compliance 75%—12–18 Years	NA	NA
Medication Compliance 75%—19–50 Years	NA	NA
Medication Compliance 75%—51–64 Years	NA	NA
Medication Compliance 75%—Total	83.74%	★★★★★
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	41.94%	★★
30-Day Follow-Up	65.59%	★★
Antidepressant Medication Management		
Effective Acute Phase Treatment[2]	65.96%	NB
Effective Continuation Phase Treatment[2]	53.19%	NB

[1] For this measure, a lower rate indicates better performance. When comparing the rates to the 2013 Quality Compass National Percentiles, percentiles were reversed (e.g., the 90th percentile became the 10th percentile).

[2] Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

NA Indicates the rate was withheld because the denominator was less than 30.

NB Comparisons to 2013 Quality Compass National Percentiles were not performed either because percentiles did not exist or comparisons were inappropriate.

Meridian reported 40 out of 49 measure indicators with rates at or above the 2013 Quality Compass or HEDIS Audit Means and Percentiles 50th percentiles, including seven of the eight incentive measures (one incentive measure was not compared to the 2013 Quality Compass National Percentiles, as indicated by NB). **Meridian** scored below the 2013 Quality Compass 50th percentiles for both measure indicators in the Behavioral Health measure set. Additionally, for the Care for Chronic Conditions measure set, 10 of the 16 measure indicators that could be compared to benchmarks were at or above the 2013 Quality Compass or HEDIS Audit Means and Percentiles 90th percentiles. Eleven measure indicators had fewer than 30 eligible cases (indicated by NA). Nine measure indicators were below the 2013 Quality Compass 50th percentiles.

NCQA HEDIS Compliance Audit Results for Meridian

The 2014 NCQA HEDIS compliance audit indicated that **Meridian** was in full compliance with the *HEDIS 2014 Technical Specifications* (Table 5.8). 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 5.8—Meridian 2014 NCQA 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	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. **Meridian** used an internally developed claim system, Managed Care System (MCS), which fully incorporated all required data elements for claims processing. The MCS system was developed by internal staff several years ago using the Progress database. The MCS system is a similar product and in many ways better. The MCS system captured all required CPT-4 codes, HCPCS codes, ICD-9 codes, and now ICD-10 codes. A system demonstration clearly showed that MCS did not allow invalid coding. Any invalid code was immediately rejected as unknown and the processor could not continue with any further entry of the claim information.

The MCS system was capable of handling both paper and electronic claim forms. The majority of claims were processed electronically from trading partners/clearinghouses; however, **Meridian** still received a fair number of paper claims. Paper claims were sent directly to the home office and scanned, vertexed, then converted into a standard 837 format. During the on-site review, HSAG examined several paper claims. Since MCS incorporated the optical character recognition (OCR) technology in the MCS system, the validation of the OCR claims to 837 was effortless, and no errors were found.

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

Meridian was fully compliant with IS standard 2.0. The MCS system was also used to capture enrollment records. **Meridian** had sufficient processes in place to ensure enrollment records were captured appropriately. **Meridian** received weekly files from the State as entered from Maximus, the enrollment broker for the State. Once information was received from the State, **Meridian** staff matched the records against existing records in MCS. If the record already existed in MCS, then **Meridian** staff updated the record with the current enrollment information. This process of pre-checking ensured that accurate data were captured and no duplicate records were entered.

Once per month, **Meridian** validated the monthly file against records in MCS to ensure that the members entered previously were actually enrolled. **Meridian** staff also ran monthly de-duplication processes to ensure no member existed under two separate identification numbers. If a member had two enrollment records, the process would combine the history and place the member under the most current identification number, thereby ensuring only one member identification for each member.

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

Meridian was fully compliant with IS standard 3.0. **Meridian** had sufficient processes in place to ensure primary care physicians (PCPs) and specialists were appropriately captured. The MCS system captured all necessary data elements required for HEDIS reporting.

A review of the credentialing files also showed that proper methodology existed during the measurement year to ensure all information was captured. **Meridian** used several delegated entities to credential providers, and all were Council for Affordable Quality Healthcare (CAQH) qualified.

There were no changes to this process from the previous year.

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

Meridian reported all required measures via the administrative methodology; therefore, medical record review, 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. **Meridian** used several supplemental data sources and only one nonstandard supplemental data source.

1. HealthyKids—Standard
2. MHP Internal—Nonstandard

3. Historical Claims—Standard
4. LabCorp—Standard

All standard data sources were found to be compliant based on Roadmap review. The nonstandard data source was approved by March 28, 2014.

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 for HEDIS 2014.

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

Meridian was fully compliant with IS 7.0 for data integration. There were no issues identified during the on-site audit. **Meridian** made no changes to the process with the exception of updating the source code in accordance with changes in the HEDIS specifications. Source code is under review, and a final determination will be made once the review is completed.

The HEDIS repository and file creation was found to be fully compliant. HSAG reviewed several records on-site for primary source verification, and all records passed inspection.

Initial administrative rates were reviewed on-site, and measures were benchmarked against the previous year and the NCQA benchmarks. All rates are reportable and source code review complete without errors.

MCO Comparisons

This section of the report compares HEDIS and CHIPRA performance measure results for each measure set for **FHN**, **Harmony**, and **Meridian** for HEDIS 2012, HEDIS 2013, and HEDIS 2014. HEDIS 2014 rates are compared to 2013 Quality Compass 50th percentiles, as represented by the red horizontal line. As mentioned above, the 2013 Quality Compass did not contain benchmarks for select measures (i.e., *Human Papillomavirus Vaccine for Female Adolescents* and *Medication Management for People with Asthma—Medication Compliance 50%* measure indicators); therefore, the 2013 HEDIS Audit Means and Percentile 50th percentile values were used for this analysis.

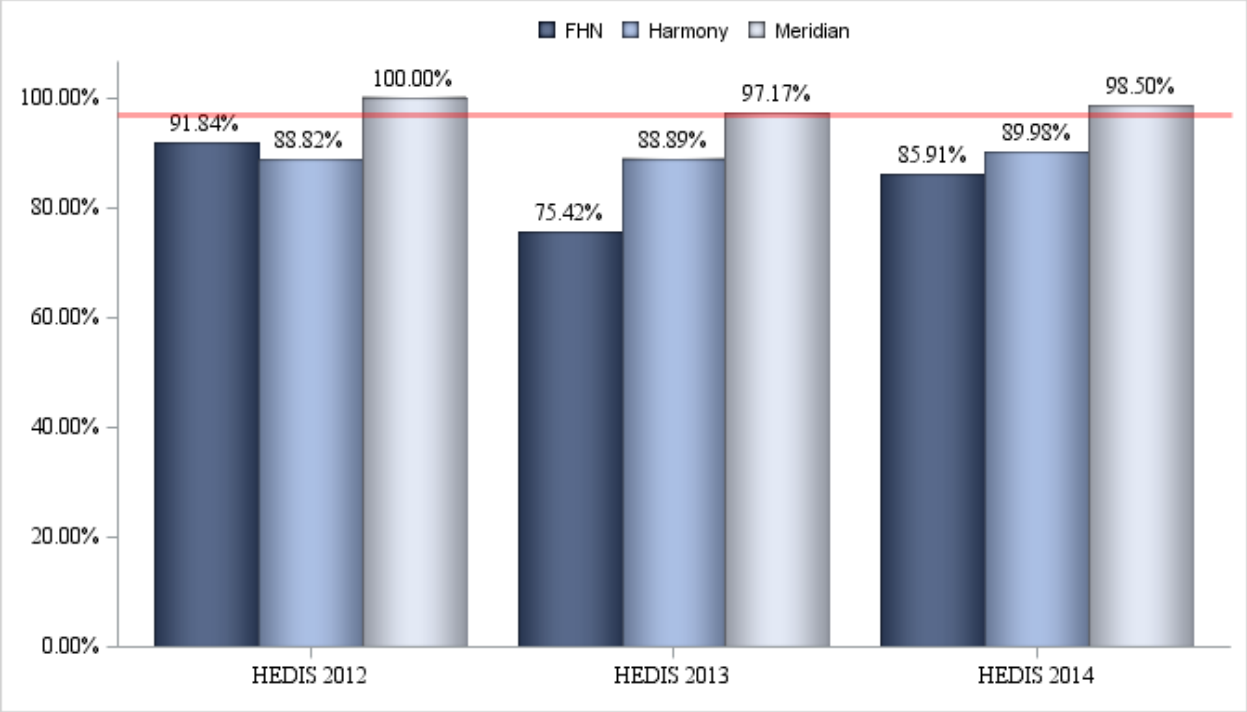
Access to Care

Children and Adolescents' Access to Primary Care Practitioners

Children and Adolescents' Access to Primary Care Practitioners—12–24 Months

Figure 5.1 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*.

Figure 5.1—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*

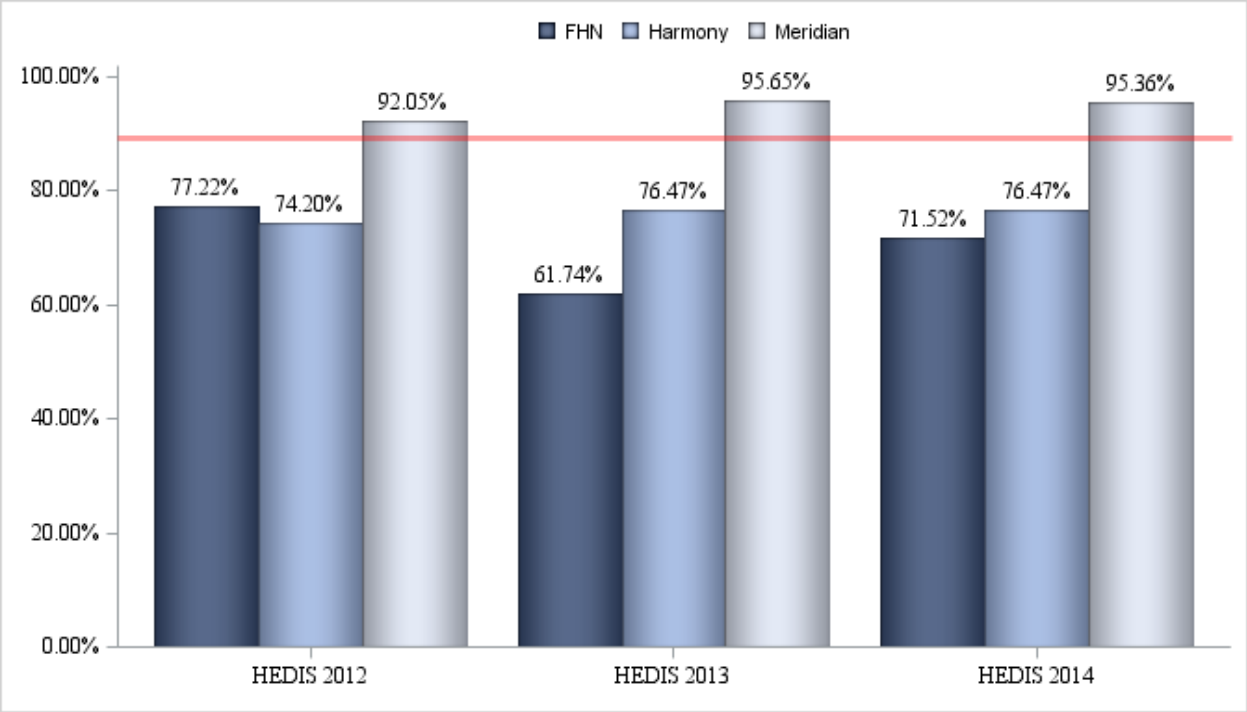


Meridian's rates from HEDIS 2012 to HEDIS 2014 consistently scored above the rates reported by **FHN** and **Harmony**. **Meridian**'s HEDIS 2014 rate was the only rate that was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014. Conversely, **FHN**'s rate increased by 10 percentage points from HEDIS 2013 to HEDIS 2014, though the HEDIS 2014 rate was still 6 percentage points below the HEDIS 2012 rate. Both **FHN** and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile, with **FHN**'s rate falling approximately 11 percentage points below the 50th percentile.

Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years

Figure 5.2 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years.*

Figure 5.2—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*

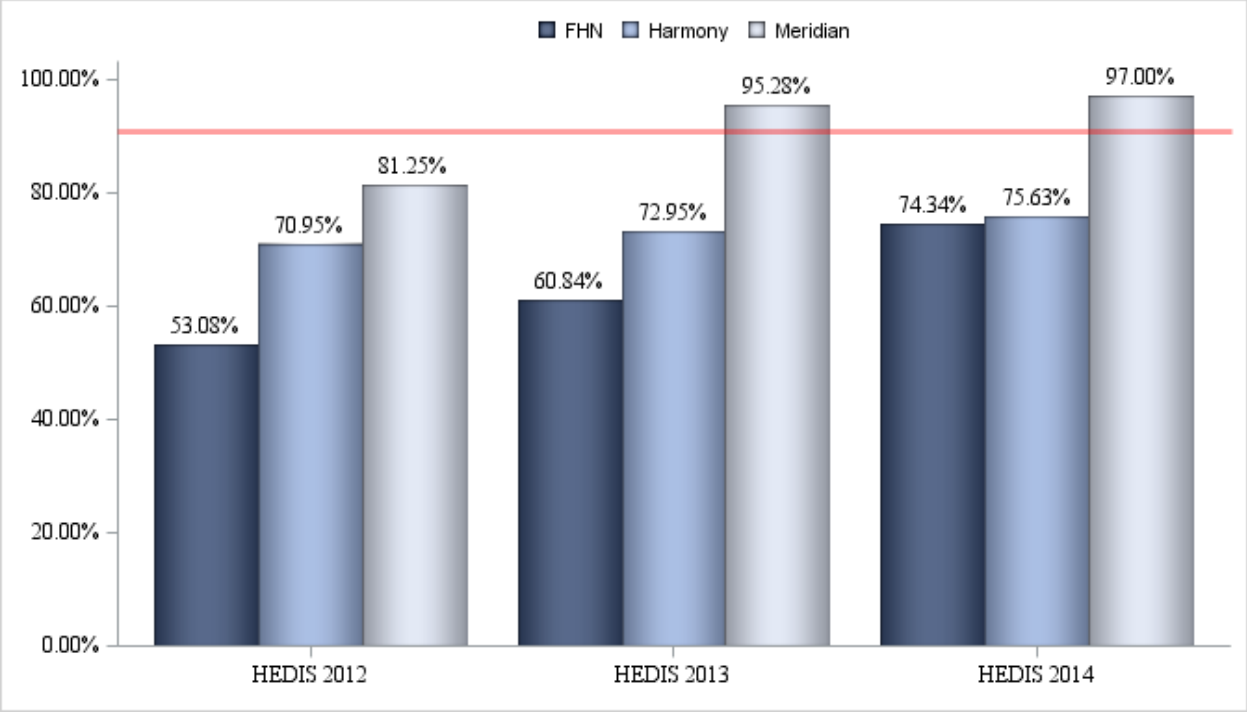


As with the previous measure, **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014. As seen with the previous measure, **FHN**'s rate increased by approximately 10 percentage points from HEDIS 2013 to HEDIS 2014, but the HEDIS 2014 rate still fell almost 6 percentage points below the HEDIS 2012 rate. Both **Harmony**'s rate and **FHN**'s rate fell below the 2013 Quality Compass 50th percentile by approximately 13 and 18 percentage points, respectively.

Children and Adolescents' Access to Primary Care Practitioners—7–11 Years

Figure 5.3 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years.*

Figure 5.3—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*

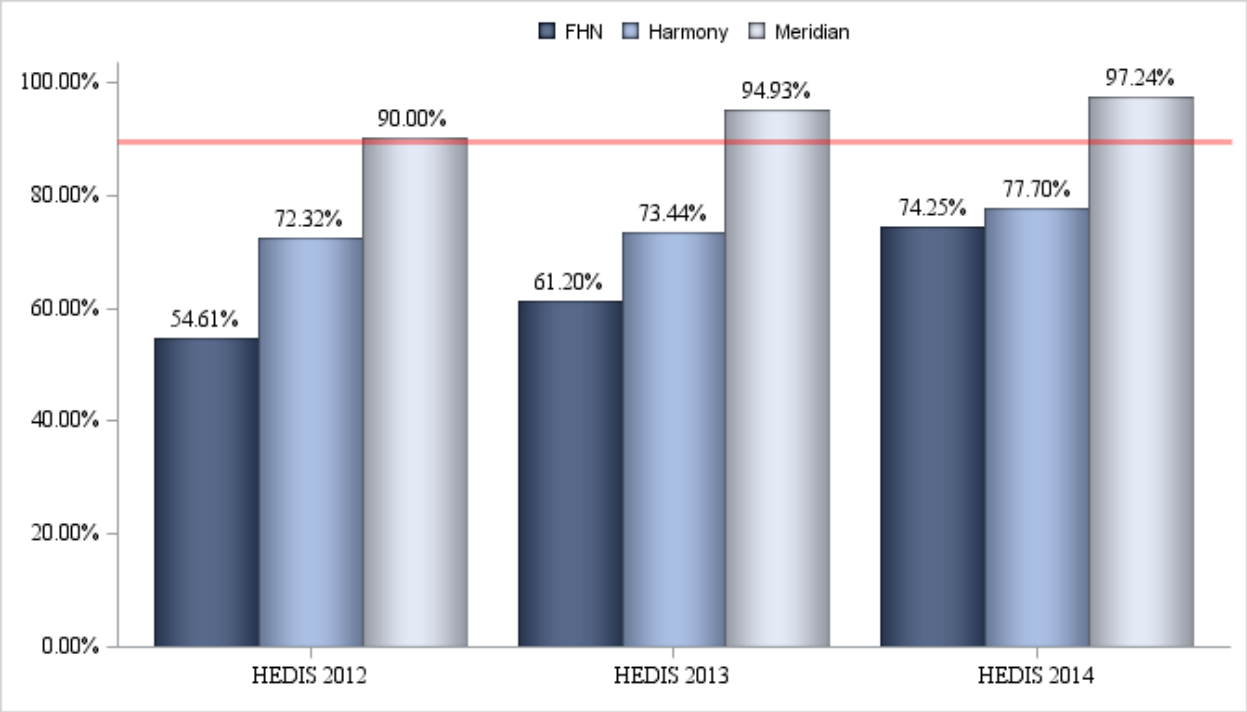


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and **Harmony**'s rate fell below the 2013 Quality Compass 50th percentile by approximately 15 percentage points. **FHN**'s rates improved each year for a total increase of 21 percentage points from HEDIS 2012 to HEDIS 2014. Despite the increased rate, **FHN**'s rate still fell below the 2013 Quality Compass 50th percentile by approximately 17 percentage points.

Children and Adolescents' Access to Primary Care Practitioners—12–19 Years

Figure 5.4 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years.*

Figure 5.4—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*



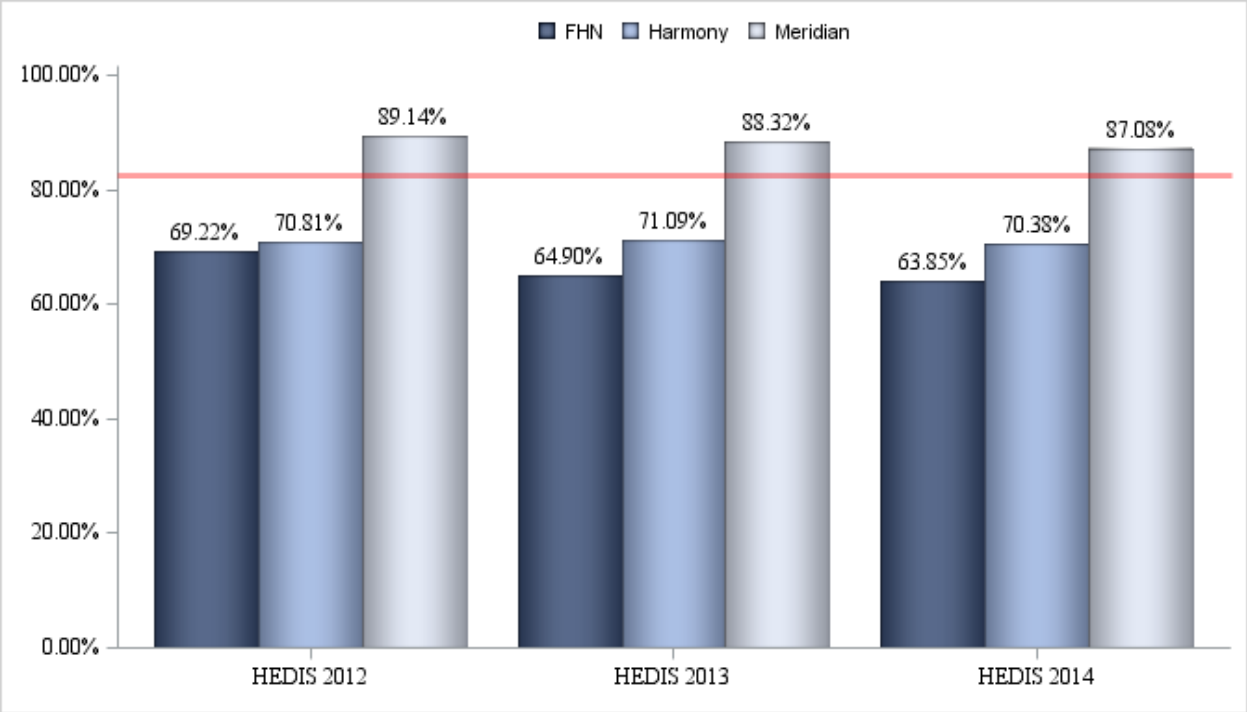
For HEDIS 2012, HEDIS 2013, and HEDIS 2014, **Meridian**'s rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and the HEDIS 2014 rate fell approximately 12 percentage points below the 2013 Quality Compass 50th percentile. **FHN**'s rates improved each year for a total increase of approximately 20 percentage points from HEDIS 2012 to HEDIS 2014. However, **FHN**'s rate still fell approximately 15 percentage points below the 2013 Quality Compass 50th percentile.

Adults' Access to Preventive/Ambulatory Health Services

Adults' Access to Preventive/Ambulatory Health Services—20–44 Years

Figure 5.5 presents comparative rates for *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years.*

Figure 5.5—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*

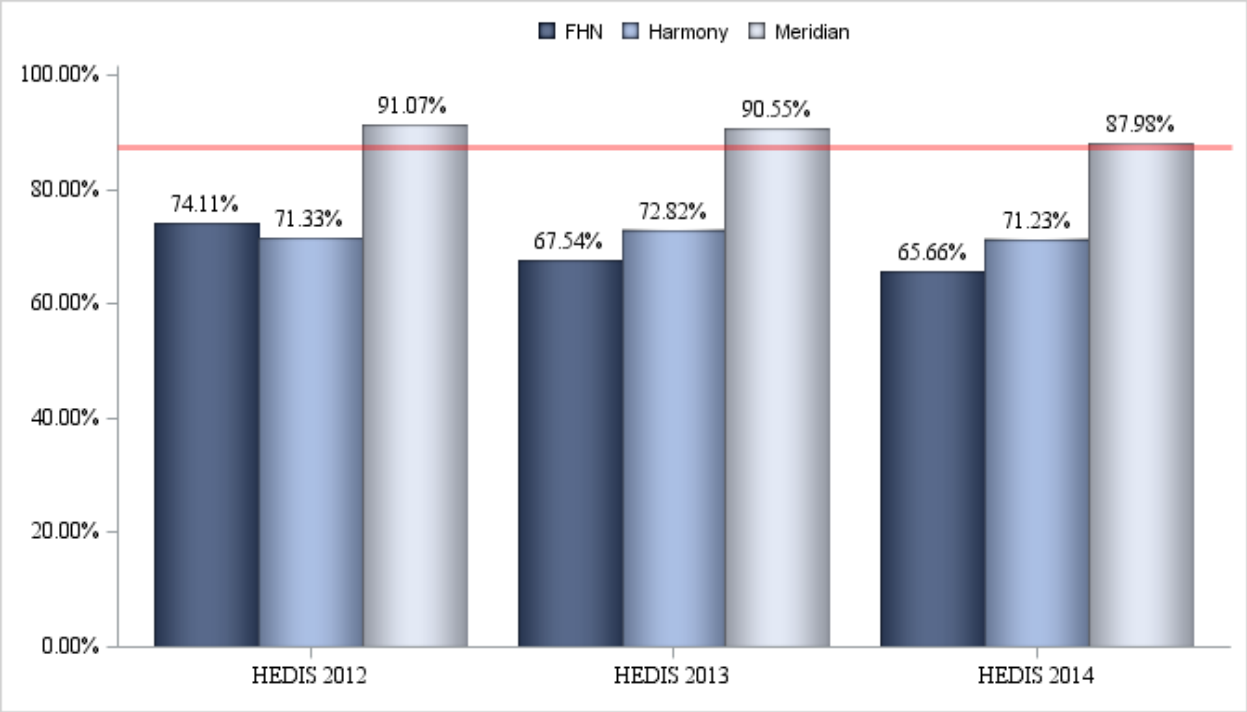


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. As with the measures discussed above, **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and fell 12 percentage points below the 2013 Quality Compass 50th percentile. **FHN**'s rates declined each year and fell below the 2013 Quality Compass 50th percentile by approximately 19 percentage points.

Adults' Access to Preventive/Ambulatory Health Services—45–64 Years

Figure 5.6 presents comparative rates for *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*.

Figure 5.6—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*

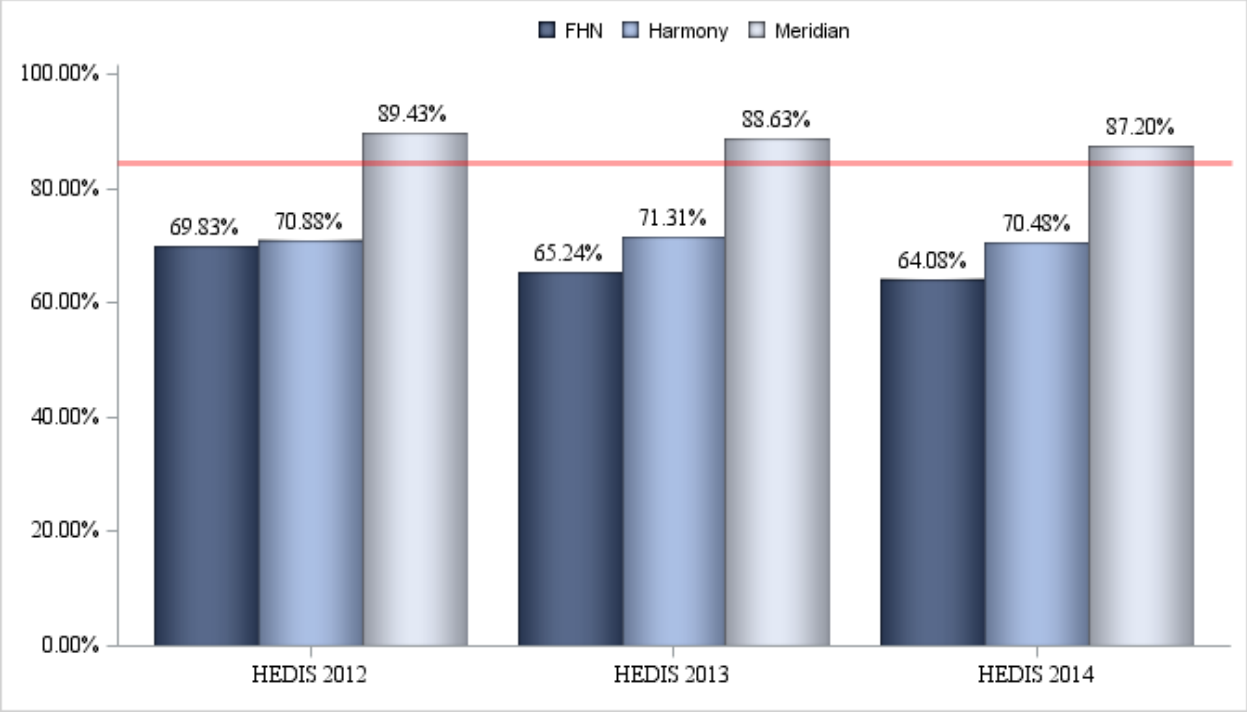


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and fell approximately 16 percentage points below the 2013 Quality Compass 50th percentile. **FHN**'s rates declined each year and fell below the 2013 Quality Compass 50th percentile by approximately 22 percentage points.

Adults' Access to Preventive/Ambulatory Health Services—Total

Figure 5.7 presents comparative rates for *Adults' Access to Preventive/Ambulatory Health Services—Total.*

Figure 5.7—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services—Total*



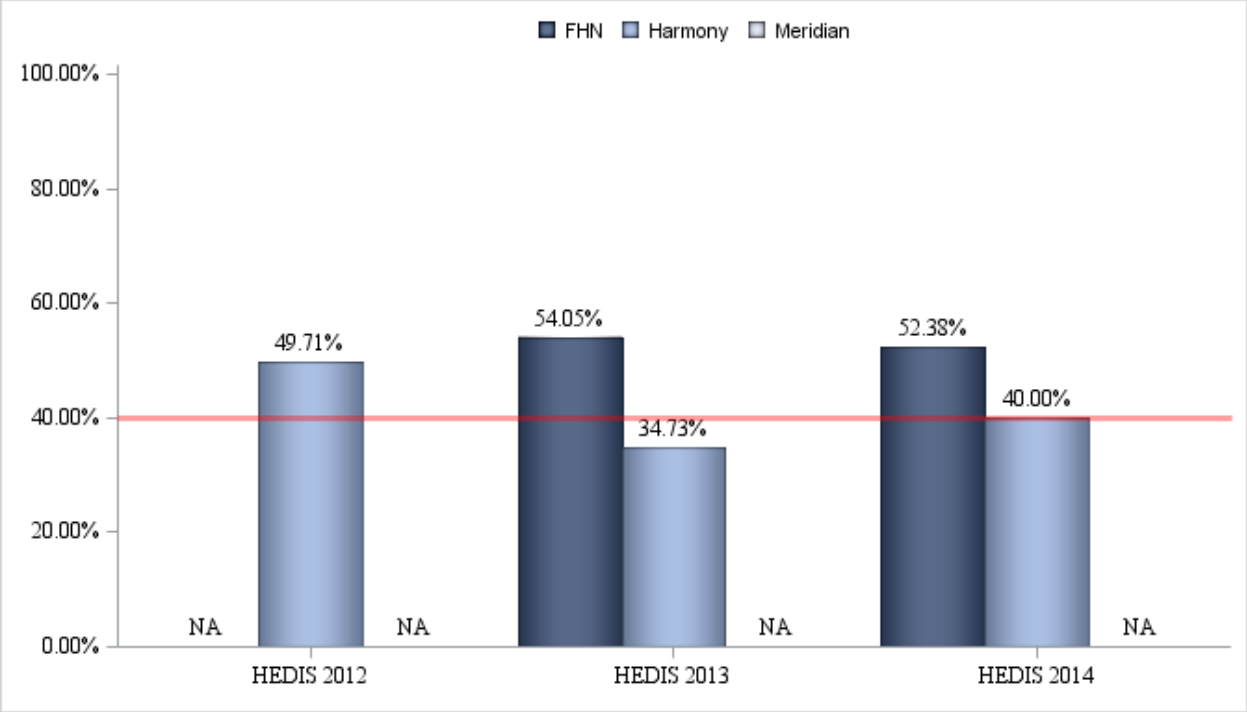
Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and fell below the 2013 Quality Compass 50th percentile by approximately 14 percentage points. Again, **FHN**'s rates declined each year and fell 20 percentage points below the 2013 Quality Compass 50th percentile.

Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment

Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—13–17 Years

Figure 5.8 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—13–17 Years*.

Figure 5.8—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—13–17 Years*

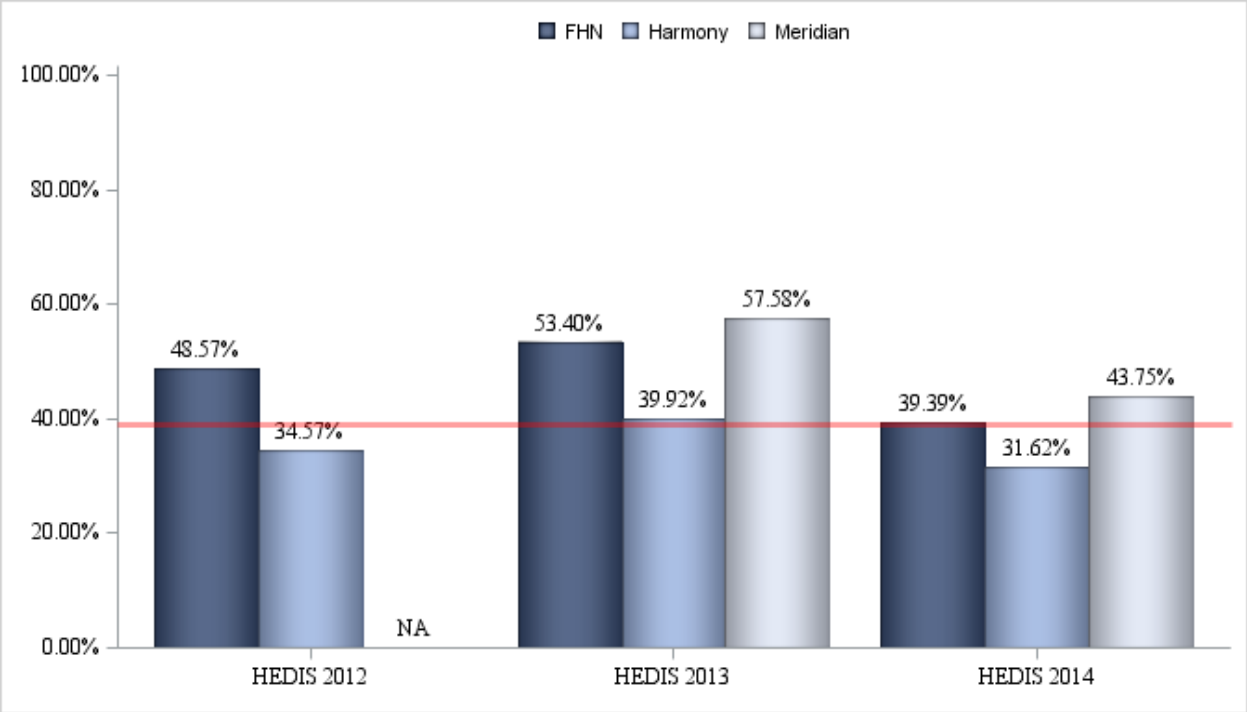


FHN's HEDIS 2013 and HEDIS 2014 rates remained stable, with the HEDIS 2014 rate exceeding the 2013 Quality Compass 50th percentile by approximately 12 percentage points. **Harmony**'s rate decreased by approximately 10 percentage points from HEDIS 2012 to HEDIS 2014; however, **Harmony**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **FHN**'s HEDIS 2012 rate and **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as the rates were based on denominators less than 30.

Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—18+ Years

Figure 5.9 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—18+ Years*.

Figure 5.9—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—18+ Years*

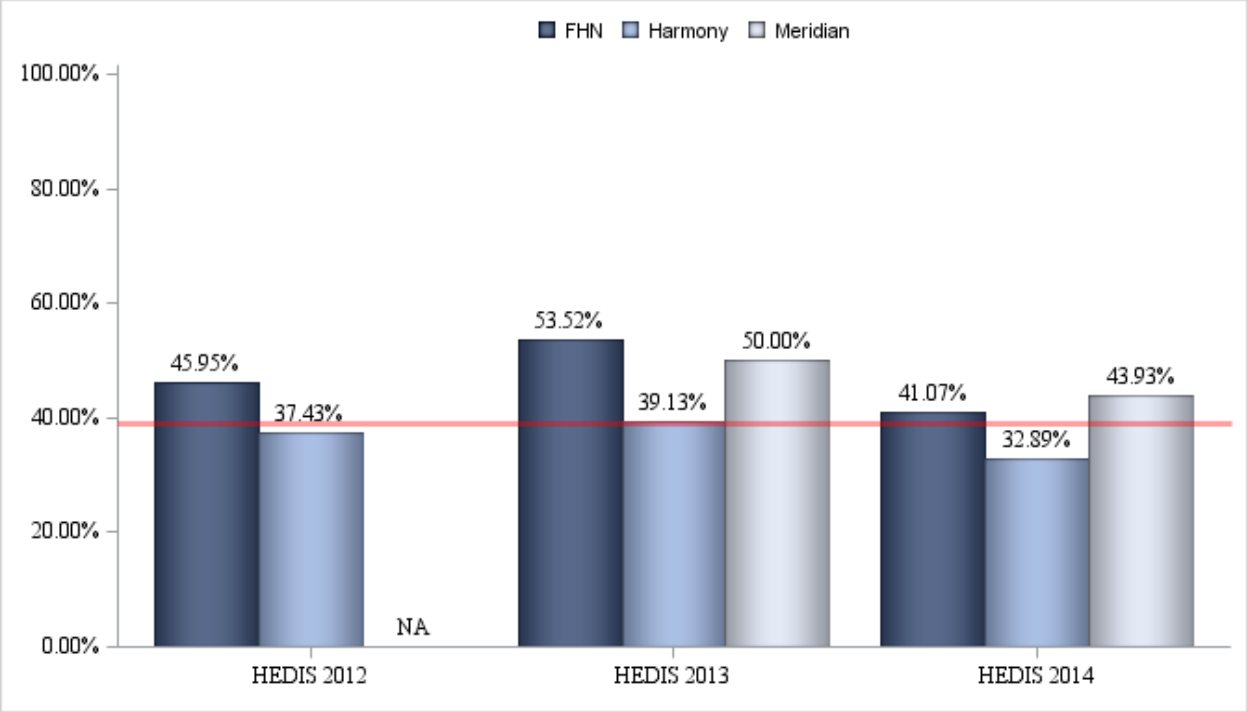


For HEDIS 2013 and HEDIS 2014, **Meridian**'s rates scored above the rates reported by **FHN** and **Harmony**. **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile; however, **Meridian**'s rate indicated performance decline as demonstrated by the decrease of approximately 14 percentage points from HEDIS 2013 to HEDIS 2014. **Harmony**'s rates increased between HEDIS 2012 and HEDIS 2013, but the HEDIS 2014 rate fell below the HEDIS 2012 performance level. Also, **Harmony**'s HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile. Similarly, **FHN**'s rate increased between HEDIS 2012 and HEDIS 2013, followed by a decline in performance from HEDIS 2013 to HEDIS 2014, decreasing approximately 14 percentage points. Despite the decline, **FHN**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total

Figure 5.10 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total.*

Figure 5.10—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*

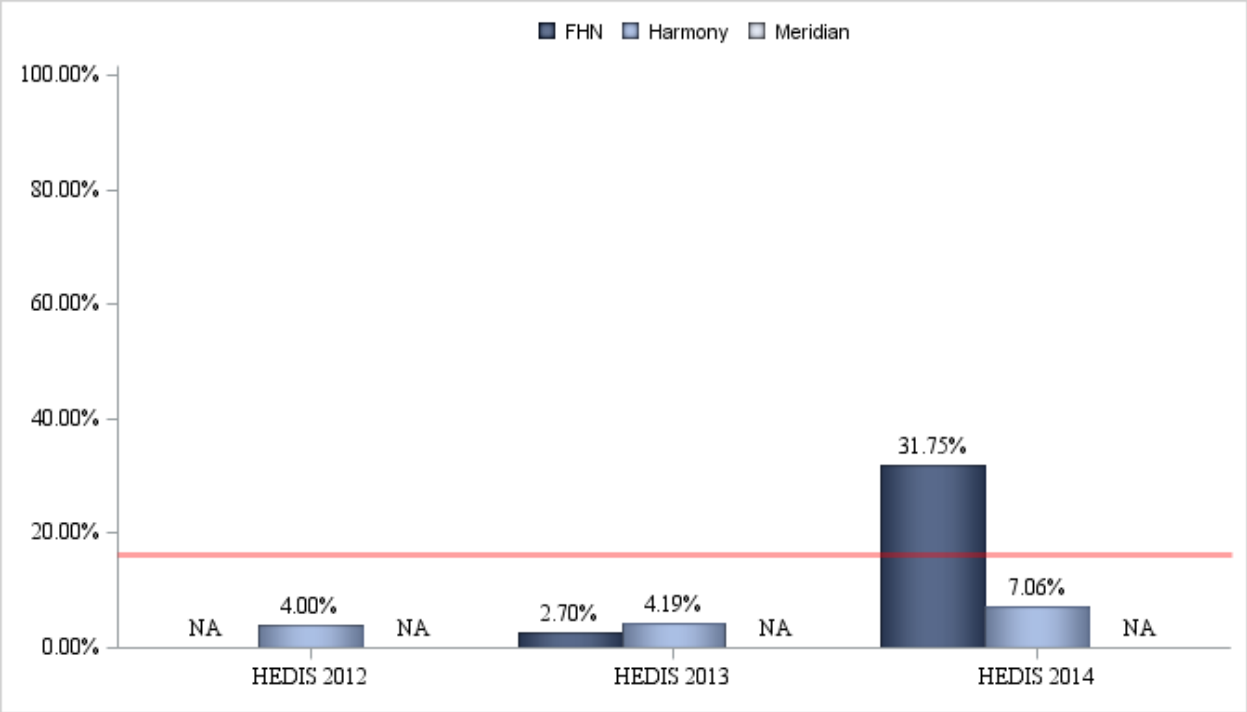


FHN's rates varied from HEDIS 2012 to HEDIS 2014, with a performance increase of 8 percentage points from HEDIS 2012 to HEDIS 2013, and a subsequent decline of 12 percentage points from HEDIS 2013 to HEDIS 2014. Despite the decrease in performance, **FHN**'s HEDIS 2014 rate was at above the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2014 rate was also at or above the 2013 Quality Compass 50th percentile; however, **Meridian**'s rate indicated performance decline from HEDIS 2013 to HEDIS 2014. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2013, but declined by more than 6 percentage points between HEDIS 2013 and HEDIS 2014. **Harmony**'s HEDIS 2014 rate also fell below the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—13–17 Years

Figure 5.11 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—13–17 Years.*

Figure 5.11—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—13–17 Years*

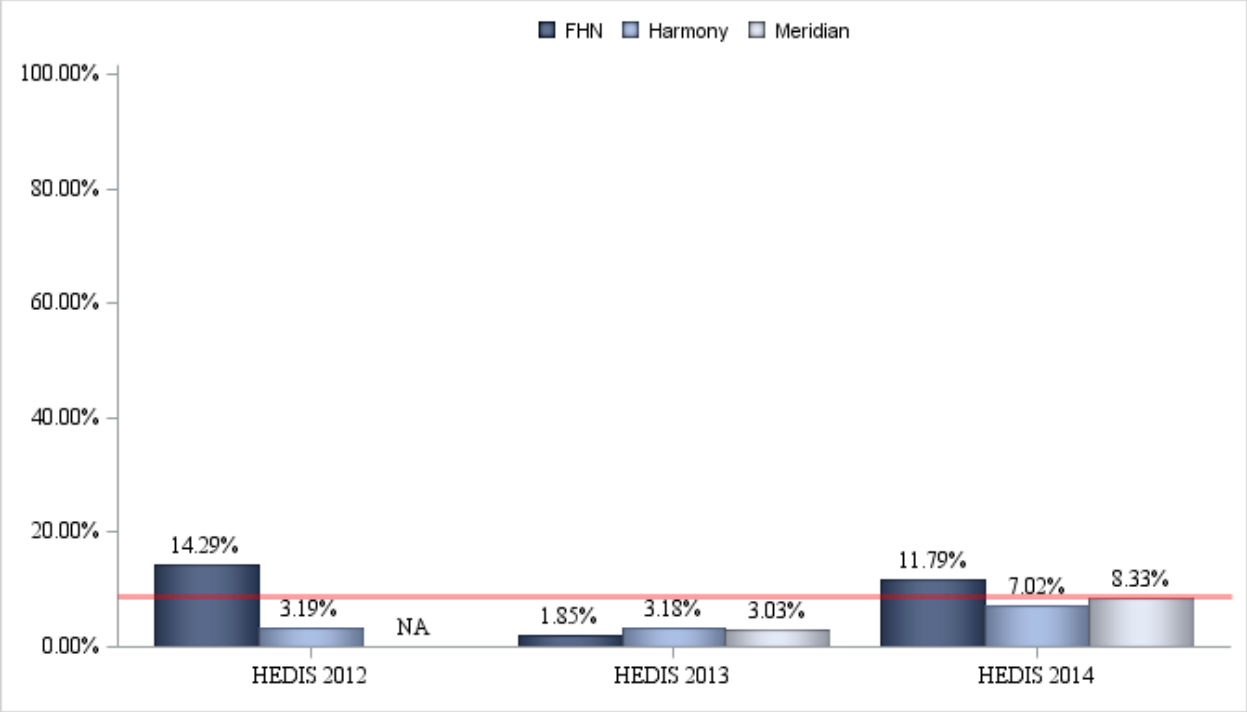


FHN's HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by approximately 15 percentage points, and increased from HEDIS 2012 by nearly 12 times. **Harmony**'s HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile, and rates remained similar from HEDIS 2012 to HEDIS 2014. **FHN**'s HEDIS 2012 rate and **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30.

Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—18+ Years

Figure 5.12 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—18+ Years*.

Figure 5.12—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—18+ Years*

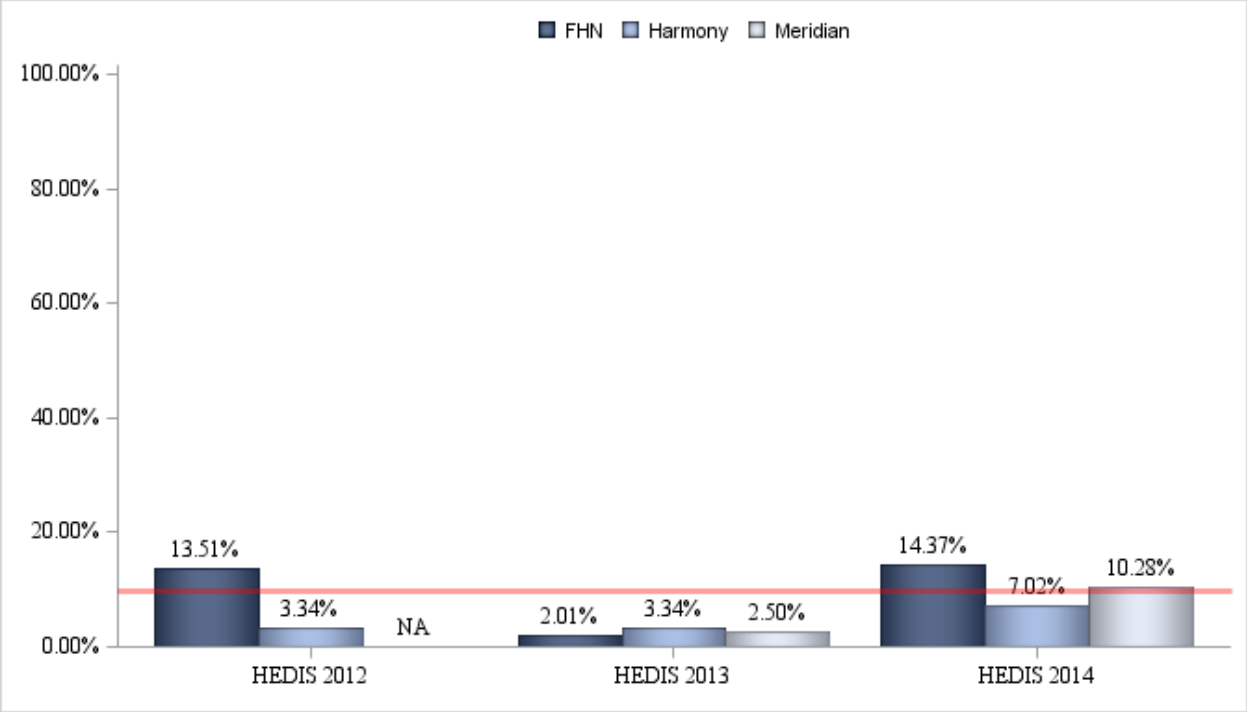


FHN's HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile, but **Meridian**'s and **Harmony**'s rates fell just below this percentile. **FHN**'s rate decreased from HEDIS 2012 to HEDIS 2013 by 12 percentage points, and subsequently increased by 10 percentage points from HEDIS 2013 to HEDIS 2014. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2013, but the rate more than doubled between HEDIS 2013 and HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total

Figure 5.13 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total.*

Figure 5.13—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*



FHN's and **Meridian**'s HEDIS 2014 rates were at or above the 2013 Quality Compass 50th percentile. **FHN**'s rate decreased from HEDIS 2012 to HEDIS 2013 by approximately 12 percentage points, and subsequently increased by 12 percentage points from HEDIS 2013 to HEDIS 2014. **Harmony**'s HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile, and rates remained similar from HEDIS 2012 to HEDIS 2013; however, the rate more than doubled between HEDIS 2013 and HEDIS 2014. **Meridian**'s rate increased by more than four times between HEDIS 2013 and HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

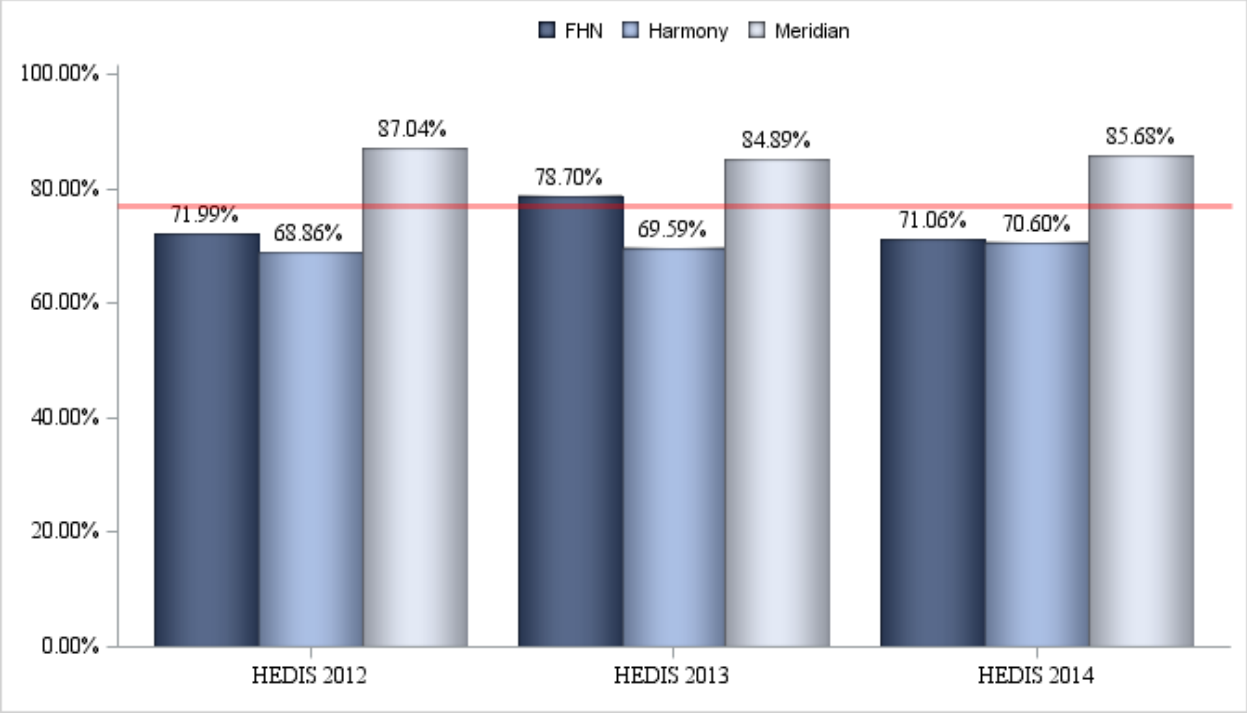
Child and Adolescent Care

Childhood Immunization Status

Childhood Immunization Status—Combination 2

Figure 5.14 presents comparative rates for *Childhood Immunization Status—Combination 2*.

Figure 5.14—Comparison of HFS MCO Performance for *Childhood Immunization Status—Combination 2*

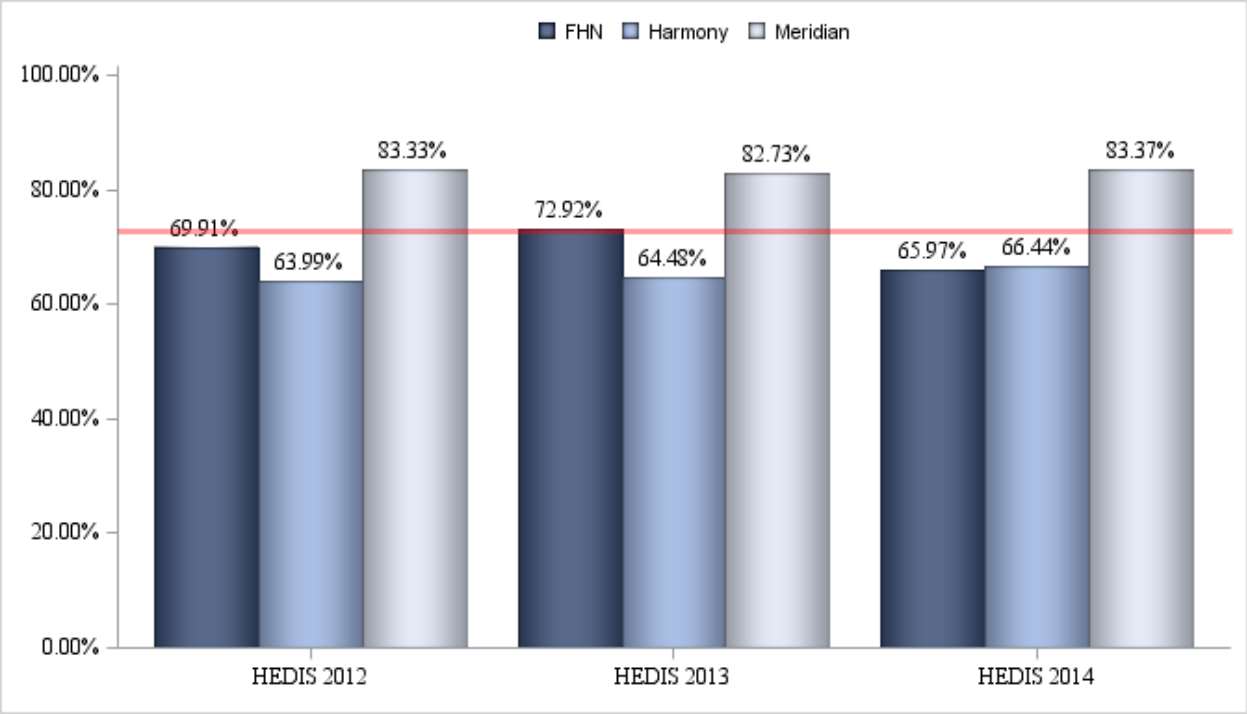


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and fell below the 2013 Quality Compass 50th percentile. From HEDIS 2012 to HEDIS 2014, **FHN**'s rate increased and then subsequently decreased, and its HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile.

Childhood Immunization Status—Combination 3

Figure 5.15 presents comparative rates for *Childhood Immunization Status—Combination 3*.

Figure 5.15—Comparison of HFS MCO Performance for *Childhood Immunization Status—Combination 3*

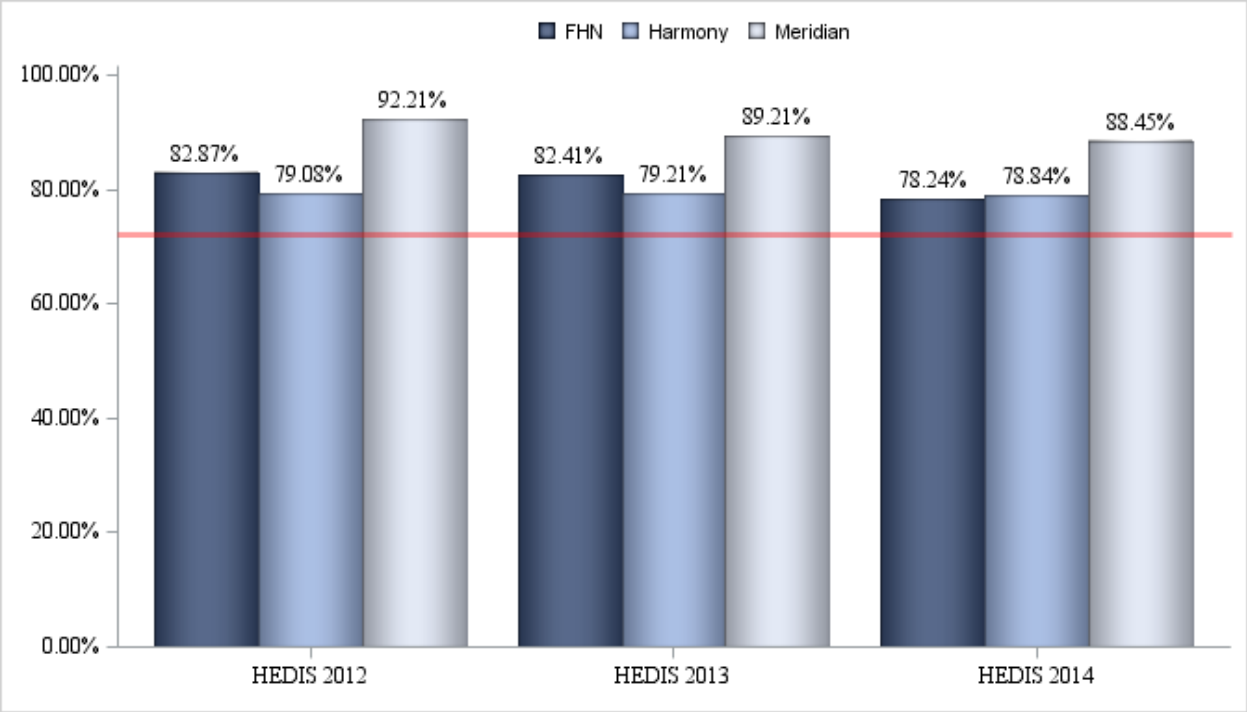


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 10 percentage points. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and fell below the 2013 Quality Compass 50th percentile. From HEDIS 2012 to HEDIS 2014, **FHN**'s rate increased and then subsequently decreased, and the HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile.

Lead Screening in Children

Figure 5.16 presents comparative rates for *Lead Screening in Children*.

Figure 5.16—Comparison of HFS MCO Performance for *Lead Screening in Children*

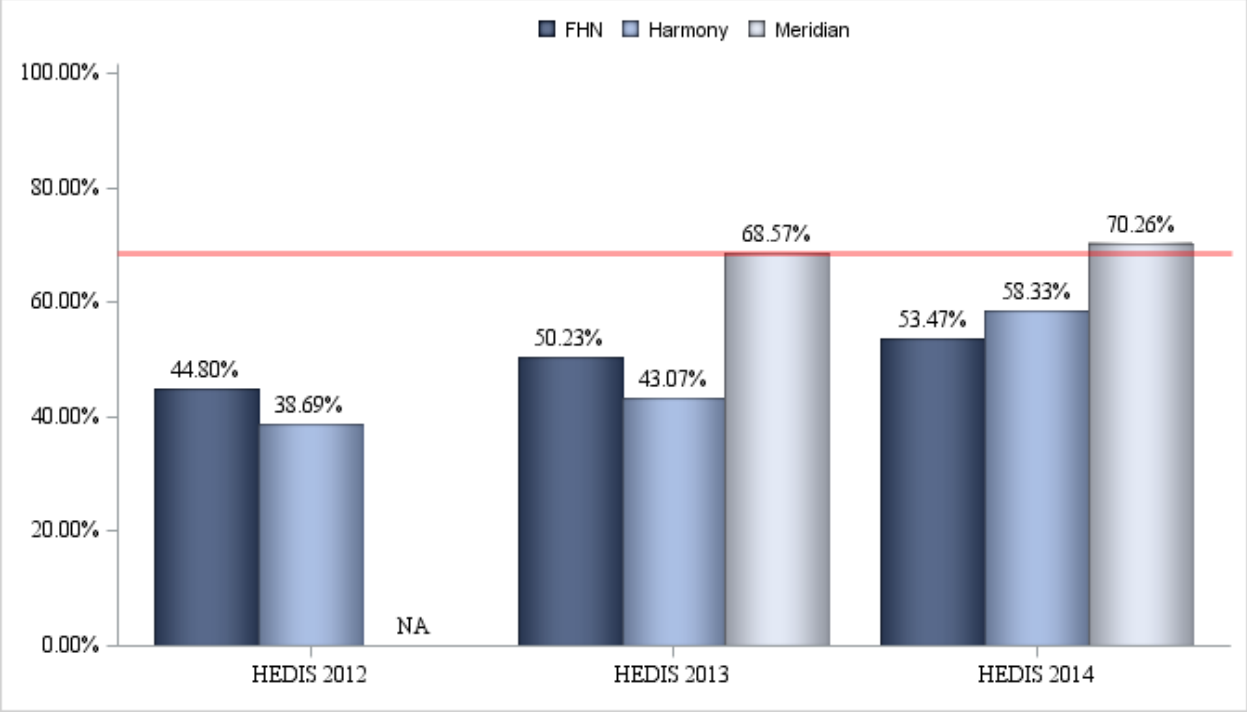


HEDIS 2014 rates for **FHN**, **Harmony**, and **Meridian** were at or above the 2013 Quality Compass 50th percentile. Most notably, **Meridian**'s HEDIS 2014 rate was 16 percentage points above the 2013 Quality Compass 50th percentile, and **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**. Rates remained similar from HEDIS 2012 to HEDIS 2014 for **FHN**, **Harmony**, and **Meridian**.

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)

Figure 5.17 presents comparative rates for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td).*

Figure 5.17—Comparison of HFS MCO Performance for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)*

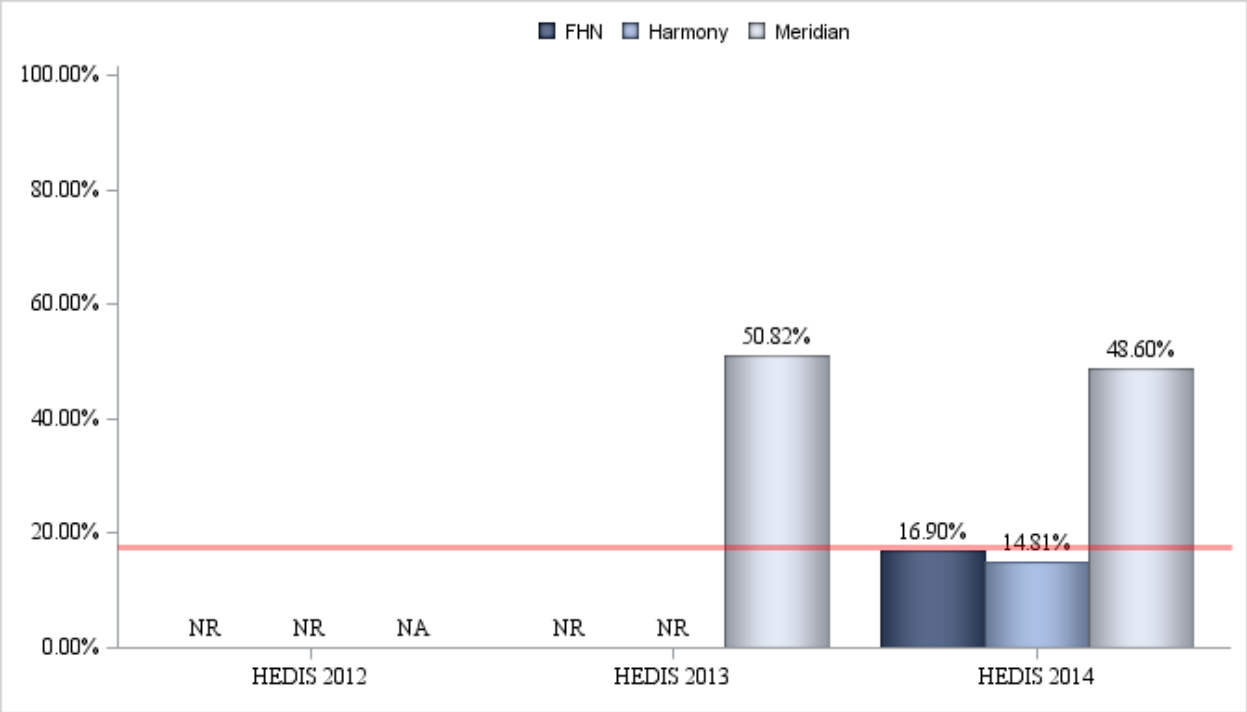


Meridian's HEDIS 2013 and HEDIS 2014 rates scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. Although **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile, **FHN**'s performance improved by approximately 8 percentage points and **Harmony**'s performance improved by approximately 19 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Human Papillomavirus Vaccine for Female Adolescents

Figure 5.18 presents comparative rates for *Human Papillomavirus Vaccine for Female Adolescents*.

Figure 5.18—Comparison of HFS MCO Performance for *Human Papillomavirus Vaccine for Female Adolescents*



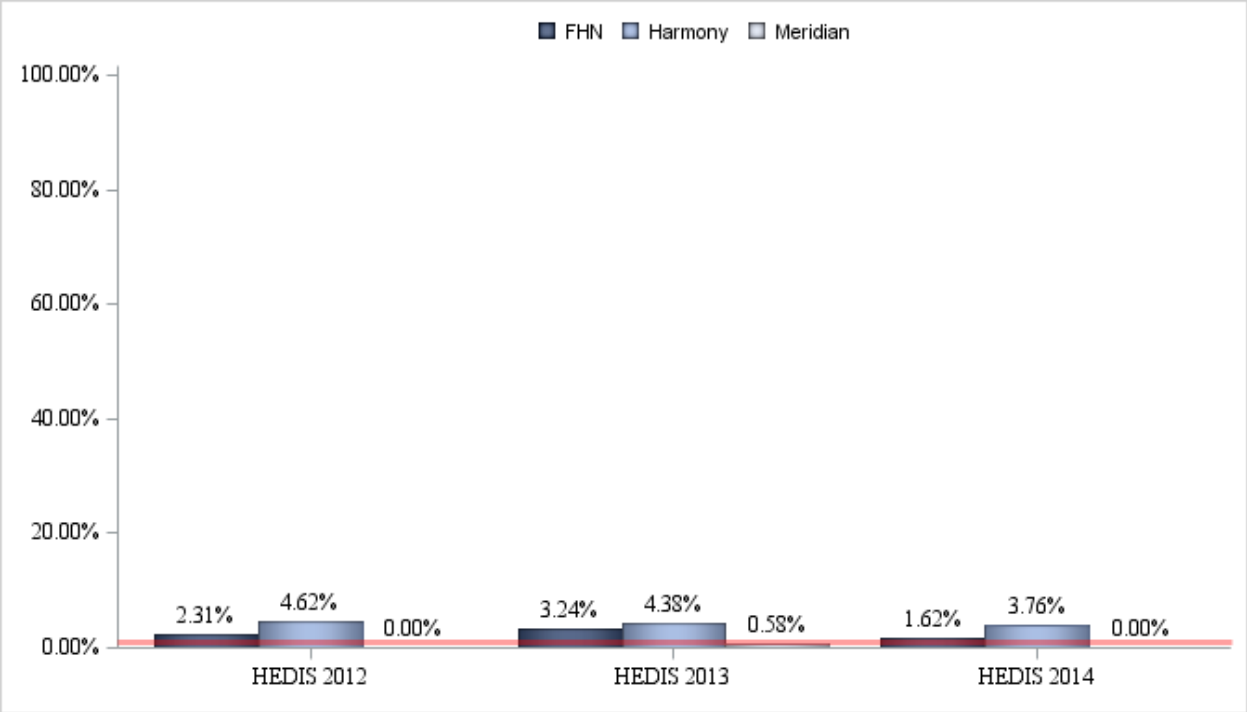
For HEDIS 2014, **Meridian**'s rate scored above the rates reported by **FHN** and **Harmony**, and exceeded the 2013 HEDIS Audit Means and Percentiles 50th percentile by 31 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 HEDIS Audit Means and Percentiles 50th percentile. **FHN**'s and **Harmony**'s HEDIS 2012 and HEDIS 2013 rates were deemed NR, and **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Well-Child Visits in the First 15 Months of Life

Well-Child Visits in the First 15 Months of Life—No Well-Child Visits

Figure 5.19 presents comparative rates for *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*. For this measure, a lower rate indicates better performance.

Figure 5.19—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—No Well-Child Visits*

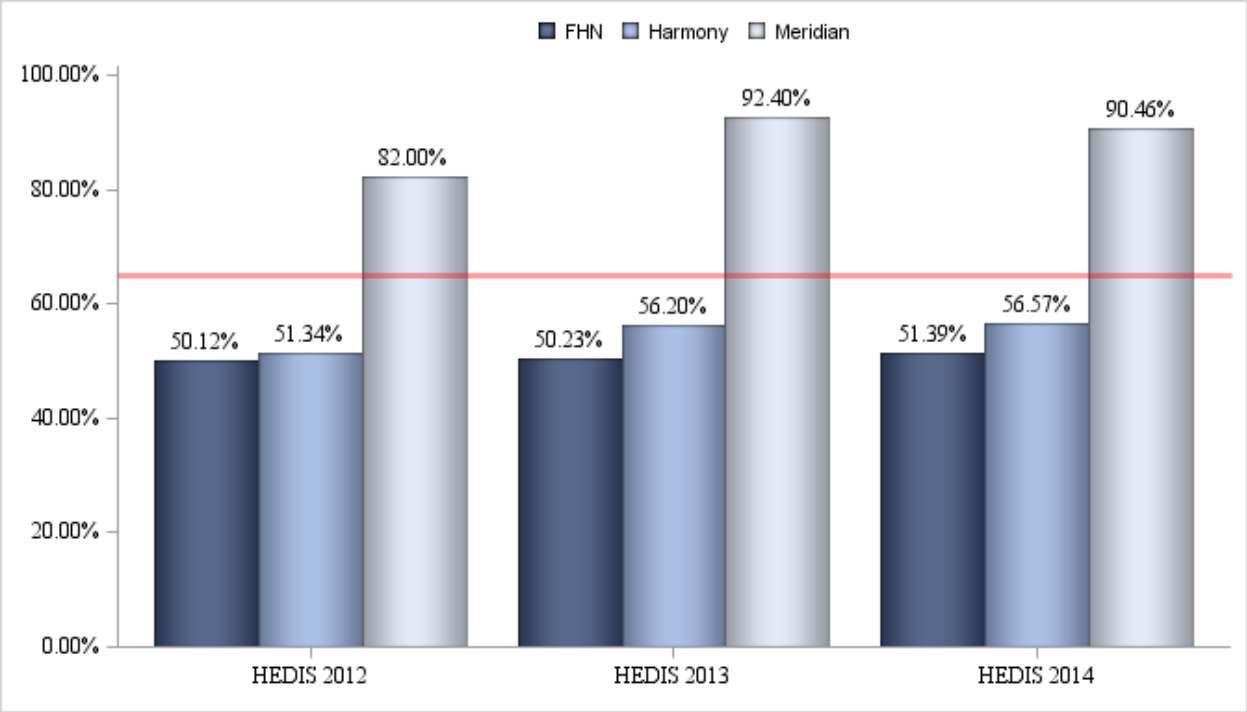


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates scored more favorably than the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was at or better than the 2013 Quality Compass 50th percentile. **FHN**'s and **Harmony**'s HEDIS 2014 rates were worse than the 2013 Quality Compass 50th percentile. **Harmony**'s performance improved from HEDIS 2012 to HEDIS 2014, and **FHN**'s performance improved from HEDIS 2013 to HEDIS 2014.

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

Figure 5.20 presents comparative rates for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*.

Figure 5.20—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—Six or More Well-Child Visits*

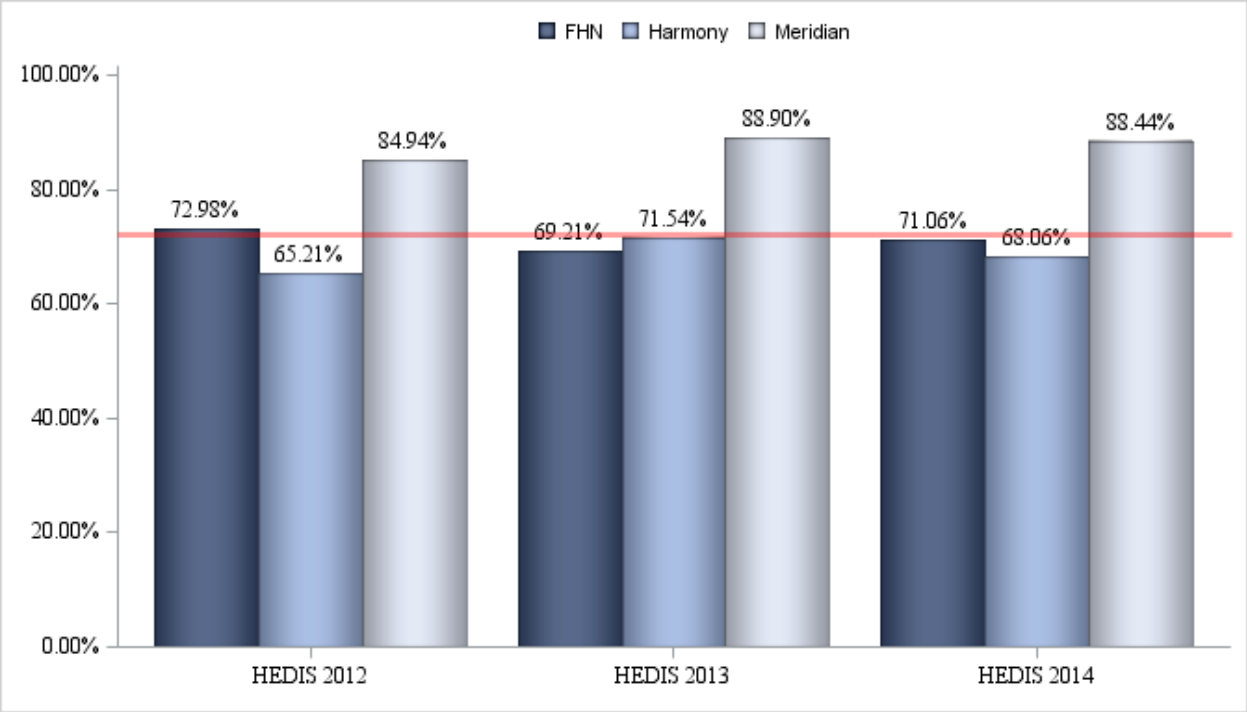


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 25 percentage points. **FHN**'s and **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and the HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile by approximately 14 and 9 percentage points, respectively.

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

Figure 5.21 presents comparative rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

Figure 5.21—Comparison of HFS MCO Performance for *Well-Child Visits During the Third, Fourth, Fifth, and Sixth Years of Life*

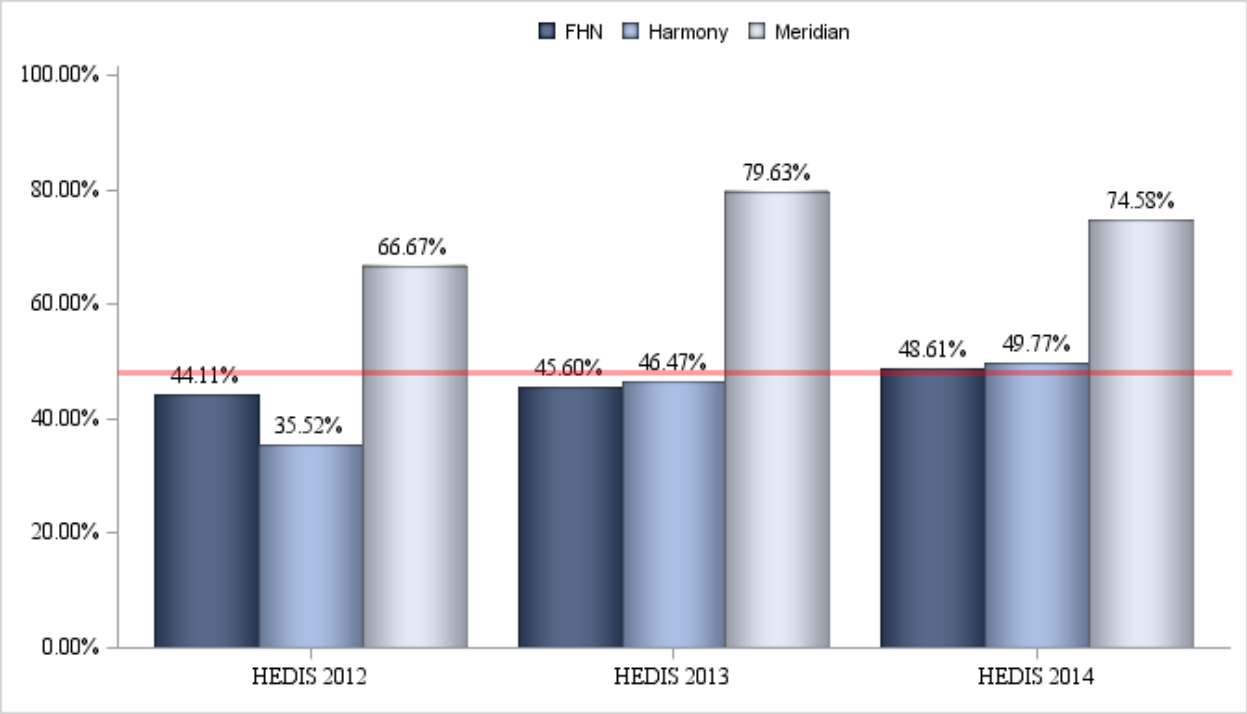


Again, **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was above the 2013 Quality Compass 50th percentile by 16 percentage points. **FHN**'s and **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, and the HEDIS 2014 rates fell slightly below the 2013 Quality Compass 50th percentile.

Adolescent Well-Care Visits

Figure 5.22 presents comparative rates for *Adolescent Well-Care Visits*. HEDIS 2011 was the first year for reporting a rate for **Meridian**.

Figure 5.22—Comparison of HFS MCO Performance for *Adolescent Well-Care Visits*

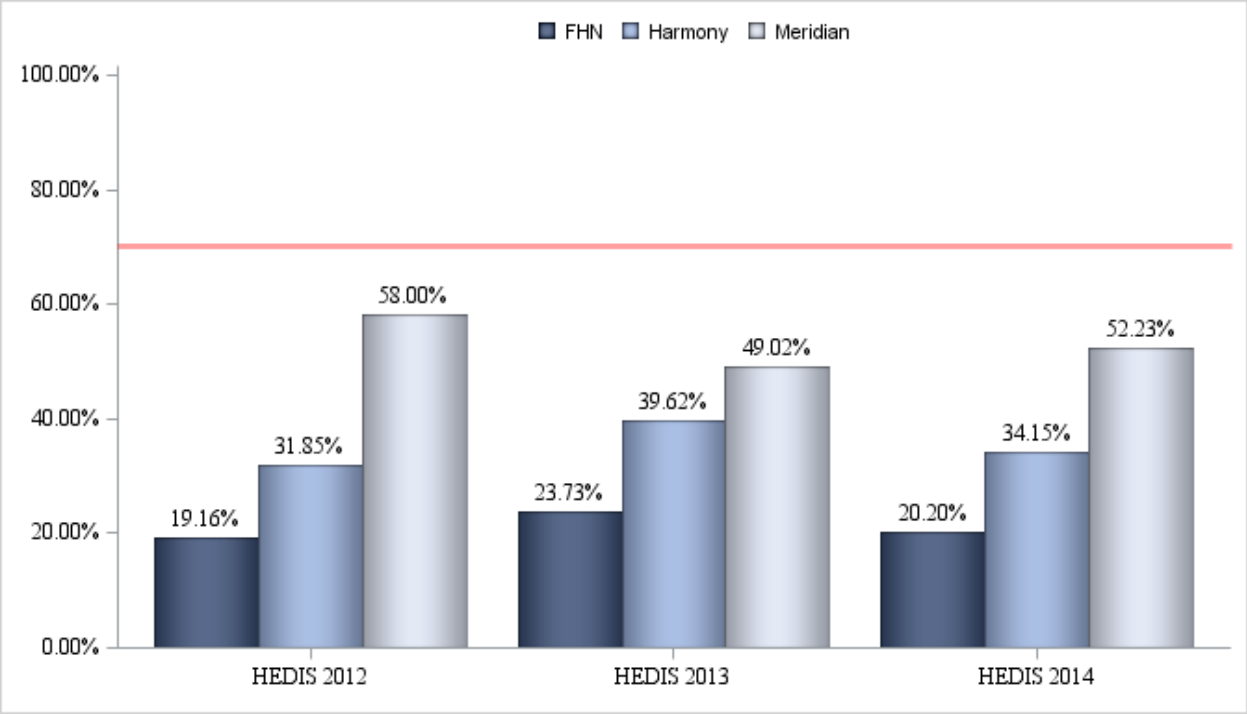


HEDIS 2014 rates for **FHN**, **Harmony**, and **Meridian** were at or above the 2013 Quality Compass 50th percentile. Most notably, **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by approximately 26 percentage points, and **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**. **Meridian**'s rates demonstrated an improvement of 8 percentage points from HEDIS 2012 to HEDIS 2014, and **Harmony**'s rates demonstrated an improvement of 14 percentage points from HEDIS 2012 to HEDIS 2014. Rates remained similar from HEDIS 2012 to HEDIS 2014 for **FHN**.

Appropriate Testing for Children With Pharyngitis

Figure 5.23 presents comparative rates for *Appropriate Testing for Children With Pharyngitis*.

Figure 5.23—Comparison of HFS MCO Performance for *Appropriate Testing for Children With Pharyngitis*



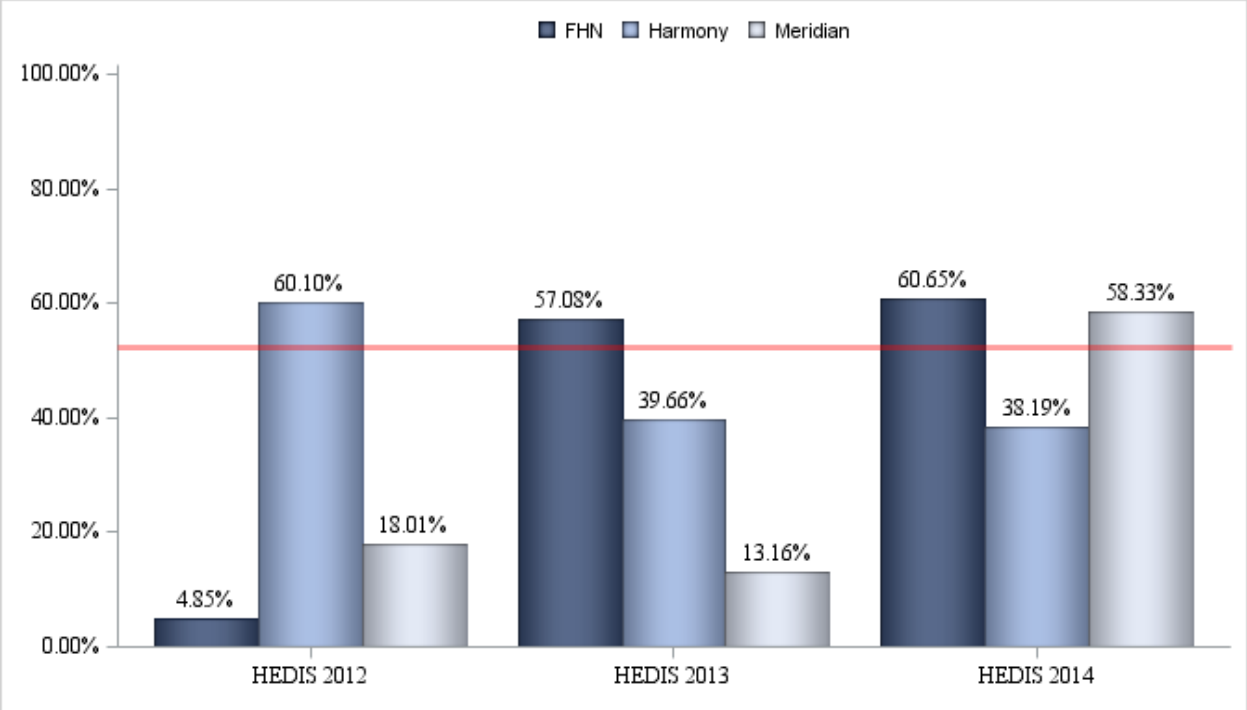
Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**; however, HEDIS 2014 rates for all three MCOs fell below the 2013 Quality Compass 50th percentile. **FHN** fell 50 percentage points below, **Harmony** fell 36 percentage points below, and **Meridian** fell 18 percentage points below the 2013 Quality Compass 50th percentile. Performance remained similar from HEDIS 2012 to HEDIS 2014 for **FHN**. **Harmony**'s rate improved by approximately 8 percentage points from HEDIS 2012 to HEDIS 2013, but subsequently declined by approximately 5 percentage points for HEDIS 2014. **Meridian**'s performance declined by 9 percentage points from HEDIS 2012 to HEDIS 2013; however, the rate subsequently improved from HEDIS 2013 to HEDIS 2014.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total

Figure 5.24 presents comparative rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total.*

Figure 5.24—Comparison of HFS MCO Performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*

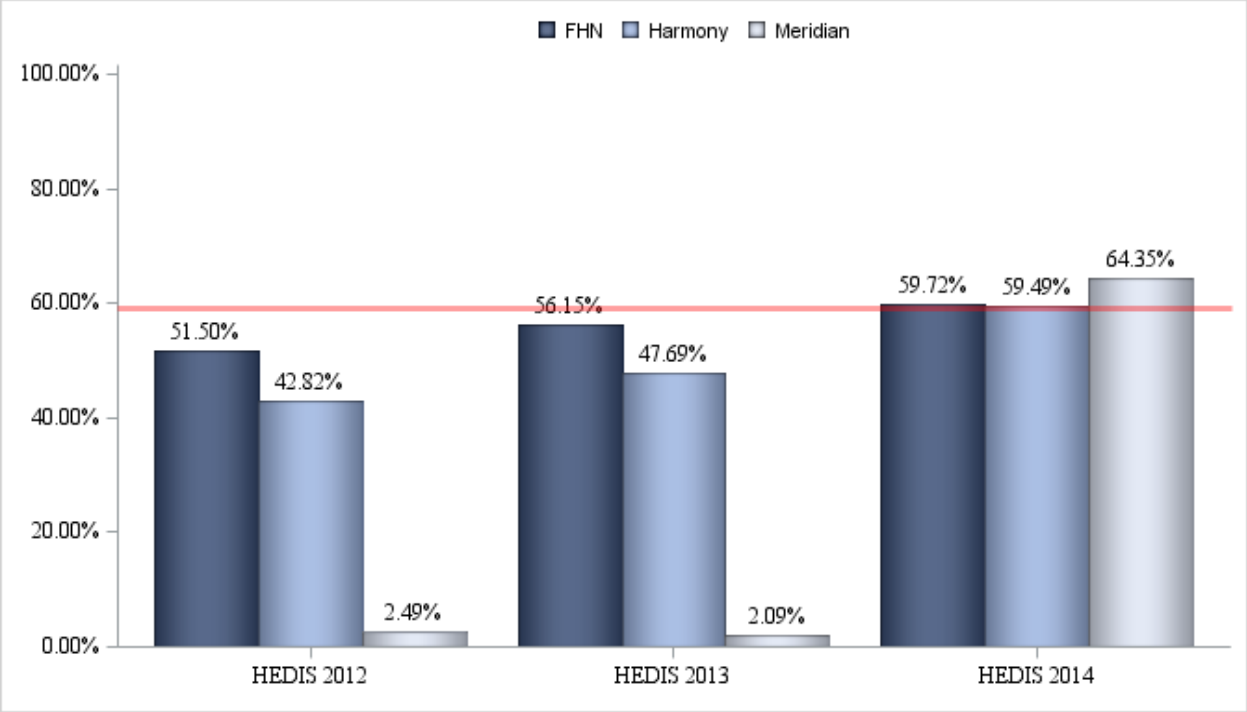


FHN's and **Meridian**'s HEDIS 2014 rates were at or above the 2013 Quality Compass 50th percentile, and **Harmony**'s HEDIS 2014 rate fell 14 percentage points below the 2013 Quality Compass 50th percentile. All three MCOs showed large changes in performance from HEDIS 2012 to HEDIS 2014. **FHN**'s performance improved by 52 percentage points from HEDIS 2012 to HEDIS 2013, and rates were similar from HEDIS 2013 to HEDIS 2014. **Meridian**'s performance was similar from HEDIS 2012 to HEDIS 2013, but the rate increased by 45 percentage points from HEDIS 2013 to HEDIS 2014. The increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. Conversely, **Harmony**'s performance declined by 20 percentage points from HEDIS 2012 to HEDIS 2013, and rates were similar from HEDIS 2013 to HEDIS 2014.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total

Figure 5.25 presents comparative rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total.*

Figure 5.25—Comparison of HFS MCO Performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

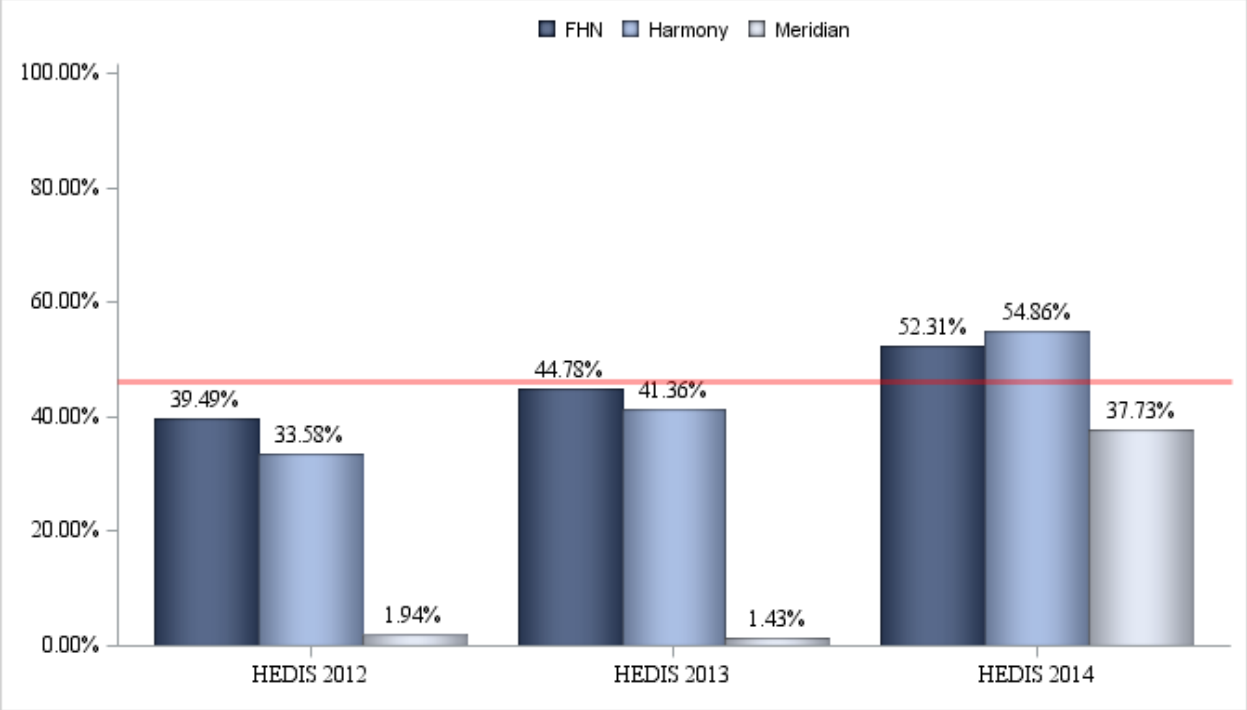


HEDIS 2014 rates for **FHN**, **Harmony**, and **Meridian** were at or above the 2013 Quality Compass 50th percentile, and rates increased for **FHN** and **Harmony** each year. From HEDIS 2012 to HEDIS 2014, **FHN**'s performance improved by 8 percentage points, **Harmony**'s performance improved by approximately 17 percentage points, and **Meridian**'s rates increased by approximately 62 percentage points. The increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total

Figure 5.26 presents comparative rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total.*

Figure 5.26—Comparison of HFS MCO Performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*



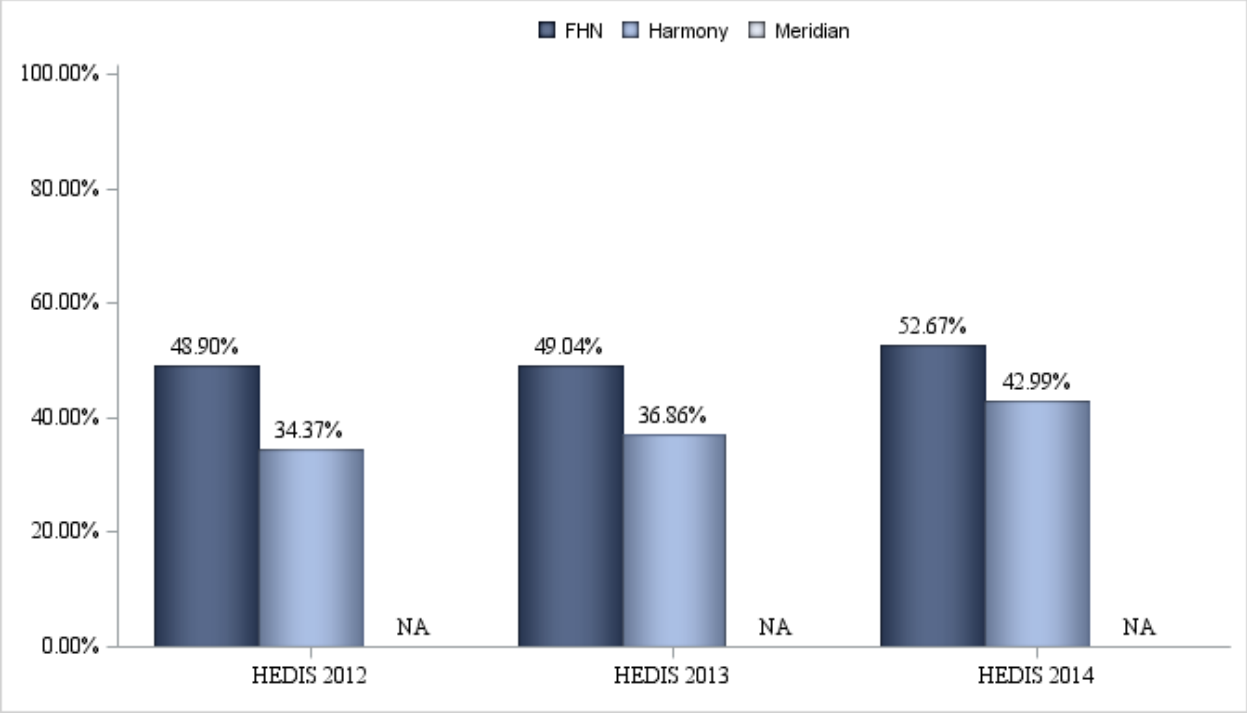
For HEDIS 2014, **FHN**'s and **Harmony**'s rates were above the 2013 Quality Compass 50th percentile. Rates increased for all three MCOs from HEDIS 2012 to HEDIS 2014. **FHN**'s performance improved by 13 percentage points, **Harmony**'s performance improved by approximately 21 percentage points, and **Meridian**'s rate increased by approximately 36 percentage points. The increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. Although **Meridian**'s rates increased, the HEDIS 2014 rate fell approximately 8 percentage points below the 2013 Quality Compass 50th percentile.

Women's Health

Breast Cancer Screening

Figure 5.27 presents comparative rates for *Breast Cancer Screening*. Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 5.27—Comparison of HFS MCO Performance for *Breast Cancer Screening*

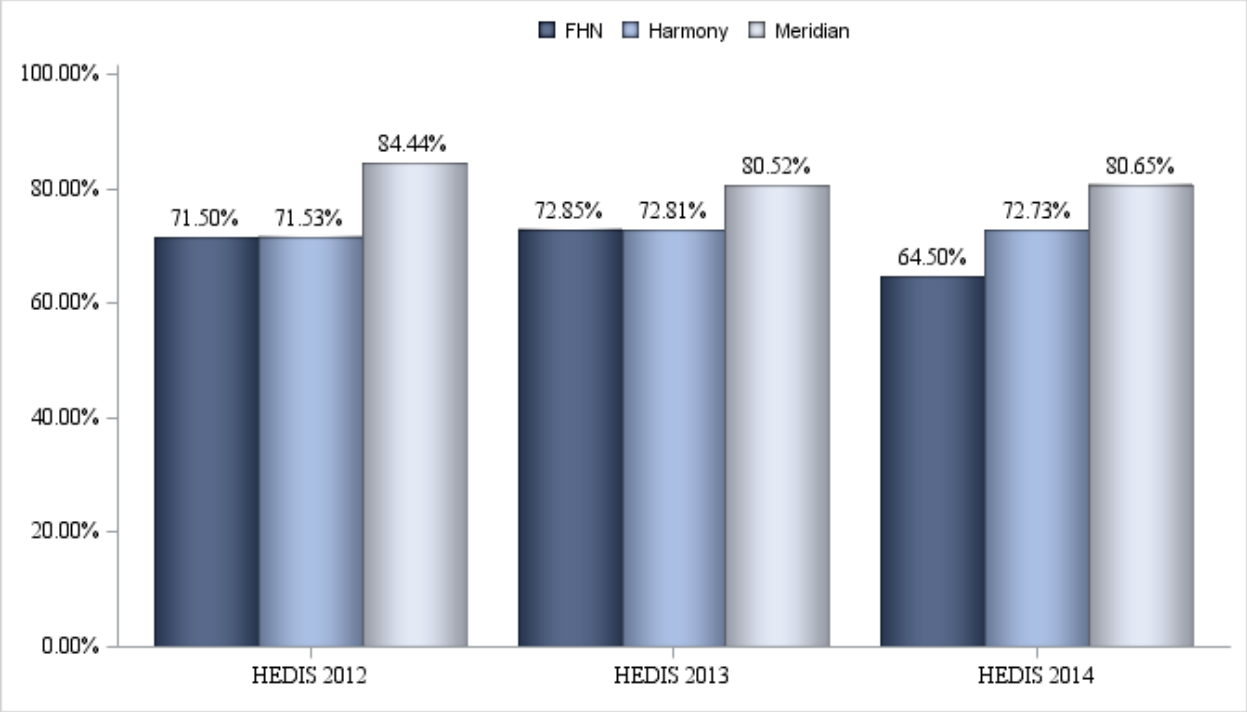


FHN's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **Harmony**. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30.

Cervical Cancer Screening

Figure 5.28 presents comparative rates for *Cervical Cancer Screening*. Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 5.28—Comparison of HFS MCO Performance for *Cervical Cancer Screening*



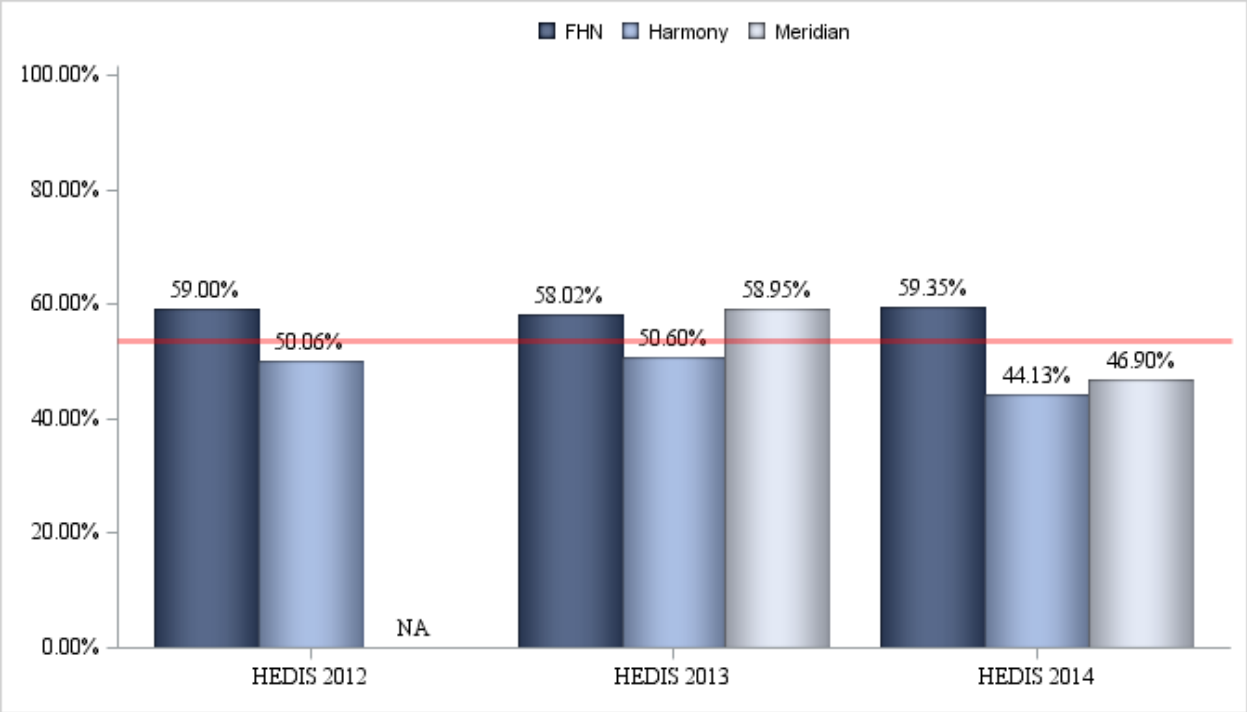
Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**. **FHN** and **Harmony** demonstrated similar performance for HEDIS 2012 and HEDIS 2013, but **Harmony** performed better than **FHN** after the *Cervical Cancer Screening* measure specifications changed for HEDIS 2014.

Chlamydia Screening in Women

Chlamydia Screening in Women—16–20 Years

Figure 5.29 presents comparative rates for *Chlamydia Screening in Women—16–20 Years*. Given the relatively low population for this measure, caution should be used when comparing across MCOs.

Figure 5.29—Comparison of HFS MCO Performance for *Chlamydia Screening in Women—16–20 Years*

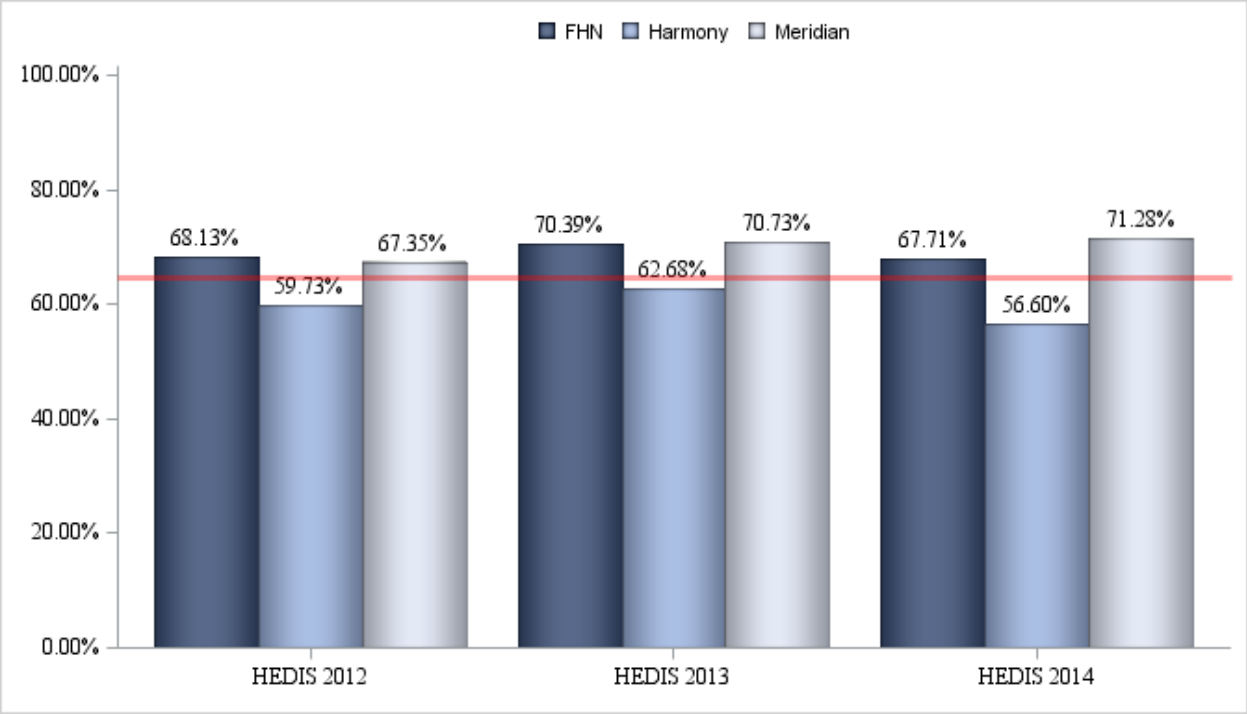


FHN's HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile, while **Harmony**'s and **Meridian**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile. Specifically, **Harmony**'s HEDIS 2014 rate was approximately 10 percentage points below the 2013 Quality Compass 50th percentile. **FHN**'s rates remained similar from HEDIS 2012 to HEDIS 2014. Conversely, **Harmony**'s rates decreased by 6 percentage points from HEDIS 2012 to HEDIS 2014. Further, **Meridian**'s rate declined by 12 percentage points from HEDIS 2013 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Chlamydia Screening in Women—21–24 Years

Figure 5.30 presents comparative rates for *Chlamydia Screening in Women—21–24 Years.*

Figure 5.30—Comparison of HFS MCO Performance for *Chlamydia Screening in Women—21–24 Years*

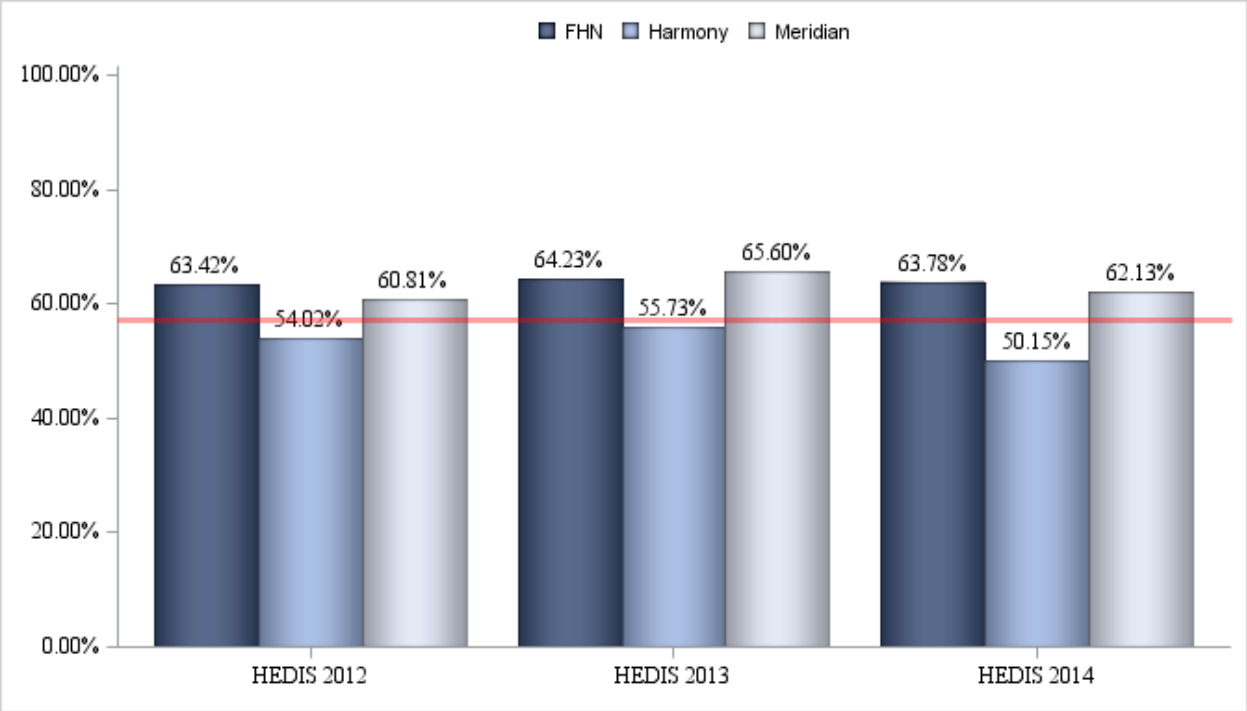


FHN's and **Meridian**'s HEDIS 2014 rates were at or above the 2013 Quality Compass 50th percentile, and performance remained similar for **FHN** and **Meridian** across all three years. **Harmony**'s performance remained stable from HEDIS 2012 to HEDIS 2013, but the HEDIS 2014 rate decreased by 6 percentage points and fell below the 2013 Quality Compass 50th percentile.

Chlamydia Screening in Women—Total

Figure 5.31 presents comparative rates for *Chlamydia Screening in Women—Total.*

Figure 5.31—Comparison of HFS MCO Performance for *Chlamydia Screening in Women—Total*



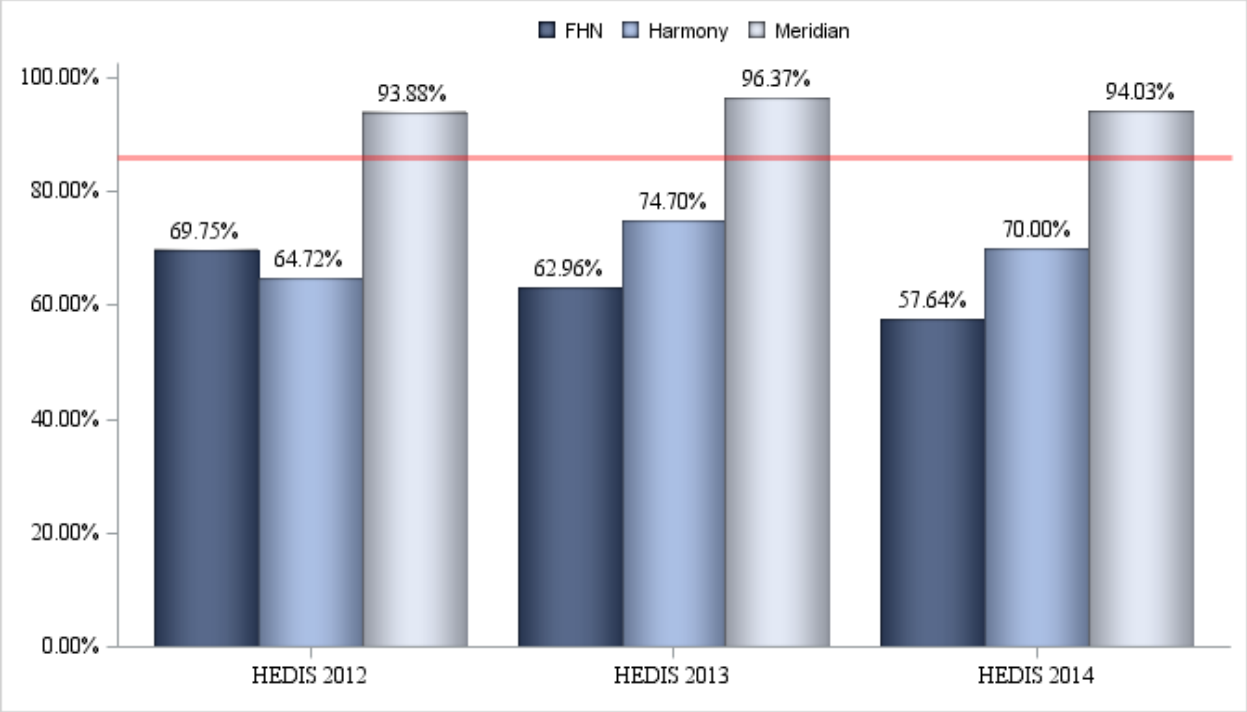
FHN's and **Meridian**'s HEDIS 2014 rates were at or above the 2013 Quality Compass 50th percentile. Performance remained similar for **FHN** across all three years. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2013, but the HEDIS 2014 rate decreased by approximately 6 percentage points. **Meridian**'s HEDIS 2012 rate increased by 5 percentage points in HEDIS 2013, and decreased slightly in HEDIS 2014.

Prenatal and Postpartum Care

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Figure 5.32 presents comparative rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

Figure 5.32—Comparison of HFS MCO Performance for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

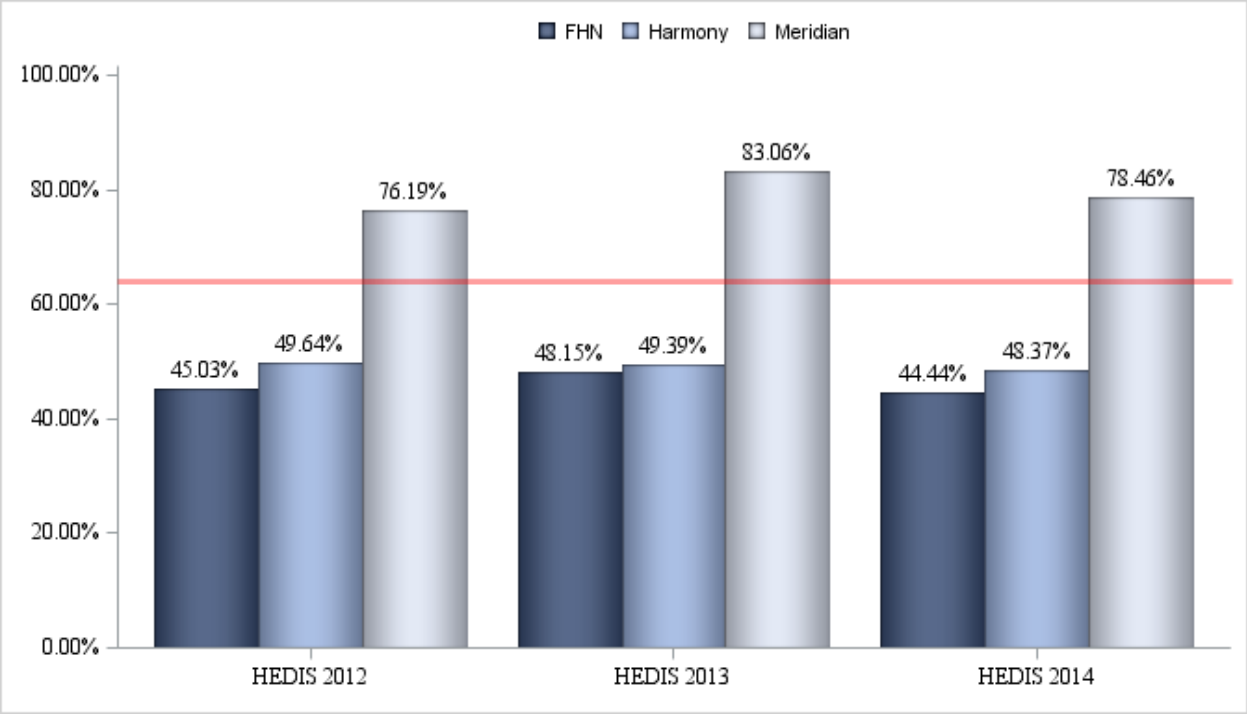


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 8 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile by approximately 28 and 16 percentage points, respectively. **Harmony**'s rates improved by 5 percentage points from HEDIS 2012 to HEDIS 2014. Conversely, **FHN**'s rates declined by 12 percentage points from HEDIS 2012 to HEDIS 2014.

Prenatal and Postpartum Care—Postpartum Care

Figure 5.33 presents comparative rates for *Prenatal and Postpartum Care—Postpartum Care*.

Figure 5.33—Comparison of HFS MCO Performance for *Prenatal and Postpartum Care—Postpartum Care*



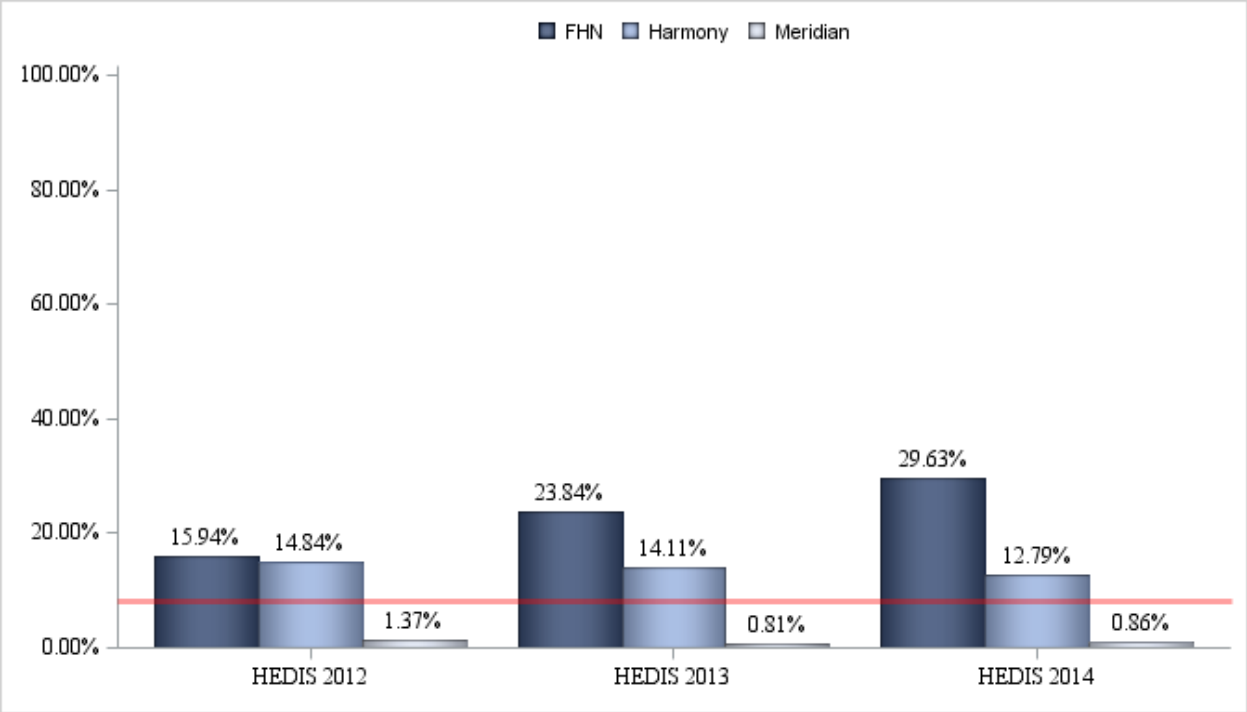
As with the previous measure, **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 14 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile by approximately 20 and 16 percentage points, respectively. **Harmony**'s and **FHN**'s rates remained similar from HEDIS 2012 to HEDIS 2014.

Frequency of Ongoing Prenatal Care

Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits

Figure 5.34 presents comparative rates for *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*. For this measure, a lower rate indicates better performance.

Figure 5.34—Comparison of HFS MCO Performance for *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*

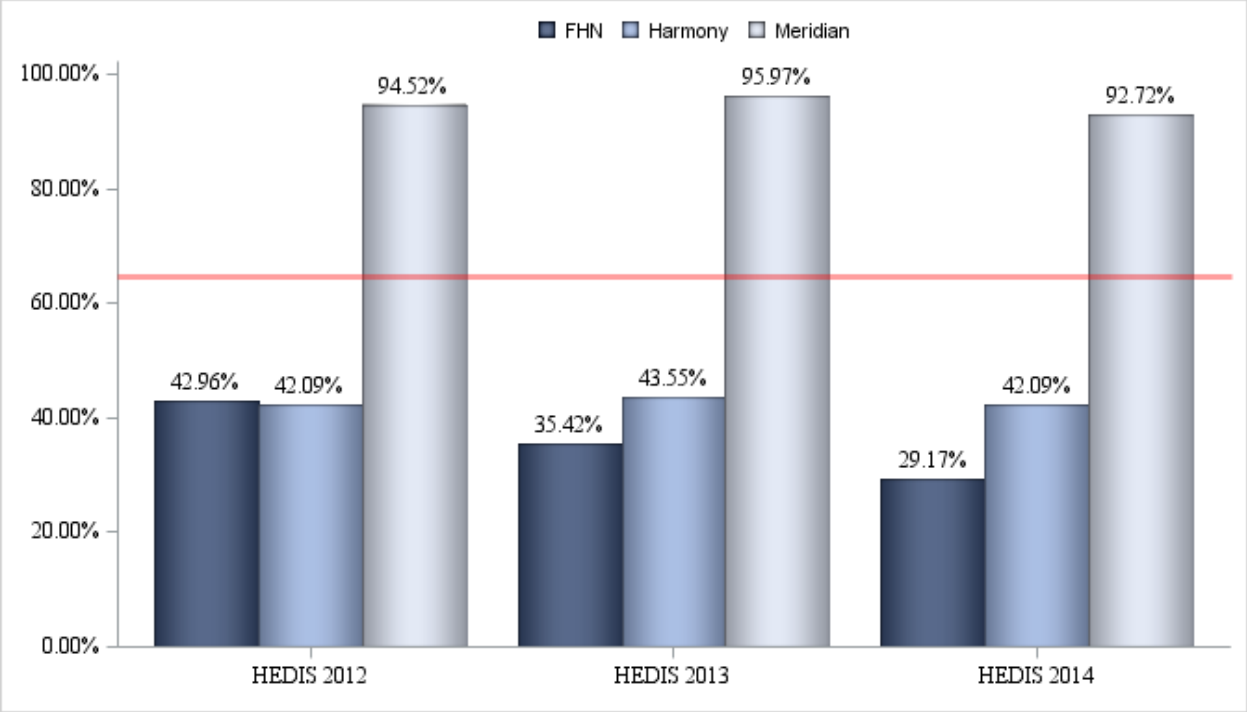


Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored more favorably than the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate was 7 percentage points below the 2013 Quality Compass 50th percentile, indicating high performance. **Meridian**'s rates also improved from HEDIS 2012 to HEDIS 2014 by 0.51 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell short of the 2013 Quality Compass 50th percentile by approximately 21 and 5 percentage points, respectively. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014, while **FHN**'s performance declined by 14 percentage points from HEDIS 2012 to HEDIS 2014.

Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits

Figure 5.35 presents comparative rates for *Frequency of Ongoing Prenatal Care—≥81Percent of Expected 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—<21 Percent of Expected Visits*.

Figure 5.35—Comparison of HFS MCO Performance for *Frequency of Ongoing Prenatal Care—≥81Percent of Expected Visits*



Meridian's HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates consistently scored above the rates reported by **FHN** and **Harmony**, more than doubling **Harmony**'s and **FHN**'s rates each year. Also, **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 28 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile by approximately 36 and 23 percentage points, respectively. **FHN**'s rates decreased by 14 percentage points from HEDIS 2012 to HEDIS 2014. **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014.

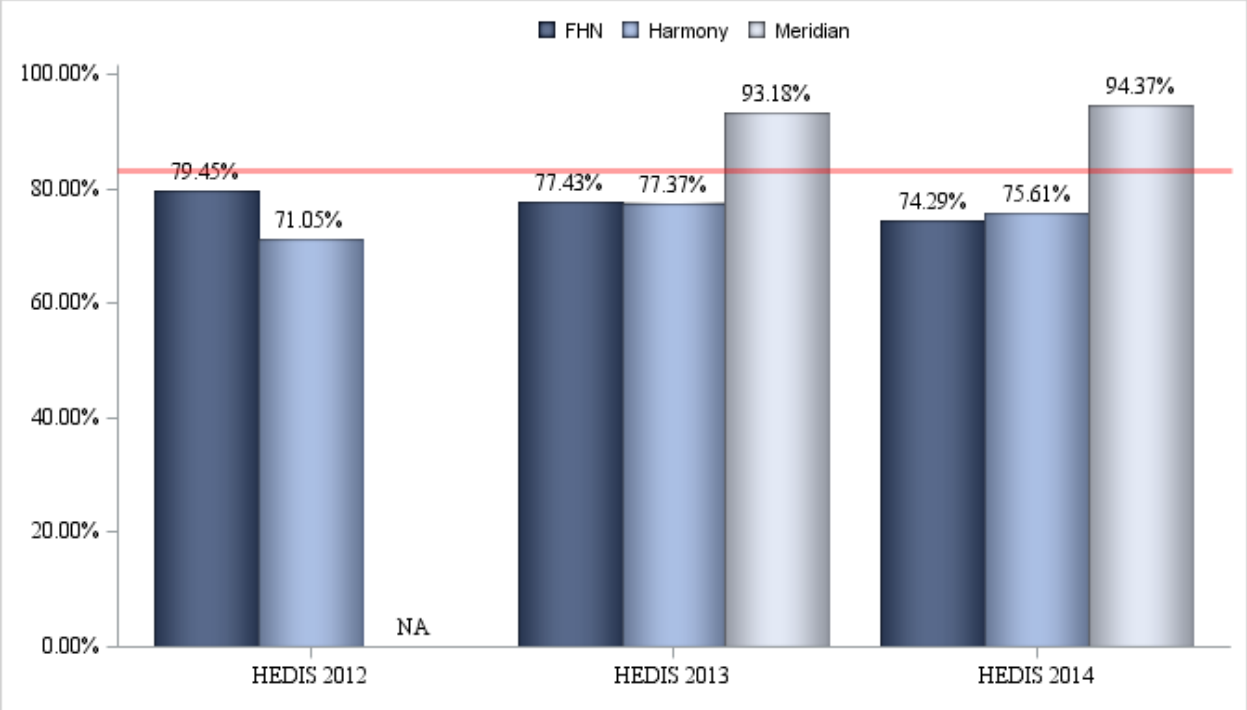
Care for Chronic Conditions

Comprehensive Diabetes Care

Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing

Figure 5.36 presents comparative rates for *Comprehensive Diabetes Care—HbA1c Testing*.

Figure 5.36—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Testing*

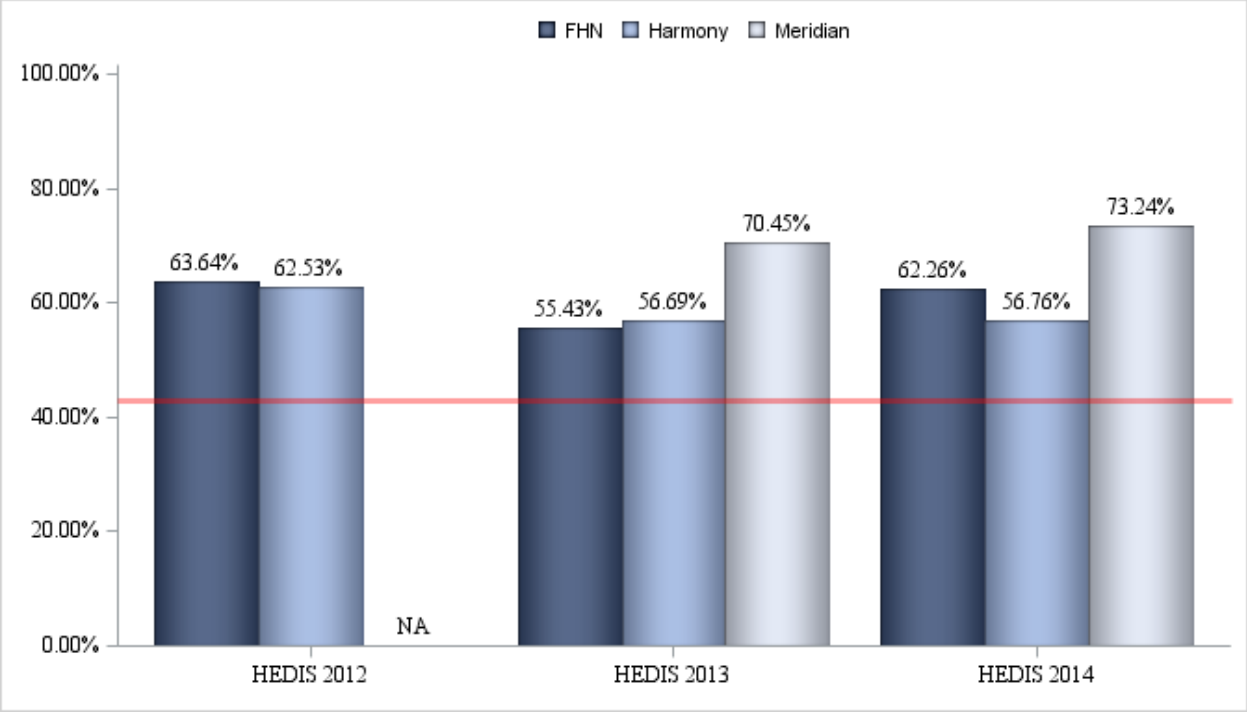


Meridian's HEDIS 2013 and HEDIS 2014 rates scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 11 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile. **FHN**'s rates decreased by 5 percentage points from HEDIS 2012 to HEDIS 2014. Conversely, **Harmony**'s rates increased by 6 percentage points from HEDIS 2012 to HEDIS 2013, and remained similar from HEDIS 2013 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)

Figure 5.37 presents comparative rates for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*. For this measure, a lower rate indicates better performance.

Figure 5.37—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*

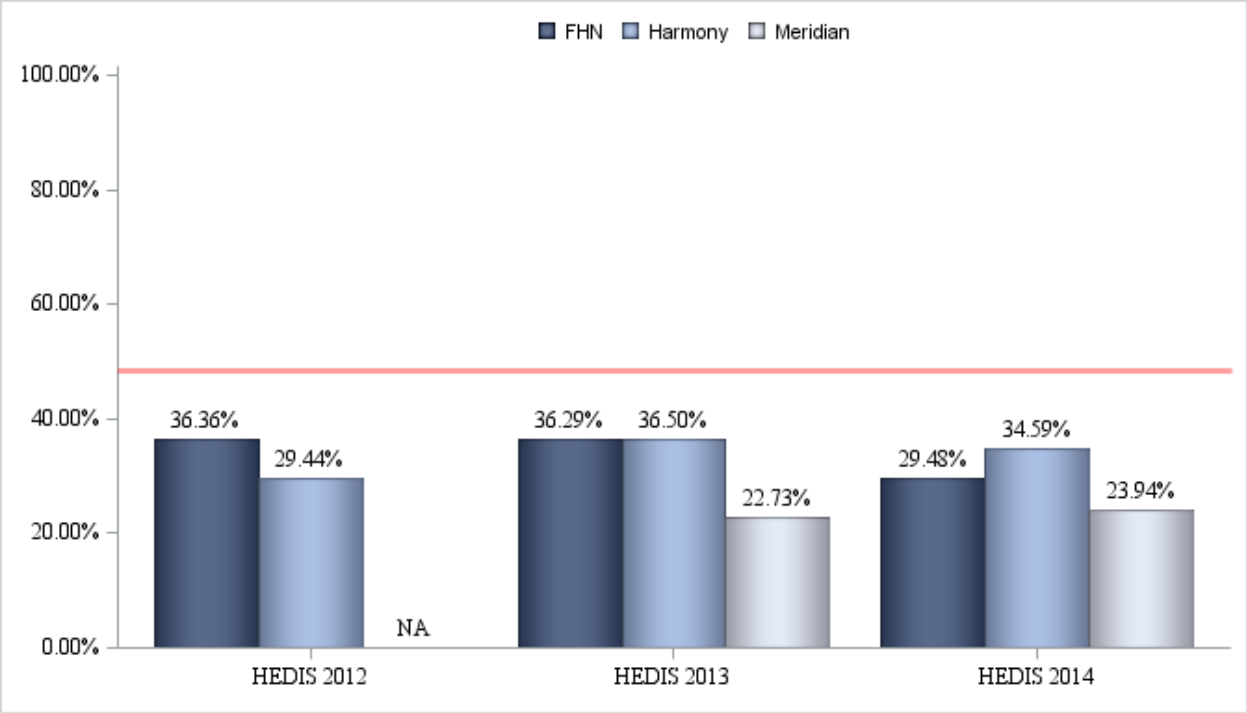


HEDIS 2014 rates for all three MCOs failed to meet the 2013 Quality Compass 50th percentile: **FHN**'s rate was 19 percentage points above, **Harmony**'s rate was 14 percentage points above, and **Meridian**'s rate was 30 percentage points above the 2013 Quality Compass 50th percentile, indicating poor performance for all three MCOs. **FHN**'s rates improved from HEDIS 2012 to HEDIS 2013 with a decrease of 8 percentage points; however, the rate increased by 7 percentage points from HEDIS 2013 to HEDIS 2014. Similarly, **Harmony**'s rate decreased by 6 percentage points from HEDIS 2012 to HEDIS 2013 and remained stable for HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30, and **Meridian**'s rates were similar from HEDIS 2013 to HEDIS 2014.

Comprehensive Diabetes Care—HbA1c Control (<8.0%)

Figure 5.38 presents comparative rates for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*.

Figure 5.38—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*

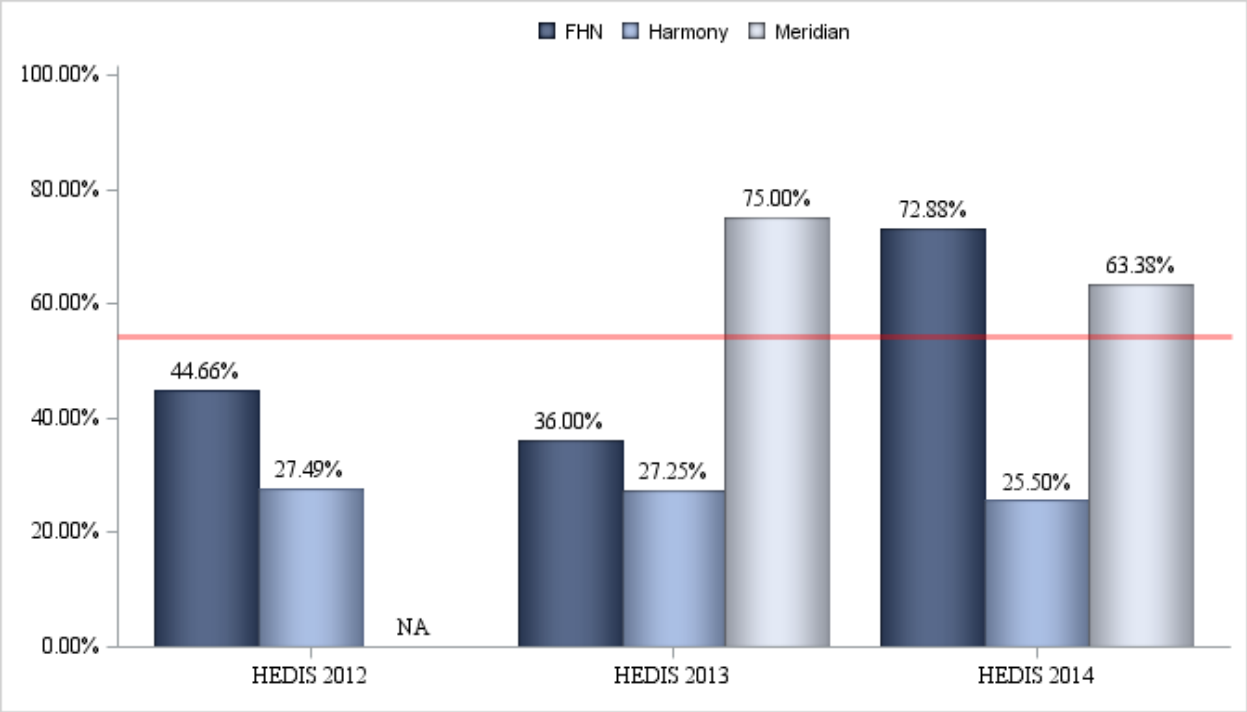


As with the previous measure, HEDIS 2014 rates for all three MCOs fell below the 2013 Quality Compass 50th percentile: **FHN**'s rate was 19 percentage points below, **Harmony**'s rate was 14 percentage points below, and **Meridian**'s rate was 25 percentage points below the 2013 Quality Compass 50th percentile, indicating poor performance for all three MCOs. **FHN**'s rates remained stable from HEDIS 2012 to HEDIS 2013; however, the rate declined by 7 percentage points from HEDIS 2013 to HEDIS 2014. **Harmony**'s HEDIS 2012 rate improved by 7 percentage points for HEDIS 2013 and remained stable for HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30, and **Meridian**'s rates were similar from HEDIS 2013 to HEDIS 2014.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Figure 5.39 presents comparative rates for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*.

Figure 5.39—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

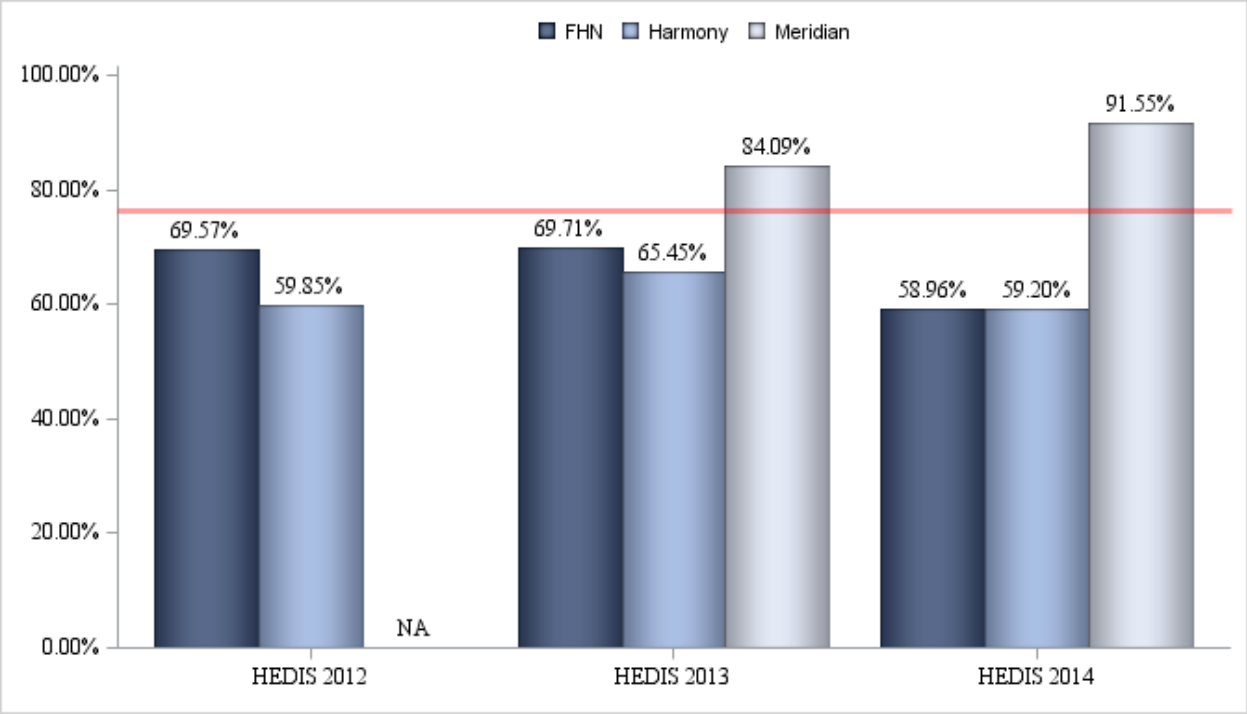


FHN's and **Meridian**'s HEDIS 2014 rates were at or above the 2013 Quality Compass 50th percentile. **FHN**'s rate was approximately 19 percentage points above and **Meridian**'s rate was 9 percentage points above the 2013 Quality Compass 50th percentile. Conversely, **Harmony**'s 2014 rate was 29 percentage points below the 2013 Quality Compass 50th percentile, and **Harmony**'s rates remained similar from HEDIS 2012 to HEDIS 2014. **FHN**'s rate declined from HEDIS 2012 to HEDIS 2013 by approximately 9 percentage points; however, **FHN**'s rate improved from HEDIS 2013 to HEDIS 2014 by approximately 37 percentage points. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30, and **Meridian**'s rate decreased from HEDIS 2013 to HEDIS 2014 by approximately 12 percentage points, indicating performance decline.

Comprehensive Diabetes Care—LDL-C Screening

Figure 5.40 presents comparative rates for *Comprehensive Diabetes Care—LDL-C Screening*.

Figure 5.40—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—LDL-C Screening*

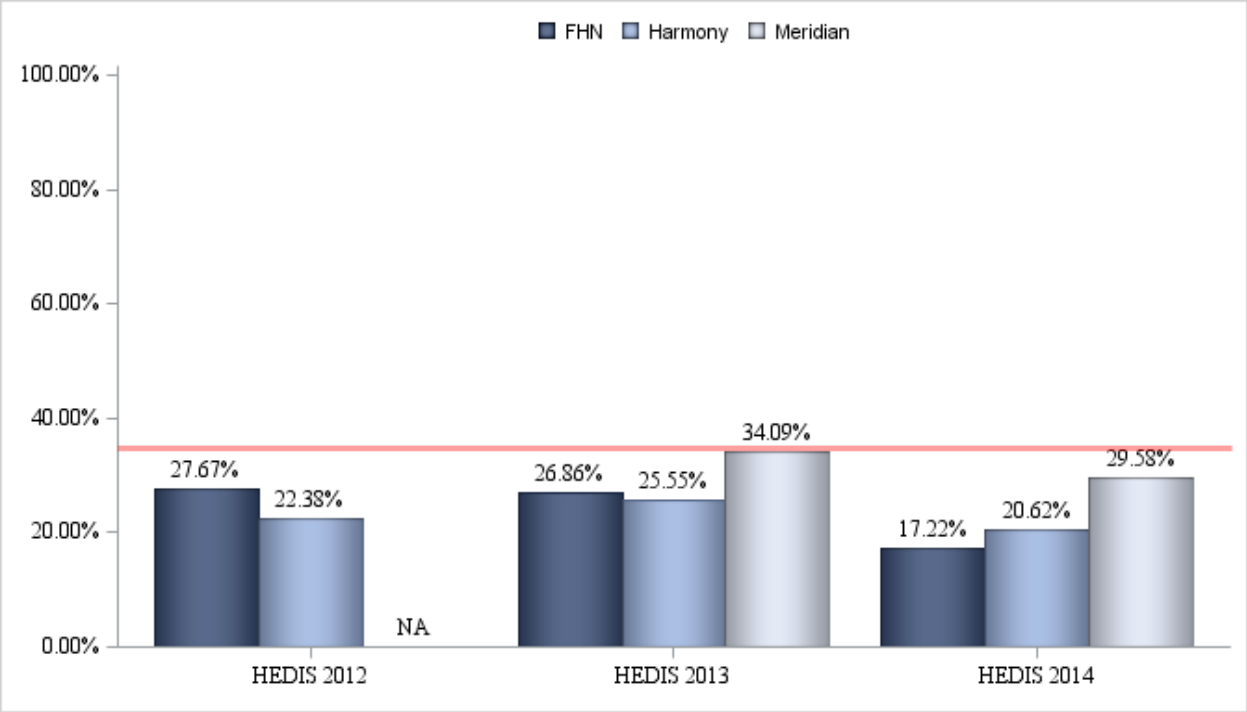


Meridian's HEDIS 2013 and HEDIS 2014 rates scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by 15 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the Quality Compass 50th percentile. **FHN**'s rates decreased by more than 10 percentage points from HEDIS 2012 to HEDIS 2014. Conversely, **Harmony**'s rates increased by approximately 6 percentage points from HEDIS 2012 to HEDIS 2013, and then returned to a rate similar to 2012 in HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Comprehensive Diabetes Care—LDL-C Control (< 100 mg/dL)

Figure 5.41 presents comparative rates for *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*.

Figure 5.41—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*

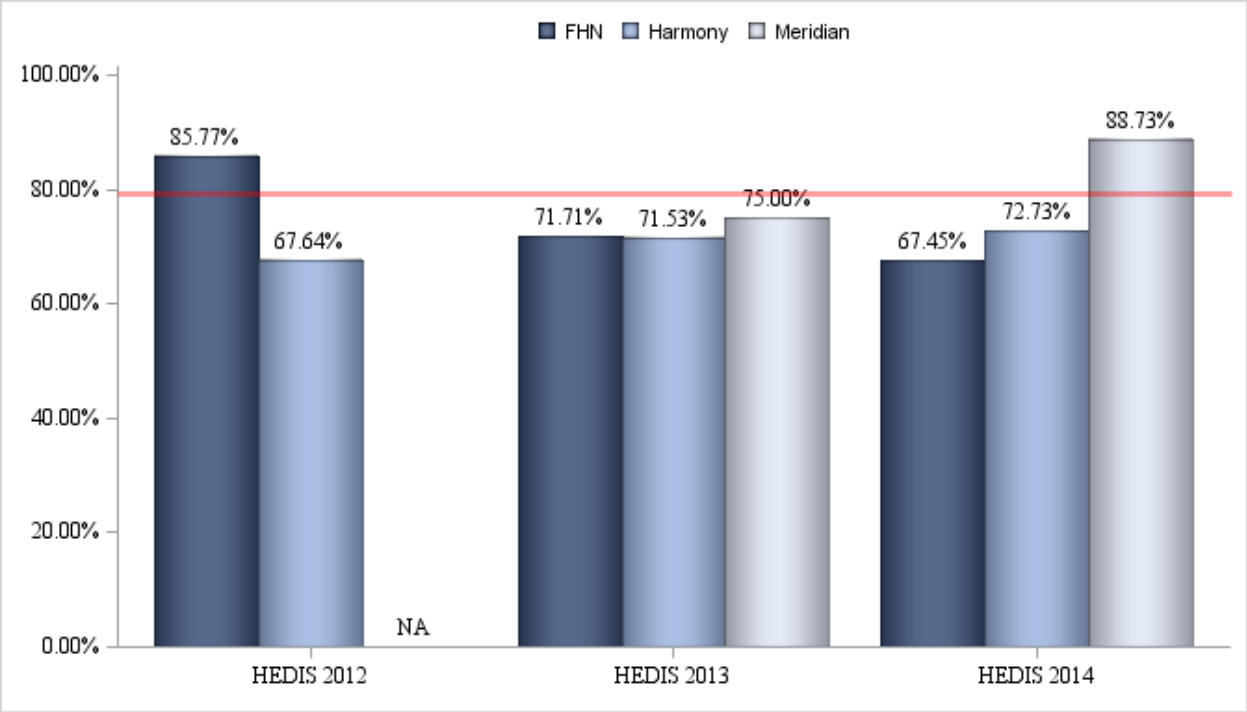


HEDIS 2014 rates for all three MCOs fell below the 2013 Quality Compass 50th percentile. Most notably, **FHN**'s rate was 18 percentage points below and **Harmony**'s rate was 14 percentage points below the 2013 Quality Compass 50th percentile. **FHN**'s rates remained stable from HEDIS 2012 to HEDIS 2013; however, the rate declined by approximately 10 percentage points from HEDIS 2013 to HEDIS 2014. Similarly, **Harmony**'s HEDIS 2012 and HEDIS 2013 rates remained stable and subsequently decreased by 5 percentage points from HEDIS 2013 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30, and **Meridian**'s rate declined by approximately 5 percentage points from HEDIS 2013 to HEDIS 2014.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

Figure 5.42 presents comparative rates for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*.

Figure 5.42—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

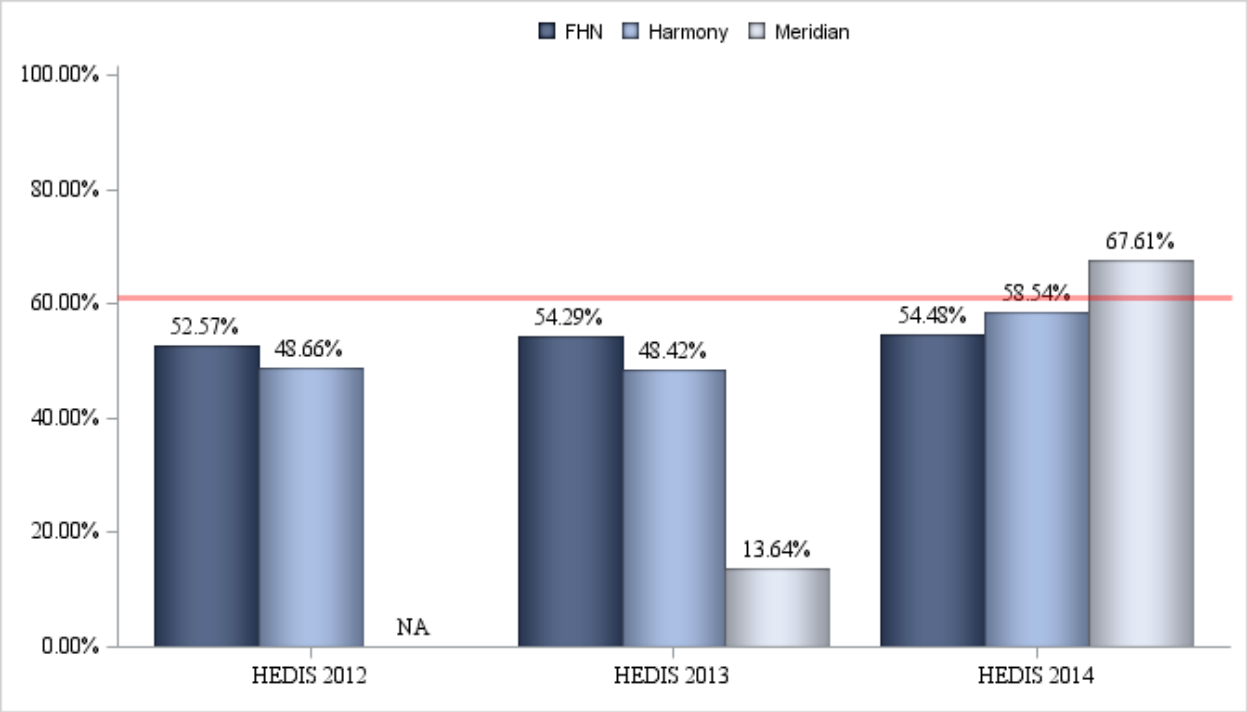


Meridian's HEDIS 2013 and HEDIS 2014 rates scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile by almost 10 percentage points. **FHN**'s and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile. **FHN**'s rates decreased by 18 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Comprehensive Diabetes Care—BP Control (< 140/90 mm Hg)

Figure 5.43 presents comparative rates for *Comprehensive Diabetes Care—BP Control (< 140/90 mm Hg)*.

Figure 5.43—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—BP Control (<140/90 mm Hg)*

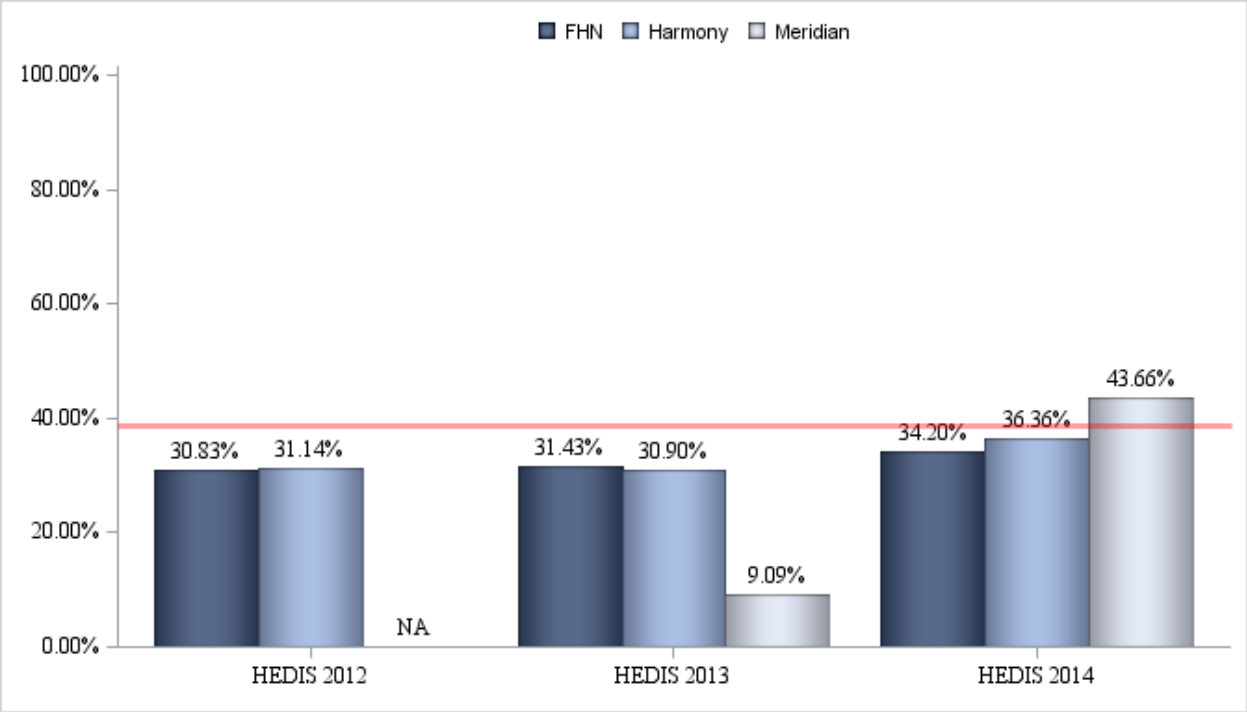


For HEDIS 2014, **Meridian**'s rate was at or above the 2013 Quality Compass 50th percentile, and **FHN**'s and **Harmony**'s rates fell below the 2013 Quality Compass 50th percentile. **FHN**'s rates remained similar from HEDIS 2012 to HEDIS 2014. **Harmony**'s rates also remained similar from HEDIS 2012 to HEDIS 2013; however, the rate improved by 10 percentage points from HEDIS 2013 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30, and **Meridian**'s rate increased by approximately 54 percentage points from HEDIS 2013 to HEDIS 2014. The increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology.

Comprehensive Diabetes Care—BP Control (< 140/80 mm Hg)

Figure 5.44 presents comparative rates for *Comprehensive Diabetes Care—BP Control (<140/80 mm Hg)*.

Figure 5.44—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—BP Control (<140/80 mm Hg)*

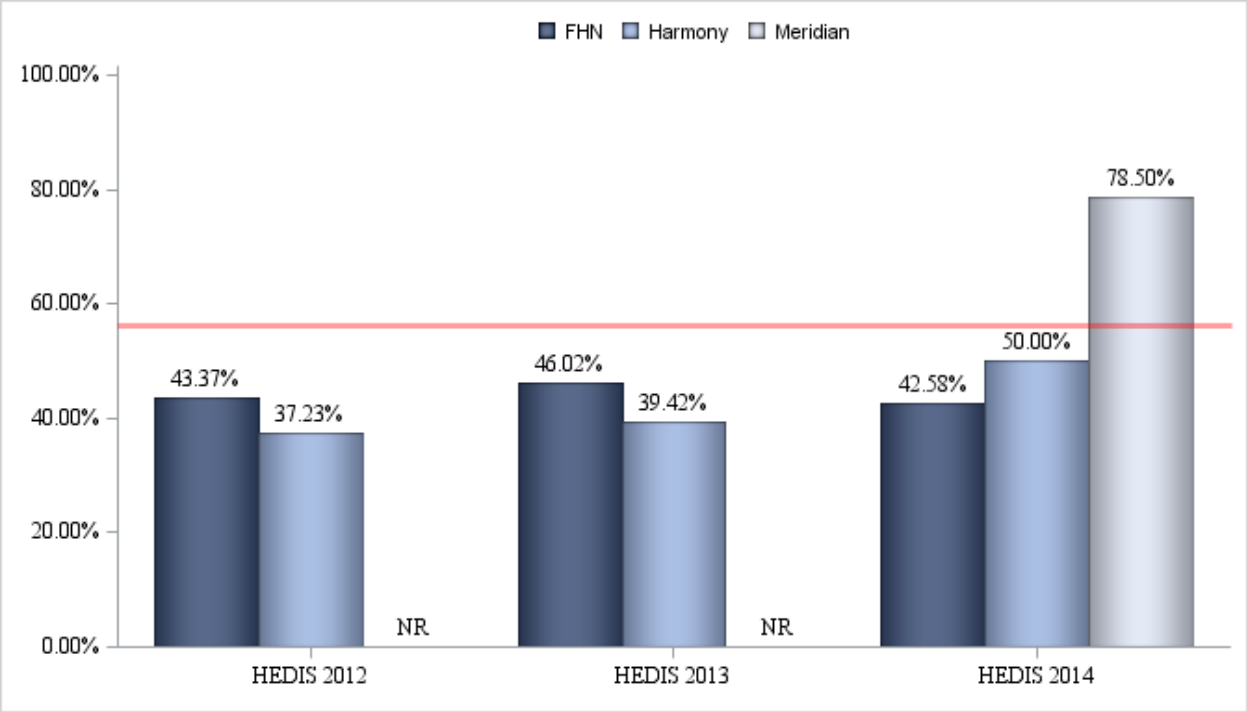


The HEDIS 2014 rates reported by **FHN** and **Harmony** fell below the 2013 Quality Compass 50th percentile. Performance remained similar from HEDIS 2012 to HEDIS 2014 for **FHN**. **Harmony**'s rate improved by 5 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s rate increased by 35 percentage points from HEDIS 2013 to HEDIS 2014, settling just above the 2013 Quality Compass 50th percentile by HEDIS 2014. The increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Controlling High Blood Pressure

Figure 5.45 presents comparative rates for *Controlling High Blood Pressure*.

Figure 5.45—Comparison of HFS MCO Performance for *Controlling High Blood Pressure*



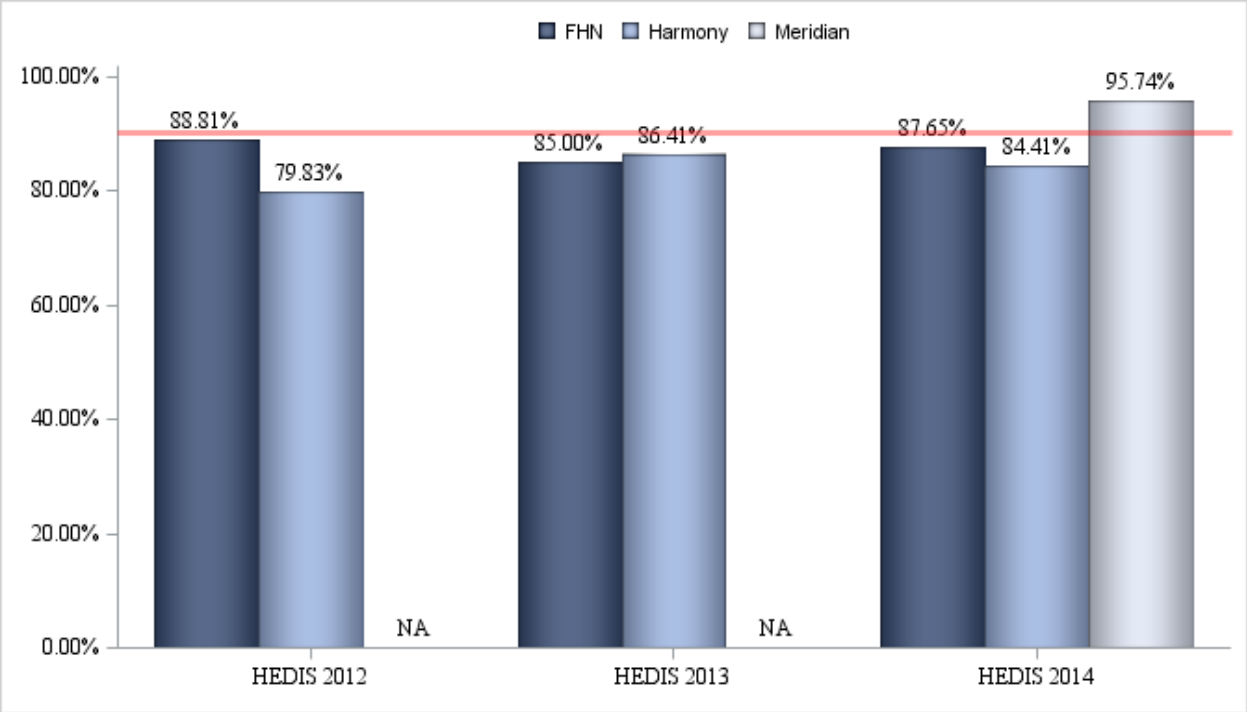
For HEDIS 2014, **Meridian**'s rate exceeded the 2013 Quality Compass 50th percentile by approximately 22 percentage points, and **FHN**'s and **Harmony**'s rates fell below the 2013 Quality Compass 50th percentile. Most notably, **FHN**'s HEDIS 2014 rate fell 14 percentage points below the 2013 Quality Compass 50th percentile. **FHN**'s rates remained similar from HEDIS 2012 to HEDIS 2014. **Harmony**'s rates also remained similar from HEDIS 2012 to HEDIS 2013; however, the rate improved by 11 percentage points from HEDIS 2013 to HEDIS 2014. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were deemed NR.

Use of Appropriate Medications for People With Asthma

Use of Appropriate Medications for People With Asthma—5–11 Years

Figure 5.46 presents comparative rates for *Use of Appropriate Medications for People With Asthma—5–11 Years*.

Figure 5.46—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—5–11 Years*

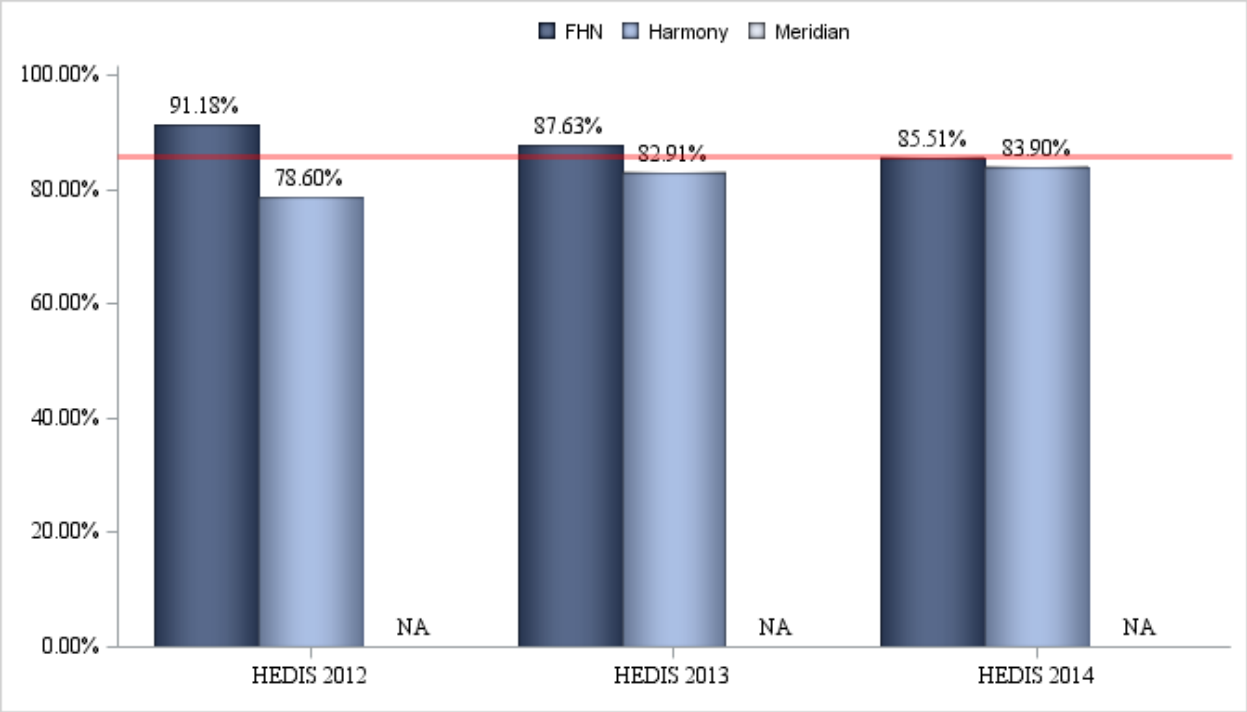


HEDIS 2014 rates reported by **FHN** and **Harmony** fell just below the 2013 Quality Compass 50th percentile. Performance remained similar from HEDIS 2012 to HEDIS 2014 for **FHN**. **Harmony**'s rate improved by 7 percentage points from HEDIS 2012 to HEDIS 2013 and remained similar from HEDIS 2013 to HEDIS 2014. **Meridian**'s HEDIS 2014 performance was above the 2013 Quality Compass 50th percentile by 5 percentage points. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30.

Use of Appropriate Medications for People With Asthma—12–18 Years

Figure 5.47 presents comparative rates for *Use of Appropriate Medications for People With Asthma—12–18 Years*.

Figure 5.47—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—12–18 Years*

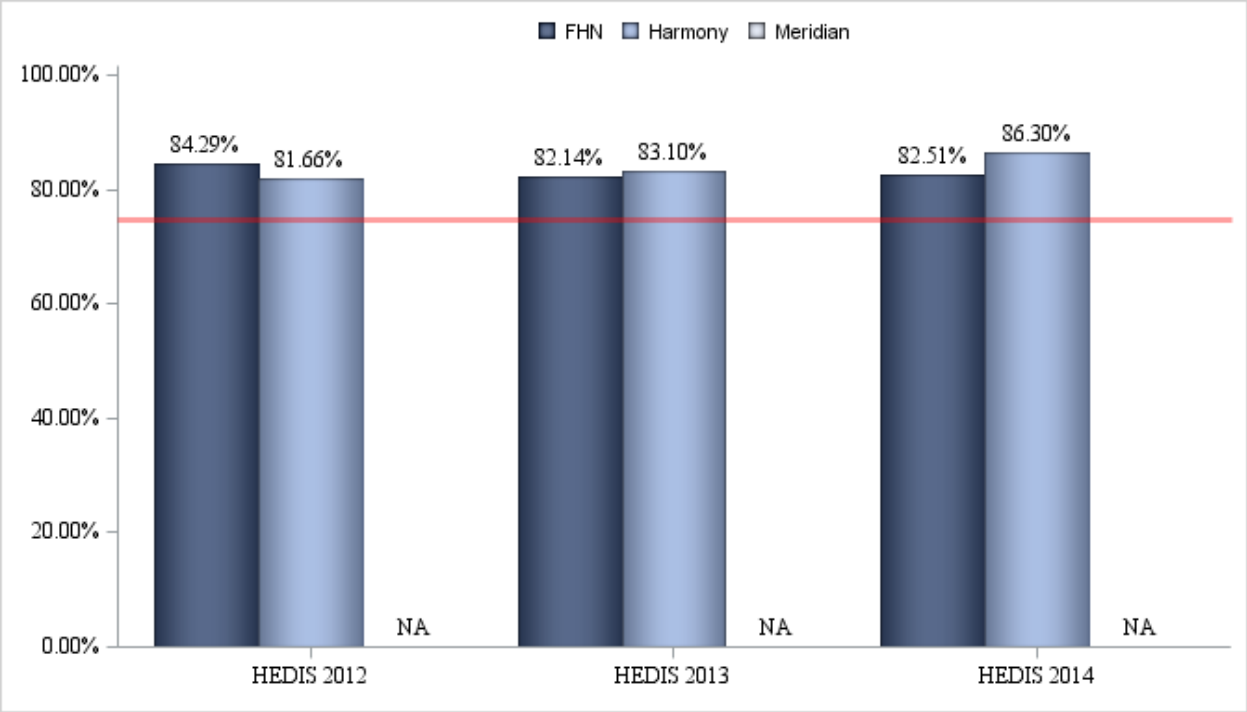


FHN's and **Harmony**'s HEDIS 2014 rates fell below the 2013 Quality Compass 50th percentile. For HEDIS 2012, HEDIS 2013, and HEDIS 2014, **FHN**'s rates exceeded **Harmony**'s rates. Although **FHN** consistently outperformed **Harmony**, **FHN**'s rates showed a decline of approximately 6 percentage points from HEDIS 2012 to HEDIS 2014. Conversely, **Harmony**'s rates improved by 5 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30.

Use of Appropriate Medications for People With Asthma—19–50 Years

Figure 5.48 presents comparative rates for *Use of Appropriate Medications for People With Asthma—19–50 Years*.

Figure 5.48—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—19–50 Years*



The 2014 rates for **FHN** and **Harmony** were at or above the 2013 Quality Compass 50th percentile. Most notably, **Harmony**'s HEDIS 2014 rate was 12 percentage points above the 2013 Quality Compass 50th percentile. Rates remained similar from HEDIS 2012 to HEDIS 2014 for **FHN** and **Harmony**. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30.

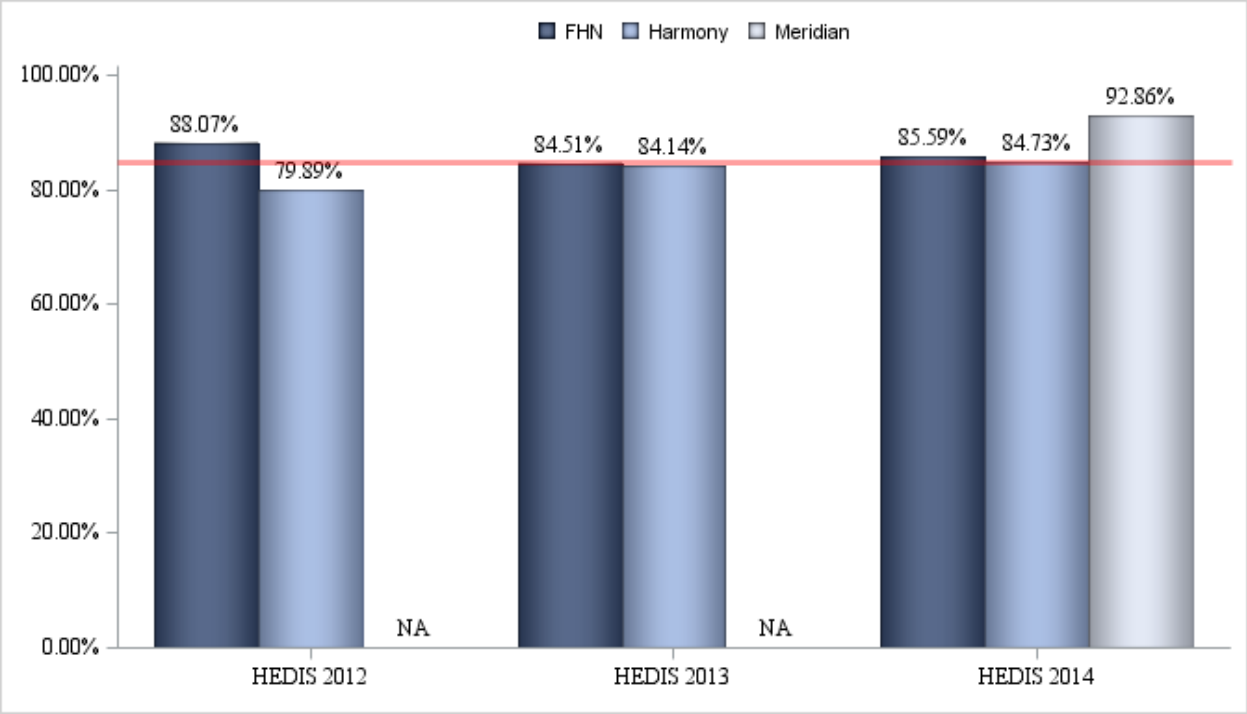
Use of Appropriate Medications for People With Asthma—51–64 Years

For *Use of Appropriate Medications for People With Asthma—51–64 Years*, all three MCOs' HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30.

Use of Appropriate Medications for People With Asthma—Total

Figure 5.49 presents comparative rates for *Use of Appropriate Medications for People With Asthma—Total*.

Figure 5.49—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—Total*



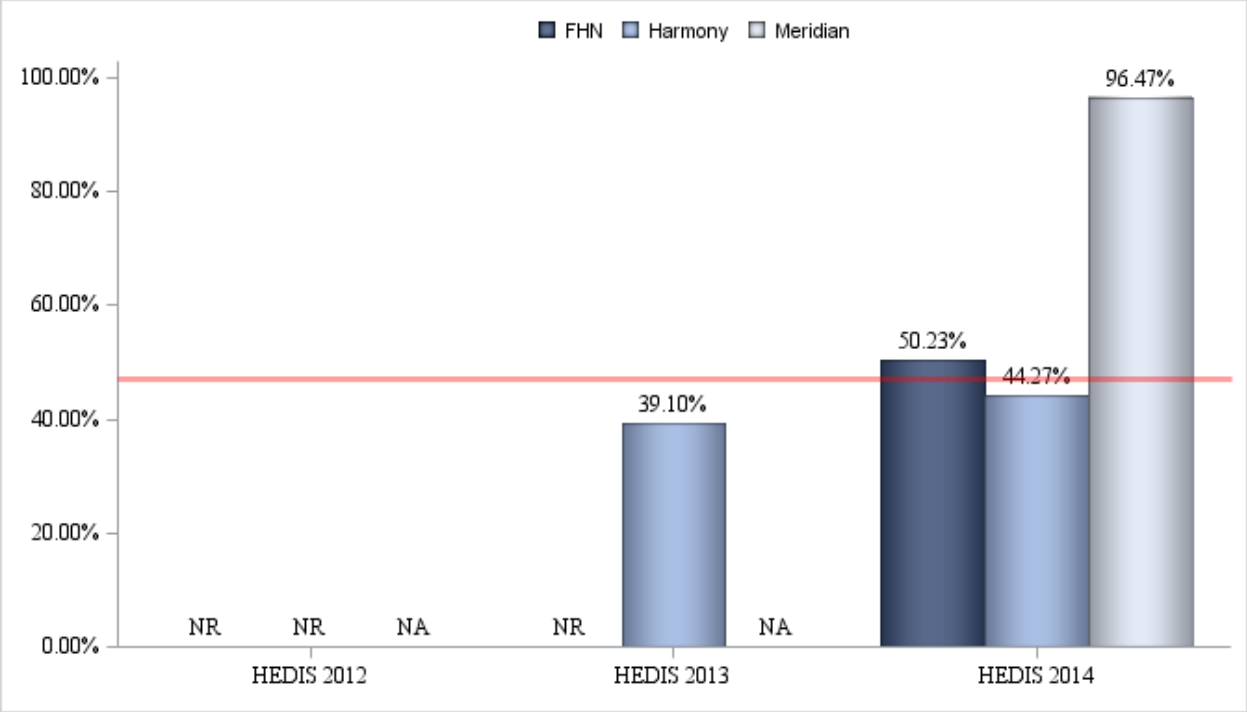
The HEDIS 2014 rates reported by **FHN** and **Harmony** were just above to the 2013 Quality Compass 50th percentile. Performance remained similar from HEDIS 2012 to HEDIS 2014 for **FHN**. **Harmony**'s rate improved by almost 5 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s HEDIS 2014 performance was above the 2013 Quality Compass 50th percentile by 8 percentage points. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30.

Medication Management for People With Asthma

Medication Management for People With Asthma—Medication Compliance 50%—5–11 Years

Figure 5.50 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—5–11 Years*.

Figure 5.50—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—5–11 Years*

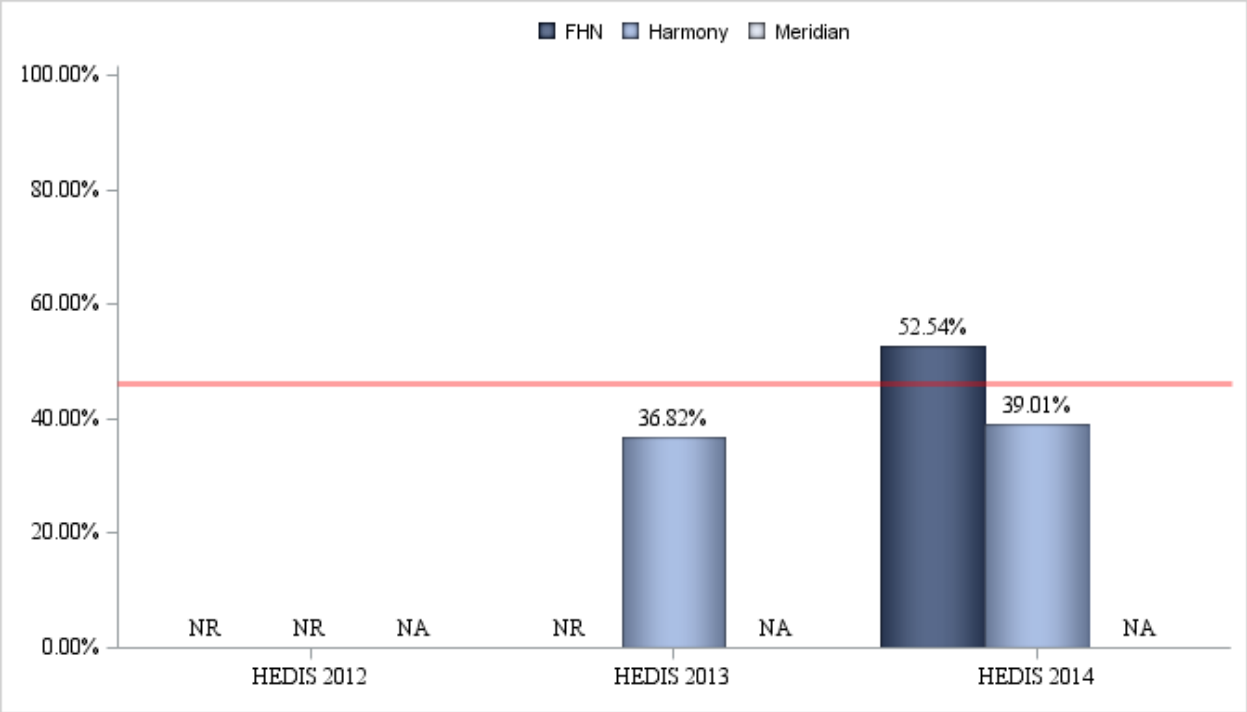


For HEDIS 2014, **FHN**'s rate scored above the rate reported by **Harmony** and exceeded the 2013 HEDIS Audit Means and Percentiles 50th percentile by approximately 3 percentage points. **Harmony**'s rate increased between HEDIS 2013 and HEDIS 2014, but continued to remain below the 2013 HEDIS Audit Means and Percentiles 50th percentile. **Meridian**'s HEDIS 2014 rate exceeded the 2013 HEDIS Audit Means and Percentiles percentile by 49 percentage points. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 50%—12–18 Years

Figure 5.51 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—12–18 Years*.

Figure 5.51—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—12–18 Years*

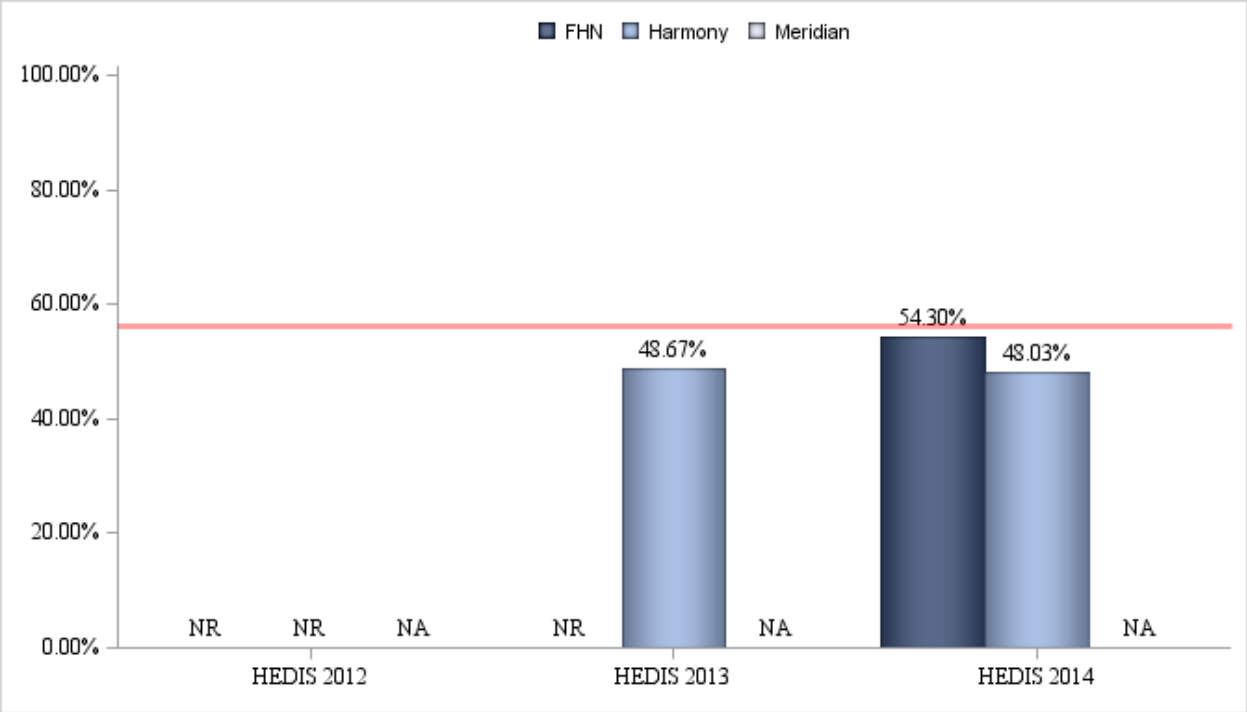


For HEDIS 2014, **FHN**'s rate scored above the rate reported by **Harmony** and exceeded the 2013 HEDIS Audit Means and Percentiles 50th percentile by 6 percentage points. **Harmony**'s HEDIS 2014 rate remained similar to the 2013 rate and fell below the 2013 HEDIS Audit Means and Percentiles 50th percentile. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 50%—19–50 Years

Figure 5.52 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—19–50 Years*.

Figure 5.52—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—19–50 Years*



FHN's and **Harmony**'s HEDIS 2014 rates fell below the 2013 HEDIS Audit Means and Percentiles 50th percentile. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

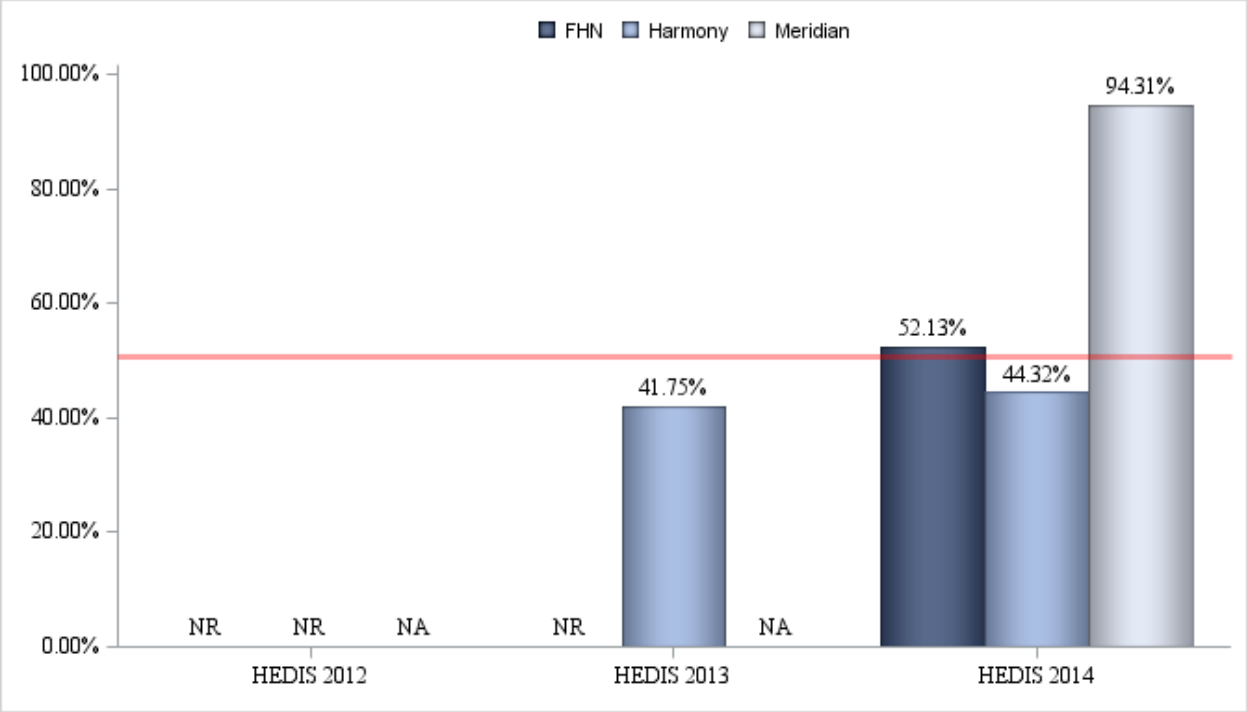
Medication Management for People With Asthma—Medication Compliance 50%—51–64 Years

For *Medication Management for People With Asthma—Medication Compliance 50%—51–64 Years*, **FHN**'s HEDIS 2014 rate, **Harmony**'s HEDIS 2013 and HEDIS 2014 rates, and **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 50%—Total

Figure 5.53 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—Total*.

Figure 5.53—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—Total*

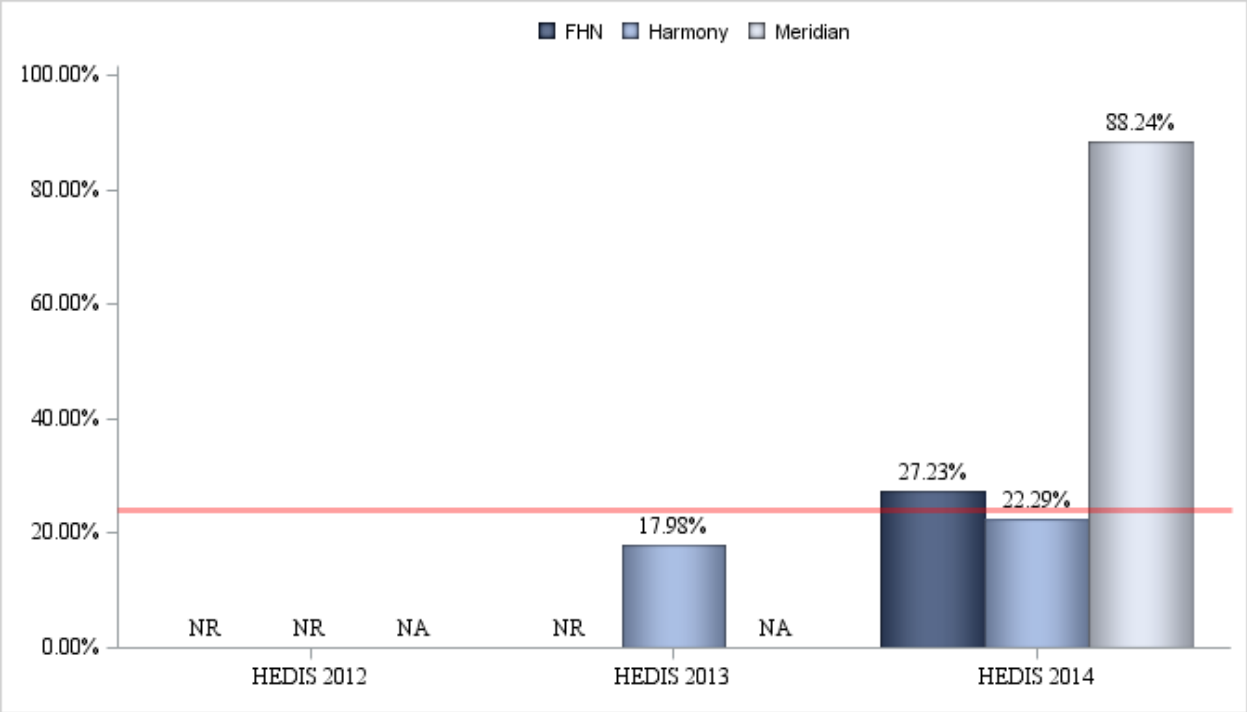


FHN's and **Meridian**'s HEDIS 2014 rates were at or above the 2013 HEDIS Audit Means and Percentiles 50th percentile. Most notably, **Meridian**'s HEDIS 2014 rate was 43 percentage points above the 2013 HEDIS Audit Means and Percentiles 50th percentile. **Harmony**'s HEDIS 2013 and HEDIS 2014 rates remained similar, and the HEDIS 2014 rate fell below the 2013 HEDIS Audit Means and Percentiles 50th percentile. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 75%—5–11 Years

Figure 5.54 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—5–11 Years*.

Figure 5.54—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—5–11 Years*

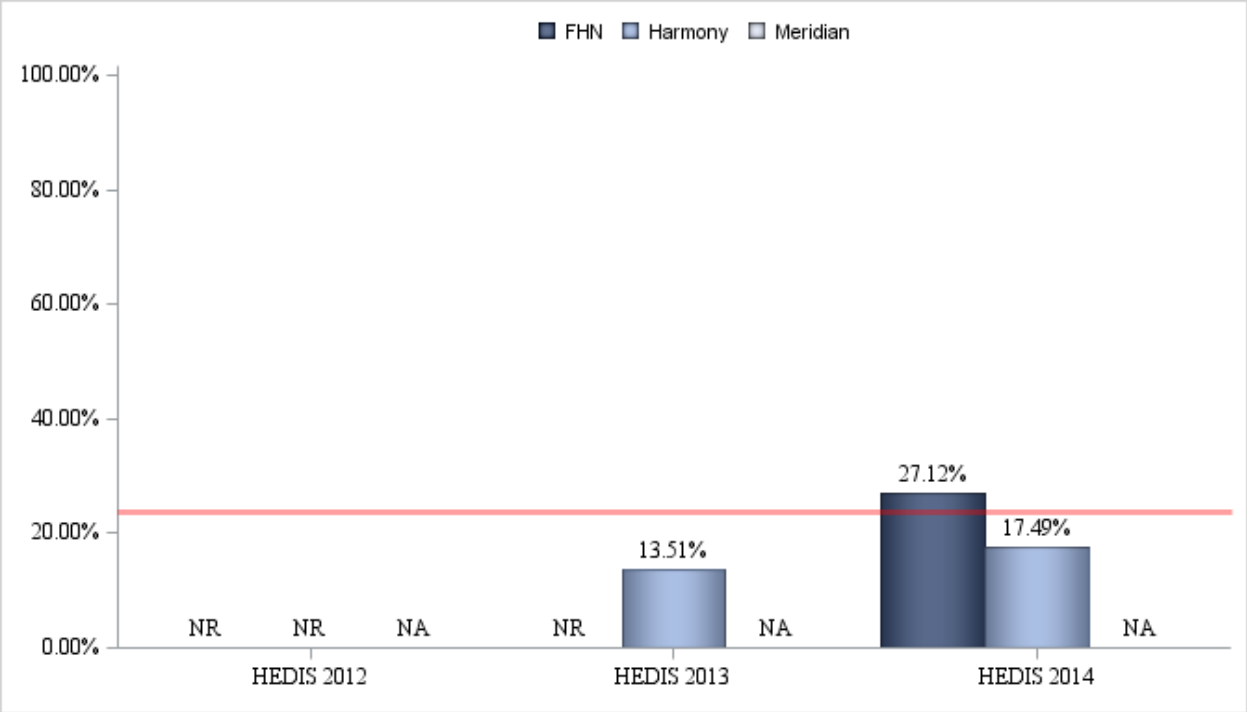


For HEDIS 2014, **Meridian**'s rate exceeded the 2013 Quality Compass 50th percentile by approximately 64 percentage points, and **FHN**'s rate was 3 percentage points above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2014 and fell below the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 75%—12–18 Years

Figure 5.55 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—12–18 Years*.

Figure 5.55—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—12–18 Years*

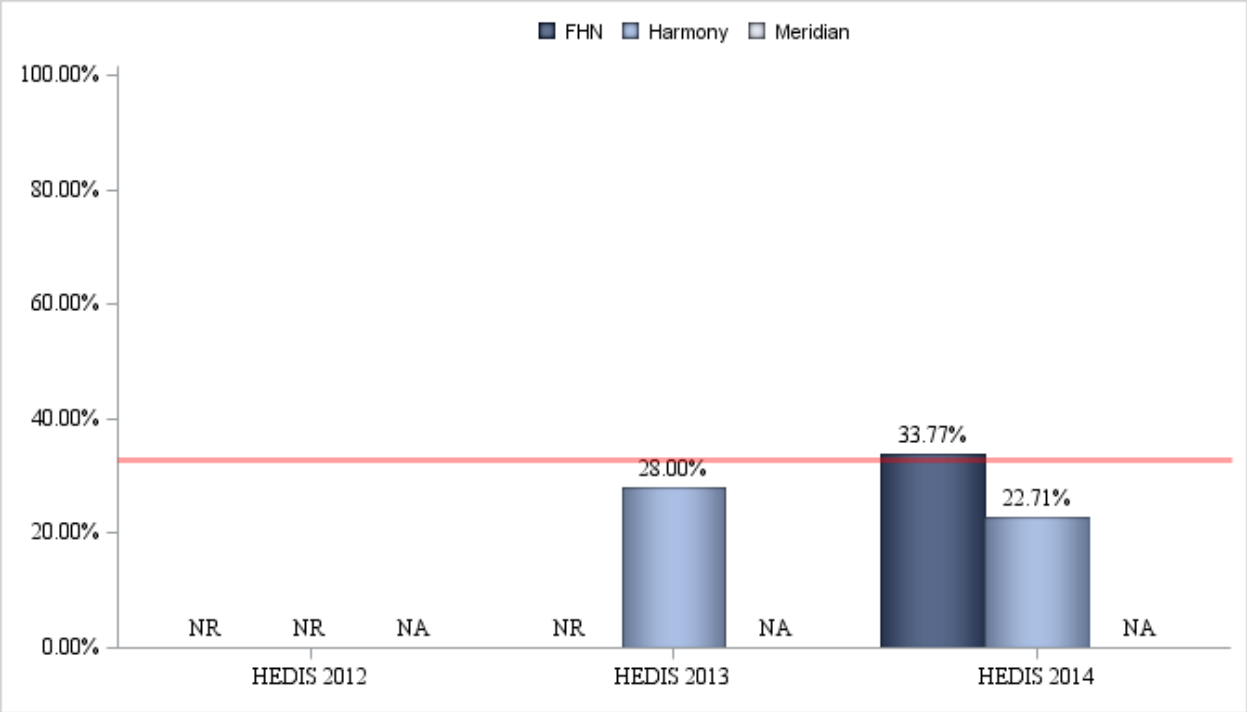


FHN's HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s HEDIS 2013 and HEDIS 2014 rates remained similar, and the HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 75%—19–50 Years

Figure 5.56 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—19–50 Years*.

Figure 5.56—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—19–50 Years*



As with the previous measure, **FHN**'s HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile. **Harmony**'s rate decreased by 5 percentage points from HEDIS 2013 to HEDIS 2014, and the HEDIS 2014 rate fell approximately 10 percentage points below the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

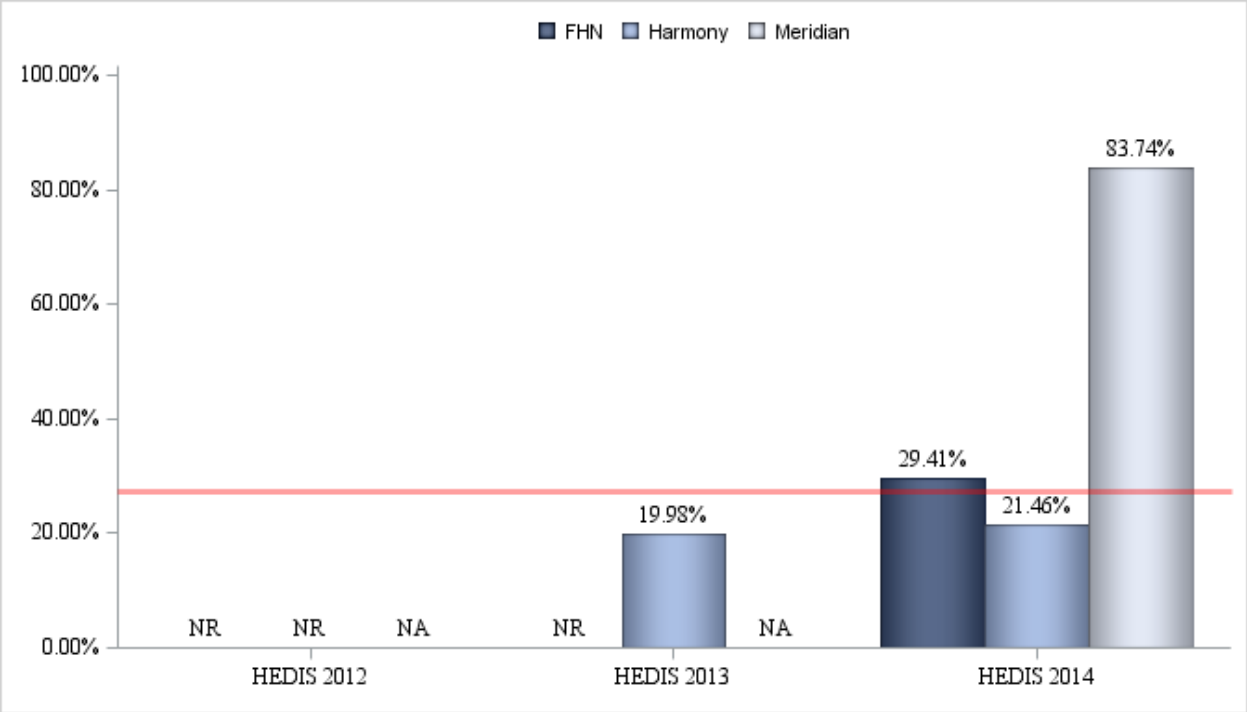
Medication Management for People With Asthma—Medication Compliance 75%—51–64 Years

For *Medication Management for People With Asthma—Medication Compliance 75%—51–64 Years*, **FHN**'s HEDIS 2014 rate, **Harmony**'s HEDIS 2013 and HEDIS 2014 rates, and **Meridian**'s HEDIS 2012, HEDIS 2013, and HEDIS 2014 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

Medication Management for People With Asthma—Medication Compliance 75%—Total

Figure 5.57 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—Total*.

Figure 5.57—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—Total*



For HEDIS 2014, **Meridian**'s rate exceeded the 2013 Quality Compass 50th percentile by approximately 56 percentage points, and **FHN**'s rate was 2 percentage points above the 2013 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2014, but the HEDIS 2014 rate fell 6 percentage points below the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30. **FHN**'s HEDIS 2012 and HEDIS 2013 rates, and **Harmony**'s HEDIS 2012 rate were deemed NR.

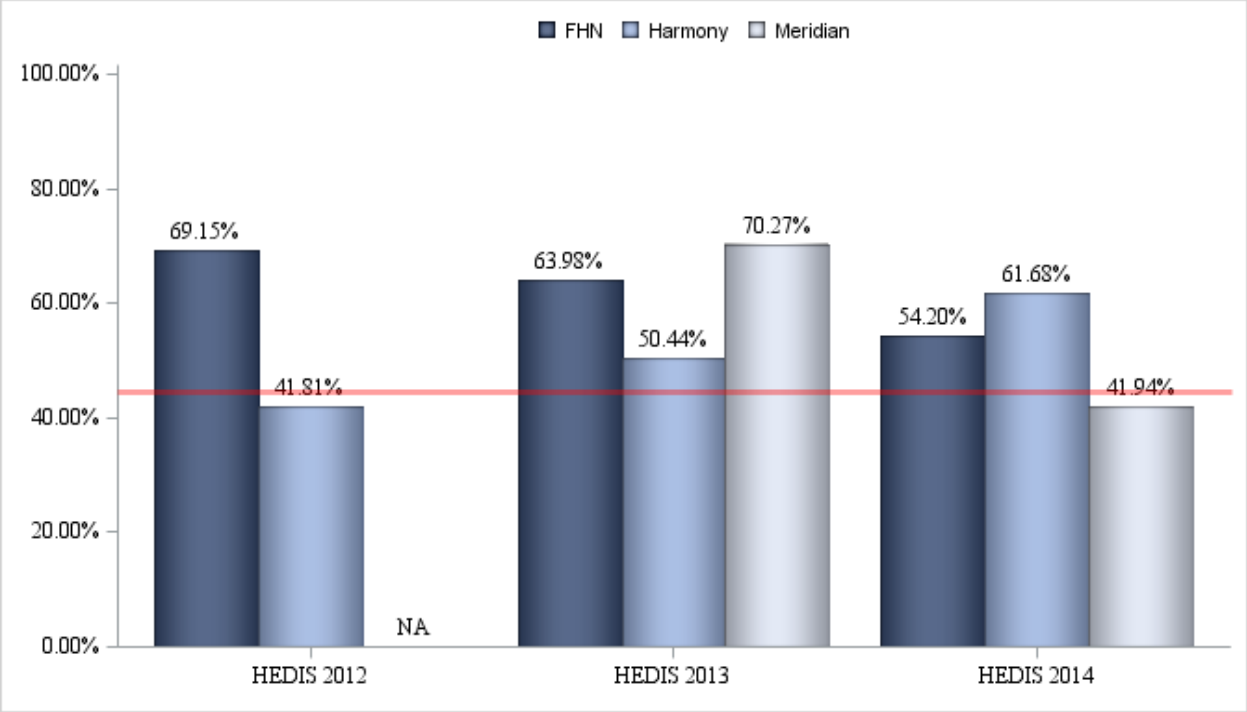
Behavioral Health

Follow-Up After Hospitalization for Mental Illness

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up

Figure 5.58 presents comparative rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*.

Figure 5.58—Comparison of HFS MCO Performance for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

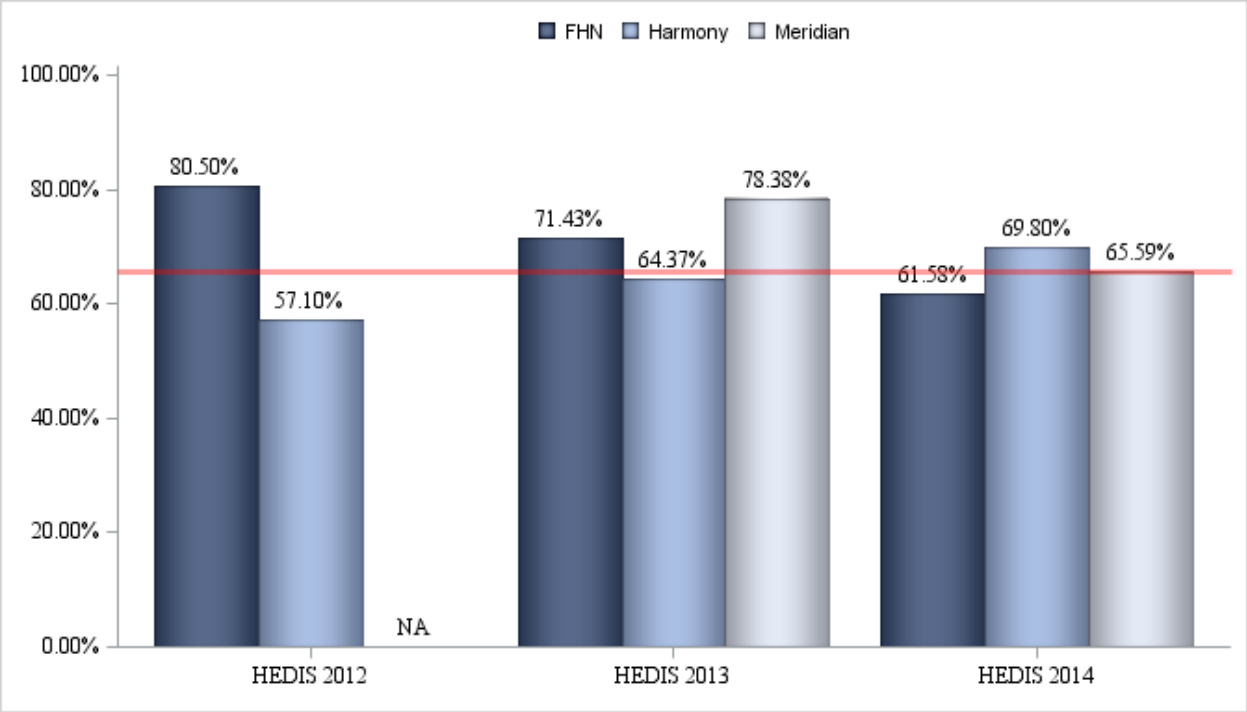


For HEDIS 2014, **FHN**'s rate was approximately 10 percentage points above the 2013 Quality Compass 50th percentile, while **Harmony**'s rate was 17 percentage points above the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2014 rate fell below the 2013 Quality Compass 50th percentile, and **Meridian**'s rate declined by 28 percentage points from HEDIS 2013 to HEDIS 2014. **FHN**'s rates declined by approximately 15 percentage points from HEDIS 2012 to HEDIS 2014. Conversely, **Harmony**'s rates improved by approximately 20 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up

Figure 5.59 presents comparative rates for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*.

Figure 5.59—Comparison of HFS MCO Performance for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*



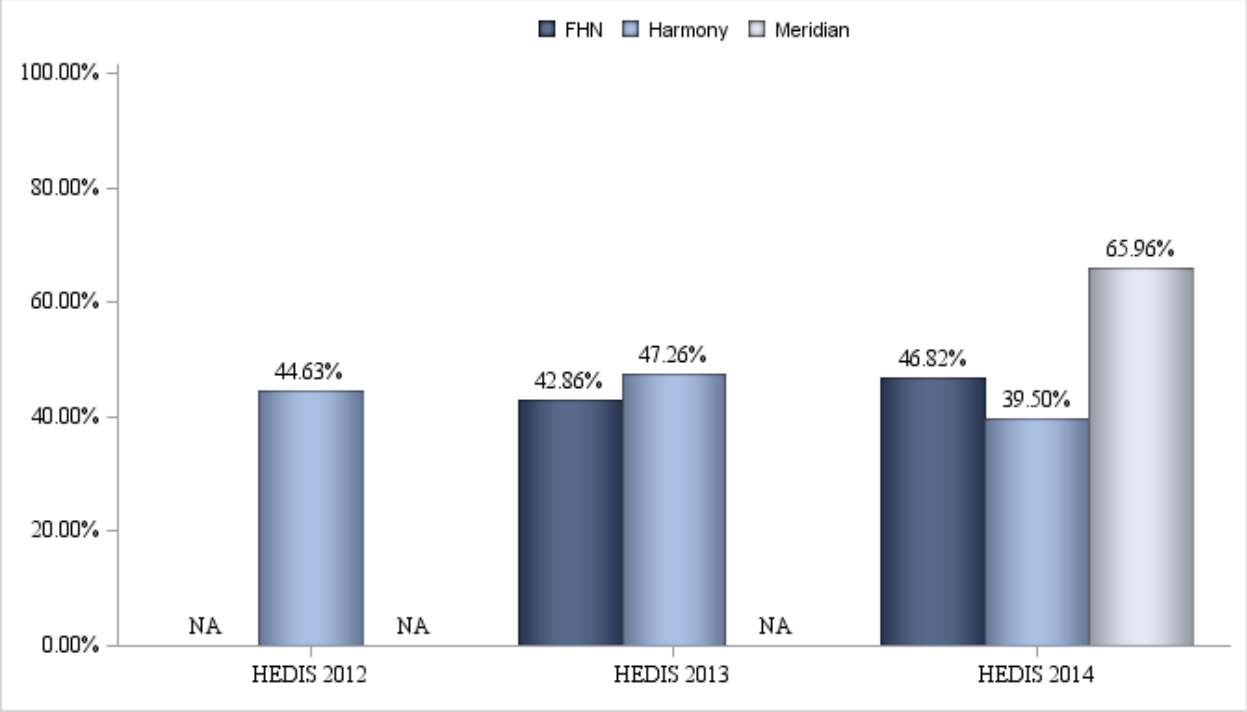
The HEDIS 2014 rates reported by **Harmony** exceeded the 2013 Quality Compass 50th percentile. **FHN**'s performance declined by approximately 19 percentage points from HEDIS 2012 to HEDIS 2014. **Harmony**'s rate improved by 13 percentage points from HEDIS 2012 to HEDIS 2014. **Meridian**'s performance declined by almost 13 percentage points from HEDIS 2013 to HEDIS 2014; however, the HEDIS 2014 rate fell just under the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2012 rate was NA as it was based on a denominator less than 30.

Antidepressant Medication Management

Antidepressant Medication Management—Effective Acute Phase Treatment

Figure 5.60 presents comparative rates for *Antidepressant Medication Management—Effective Acute Phase Treatment*. Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 5.60—Comparison of HFS MCO Performance for *Antidepressant Medication Management—Effective Acute Phase Treatment*

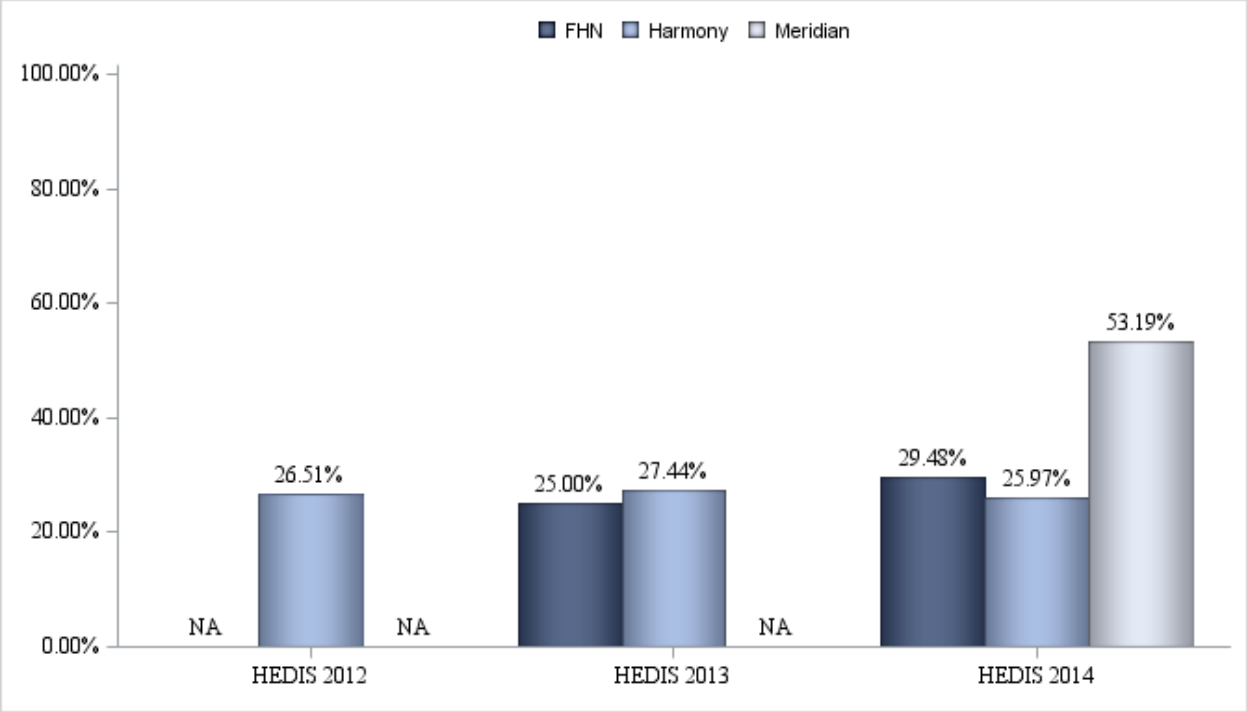


Meridian's HEDIS 2014 rate was 19 percentage points higher than **FHN**'s HEDIS 2014 rate, and **Harmony**'s rate was the lowest reported HEDIS 2014 rate. **FHN**'s HEDIS 2012 rate and **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30.

Antidepressant Medication Management—Effective Continuation Phase Treatment

Figure 5.61 presents comparative rates for *Antidepressant Medication Management—Effective Continuation Phase Treatment*. Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 5.61—Comparison of HFS MCO Performance for *Antidepressant Medication Management—Effective Continuation Phase Treatment*



For HEDIS 2014, **Meridian**'s rate exceeded **FHN**'s and **Harmony**'s rates by approximately 24 and 27 percentage points, respectively. **FHN**'s HEDIS 2012 rate and **Meridian**'s HEDIS 2012 and HEDIS 2013 rates were NA as they were based on denominators less than 30.

CHIPRA Results

This section presents the following 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 Three Years of Life*. This was the second year the three MCOs reported these measures. The measures are not HEDIS measures and have no benchmarks for comparison.

Table 5.9—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**	9.81%	21.73%	22.47%
Annual Pediatric A1c Testing	24.32%	65.52%	NA
Developmental Screening in the First Three Years of Life—Year 1	36.81%	45.53%	67.16%
Developmental Screening in the First Three Years of Life—Year 2	36.81%	42.36%	66.58%
Developmental Screening in the First Three Years of Life—Year 3	20.41%	29.86%	61.67%
Developmental Screening in the First Three Years of Life—Total	31.25%	39.58%	64.84%
*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*. **FHN** reported the rate indicating the best performance, at 9.81 percent.

For *Annual Pediatric A1c Testing*, **Harmony**'s rate of 65.52 percent was more than twice the rate of **FHN**, at 24.32 percent. **Meridian** had less than 30 cases; therefore, the MCO's result is reported as NA.

The overall rate for *Developmental Screening in the First Three Years of Life—Total* ranged from 31.25 percent for **FHN** to 64.84 percent for **Meridian**. **Harmony** reported rates for *Year 1–Year 3* for the first time in 2014. All of **Harmony**'s rates exceeded **FHN**'s rates but were lower than **Meridian**'s reported rates.

Although this was the second 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 5.10 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 Table 5.10 represent the percentage of the final HEDIS rates that were determined solely through the use of administrative encounter data. Note that **Meridian** used only administrative data, except for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Comprehensive Diabetes Care* measures; therefore, this assessment could not be performed for all measures.

Table 5.10—Estimated Encounter Data Completeness for Hybrid Measures

HEDIS Measure	Percentage of Numerator Positive Cases Determined by Administrative Data								
	FHN			Meridian			Harmony		
	2014	2013	2012	2014	2013	2012	2014	2013	2012
Child and Adolescent Care									
Childhood Immunization Status									
Combination 2	59.28%	59.41%	6.43%				82.30%	72.03%	72.79%
Combination 3	46.67%	49.52%	5.96%				79.79%	67.92%	69.58%
Lead Screening in Children									
Lead Screening in Children	69.82%	80.06%	77.09%				82.68%	92.31%	96.31%
Immunizations for Adolescents									
Combination 1 (Meningococcal, Tdap/Td)	81.39%	72.35%	66.49%				79.76%	84.75%	83.02%
Human Papillomavirus Vaccine for Female Adolescents									
Human Papillomavirus Vaccine for Female Adolescents	54.79%						60.94%		
Well-Child Visits in the First 15 Months of Life									
No Well-Child Visits	100.00%	100.00%	100.00%				100.00%	100.00%	100.00%
Six or More Well-Child Visits	54.50%	41.94%	48.85%				78.84%	85.28%	79.62%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life									
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.50%	68.56%	84.81%				95.10%	96.65%	92.54%
Adolescent Well-Care Visits									
Adolescent Well-Care Visits	79.05%	64.97%	83.77%				89.77%	93.72%	91.78%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents									
BMI Percentile Documentation—Total	3.05%	0.41%	0.00%	67.86%			10.30%	6.75%	1.21%
Counseling for Nutrition—Total	1.55%	0.41%	0.00%	67.27%			3.50%	1.02%	0.00%
Counseling for Physical Activity—Total	0.00%	0.00%	0.00%	54.60%			3.38%	0.59%	0.00%

HEDIS Measure	Percentage of Numerator Positive Cases Determined by Administrative Data								
	FHN			Meridian			Harmony		
	2014	2013	2012	2014	2013	2012	2014	2013	2012
Women's Health									
Breast Cancer Screening									
Breast Cancer Screening	86.96%	85.80%	95.49%						
Cervical Cancer Screening									
Cervical Cancer Screening	76.62%	73.89%	80.39%				88.67%	95.58%	95.92%
Chlamydia Screening in Women									
16–20 Years	58.82%	64.47%	74.36%						
21–24 Years	59.84%	64.37%	76.13%						
Total	59.39%	64.42%	75.28%						
Prenatal and Postpartum Care									
Timeliness of Prenatal Care	58.23%	55.88%	34.11%				92.36%	90.23%	54.51%
Postpartum Care	72.92%	67.31%	28.21%				81.73%	88.67%	67.65%
Frequency of Ongoing Prenatal Care									
<21 Percent of Expected Visits	95.31%	93.20%	79.71%				94.55%	89.66%	0.00%
≥81 Percent of Expected Visits	19.84%	35.29%	52.15%				80.66%	81.56%	82.08%
Care for Chronic Conditions									
Comprehensive Diabetes Care									
Hemoglobin A1c (HbA1c) Testing	49.84%	42.80%	8.46%	100.00%			81.82%	93.71%	92.81%
HbA1c Poor Control (>9.0%)	72.73%	62.89%	0.00%	100.00%			69.92%	72.96%	100.00%
HbA1c Control (<8.0%)	0.00%	0.00%	0.00%	52.94%			7.05%	15.33%	22.31%
Eye Exam (Retinal) Performed	98.38%	83.33%	62.83%	100.00%			80.00%	70.54%	90.27%
LDL-C Screening	48.40%	56.97%	12.50%	100.00%			78.65%	89.96%	90.24%
LDL-C Control (<100 mg/dL)	0.00%	1.06%	0.00%	42.86%			21.51%	19.05%	36.96%
Medical Attention for Nephropathy	93.71%	88.84%	34.56%	100.00%			94.21%	97.96%	95.32%
BP Control (<140/90 mm Hg)	0.00%	0.53%	0.00%	10.42%			1.89%	0.00%	0.00%
BP Control (<140/80 mm Hg)	0.00%	0.00%	0.00%	9.68%			3.05%	0.00%	0.00%

Note: Table cells containing rates with more than 75 percent data completeness are shaded in green; cells containing rates with less than 50 percent data completeness are shaded in red.

For **FHN**, four HEDIS 2014 measure indicators had encounter data that were more than 90 percent complete, two measure indicators had encounter data completeness rates between 80 percent and 89 percent, five measure indicators had encounter data completeness rates between 70 percent and 79.99 percent, and eight measure indicators had data completeness rates between 50 percent and 69.99 percent. The remaining 11 measure indicators for **FHN** in HEDIS 2014 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 HEDIS 2014 encounter data submission rates met or exceeded **FHN**'s rates for every measure indicator that both MCOs reported using the hybrid methodology, except four. **Harmony** had five HEDIS 2014 measure indicators with encounter data completeness levels of 90 percent or greater (compared to eight measure indicators for HEDIS 2013), while seven measure indicators had encounter data completeness rates below 50 percent for HEDIS 2014. **Harmony** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission.

Meridian had encounter data for 12 measure indicators in HEDIS 2014, with five measure indicators achieving encounter data completeness levels of 100 percent. Of the remaining measures, four measure indicators had encounter data completeness rates above 50 percent, and three measure indicators had data completeness rates below 50 percent for HEDIS 2014. **Meridian** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission for the select measures that are not solely determined through administrative data.

MCO Interventions

As set forth in 42 CFR 438.364(a)(5), this section includes an assessment of each MCO's efforts to address the recommendations for quality improvement made by the EQRO during the previous year. The initiatives, program changes, or other actions taken by the MCO to address the EQRO's recommendations for the prior year are discussed.

FHN

To improve **access to care**, **FHN**:

- Continued member education via the member handbook and member newsletter articles as well as through its semiannual notification to members of missing preventive services and quarterly notification of members missing services to medical groups.

To address recommendations for the **child and adolescent care** measure set, **FHN**:

- Identified member, provider, and system barriers for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) PIP that was redesigned to focus on improving performance related to well-child visits and developmental screenings.

To improve **women's health**, **FHN**:

- Reported that the MCO's behavioral health vendor continued its intensive care management and home intervention programs, and conducts direct postpartum follow-up with patients.

Also, the Brighter Beginnings program for pregnant members and their babies continued, as well as most of **FHN**'s ongoing interventions such as provider education, partnering with "Text4Baby," and member and provider incentives. The MCO offers a mammography incentive program and annually mails letters to coincide with Breast Cancer Awareness Month.

To improve rates for **care for chronic conditions**, **FHN**:

- Continued comprehensive care/disease management for asthmatic and diabetic members, members with obesity and hypertension, and children with special healthcare needs since during the prior reporting year, none of the measures reported by **FHN** for the this measure set met the National HEDIS 2012 Medicaid 50th percentiles. **FHN** also renewed its partnership with Sinai Urban Health Institute's Asthma Care Partners; continued the diabetes member incentive (which awards members a $50 gift card for submitting proof of an annual PCP visit and all required screenings for effective diabetes management); and facilitated the participation of members in the 2nd Annual Diabetic Expo aimed at improving diabetes awareness, healthy life habits, and well-being of persons with diabetes. Finally, the MCO mailed health risk surveys/screening tools monthly to new members, with telephonic follow-up by member services representatives.

To sustain improvement in **behavioral health** measures:

- PsycHealth, **FHN**'s behavioral health vendor, continued both its home intervention program and 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. PsycHealth also continued its Readmission Outreach Project, targeting those members hospitalized in the past year for outreach to review triggers or warning symptoms, services offered, and methods for reaching PsycHealth in case of an emergency. PsycHealth's Home Intervention Program (HIP) and Transitional Care Visit (TCV) Program continued to reach high-risk patients whose hospital readmission rates were significant and provided an in-home visit within seven days to members who have been discharged for inpatient psychiatric admissions.

Regarding **encounter data**:

- No **encounter data** were more than 90 percent complete for **FHN**, so the EQRO strongly recommended that the MCO focus efforts on improving encounter data submission. In response, progress was made in improving and aligning the data management infrastructure at **FHN**. This occurred through the implementation of software systems to support critical workflows in member and provider management, encounter data and HEDIS scoring, and disease/care management. While the implementation of multiple systems is considered 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. In addition, **FHN** continued with provider education on preventive care guidelines, appropriate coding, and the importance of

encounter/claims data submission via group sessions, one-on-one sessions and through the provider newsletter.

Harmony

To improve its rates in the **access to care** measure set, **Harmony**:

- Continued to monitor PCPs on their access and availability for both regular appointments and after-hours coverage. Since rates for many of the measures in this set remained low and well below the national 50th percentiles during the prior reporting year, the EQRO recommended that the MCO examine its network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education. The network management team logged over 300 meetings with and visits to IPA and federally qualified health center (FQHC) administrators, PCPs, and hospitals. The HEDIS Inbound Care Gap program was also continued. This intervention involves members who call Customer Service and are identified as having a HEDIS care gap. The representative 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.

For **child and adolescent care**, **Harmony**:

- Identified member, provider, and system barriers for the EPSDT PIP, which was redesigned to focus on improving performance related to well-child visits and developmental screenings. To address and overcome barriers, **Harmony** implemented improvement strategies that included member, provider, and system-focused interventions which are described in Section 4 of this report.

To improve rates in the **women's health** measure set, **Harmony**'s interventions included:

- Member outreach and education in addition to enrolling members in the Harmony Hugs program. The MCO also conducted provider outreach/education and audits, and it also required corrective action plans for noncompliant providers. The MCO partnered with Planned Parenthood and developed a postpartum outreach initiative process improvement plan. Continuing the mailing of preventive care booklets which highlight the importance of receiving preventive services, **Harmony** sent 33,689 booklets to new members.

Harmony strived to improve rates in the **care for chronic conditions** set:

- The MCO-reported rates for nearly all of the measures in the measure set were lower than the National Medicaid HEDIS 2012 50th percentiles. In response, the MCO focused on asthma and diabetes during this reporting period by continuing member education outreach and substantially increasing the number of members in the disease management program. The MCO also redesigned a former initiative to create the HEDIS Education and Screening Program (ESP).

To sustain some improvement for **behavioral health measures** from the prior year, **Harmony**:

- Created the role of BH QI project manager, which proved to be invaluable in identifying opportunities related to behavioral health and forging collaborative relationships with community-based behavioral health providers. As of December 1, 2013, a major change occurred when the entire corporate and market behavioral health functions were integrated into an internal operation. Utilization management (including authorizations and concurrent review) and case management are now performed in **Harmony**'s corporate office. Finally, specific interventions such as the Hospital to Home (H2H) initiative and Bridge Appointments were continued.

Regarding encounter data, **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. Therefore, the EQRO recommended that **Harmony** continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission. In response, the MCO conducted focused clinical provider visits using a team approach to education of provider groups. **Harmony** also set up a cross-functional taskforce to determine the issues, create provider education materials, and educate providers on how to correctly submit claims/encounters. A root cause analysis revealed that the difficulty in tracking and recording inbound encounters was related to providers submitting encounter data through clearinghouses without markers to identify the IPA or medical group. The team has also focused efforts on developing a process to identify providers affiliated with multiple groups but practicing at a single location, resulting in improved encounter submission acceptance rates. Lastly, the cross-functional task force is ensuring the implementation of regulatory requirements to successfully process encounters. An encounter data work group is in the process of developing an IPA scorecard which shows month-over-month encounter acceptance rates and percentage of paper versus electronic claim/encounter submissions.

Meridian

In the **access to care** measure set, **Meridian**:

- Achieved rates at or above the Medicaid 2012 HEDIS 50th percentiles for three of the four measures, but the MCO still performed an annual audit in which access data were aggregated and analyzed for reporting to the Quality Improvement Committee. The three metrics included in the access audit were appointment access, after-hours care access, and handicap access. More than 90 percent of **Meridian**'s provider offices that were audited met the appointment, after-hours care access, and handicap access standards in state fiscal year (SFY) 2014. **Meridian** also conducted after-hours phone access reviews to ensure that proper after-hours access is being

provided for members. In the reporting year, **Meridian** telephonically contacted 72 primary care providers and 17 behavioral health providers. Ninety-eight percent of primary care providers and 100.0 percent of behavioral health providers were compliant with the after-hours access audit metric.

To continue improvement in the **child and adolescent care** measure set, **Meridian**:

- Created the HEDIS secure mobile application so that provider network development representatives are able to collect medical record documentation to meet HEDIS measures. **Meridian** also provided weekly employee HEDIS education to all staff, continued mailing age-specific member flyers, and conducted targeted outreach of parents to promote preventive care for their children.

To improve performance in the **women's health** measure set, **Meridian**:

- Continued to utilize a maternity care coordination program to manage its maternity population. In addition, the MCO conducted root cause analysis for the chlamydia screening measure, developed a member incentive for members who complete a chlamydia screening, and educated maternity care coordinators to request that a chlamydia screening be completed during the postpartum office visit. **Meridian** updated the monthly HEDIS reports to include a "hot list" of members who have outstanding, time-sensitive service needs and the incentives associated with these services, as well as offered providers the ability to view missing HEDIS needs, report these electronically, and send postcard reminders to members needing preventive care and routine visits.

For the care for **chronic conditions** measure set:

- **Meridian** did not have a sufficient number of eligible members to be able to report some of the measures. However, **Meridian**'s rates fell below the 50th percentile for four diabetes care measures. In response, the MCO encouraged member participation in disease education classes through telephonic outreach and enhanced education provided via disease management and stratification mailings. Members with acute, chronic, and complex medical, behavioral health, substance abuse, and comorbid conditions continued to receive care coordination and additional information about disease and self-management through interdisciplinary team contacts.

Regarding **behavioral health** measures **Meridian**'s rates were not reported last year for behavioral health due to low eligible population.

Validation of Performance Measures—Integrated Care Program (ICP) Findings—SFY 2014

Background

HFS implemented the ICP on May 1, 2011, for seniors and persons with disabilities who are eligible for Medicaid but not eligible for Medicare. The ICP provides integration of all of the individual's physical, behavioral, and social needs to improve health outcomes and enhance the individual's quality of life by providing the support necessary to live more independently in the community. The ICP initially began delivering services in two service packages. Service Package I covered all standard Medicaid medical services, such as physician and specialist care, emergency care, laboratory and x-rays, pharmacy, and mental health and substance abuse services. Service Package II was implemented February 1, 2013, to include nursing facility services and the care provided through some of the HCBS waivers operating in Illinois (excluding Developmentally Disabled/DD waiver services).

The ICP is mandatory managed care that began as a pilot program in the greater Chicago region including suburban Cook, DuPage, Kane, Kankakee, Lake, and Will counties. It now operates in 29 counties in five regions of Illinois. Those regions include the Rockford region (July 2013), the Central Illinois region (Sept 2013), the Metro East region (Sept 2013), and the Quad Cities region (November 2013).

ICP Findings and Comparisons

Aetna Better Health (**Aetna**) and **IlliniCare Health Plan, Inc.** (**IlliniCare**) have participated in the ICP since 2011. SFY 2014 was the second year reporting the ICP measures. HFS calculated the baselines for the ICP measures using FFS claims data. The utilization measures, with the exception of emergency department (ED) visits, are presented for information purposes but are not included when comparing the 2014 reported rates to the 2012 baseline rates.

The ICP 2014 rates for the 37 non-incentive measures for **Aetna** and **IlliniCare** are presented in Table 5.11. Rates in red font indicate that performance declined from the baseline rate.

Table 5.11—ICP Rates for Non-Incentive Measures

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2014 Rate	Change From Baseline	IlliniCare 2014 Rate	Change From Baseline
Access to Care Measures (Percentages)					
*Inpatient Hospital 30-Day Readmission Rate**	8.31%	8.55%	0.24%	11.72%	3.41%
*Inpatient Mental Hospital 30-Day Readmission Rate**	24.20%	23.93%	-0.27%	25.28%	1.08%
Access to Member's Assigned PCP	NA	50.26%	NA	51.44%	NA
Preventive Care Measures (Percentages)					
Influenza Immunization	9.92%	14.09%	4.17%	12.03%	2.11%
Colorectal Cancer Screening	NA	30.82%	NA	36.81%	NA
Breast Cancer Screening	NA	46.09%	NA	47.58%	NA
Cervical Cancer Screening	40.81%	43.85%	3.04%	43.39%	2.58%
Adult BMI Assessment	NA	70.58%	NA	68.98%	NA
Appropriate Care Measures (Percentages)					
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.00%	89.89%	3.89%	90.66%	4.66%
Annual Monitoring for Patients on Persistent Medications—Digoxin	81.46%	86.81%	5.35%	93.37%	11.91%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.60%	89.97%	3.37%	91.71%	5.11%
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	74.49%	81.21%	6.72%	80.21%	5.72%
Annual Monitoring for Patients on Persistent Medications—Total	84.12%	88.24%	4.12%	89.33%	5.21%
Comprehensive Diabetes Care—HbA1c Testing (DD Population Only)	79.05%	83.95%	4.90%	70.97%	-8.08%
Behavioral Health Measures (Percentages)					
*Adherence to Antipsychotic Medications for Individuals with Schizophrenia***	NA	81.29%	NA	76.20%	NA
*Behavioral Health Risk Assessment (BHRA) Completed within 60 Days of Enrollment***	NA	24.03%	NA	44.42%	NA
*Follow-Up Completed within 30 Days of Positive BHRA***	NA	20.45%	NA	7.87%	NA
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Initiation of AOD Treatment	45.71%	44.29%	-1.42%	49.69%	3.98%
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Engagement of AOD Treatment	8.97%	7.75%	-1.22%	6.68%	-2.29%
Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up	34.67%	26.19%	-8.48%	39.49%	4.82%

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2014 Rate	Change From Baseline	IlliniCare 2014 Rate	Change From Baseline
Utilization Measures (Per 1,000 Member Months)					
*Ambulatory Care—ED Visits Per 1,000 Member Months (DD Population Only)**	112.06	50.66	-61.40	41.95	-70.11
*Dental ED Visits Per 1,000 Member Months**	11.37	0.97	-10.40	0.76	-10.61
Inpatient Utilization (Per 1,000 Member Months)^					
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient Discharges (Per 1,000 Member Months)	40.35	23.43	-16.92	24.83	-15.52
Inpatient Utilization—General Hospital/Acute Care: Total Medicine Discharges (Per 1,000 Member Months)	28.95	15.93	-13.02	16.89	-12.06
Inpatient Utilization—General Hospital/Acute Care: Total Surgery Discharges (Per 1,000 Member Months)	10.78	7.05	-3.73	7.51	-3.27
Inpatient Utilization—General Hospital/Acute Care: Total Maternity Discharges (Per 1,000 Member Months)	0.62	0.57	-0.05	0.59	-0.03
Mental Health Utilization Inpatient and Outpatient (Percentages)^					
Mental Health Utilization—Any Services Total	25.04%	25.61%	0.57%	16.70%	-8.34%
Mental Health Utilization—Inpatient Total	6.11%	8.49%	2.38%	5.36%	-0.75%
Mental Health Utilization—Intensive outpatient/partial Hospitalization Total	2.74%	0.20%	-2.54%	0.15%	-2.59%
Mental Health Utilization—Outpatient Total	23.32%	21.55%	-1.77%	14.39%	-8.93%
Long Term Care (Per 1,000 Member Months)					
*Long Term Care Urinary Tract Infection Admission Rate**	2.17	1.04	-1.13	0.42	-1.75
*Long Term Care Bacterial Pneumonia Admission Rate**	2.42	1.01	-1.41	1.48	-0.94
Member Movement (Percentages)^					
Movement of Members—Started and Ended in Community	NA	82.59%	NA	79.84%	NA
Movement of Members—Started and Ended in HCBS (LTSS)	NA	78.91%	NA	74.45%	NA
Movement of Members—Started and Ended in LTC	NA	80.95%	NA	73.41%	NA
Movement of Members—Total Medicaid Members with No Movement	NA	82.12%	NA	78.93%	NA
Movement of Members—No Longer Enrolled	NA	14.47%	NA	17.67%	NA

* Lower rates represent better performance for these measures.
**There were no baseline rates established for these measures.
^ Indicates measure is utilization based, not performance based; therefore, changes in rates are not necessarily indicative of changes in performance.

Aetna's rates for four measures represented a decline in performance, although the difference between **Aetna**'s 2014 rate and its baseline rate for *Inpatient Hospital 30-Day Readmission Rate* was only 0.24 percentage point, indicating only a slight decrease in performance. Overall, 13 performance-related measure rates improved from the baseline rates. The rates for **IlliniCare** showed that four measures represented a decline from the baseline rates. Overall, **IlliniCare** showed that 13 measure rates improved from the baseline rates.

Aetna's scores for the following four performance-related measures exceeded **IlliniCare**'s scores by more than 5.0 percentage points: *Comprehensive Diabetes Care—HbA1c Testing (DD Population Only), Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Follow-Up Completed within 30 Days of Positive BHRA,* and *Ambulatory Care—ED Visits Per 1,000 Member Months (DD Population Only).*

IlliniCare's scores for the following five performance-related measures exceeded **Aetna**'s scores by more than 5.0 percentage points: *Colorectal Cancer Screening; Annual Monitoring for Patients on Persistent Medications—Digoxin; Behavioral Health Risk Assessment (BHRA) Completed within 60 Days of Enrollment; Initiation and Engagement of AOD Dependence Treatment 18+ Years—Initiation of AOD Treatment;* and *Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up.*

ICP Pay-for-Performance Results

Table 5.12 and Table 5.13 display the results for the 21 pay-for-performance measures for **Aetna** and **IlliniCare**, respectively. The target goals were established using the baseline rate, along with minimum expected improvement. **Aetna**'s and **IlliniCare**'s performance for the pay-for-performance measures in 2013 was also used to establish revised target goals for 2014. Therefore, the target goals may differ between **Aetna** and **IlliniCare**. In addition, to achieve an overall *Met* status, several of the performance measures were grouped together and had specific requirements for the rates within the group. For example, the Congestive Heart Failure group 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 in red font indicate that performance declined from the baseline rate.

Table 5.12—ICP Pay-for Performance Results for 2014 Contracted Goals and Results

Measure	Aetna			
	2013 Rate	Target Goal	2014 Rate	Overall Result
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	44.03%	59.88%	49.59%	NOT MET
Antidepressant Medication Management—Effective Acute Phase Treatment	55.44%	59.90%	76.99%	**MET**
Antidepressant Medication Management—Effective Continuation Phase Treatment	47.67%	52.90%	64.52%	**MET**
Access/Utilization of Care				
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.92%	46.83%	42.24%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	54.10%	58.69%	52.87%	NOT MET
*Ambulatory Care—ED Visits per 1,000 Member Months**	76.93	69.24	75.69	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met target goal for 2 measures from #1–3 and 1 measure from #4–5***			
1. HbA1c Testing	83.39%	85.05%	85.62%	**MET**
2. Nephropathy Monitoring	80.47%	82.42%	80.53%	
3. LDL-C Screening	80.84%	82.76%	83.63%	
4. Statin Therapy (80% of Eligible Days)	41.21%	47.09%	48.86%	
5. ACEI/ARB Therapy (80% of Eligible Days)	40.40%	46.36%	51.88%	
Congestive Heart Failure (CHF)	***The CHF measure requires a Met target goal for 2 measures from #1–3***			
1. ACEI/ARB Therapy 80% of the Time	44.61%	50.15%	55.81%	**MET**
2. Beta Blockers 80% of the Time	68.90%	72.01%	88.07%	
3. Diuretics 80% of the Time	42.65%	48.39%	55.97%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met target goal for 2 measures from #1–4***			
1. Cholesterol Testing	77.52%	79.77%	78.70%	**MET**
2. Statin Therapy 80% of the Time	45.75%	51.18%	53.90%	
3. ACEI/ARB Therapy 80% of the Time	40.88%	46.79%	50.96%	
4. Persistence of Beta-Blocker Treatment After a Heart Attack	86.00%	87.40%	93.33%	

Measure	Aetna			
	2013 Rate	Target Goal	2014 Rate	Overall Result
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met target goal for 2 measures from #1–3***			
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	69.97%	72.97%	69.21%	NOT MET
2. Bronchodilator Dispensed within 30 Days of the Event	89.47%	90.52%	89.40%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)***	NA	36.70%	NA	NA
* Lower rates represent better performance for these measures.				
** The SPR measure required two years of continuous enrollment for members; therefore, the rate was not applicable.				

Overall, **Aetna** achieved a *Met* status for five measures, which included meeting the target goals for 12 of the individual rates. Eight individual rates did not meet the target goals. **Aetna** achieved a *Met* status for CHF for a second year in a row, and improved performance for both CDC and CAD to meet the overall goals. **Aetna** also continued to show good performance for reducing ambulatory care ED visits and effectively monitoring antidepressant medication management.

Table 5.13—ICP Pay-for-Performance Results for 2014 Contracted Goals and Results

Measure	IlliniCare			
	2013 Rate	Target Goal	2014 Rate	Overall Result
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	40.90%	59.88%	55.11%	NOT MET
Antidepressant Medication Management—Effective Acute Phase Treatment	49.31%	56.85%	50.82%	NOT MET
Antidepressant Medication Management—Effective Continuation Phase Treatment	36.11%	47.37%	36.07%	NOT MET
Access/Utilization of Care				
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.11%	46.23%	40.28%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	50.96%	55.86%	54.50%	NOT MET
*Ambulatory Care—ED Visits per 1,000 Member Months**	80.55	72.50	74.93	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met target goal for 2 measures from #1–3 and 1 measure from #4–5***			
1. HbA1c Testing	79.69%	81.72%	85.42%	NOT MET
2. Nephropathy Monitoring	82.78%	84.50%	85.65%	
3. LDL-C Screening	75.50%	78.07%	80.56%	

Measure	IlliniCare			
	2013 Rate	Target Goal	2014 Rate	Overall Result
4. Statin Therapy (80% of Eligible Days)	38.32%	46.77%	42.11%	
5. ACEI/ARB Therapy (80% of Eligible Days)	38.10%	44.54%	41.67%	
Congestive Heart Failure (CHF)	***The CHF measure requires a Met target goal for 2 measures from #1–3***			
1. ACEI/ARB Therapy 80% of the Time	36.48%	42.83%	39.41%	NOT MET
2. Beta Blockers 80% of the Time	78.70%	80.83%	81.69%	
3. Diuretics 80% of the Time	42.86%	48.57%	45.14%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met target goal for 2 measures from #1–4***			
1. Cholesterol Testing	74.72%	78.41%	79.79%	**MET**
2. Statin Therapy 80% of the Time	43.38%	49.04%	47.48%	
3. ACEI/ARB Therapy 80% of the Time	37.69%	43.92%	39.37%	
4. Persistence of Beta-Blocker Treatment After a Heart Attack	87.80%	89.02%	96.43%	
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met target goal for 2 measures from #1–3***			
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	72.37%	75.13%	77.11%	NOT MET
2. Bronchodilator Dispensed within 30 Days of the Event	90.79%	91.71%	89.88%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)***	NA	36.70%	NA	NA

* Lower rates represent better performance for these measures.

** The SPR measure required two years of continuous enrollment for members; therefore, the rate was not applicable.

IlliniCare achieved a *Met* status for one measure and seven individual rates; the remaining 13 individual rates reported did not meet the target goals. **IlliniCare** improved performance for CAD to meet the overall measure goal, after previously failing to meet the overall goal, and continued to show good performance for reducing ambulatory care ED visits.

Aetna and **IlliniCare** both failed to meet the target goals for the PCE measure category. In addition, neither ICP health plan met the target goals for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up, Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit*, *Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge*, *Ambulatory Care—ED Visits per 1,000 Member Months,* and *Bronchodilator Dispensed within 30 Days of the Event.*

ICP Health Plan Interventions

This section includes an assessment of each ICP health plan's efforts to address the areas needing quality improvement identified by the EQRO during the previous year. The initiatives, program changes, or other actions implemented are discussed.

Aetna

Aetna's efforts to improve **preventive care** measures included:

- Cervical cancer screening reminder mailings, EPSDT birthday reminder mailings, and annual birthday reminder mailings to female members 40 years of age and older for breast cancer screening. In addition, **Aetna** screens for preventive health services during care management outreach and implemented a gaps in care overlay in the care management documentation platform. Health education was also provided to members through newsletters, community resources, and telephone "hold time" messaging.

Aetna implemented several new interventions for **behavioral health** including:

- A behavioral health huddle that occurs twice a week to discuss each member admitted to a hospital for a behavioral health diagnosis. If case management issues are identified, that information is shared with the assigned case manager. Another new intervention, mental health first aid champion status, was achieved by sponsoring the training of a behavioral health clinical liaison who then leads trainings on-site for care coordination staff who have direct contact with members. **Aetna** also hired a full-time, certified recovery support specialist who meets with members on an as-needed basis. An ongoing intervention, medication reconciliation, involves faxing medication history when members with primary psychiatric diagnoses are admitted to an inpatient psychiatric setting.

To ensure members are receiving **appropriate care**, **Aetna**:

- Utilizes a telehealth home monitoring system to observe and track basic health conditions of at-risk members in the home setting. For select high-risk members with heart disease, diabetes, pulmonary disease, or asthma, **Aetna** placed electronic monitoring devices in these members' homes which provide real-time information to care coordinators so that they may implement rapid interventions with members and providers.

To improve its **inpatient utilization** rates, **Aetna**:

- Partnered with a community-based organization through the Aetna Thresholds Pilot, which identified 10 members with high ED use and behavioral health inpatient hospitalization/high cost. The goal is to reduce those metrics, increase utilization of outpatient services, and improve the quality of life of members participating in the project. Close communication occurs between Thresholds case managers and Aetna case managers for seamless service. The

utilization management team conducts behavioral health "clinical rounds" with the medical directors, behavioral health coordinators, and care coordination staff. These twice-weekly, clinical discussion sessions provide a forum to brainstorm ideas that will assist the individual member's recovery, rely on the member's strengths and resilience, and increase natural and community supports when possible. Another initiative is the integration of a revised behavioral health strategy into the daily utilization management behavioral health (UMBH) concurrent review process. This strategy places the Level of Care Utilization System (LOCUS) criteria at the center of every clinical review discussion between the MCO and providers. In addition, the UMBH nurse team conducts a daily huddle.

IlliniCare

In 2013, **IlliniCare** promoted **preventive and appropriate care** by:

- Initiating a continuous quality improvement (CQI) project focused on attainment of preventive screening tests for the diabetic population. This initiative was selected due to both the high prevalence of diabetes in the MCO's member population and the inability to achieve the LDL screening goal in 2012. As a result, **IlliniCare** contracted with Home Physician Outreach groups to perform "home-based physical exams" for noncompliant members. The MCO also partnered with Nurtur (a disease management vendor) to conduct a pilot program. The pilot involved calling members who had not followed up with PCPs after screenings, scheduling appointments, and conducting medication coaching and counseling. The breast cancer screening and treatment initiative was also a pilot project, with the goal of increasing breast cancer screenings for women ages 40–65 in communities that have the highest incidences of mortality rates related to breast cancer and to facilitate timely treatment following a positive screening. In the past year, **IlliniCare** conducted a call campaign to reach out to members who have not seen their PCP in the past year, analyzed the effectiveness of the incentive programs and considered developing an ongoing incentive program, continued member education initiatives to receive necessary services, and continued targeted interventions to practitioners and members identifying those in need of specific services. One of the main ways **IlliniCare** encouraged members to obtain necessary tests and exams is through the incentive program CentAccount. This reward card gives reward dollars to members who finish certain healthy behaviors, which can be used toward acquiring a number of health-related items and are accepted at most pharmacies. A second multidisciplinary CQI project focused on adherence of medication management for members with chronic conditions such as diabetes, coronary artery disease, and congestive heart failure. This project was selected because of its integration of case management, medication management, and practitioner participation. After identifying barriers, **IlliniCare** launched a collaborative pharmacy intervention which coordinated outreach to physician offices and members to obtain prescriptions for 30-, 60-, and 90-day prescriptions. The MCO also extended

authorization in the computer system to allow for 90-day prescriptions. Nurtur was also used to provide outreach and education to members, with emphasis on medication refills, and the integrated care teams participated in outreach calls to members to educate and remind them to pick up refills that were faxed to the pharmacy by physician offices.

For **behavioral health**, **IlliniCare**:

- Continues to participate in a pilot project with Thresholds Community Mental Health Center. The pilot program was developed as a way to identify and reduce the IP admissions for some high-cost, high-utilizing members. The hope of this pilot is to encourage greater outpatient follow-up and care for members, and in turn reduce the frequency of inpatient admissions.

To reduce and manage emergency room **utilization**, **IlliniCare**'s:

- MemberConnections Team has been partnering with various hospital systems to reach members within 72 hours of admission. The team follows up with a home visit. The main goal of this program is to help reduce emergency room utilization and to ensure that those members who are admitted visit their doctor within 14 days. The SNFist Program was implemented to improve the results for provider follow-up after inpatient discharge and ED visits. Nurse practitioners or physicians make routine visits to members living in skilled nursing facilities as well as follow up on referrals from an integrated care team staff and utilization review nurses.

Introduction

As set forth in 42 Code of Federal Regulations (CFR) 438.358(3), States are required to conduct a compliance review of each health plan, within the previous three-year period, to determine health plan compliance with federal regulatory provisions, State standards, and contract requirements. The Illinois Department of Healthcare and Family Services (HFS) has an annual monitoring process in place to ensure the CFR and Balanced Budget Act (BBA) requirements are met over a three-year period. Health Services Advisory Group, Inc. (HSAG) reviews health plan compliance with the State standards, and in accordance with 42 CFR 438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR 438.206–42 CFR 438.242, which address requirements related to access, structure and operations, and measurement and improvement standards. Compliance is also determined through review of individual files to evaluate implementation of standards.

During State Fiscal Year (SFY) 2014, HFS' External Quality Review Organization (EQRO), HSAG focused on working with HFS to develop and conduct the readiness review process for the Family Health Plan/Accountable Care Act (FHP/ACA), Integrated Care Program (ICP), Care Coordination Entities (CCEs), Accountable Care Entities (ACEs), and the Medicare-Medicaid Alignment Initiative (MMAI) as part of the expansion of managed care.

Readiness Review Process

Overview

Title 42 CFR 438.358 describes activities related to required external quality reviews of a health plan's compliance with state and federal standards related to access, structure and operations, and measurement and improvement. Due to the extensive Medicaid expansion efforts, HFS contracted HSAG to conduct a series of operational readiness reviews across several programs.

Procedure

The primary objective of HSAG's readiness reviews was to evaluate implementation by the health plans of their programs and readiness to provide services and/or to ensure that health plans had the system capacity needed to enroll recipients in their designated service areas.

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 health plan staff.
- Aggregation and analysis of data and information collected.
- Preparation of implementation grids to track progress and reports, and based on a compilation of all findings.

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.
- Report its findings.

To accomplish its objective, and based on the results of collaborative planning with HFS, HSAG developed standardized data collection tools and processes to assess and document each health plan's compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements. HSAG developed tools and documents using specific criteria from applicable CFRs, the Illinois Compiled Statutes (ILCS), HFS contracts, and the related Requests for Proposal (RFPs).

Each health plan received a pre-assessment form and document checklist and a customized set of readiness review tools which facilitated the preparation for the 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 tool included requirements that addressed operational areas necessary to service the targeted population and ensure that health plans had the system capacity needed to enroll recipients in their designated service areas. The health plan was expected to describe in detail and provide supporting policies and procedures for the operational areas identified in the tool.

Data Collection and Analysis

Throughout preparation for readiness reviews and performance of on-site reviews, HSAG worked closely with HFS and the health 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 documents prior to the on-site portion of the review. The desk review assisted in determining areas that required additional focus during the on-site 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 health plans 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, to obtain further information to determine the health plan's compliance with contract requirements, and to review systems demonstrations. HSAG then conducted a closing conference to summarize preliminary findings, 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 analyzed the review information to determine the organization's performance and used the designations *Met*, *Partially Met*, and *Not Met* to document the degree to which the health plan complied with the requirements. Certain elements were designated by HFS and HSAG as critical and had to be in compliance prior to a health plan receiving enrollment.

HSAG noted any elements that were identified as *Partially Met* and *Not Met* and the corrective action the health plan needed to take to bring the requirement into compliance. HSAG used the standardized monitoring tools 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 health plan's internal organizational structure, health information systems, staffing, and oversight were sufficient to ensure compliance with contract requirements, quality oversight, and monitoring. Once the health plan began enrollment, monthly reports on 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 health plans following review of the required reports.

FHP/ACA Readiness Reviews

Voluntary managed care (VMC) was a healthcare option for medical assistance participants in Illinois since 1976. Starting in July 2014, HFS phased in the FHP/ACA program in the five most heavily populated regions of the State as part of the rollout to mandatory managed care. FHP/ACA is a mandatory program for children and their families as well as the newly eligible ACA adults. VMC remains an option in some counties outside of the mandatory regions. In the reporting period, HSAG conducted readiness reviews to ensure the health plans that would serve the FHP/ACA population were prepared for the rollout from voluntary to mandatory managed care.

Table 6.1 details the FHP/ACA review activities conducted in SFY 2014, as well as the "go live" date for each health plan which indicates when the health plan began accepting enrollment for the FHP/ACA program.

Table 6.1—FHP/ACA Readiness Reviews

Operational Readiness Reviews			
Program	**Health Plan**	**Date of Review**	**Go Live Date**
FHP/ACA	CountyCare Health Plan (CountyCare)	March 25–26, 2014	October 1, 2014
	Meridian Health Plan, Inc. (Meridian)	May 6–7, 2014	July 1, 2014
	Molina Healthcare of Illinois, Inc. (Molina)	May 13–14, 2014	July 1, 2014
	Harmony Health Plan of Illinois, Inc. (Harmony)	May 15–16, 2014	July 1, 2014
	Family Health Network (FHN)	May 22–23, 2014	September 1, 2014

Scope of FHP/ACA Readiness Review

HSAG conducted a desk review, site visit, and review of supporting care coordination systems to evaluate if the FHP/ACA health plans demonstrated appropriate knowledge of FHP/ACA contract requirements and systems preparedness in the following key operational areas:

- Availability of Services
- Assurance of Adequate Capacity and Services
- Coordination and Continuity of Care (Including Transition of Care)
- Coverage and Authorization of Services
- Credentialing and Recredentialing
- Subcontractual Relationships and Delegation
- Enrollee Information/Enrollee Rights
- Confidentiality

- Enrollment and Disenrollment
- Grievance and Appeal Processes
- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information System
- Required Minimum Standards of Care
- Fraud and Abuse

Pre-Implementation Operational Readiness Review Findings

The information below is a summary of the readiness review activities for the FHP/ACA program implementation. The background information for each health plan was submitted to HSAG by the health plans in their pre-on-site review documents.

CountyCare

CountyCare is an Illinois Medicaid Demonstration program which permits the Cook County Health and Hospital System (CCHHS) to early-enroll ACA qualifying individuals (ages 19–64) into Medicaid prior to 2014. Once enrolled in **CountyCare**, members receive covered services at no cost to them including (but not limited to) primary and specialty visits within a broad network of doctors and hospitals, prescription drugs, laboratory, X-ray and other diagnostics services, comprehensive women's health, mental health and substance abuse treatment, and access to transportation. **CountyCare** contracted with **IlliniCare**/**Centene** to provide all the back-office functions for the health plan.

Findings

HSAG conducted an on-site pre-implementation readiness review for **CountyCare** for FHP/ACA on March 25–26, 2014. HSAG conducted the readiness review at the **IlliniCare** office as all back-office functions were delegated to **IlliniCare**. Staff from both **CountyCare** and **IlliniCare** participated in the on-site readiness review. Following the pre-implementation readiness review, **CountyCare** worked with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved by the end of August 2014 prior to accepting FHP/ACA enrollment under mandatory managed care in October 2014.

Access Requirements

CountyCare/**IlliniCare** had established policies and procedures that addressed network adequacy and availability of services, coordination and continuity of care, and coverage and authorization of

services that were generally compliant with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements for access standards.

The Quality Improvement Committee (QIC) is responsible for oversight of the provider network. Provider availability is monitored by the Provider Relations Department and Network Management Department on an ongoing basis. Results are reviewed and recommendations are made to the QIC to address any deficiencies in the number and distribution of primary care and high-volume specialists.

CountyCare/**IlliniCare** had a Health Plan Care Coordination/Case Management Program Description in place which described the purpose and scope of the program, staffing, software, member satisfaction, outcome measurement, authority, and committee oversight. The **CountyCare**/**IlliniCare** Integrated Care Teams (ICTs) consisted of social workers, care coordinators, MemberConnections® staff, and health coaches. The social workers are licensed staff with medical and behavioral health experience; the care coordinators are nonclinical staff with experience in healthcare or health insurance settings whose primary role is to assist members with their care coordination needs. MemberConnections® representatives are nonclinical staff who support the care coordinator with activities such as home visits to assist the member in completing health risk assessments or with understanding the benefits of his or her health plan, and evaluation of the home setting.

CountyCare/**IlliniCare** uses Impact Pro, an episode-based predictive modeling and care management analytics tool integrated with a **Centene**'s Oracle-based Enterprise Data Warehouse (EDW). EDW regularly updates Impact Pro with data such as member demographics (including age, gender, and diagnoses); clinical and behavioral health claims data; lab test results; and, if made available, pharmacy utilization data. Impact Pro contains algorithms from several different industry standard predictive modeling approaches. It can stratify members according to risk and provide member profiles showing historical diagnoses, care episodes, and service utilization.

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

CountyCare/**IlliniCare** 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 completed an analysis and validation of the updated **CountyCare** provider network capacity and monitored ongoing development of the FHP/ACA provider networks.

The **CountyCare**/**IlliniCare** Medical Management Department maintains a Utilization Management (UM) Program Description, which encompasses the functions of pre-authorization,

concurrent review, retrospective review, and discharge planning. The UM Program incorporates preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care, and ancillary care services. The **IlliniCare** Board of Directors (BOD) oversees development, implementation, and evaluation of the UM Program.

During the on-site reviews, HSAG evaluated the effectiveness of the case management software, CareEnhance Clinical Care Management Software (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.

CountyCare/**IlliniCare** used nationally recognized standards and practice guidelines when reviewing and making decisions regarding provider and member requests for services. The health plan used qualified staff to review and make authorization and denial of service decisions.

Through review of the staffing worksheet, organizational charts, and interviews, **CountyCare**/**IlliniCare** demonstrated a sufficient number of staff to begin accepting enrollment for FHP/ACA as a Managed Care Community Network (MCCN).

After the pre-implementation review, **CountyCare** was required to follow up on the items below for the access standards:

- The Provider Contract Amendment should include all required elements such as cultural competency, nondiscrimination, and Health Insurance Portability and Accountability Act (HIPAA).
- Complete development of the Provider Directory and obtain the necessary **CountyCare** and HFS approvals before "going live."
- Develop a process for monitoring and oversight of the provider network.
- Submit policies and procedures that support the requirements of the medical home; for example assisting providers with self-assessment.
- Submit a copy of the formulary, including contraceptives.
- Submit a copy of the Americans with Disabilities Act (ADA) monitoring tool and policy and procedure for conducting the oversight.
- **IlliniCare**, on behalf of **CountyCare,** should continue outreach and contracting efforts with **CountyCare** providers.
- Update the **IlliniCare** organizational chart to include both existing and projected staffing to accommodate the **CountyCare** enrollment.
- **IlliniCare** to develop detailed policies and procedures and a transition plan for the **CountyCare** enrollees. Obtain prior approval from **CountyCare** and HFS on the transition plan.

- Document the process between **CountyCare** and **IlliniCare** to delineate responsibilities for discharge planning and follow up for the county hospital.
- Submit a **CountyCare** organizational chart.
- Revise the Case Management/Care Coordination Program description to include: 1) the role of **CountyCare**, 2) role of the **CountyCare** medical director, and 3) oversight responsibilities of the care management/care coordination of the **CountyCare** enrollees.
- Develop a transition report that clearly identifies high, medium, and low enrollees and how **CountyCare**/**IlliniCare** will prioritize outreach and engagement.
- Revise the UM Program Description to ensure inclusion of the **CountyCare** populations covered under the agreement including the role of **CountyCare** in utilization management oversight.
- Submit the Appeals template letters with **CountyCare** branding for review and approval to HSAG and HFS.
- Develop and define the **CountyCare** oversight and monitoring process, including credentialing committee and peer review.

Structure and Operations Requirements

CountyCare/**IlliniCare** 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.

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

CountyCare/**IlliniCare** has policies, procedures, and processes in place for monitoring the performance of its affiliated providers and subcontractors. **CountyCare**/**IlliniCare** also had mechanisms in place for quarterly, semiannual, and annual oversight and monitoring of its affiliated providers and subcontractors.

After the pre-implementation review, **CountyCare** was required to follow up on the items below for the structure and operations standards:

- Submit the **CountyCare** oversight and monitoring process for ensuring annual review of delegate contract compliance.
- Complete development of the Enrollee Handbook, enrollment materials, and identification (ID) card, and obtain the necessary **CountyCare** and HFS approvals.
- Complete development and implementation of the provider portal—scheduled for implementation July 1, 2014.
- Submit copies of the following attachments to the policies and procedures:
  - Documenting Disclosures of Protected Health Information (PHI)
  - Breach Assessment Form
  - Privacy Breach Incidents
  - Privacy Breach Module Users Guide
- Submit the grievance letter templates with **CountyCare** branding to HSAG/HFS for approval.

Measurement and Improvement Requirements

CountyCare/IlliniCare had established policies and procedures 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 Illinois contract requirements for QAPI Program standards.

CountyCare/IlliniCare had a process in place to annually evaluate provider adherence to the practice guidelines through review of the treatment rendered to members for a specific condition or diagnosis and/or review of practitioner records to evaluate compliance with the guidelines. Guidelines were being disseminated to providers through the new practitioner orientation materials, provider newsletters, and provider website, and to members through the member handbook, member newsletters, and special educational mailings.

The **CountyCare/IlliniCare** 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 health plan's physicians.

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

After the pre-implementation review, **CountyCare** was required to follow up on the items below for the measurement and improvement standards:

- Revise the QAPI program description to include the role, responsibility, and participation of **CountyCare** in the QAPI; for example, define **CountyCare**/**IlliniCare** roles in credentialing and peer review.
- Continue development of the Joint Operating Committee which will contain senior staff from both organizations. Develop a description, roles, and responsibilities of this committee.
- Submit the staffing formula that identifies assessment of operational staffing needs.
- Submit a **CountyCare** organizational chart that clearly identifies positions as discussed during the readiness review and included below:
  - Staffing **CountyCare**
  - Director of Operations
  - Medical Director
  - Director, Clinical Services
  - Director, Provider Relations
  - Finance Director
  - Compliance Director
- Develop a process and timeline for HFS-required monthly/quarterly and annual reports to include **CountyCare** in the oversight process.

Health Information Requirements

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

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

CountyCare/**IlliniCare** uses Quality Spectrum Insight (QSI), a Catalyst Technologies/MedAssurant Solution, to support performance measurement and QI reporting. QSI produces results for the Healthcare Effectiveness Data and Information Set (HEDIS), state-

specific measures, pay-for-performance measures, internally designed QI studies, and provider reporting studies.

CountyCare was also required to follow up on the following health information items:

- Submit a schematic that includes data flows between health information systems.
- Submit results of testing for enrollment/disenrollment and claims files.
- Develop a Critical Incident reporting module for **CountyCare** and submit screen shots when development is complete.

FHN

FHN provides access to cost-effective quality healthcare for people who could not otherwise afford it through enrollment in **FHN** and support to safety net providers. Founded in 1995, **FHN** is a not-for-profit corporation directed by safety net hospitals in Illinois. Operational for 19 years, **FHN**'s model aligns provider incentives and results in quality care for enrollees. Providers, including hospitals, are rewarded for efficiencies and quality outcomes.

Findings

HSAG conducted an on-site, pre-implementation readiness review for **FHN** for FHP/ACA on May 22–23, 2014. Following the pre-implementation readiness review, **FHN** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting FHP/ACA enrollment under mandatory managed care in September 2014.

Access Requirements

FHN 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 were responsible for monitoring the provider network to ensure that a sufficient number and types of primary care providers/medical homes and specialty physicians, dentists, behavioral health (including substance abuse), home and community-based providers, and other ancillary services are available to meet members' medical and behavioral health needs. **FHN** demonstrated that it has a process in place and can analyze the geographic distribution of its provider network quarterly, using Quest Analytics software. In addition, **FHN** was able to demonstrate that it has a process in place to monitor appointment availability through a secret shopper" survey process. **FHN** monitored other network adequacy indicators such as complaints/grievances related to access received through the enrollee and provider call center.

FHN 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 completed an analysis and validation of the updated **FHN** provider network capacity and monitored ongoing development of the FHP/ACA provider networks.

During the on-site reviews, HSAG evaluated the effectiveness of the case management software, CareEnhance 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 interviews, **FHN** demonstrated a sufficient number of staff to begin accepting enrollment for FHP/ACA under mandatory managed care.

The UM Program Description included policies and procedures to evaluate medical necessity, the criteria used, information sources, the process used to review and approve the provision of medical services, and the annual evaluation of program effectiveness. **FHN** had nationally recognized standards and practice guidelines (InterQual) for reviewing and making decisions on provider and member requests for services. **FHN** had qualified staff available to review and make authorization and denial of service decisions.

After the pre-implementation review, **FHN** was required to follow up on the items below for the access standards:

- Continue contract negotiations to build the Cook and Collar counties, and Rockford Region network for the following provider types:
  - Behavioral Health
  - Pediatrics
  - Pediatric Sub-specialty Groups
  - Children's Hospitals
  - Perinatologists
  - High-risk Obstetrics and Gynecology (OB/GYNs)
- Continue provider contracting and development of the collar counties and Rockford.
- Continue to finalize the provider contracts and expedite the credentialing process.
- Revise policy MM0237 to clearly describe the remediation process for noncompliance findings for the secret shopper survey.
- Submit a revised organizational chart that clearly identifies projected staffing for the Case Management/Care Coordination program.
- Develop a transition plan for hospitalized members during implementation of the FHP/ACA program.
- Implement a risk stratification/predictive modeling process as required by HFS contract.
- Update policies and procedures as necessary upon receipt of the FHP/ACA contract.
- Develop a workflow that clearly demonstrates the communication flow between PsychHealth and **FHN**.
- Develop and submit a medication management policy and procedure.

- Update the UM organizational chart and identify the full time equivalent (FTE) projections for expansion.
- Request appeals template letters from HFS and update existing documents to align with the template letters.
- Ensure delegated UM reports are reviewed by the UM/Quality Management (QM) committee. Identify reports that trend utilization by delegated provider group.

Structure and Operations Requirements

FHN 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.

FHN worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the FHP/ACA program requirements. 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. **FHN** completed training of all staff, which included information regarding enrollee rights and responsibilities.

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

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

FHN 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, **FHN** 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.

After the pre-implementation review, **FHN** was required to follow up on the items below for the structure and operations standards:

- Submit the updated delegation corrective action policies and procedures.
- Update the Quality Assurance (QA) plan description and QA work plan to reflect the changes to the delegation oversight.
- Review the delegation oversight agreement for compliance.
- Institute monthly joint operations meetings including regular monitoring of enrollee complaints.
- Submit the delegation oversight files for PsychHealth, Metropolitan Chicago Health Associates, and Ambay Health Network.
- Update the member handbook upon receipt of the contract from HFS and provide verification of HFS approval.
- Submit the welcome script for the expansion population.
- Forward call center monitoring reports (weekly) following "going live."
- Update the member services organizational chart to clearly identify the staff allocated for the expansion population. Identify customer services versus staff who conduct the health risk screenings.
- Submit the policy and procedure for monitoring the after-hours line.
- Develop and submit policies and procedures to describe compliance with the standards of care as outlined in Attachment XXI of the FHP/ACA Contract 2015-24-002.
- Submit a flowchart on the process for handling quality of care grievances.

Measurement and Improvement Requirements

FHN 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.

FHN'S QAPI Program Description described the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the 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 health plan's physicians.

The **FHN** 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 **FHN** medical director, the **FHN** vice president of healthcare management, the **FHN** 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 **FHN** 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 **FHN** were written using evidence-based, standardized practices. The CPGs were available to enrollees and providers on the **FHN** website. **FHN** had established mechanisms for dissemination of practice guidelines to providers and upon request to consumers. **FHN** had a process in place to annually evaluate provider adherence to the practice guidelines through review of medical records and utilization management reports.

FHN 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 the health plan's service population.

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

After the pre-implementation review, **FHN** was required to follow up on the items below for the measurement and improvement standards.

- Review the need for additional practice guidelines for the FHP/ACA population.
- Develop an implementation work plan for the rollout of the FHP/ACA population.
- Submit the Quality organizational charts.
- Revise the Quality Program Description and organizational structure to include the compliance committee.
- Revise the program description and QM/UM charter to include a pharmacist and psychiatrist.
- Evaluate current committee membership and ensure representation of a behavioral health provider on the QM/UM committee.

Health Information Requirements

FHN was also required to follow up on the below health information items:

- Submit FHP/ACA enrollment file testing prior to "going live."
- Evaluate the integration of pharmacy data from CVS pharmacy into CCMS.

- Evaluate integration of PsychHealth care coordination with CCMS.
- Create logic in the case management system for an auto-trigger event based on established standards (e.g., postpartum visit 21–56 days).
- Submit a timeline for development, testing, and implementation of a provider portal.
- Submit a schema for the data warehouse when available.
- Submit an IT organizational chart.
- Evaluate connectivity between the delegated groups and **FHN**, CCMS, and QNXT.

Harmony

Founded in 1985, **WellCare Health Plans, Inc.** (**WellCare**) is headquartered in Tampa, Florida, and provides managed care services to government-sponsored Medicaid and Medicare programs. **WellCare** purchased **Harmony** in 2004. **Harmony** was incorporated in Illinois on August 18, 1995, to provide comprehensive managed healthcare services to eligible Medicaid residents of Illinois. On April 16, 1996, **Harmony** received approval from the Illinois director of insurance to acquire **MultiCare Inc.** (**MultiCare**), an Illinois HMO, in a court-ordered liquidation. On May 15, 1996, pursuant to an Agreement and Plan of Merger, **MultiCare** merged with and into **Harmony**, whereupon **MultiCare** ceased to exist and **Harmony** continued as the surviving corporation. On the same date, **MultiCare**'s Certificate of Authority to operate as an HMO in Illinois was transferred to **Harmony** and was approved by the Illinois director of insurance.

Since 1997, **Harmony** has continuously held written agreements with the Illinois Department of Healthcare and Family Services (formerly the Illinois Department of Public Aid) to provide managed care services to eligible Medicaid participants. The current agreement, a "Contract for Furnishing Health Services by a Managed Care Organization," became effective as of October 1, 2009. Initially operating only in Cook County, Illinois, **Harmony** has expanded its Medicaid service area to Kane, St. Clair, Madison, Randolph, Jackson, Perry, Washington, and Williamson counties.

On March 3, 2004, HHS entered into a definitive agreement to be acquired by **WellCare**, a Medicaid and Medicare managed care organization operating health plans in other states. The acquisition subsequently received regulatory approval, and **Harmony** became an indirect wholly-owned subsidiary of **WellCare** in June 2005.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Harmony** for FHP/ACA on May 15–16, 2014. Following the pre-implementation readiness reviews, **Harmony** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved by the end of August 2014 prior to accepting FHP/ACA enrollment under mandatory managed care in July 2014.

Access Requirements

Harmony 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 Harmony Contracting and Provider Services Department is responsible for quarterly GeoAccess reporting to monitor the network standards and identify any gaps in the provider network.

Harmony 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 completed an analysis and validation of the updated **Harmony** provider network capacity and monitors ongoing development of the FHP/ACA provider networks.

Harmony had a 2014 Integrated Program Description (Care Management Program Description) which described the purpose and scope of the program, staffing, software, member satisfaction, outcome measurement, authority, and committee oversight. The Care Management (CM) department is positioned within **Harmony**'s Clinical Services. The leadership team reports to the vice president (VP) of clinical services who reports to the chief medical officer (CMO). The corporate care management managers report to of the VP of clinical services and the market-based telephonic and field care managers report to each market's designated medical director.

Harmony uses a proprietary model to identify and stratify members each month for management. The model has several components including disease status identification, severity, cost, and utilization factors. The model subjects all eligible members to a scoring algorithm which assigns a score based on severity, cost, and utilization. The severity portion of the model is based on the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system.

Harmony maintains a health information system called Enterprise Medical Management Application (EMMA). EMMA is a role-based system which allows access based on specific security settings. The system is used by staff involved in care management, intake, prior-authorization, appeals, QI, pharmacy, and customer service. The end users are able to follow a member through the intake process, hospitalizations, authorization processes, and short-term and long-term care, all in the same system. The records are linked by the member subscriber number in EMMA and include all care management interactions with **Harmony.** The system automatically time and date stamps any note or assessment entered into the system and the name of the user who has entered the information into the system. The system permits identification of a "To Do" list with a narrative entry of what needs to be accomplished, along with a targeted completion date. Once set, the alert will appear without prompts.

After the pre-implementation review, **Harmony** was required to follow up on the items below for the access standards:

- Develop an immediate staffing contingency plan to identify Illinois-based care management/care coordination staff other than the three "OB Hugs" nurses.
  - Identify the number of FTEs needed to cover the Metro East region for "going live."

  - Mix of proposed staffing should include staff with pediatric and behavioral health experience.
  - Community health workers and the number of FTEs needed to support the ICT team.
- Submit diagnosis algorithm for risk stratification.
- Submit reporting for health risk assessment (HRA) completed by Eliza for the last quarter (adult and pediatric).
- Submit a copy of the Pediatric Behavioral Health Assessment tool when development is complete.
- Submit a current copy of the Illinois HRA conducted by Eliza.
- Update CM and UM policies and procedures as necessary upon receipt of the FHP/ACA contract.
- Complete the business requirements documents and a timeline for design, development, testing, and implementation of EMMA (prior authorization software) to accommodate the needs of the Home and Community Based Services (HCBS) program for service plan authorizations.
- Revise the UM plan to meet the requirements of the FHP/ACA contract.

Structure and Operations Requirements

Harmony 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.

Harmony worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the FHP/ACA requirements. **Harmony** is also working with HFS on the welcome script that will be used by member services staff. In addition, **Harmony** had not completed training for member services staff on the FHP/ACA benefit package.

Written enrollee materials were at the sixth-grade level and available in alternative formats and languages. **Harmony** developed cultural competency training materials which were used for training **Harmony** staff and network providers. The training will be provided during orientation and annually for **Harmony** employees and affiliated providers.

Harmony had policies and procedures regarding PHI and confidentiality.

Harmony 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. During the readiness review interviews, **Harmony** staff could not describe how to process quality of care grievances. **Harmony** will be required to submit a policy and procedure and provide evidence that staff members have been appropriately trained in the handling of quality of care grievances.

After the pre-implementation review, **Harmony** was required to follow up on the items below for the structure and operations standards:

- Submit the following for the delegated vendor Eliza
  - Copy of the delegation agreement
  - Annual delegation oversight audit
  - Copies of any corrective actions
  - Copies of required reports from the delegate
- Update member handbook upon receipt of the contract from HFS and provide verification of HFS approval.
- Submit training for the call center staff on the FHP/ACA population.
- Submit the call center welcome scripts for the FHP/ACA population.
- Forward call center monitoring reports every two weeks following "going live."
- Update the Member Services Organizational Chart to clearly identify the staff allocated for Illinois and include the following:
  - Reporting structure
  - Names of staff members
  - Full- and part-time FTEs
  - Open positions
- Submit a policy and procedure for processing quality of care grievances.
- Submit copies of grievance reports including reasons for change in Primary Care Providers (PCP) covering first quarter 2014.

Measurement and Improvement Requirements

Harmony had 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.

Harmony's 2014 Quality Improvement Program Description 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 **Harmony** enrollees.

Harmony had clinical guidelines in place that had been reviewed and approved and were available to the providers through the Provider Manual which was accessible through the **Harmony** website; however, the health plan had not conducted an assessment of the practice and preventive guidelines for the FHP/ACA population.

Harmony had an information system capable of integrating incoming enrollment and disenrollment data files, including all member demographic information.

Harmony had not completed Critical Incidents and Abuse, Neglect, and Exploitation training for employees.

After the pre-implementation review, **Harmony** was required to follow up on the items below for the measurement and improvement standards:

- Review the need for additional practice guidelines for the FHP/ACA population.
- Develop an implementation work plan for the rollout of the FHP/ACA population.
- Revise the Quality Program Description upon receipt of the HFS contract to include the requirements for the FHP/ACA population.
- Submit a resume for the medical director.
- Develop a Consumer Advisory Committee and include a description of the roles, responsibilities, and meeting frequency in the Quality Program Description.
- Identify the accountable body, compliance versus quality, responsible for monitoring critical incidents.
- Develop and submit the business requirements document for the Critical Incident database.
- Provide a work plan that includes development, testing, training, and implementation of the database.
- Develop and implement Health & Safety Monitoring (critical incident) training for staff and network providers.

Meridian

Meridian is a physician-owned and member-focused organization operating as a full-service HMO since January, 2000. **Meridian**'s Care Coordination module utilizes a health risk assessment and "predictive modeling" software to stratify enrollees as a function of their potential high-cost risk. Stratified enrollees are case managed based on their stratification placement by care coordinators and associated care coordinator consultants, such as behavioral health, pharmacy, or nutrition. This model prioritizes enrollee cases by potential risk, allowing the focus of the case management function and resources on those enrollees with the greatest need and the greatest potential for cost reduction via managed care.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Meridian** for FHP/ACA on May 6–7, 2014. Following the pre-implementation readiness reviews, **Meridian** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved by the end of May and early June 2014 prior to accepting FHP/ACA enrollment under mandatory managed care in June 2014.

Access Requirements

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 FHP/ACA 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 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 completed an analysis of the updated **Meridian** provider network capacity and monitors ongoing development of FHP/ACA 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 Johns 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.

Case management policies and procedures were amended by **Meridian** to meet FHP/ACA-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.

The 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.

After the pre-implementation review, **Meridian** was required to follow up on the items below for the access standards:

- Continue contract negotiations to build the Metro East provider network. Continue to finalize the provider contracts and expedite the credentialing process to ensure an adequate network prior to "going live" for the following provider types:
  - Behavioral Health Providers
  - Pediatric Sub-specialty Providers
  - Children's Hospitals
  - Perinatologists
  - High-risk OB/GYNs.
- Submit a GeoAccess Report for Metro East.
- Forward a copy of the Health Risk Screening (HRS) Tool. Ensure policies and procedures align with the change in the HRS process if **Meridian** is going to add questions to the HRS tool.

- Develop and submit a process flow that maps how enrollees will be triaged and outreached upon receipt of the enrollment file from HFS including enrollees with no utilization data history.
- Submit a revised organizational chart that clearly identifies key personnel, community care coordination personnel, virtual care coordination, and community health outreach workers (CHOWs) for Illinois.
- Submit the job aids that demonstrate training for care coordination staff on the FHP/ACA populations.
- Develop a transition plan for hospitalized members during program implementation.
- Update policies and procedures as necessary upon receipt of the FHP/ACA contract.
- Update the organizational chart to include the UM staff specific to Illinois and the Metro East region.
- Submit family planning documents: contraceptive formulary and prior authorization policy.

Structure and Operations Requirements

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 FHP/ACA contract. **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.

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

- Submit the job aids for training call center staff for the FHP/ACA populations.
- Submit the call center welcome scripts for review.
- Forward call center monitoring reports every two weeks following "going live."

- Update the Member Services Organizational chart to clearly identify the staff allocated to Illinois.

Measurement and Improvement Requirements

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 2014 Quality Improvement Program Description identified the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the 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 health 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 QIC.

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

After the pre-implementation review, **Meridian** was required to follow up on the items below for the measurement and improvement standards:

- Review the need for additional practice guidelines for the FHP/ACA populations.
- Develop and submit an implementation work plan for the rollout of the FHP/ACA population.
- Revise the Quality Program Description upon receipt of the FHP/ACA contract for inclusion of the Family Planning requirements under Attachment XXI.

Molina

Molina Healthcare, Inc., 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 Fortune 500 company. It 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. Currently, **Molina** arranges for the delivery of healthcare services for nearly 4.3 million individuals and families who receive their care through Medicaid, Medicare, and other government-funded programs in 16 states. It operates Medicaid health plans serving 1.8 million members and Medicare Advantage plans designed to meet the needs of individuals with Medicare or both Medicaid and Medicare coverage. **Molina** 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.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Molina** for FHP/ACA on May 13–14, 2014. Following the pre-implementation readiness reviews, **Molina** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting FHP/ACA enrollment under mandatory managed care in July 2014.

Access Requirements

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 FHP/ACA 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. **Molina** worked with HSAG in submission of the network data for both the ICP and FHP/ACA programs. Following receipt of the data, HSAG completed an analysis of

the updated **Molina** provider network capacity and monitors ongoing development of the FHP/ACA provider networks.

Molina uses the Chronic Illness and Disability Payment System (CDPS) 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.

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.

Case management policies and procedures were amended by **Molina** to meet FHP/ACA-specific requirements. **Molina** will use the existing case management software application, Clinical Care Advance, to document care management/care coordination activities for the FHP/ACA population.

The **Molina** Health Services Program Description (Utilization Management 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 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.

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 FHP/ACA population.

After the pre-implementation review, **Molina** was required to follow up on the items below for the access standards:

- Provide ongoing network capacity reports to HFS both before, during, and post-implementation of the FHP/ACA Program.
- Update policies to include the process for members who are assigned, but out-of-area.
- Submit emergency department (ED) utilization report used to identify issues with PCP after-hours services.

- Submit policies and procedures that meet the requirements of Standards of Care including family planning as outlined in Attachment XXI—Required Minimum Standards of Care.
- Submit a copy of the ADA tool used to validate ADA compliance in the provider offices.
- Submit a copy of the Appointment Availability Survey tool and incorporate the FHP/ACA appointment requirements.
- Revise and submit network adequacy policies and procedures to include the network capacity standards for the FHP/ACA contract.
- Submit a copy of the last access and availability audit report.
- Submit a copy of the provider agreement amendment template for FHP/ACA.
- Submit the flowchart for telephonic outreach assessments.
  - Submit the training outline for the telephonic outreach staff, specific to FHP/ACA populations.
- Submit the Children with Special Health Care Needs (CSHCN) plan, which includes the following:
  - Case management/care coordination policies and procedures
  - Quality program description
  - Transitions of care
- Update policies and procedures, as necessary, upon receipt of the FHP/ACA contract.
- Submit a staffing turnover report (including management positions) from October 2013 to August 2014, include the following departments:
  - Quality and Healthcare Services (UM and CM).

Structure and Operations Requirements

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 FHP/ACA contract requirements for structure and operations standards.

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

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

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

Molina worked closely with HFS during the pre-implementation phase to complete the revisions to the Enrollee Handbook to include the FHP/ACA program requirements. The **Molina** Enrollee Handbook, once approved by HFS, will be 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 online 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 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, **Molina** 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.

After the pre-implementation review, **Molina** was required to follow up on the items below for the structure and operations standards:

- Submit an organizational chart for the call center identifying FTEs dedicated to Illinois FHP/ACA populations.
- Forward call center monitoring reports (weekly) following "going live."
- Submit a copy of Business Requirement document for the Appeals and Grievance system enhancement.

Measurement and Improvement Requirements

Molina had 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 FHP/ACA contract requirements.

Molina's Quality Improvement Program Description described the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for

the QI program, purpose of the program, goals and objectives, scope of activities, committee structures and reporting, and responsibilities of the quality management department. The QIC oversees and coordinates the QI Program activities. The committee structure demonstrated participation by the health plan's physicians. **Molina** revised the existing QIP to include the specific FHP/ACA program requirements.

Molina's QIP 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** will need to review the existing practice and preventive care guidelines to cover the needs of the FHP/ACA population.

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.

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

- Develop an implementation work plan for the rollout of the FHP/ACA populations.
- Submit the QI staffing organizational chart.
- Review existing Clinical Practice and Preventive Care guidelines and revise and update, as necessary, for the FHP/ACA populations.
- Review, revise, and submit the Cultural Competence Plan.

Health Information Requirements

Molina was also required to follow up on the below health information items:

- Submit testing scenario and results of testing prior to "going live" for all enrollment files.
- Submit Care Advance system overview.
- Submit a plan to streamline the recording of the authorized representative for children in the Care Advance system.

Ongoing Monitoring

Upon completion of the on-site activities, all deficiencies from the desk review and site visits were identified, and the FHP/ACA health plans were required to remedy each deficiency prior to

program implementation. HSAG and HFS used a standardized monitoring tool to document follow-up on any elements that required remediation and monitored corrective actions until successfully completed to ensure ongoing compliance with contract requirements, quality oversight, and monitoring.

Once enrollment began, the FHP/ACA health plans were required to submit monthly reports monitoring care coordination, enrollment, network development, utilization, and staffing. Ongoing feedback was provided by HSAG and HFS to the health plans following review of the required reports.

ICP Readiness Reviews

The ICP initially began delivering services in two service packages. Service Package I (SP I) covered all non-long-term care services and mental health and alcohol and substance abuse services, including medical care services of nursing facility residents. Select long-term care services, including several 1915(c) HCBS waivers, were added under Service Package II (SP II), and implemented in 2012. ICP enrollees in these areas have their waiver services administered through their health plan to more effectively coordinate and meet the total needs of the participant. During the reporting year, there were nine health plans participating in the ICP, although some began servicing this population at a later date than others. Table 6.2 details the ICP readiness review activities conducted in SFY 2014, as well as the "go live" date for each health plan which indicates when the health plan began accepting enrollment for the ICP.

Table 6.2—ICP SP I and SP II Operational Readiness Reviews

Operational Readiness Reviews Overview				
Program	**Health Plan**	**Date of SP I Review**	**Date of SP II Review**	**Go Live Date**
ICP SP I and SP II	**Humana Health Plan, Inc. (Humana)**	August 14–15, 2013	August 14–15, 2013	March 1, 2014
	Cigna HealthSpring of Illinois (Cigna)	November 18, 2013	August 19–20, 2013	March 1, 2014
	Blue Cross Blue Shield of Illinois (BCBSIL)	November 20, 2013	August 27, 2013	March 1, 2014

Scope of ICP Readiness Review

HSAG conducted a desk review, site visit, and supporting care coordination systems to evaluate if the ICP health plans demonstrated appropriate knowledge of ICP contract requirements and systems preparedness in the following key operational areas:

- Availability of Services
- Assurance of Adequate Capacity and Services

- Coordination and Continuity of Care (Including Transition of Care)
- Coverage and Authorization of Services
- Credentialing and Recredentialing
- Subcontractual Relationships and Delegation
- Enrollee Information/Enrollee Rights
- Confidentiality
- Enrollment and Disenrollment
- Grievance Process
- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information System
- Fraud and Abuse

Pre-Implementation Operational Readiness Review Findings

The information below describes the readiness review summary for each ICP health plan. The background information for each ICP health plan was submitted to HSAG by the health plans in their pre-on-site review documents.

BCBSIL

Blue Cross Blue Shield Illinois (**BCBSIL**), a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, is the largest and most experienced health insurance company in Illinois, providing more than 7 million members with comprehensive and affordable health plans. As a division of HCSC, **BCBSIL** provides its members with a high level of confidence and security by including flexible benefit designs and access to the largest network of hospitals and physicians in the State. **BCBSIL** is committed to the highest standards of business ethics and integrity, and to fulfilling its corporate citizenship responsibilities to the communities served. **BCBSIL** partners with providers and communities to implement new, innovative models of care that improve value and quality of health for Illinois residents.

Findings

HSAG conducted an on-site, pre-implementation readiness review for **BCBSIL** for ICP SP I on August 27, 2013, and SP II on November 20, 2013. Following the pre-implementation readiness reviews, **BCBSIL** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-

implementation status grid were completed and approved prior to accepting ICP–SP I and SP II enrollment in March 2014.

Access Requirements

BCBSIL 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.

BCBSIL's Network Management Department evaluates 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. GeoAccess was used to display distribution of enrollee to PCP through graphs and maps. **BCBSIL** submitted network capacity reports regularly to HSAG.

BCBSIL began working with HSAG in SFY 2014 to begin submission of the provider network data to HSAG. Following receipt of the data, HSAG completes an analysis and validation of the **BCBSIL** provider network capacity and monitors ongoing development of the ICP SP I and SP II provider networks.

Case management policies and procedures were developed by **BCBSIL** to meet waiver-specific requirements. **BCBSIL**'s Case Management Program Description (CMPD) focused on providing coordination of care, benefits, and services through multiple activities and programs designed to promote continuity, remove barriers to care, prevent complications, and improve member quality of life. The CMPD is reviewed annually and is submitted to the corporate QIC and the health plan's QIC for review.

BCBSIL uses an integrated predictive model engine called Thomson Medstat Advantage Suite® predictive modeling to stratify members into severity levels which assist in assigning members to case management. The predictive model process uses the most technologically advanced data mining capabilities by utilizing a population-based risk adjustment methodology Diagnostic Cost Grouper (DCG). The DCG uses an individual's age, gender, diagnostic information, and months of eligibility for a 12-month period. The advanced analytics, offered by Thomson Reuters and MEDecision®, assigns each individual member a health status and a numeric value known as an opportunity score. These classifications are used as a key component in the decision-making to route members into appropriate care management programs. Proprietary algorithms stratify members by risk and severity and assign each member a position along the continuum of care in mutually exclusive hierarchical groups. This allows **BCBSIL** to more efficiently use care management resources by targeting the appropriate members for the most appropriate intervention.

BCBSIL uses the Aerial/Alineo care management system platform for documenting all care management activities. In this system, ICT members have the ability to create and/or manage the records of all their enrollees, including: name, demographic information, provider network, ICT member notes, assessments, plan of care, medications, and claims information from the analytic process. ICT members will have an assigned homepage to house all of their enrollee information. HCSC uses Aerial/Alineo and a Blue Star membership system to capture and track key dates and time frames, including, but not limited to, enrollment, dates of care plan development, authorization, initial delivery of each service, level of care reassessments, updates, and transitions of care. The healthcare management platform, Alineo, automatically generates caseload reports. The reports for each care coordinator or case manager include the number of active cases, closed cases, the number of outreach calls made, the number of comprehensive assessments and care plans completed, and the number of members who achieved their goals.

BCBSIL was in the process of training the HCBS Waiver Care Coordination staff at the time of the SP I and SP II on-site reviews. **BCBSIL** continued to provide updates on the status of staff training following the pre-implementation review. The **BCBSIL** care management/care coordination team training program included HCBS Waiver-required topics that met the requirements as outlined in the contract.

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

After the pre-implementation review, **BCBSIL** was required to follow up on the items below for the access standards:

- Continue development of the provider and HCBS networks requirements of the medical home; for example, assisting providers with self-assessment.
- Continue to work on contracting with SNFist and homebound providers.
- Develop and submit a documented process to track the 90-day completion requirement for environmental adaptations.
- Submit a Hospitalist Program policy and procedure.
- Provide a list of the community mental health centers (CMHCs), federally qualified health centers (FQHCs), and provider practices that have medical home accreditation, including the level of accreditation.

- Continue to update the staffing plan for implementation of SP II, including completing the staffing, qualifications, and training worksheet and begin submission once hiring begins for long-term services and supports (LTSS).
- Develop a methodology for 100 percent oversight audits of the LTSS care coordinators including remediation plans.
- Submit an updated work plan to show progress toward implementation of systems, staffing, and programs.
- Complete and submit the Care Coordination tool kit including contact numbers for reporting critical incidents, and how to obtain the most recent waiver specific pamphlets.
- Develop a process to complete an annual review of the waiver training to ensure any change in waiver requirements are included in the training.
- Submit a copy of the Service Plan form.
- Submit a checklist for the LTSS care coordinators' face-to-face visits.
- Revise the CM program description for caseload requirements for TBI/HIV as 1:30
- Submit screen shots of upgrades to the Alineo healthcare management documentation system.
- Submit an organizational chart that displays care management/care coordination staffing. Include reporting structure and medical director/physician oversight.

Structure and Operations Requirements

BCBSIL 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.

BCBSIL 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 **BCBSIL** Enrollee Handbook described the **BCBSIL** website, member services, the PCP, hospital care, benefits, and special healthcare programs.

Confidentiality policies and procedures described **BCBSIL** processes which were in place to protect enrollee health information. **BCBSIL** had formal processes in place to report incidents regarding abuse, neglect, or exploitation of an enrollee.

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 State fair hearings staff provided training to the health plans on the changes needed to ensure the health plans were in compliance with State, federal, and waiver requirements.

After the pre-implementation review, **BCBSIL** was required to follow up on the items below for the structure and operations standards:

- Revise policy and procedures to include the oversight of delegation as required by HFS contract including quarterly delegation oversight audits and monthly joint operations meetings and regular monitoring of enrollee complaints.
- Complete delegation agreements and submit a copy of each agreement.
- Complete and submit the pre-delegation audits of all delegated entities.
- Develop a policy and work flow diagram on the submission and receipt of CCA's detailed reports of staffing, qualifications, and training of the delegated care coordination staff.
- Submit a policy/protocol that describes reporting from the 24/7 nurse line to care managers and how they are alerted if a member has accessed the 24/7 nurse line.
- Submit evidence of training for customer services staff that includes Illinois specific benefits, and critical incidents and grievances.
- Revise the grievance policy and procedure to remove State Fair Hearings as this process does not apply to grievances.
- Revise the appeals letters to ensure compliance with the HFS templates.

Measurement and Improvement Requirements

BCBSIL had established policies and procedures 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 **BCBSIL** 2013 Quality Improvement Program Description identified the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the 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 health plan's physicians.

BCBSIL has a QI Critical Incident Committee (CIC) responsible for all open critical incident cases. The committee makes recommendations for further follow up, corrective actions, or makes a determination when the case is complete and ready for closure.

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

Claims, credentialing, provider, member, preventive services, authorizations, and case and disease management data are all housed in **BCBSIL**'s health information system.

After the pre-implementation review, **BCBSIL** was required to follow up on the items below for the measurement and improvement standards:

- Continue to update the work plan to include system upgrades/interface—include programming/testing and production schedule in the implementation plan to include the following:
  - Enrollment file
  - Provider directory
  - RSA interface
  - Alineo
  - Critical incidents
  - Grievances
- Develop and submit a method to document training of enrollee family members on critical incidents.
- Submit screen shots of the critical incident database when complete.
- Revise critical incidents policies and procedures to meet the Illinois specific requirements and forward to HFS for review and approval.

Cigna

Cigna-HealthSpring, a subsidiary of Cigna Health and Life Insurance Company, is a Medicare Advantage organization contracted with the Centers for Medicare & Medicaid Services (CMS) to provide healthcare benefits for Medicare and Medicare/Medicaid dual-eligible beneficiaries. Headquartered in Nashville, Tennessee, **Cigna** operates Medicare Advantage, PPO, and Medicare Special Needs Plans for members in Alabama, Arizona, Arkansas, Florida, Delaware, Georgia, Illinois, Maryland, Mississippi, New Jersey, Oklahoma, Pennsylvania, Tennessee, Texas, and the District of Columbia. **Cigna** also contracts with the Texas Health and Human Services Commission to provide healthcare benefits for Medicaid recipients over age 65 and those with disabilities through the Texas STAR+Plus program.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Cigna** for ICP SP I on August 19–20, 2013, and SP II on November 18, 2013. Following the pre-implementation readiness reviews, Community Health Solutions of America (CHS) continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ICP SP I and SP II enrollment in March 2014.

Access Requirements

Cigna 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.

In conjunction with the Quality Improvement Department, **Cigna**'s Provider Services 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. **Cigna** submitted network capacity reports regularly to HSAG.

Cigna began working with HSAG in SFY 2014 to begin submission of the provider network data to HSAG. Following receipt of the data, HSAG completes an analysis and validation of the **Cigna** provider network capacity and monitors ongoing development of the ICP SP I and SP II provider networks.

Case management policies and procedures were developed by **Cigna** to meet Waiver-specific requirements. **Cigna**'s CMPD focused on providing coordination of care, benefits, and services through multiple activities and programs designed to promote continuity, remove barriers to care,

prevent complications, and improve member quality of life. The CMPD is reviewed annually and is submitted to the corporate QIC and the health plan's QIC for review.

Case management uses predictive modeling to stratify members into severity levels which assist in assigning members to case management. The predictive model serves as a repository for reviewing clinical indicators such as inpatient admissions, lab values, and pharmacy usage, either directly from the tool or imbedded in the medical management systems.

Cigna uses CareEnhance, a clinical management McKesson software product, to document all care management/care coordination activities.

Cigna was in the process of training the HCBS Waiver Care Coordination staff at the time of the SP I and SP II on-site reviews. **Cigna** continued to provide updates on the status of staff training following the pre-implementation review. The **Cigna** Care Management/Care Coordination Team training program included HCBS Waiver-required topics that met the requirements as outlined in the contract.

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

After the pre-implementation review, **Cigna** was required to follow up on the items below for the access standards:

- Develop a policy and procedure describing participant access to providers of waiver services including freedom of choice and access to all willing and qualified providers.
- Develop a policy and procedure for determination of need, assessments, and service planning including risk mitigation, physician certifications (currently required), reevaluations, and back-up plans for providers.
- Develop a policy and procedure for assessment and service planning for Supportive Living Facility (SLF) residents.
- Develop a policy and procedure for oversight and monitoring of content and timeliness of assessments and service plans.
- Documentation of staff training for SP II care coordination requirements including use of the determination of need and risk assessments in developing the service plan.
- Develop a staffing plan for implementation of SP II and complete the staffing, qualifications, and training worksheet and begin submission once hiring begins for LTSS.

- Develop an organizational chart to display a staffing plan for SP I, SP II, and MMAI.
- Submit an updated work plan post implementation review to show progress toward implementation of systems, staffing, and programs.

Structure and Operations Requirements

Cigna 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.

Cigna 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 **Cigna** Enrollee Handbook described the **Cigna** website, member services, the PCP, hospital care, benefits, and special healthcare programs.

Confidentiality policies and procedures described **Cigna**'s processes which were in place to protect enrollee health information. **Cigna** had formal processes in place to report incidents regarding abuse, neglect, or exploitation of an enrollee.

The **Cigna** UM subcommittee was responsible for the oversight of enrollee appeals and grievances. Training was provided during employee orientation, and on an ongoing 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 State fair hearings staff provided training to the health plans on the changes needed to ensure the health plans were in compliance with State, federal, and waiver requirements.

After the pre-implementation review, **Cigna** was required to follow up on the items below for the structure and operations standards:

- Develop a policy and procedure for use of service cost maximum in the service authorization process.
- Develop a policy and procedure for waiver service authorizations to ensure services are covered during the transition of care period.
- Develop a policy and procedure describing ICP health plan staff member qualifications to meet the care coordinator/case manager qualifications for waiver programs.

- Develop a policy and procedure describing oversight and monitoring of delegated entities providing care coordination to ensure compliance with assessment and service planning requirements including the following:
  - Risk assessments and risk mitigation
  - Physician certifications
  - Reevaluations
  - Member signatures on service plans and freedom of choice documents
- Description/policy and procedure of the planned, ongoing oversight and monitoring of delegated entities to occur during the transition and implementation of SP II.
- Documentation of training provided to prepare members services/call center staff with handling questions regarding waiver services including copies of training materials.
- Policy and procedure describing personal assistance forms and the personal assistant handbook.
- Sample copies of the personal assistance forms and personal assistant handbook.
- Policy and procedure describing the distribution of the Resident Rights brochure to SLF residents.
- Submit grievance and appeals policies and procedures.
- Submit health and safety monitoring policies and procedures.
- Obtain approval for all policies and procedures and template letters for grievances and appeals from HFS.
- Submit training documentation on Illinois-specific grievance requirements.

Measurement and Improvement Requirements

Cigna had established policies and procedures 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 **Cigna** 2013 Quality Improvement Program Description identified the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the 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 health plan's physicians.

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

Claims, credentialing, provider, member, preventive services, authorizations, and case and disease management data are all housed in **Cigna**'s TriZetto–QNXT health information system.

After the pre-implementation review, **Cigna** was required to follow up on the items below for the measurement and improvement standards:

- Describe committees responsible for oversight and monitoring of the implementation of the waiver services and waiver program requirements.
- Revise the quality program description to include oversight and monitoring of the requirements for SP II.
- Submit a description of the tracking system for unusual incident report handling including intake, investigation, resolution, and reporting.
- Description of system indicator, identifier, or "flag" used to identify waiver service providers.
- Description of system indicator, identifier, or "flag" used to identify waiver participants.
- Description of review of payment logic affiliated with waiver services codes, location codes, and provider type codes.

Humana

Humana is a leading healthcare company that offers a wide range of insurance products and health and wellness services that incorporate an integrated and holistic approach to lifelong well-being. The company provides its health plan members quality, affordable care combined with a positive consumer experience. **Humana**'s strategy is an integrated care delivery model, which is designed to seamlessly unite quality care and high member engagement, enabled by sophisticated data analytics. The model puts primary care providers at the center, providing and coordinating care that is consistent, integrated, cost-effective, and member-focused. Through aligned incentives and real-time, actionable information, the model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering **Humana** members a simple, seamless healthcare experience. **Humana**'s diverse lines of business position the company well to serve many types of consumers. Our 12 million medical plan members and eight million specialty product members include Medicare-eligible seniors, Medicaid-eligible beneficiaries, active duty and retired military, employer groups, individual consumers, and self-insured employers.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Humana** for ICP SP I and SP II on August 14-15, 2013. Following the pre-implementation readiness reviews, **Humana** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ICP SP I and SP II enrollment in March 2014.

Access Requirements

Humana 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 ICP contract requirements for access standards.

Humana began working with HSAG in SFY 2014 to begin submission of the provider network data to HSAG. Following receipt of the data, HSAG completes an analysis and validation of the **Humana** provider network capacity and monitors ongoing development of the ICP SP I and SP II provider networks.

Care management policies and procedures were developed by **Humana** to meet Waiver-specific requirements. **Humana**'s CMPD focused on providing coordination of care, benefits, and services through multiple activities and programs designed to promote continuity, remove barriers to care, prevent complications, and improve member quality of life. The CMPD is reviewed annually by the corporate QIC and the health plan's QIC.

Case management uses predictive modeling to stratify members into severity levels which assist in assigning members to case management. **Humana** applies its proprietary predictive model, the Claims-Based Algorithm (CBA), to the membership data file initially and on a monthly basis to determine the risk level of each ICP enrollee.

Humana uses Clinical Guidance Exchange (CGX), a web-based application that links **Humana**'s care management and health planning support programs. CGX is a clinical tool designed to share member information and transfer data to appropriate departments to facilitate referrals and expedite decisions.

Humana was in the process of training the HCBS Waiver Care Coordination staff at the time of the SP I and SP II on-site reviews. **Humana** continued to provide updates on the status of staff training following the pre-implementation review. The **Humana** care management/care coordination team training program included HCBS Waiver-required topics that met the requirements as outlined in the contract.

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

After the pre-implementation review, **Humana** was required to follow up on the items below for the access standards:

- Complete the provider directory. Update the directory to include additional cultural competency detail including handicap accessible, impaired hearing, transportation, access to public transport, and languages spoken by providers.
- Develop and submit a methodology for 100 percent oversight audits of the LTSS care coordinators including remediation plans. Specifically, identify the oversight process for the care coordinators from the subcontractors.
- Update the staffing plan to include SP I, SP II, and MMAI.
- Submit an updated work plan following the pre-implementation review to show progress toward implementation of systems, staffing, and programs.
- Submit a copy of the methodology used for predictive modeling (claims-based algorithm).

Structure and Operations Requirements

Humana 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.

Humana 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. **Humana**'s Enrollee Handbook described the **Humana** website, member services, the PCP, hospital care, benefits, and special healthcare programs.

Confidentiality policies and procedures described **Humana**'s processes which were in place to protect enrollee health information. **Humana** had formal processes in place to report incidents regarding abuse, neglect, or exploitation of an enrollee.

Humana delegates behavioral health services to Beacon Health Strategies (Beacon). Beacon is contracted to conduct credentialing/recredentialing, utilization review (UR), and UM activities for the health plan. Review of documentation provided by **Humana** demonstrated oversight of the delegated vendor; however, **Humana** is required to incorporate the Illinois-specific contract oversight requirements into the delegation oversight process.

The **Humana** QIC was responsible for the oversight of the delegate and its delegated activities and reporting. The Beacon Quality Improvement Council reports into the QIC.

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 State fair hearings staff provided training to the health plans on the changes needed to ensure the health plans were in compliance with State, federal, and waiver requirements.

After the pre-implementation review, **Humana** was required to follow up on the items below for the structure and operations standards:

- Implement a process to meet the delegation oversight process for delegated vendors to include the following:
  - Quarterly delegation oversight audits
  - Monthly joint operations meetings
  - Regular monitoring of enrollee complaints
- Obtain approval for the draft member handbook and LTSS insert from HFS.
- Submit evidence of training for Member Services staff to include these topics:

  - Illinois-specific Benefits
  - Cultural Competency
  - Health and Safety Monitoring (Critical Incidents)
  - Grievances and Appeals
- Obtain approval for all policies and procedures and template letters for grievances and appeals from HFS.
- Submit evidence of training for Illinois-specific grievance requirements.
- Revise the expedited appeals policy and procedure to include the required response time of 24 hours from the receipt of information.
- Forward the training module for provider health and safety monitoring once complete.

Measurement and Improvement Requirements

Humana had established policies and procedures 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.

Humana developed an addendum to the Corporate QI Program Description to include the requirements for the ICP. The QI Program Description identified the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the QI program, purpose of the program, goals and objectives, scope of activities, committee structures and reporting, and responsibilities of the quality management department. The **Humana** internal board/executive committee had ultimate responsibility for oversight of quality improvement activities. The committee structure demonstrated participation by the health plan's physicians.

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

After the pre-implementation review, **Humana** was required to submit an implementation work plan that demonstrates the schedule for all IT programming, testing, and implementation of systems.

Ongoing Monitoring

Upon completion of the on-site activities, all deficiencies from the desk review and site visits were identified, and the ICP health plans were required to remedy each deficiency prior to program implementation. HSAG and HFS used a standardized monitoring tool to document follow-up on any elements that required remediation and monitored corrective actions until successfully

completed to ensure ongoing compliance with contract requirements, quality oversight, and monitoring.

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

MMAI Program Readiness Reviews

In March 2014, voluntary enrollment began for the MMAI Program. Eight health plans were selected to serve clients in the MMAI program serving five counties in the greater Chicago area and 15 counties in Central Illinois. This program was a result of a three-way contract between HFS, CMS, and health plans, and it impacts those who are dually eligible for full Medicaid and Medicare benefits. MMAI readiness reviews were conducted for the following eight health plans: **Aetna Better Health**, **Blue Cross Blue Shield of Illinois**, **Humana HealthSpring**, **Health Alliance Connect, Inc.**, **Humana Health Plan, Inc.**, **IlliniCare Health Plan, Inc.**, **Meridian Health Plan, Inc.**, and **Molina Healthcare of Illinois, Inc.**

Scope of the CMS MMAI Program Readiness Review

Under contract with the Medicare-Medicaid Coordination Office (MMCO) within the CMS, NORC at the University of Chicago (NORC) assisted HFS and MMCO in assessing the readiness of each health plan to participate in the Illinois MMAI Program.

NORC led the desk review, site visit, and systems testing, as well as pre-enrollment portions of the readiness review. The purpose of the review was to determine it if the MMAI health plans had the appropriate knowledge of Demonstration requirements and systems preparedness. NORC worked with CMS and HFS to develop a state-specific readiness review tool that contained functional areas and criteria within each functional area that health plans were required to meet. Plans were asked to submit documents to be reviewed as part of the desk review as well as documents to rectify outstanding deficiencies identified through the Medicare Capitated Financial Alignment Demonstration application process, if applicable. The NORC team then reviewed documentation submitted by the health plans in response to state-specific readiness review criteria, assessed compliance in conjunction with the MMCO to address outstanding deficiencies identified through the application process (if applicable), and assessed whether the deficiency had been corrected. The NORC team also reviewed the health plan's systems implementation project plans to assess readiness for systems testing during the site visit.

Two teams participated in each site visit: one team interviewed health plan staff about key operational areas; the other reviewed the health plan's systems and systems-related functions,

including key health plan and First Tier, Downstream, and Related Entities staff responsible for these operations. The health plan was also asked to describe functional areas using a comprehensive care coordination systems testing scenario.

Upon completion of the on-site activities, NORC submitted draft deficiency reports to CMS that included all remaining deficiencies from the desk review and notified health plans of identified deficiencies and the steps required to remedy each deficiency. The health plans had 25 calendar days to correct identified deficiencies, after which time NORC reviewed the resubmitted and supplemental materials to determine any remaining deficiencies.

For network validations, health plans were asked to submit Medicare facility and provider health services delivery (HSD) tables, and HFS Medicaid provider network tables. CMS and HFS analyzed the submitted tables, and NORC pulled a random sample of providers or facilities from each table. NORC also pulled a sample from each health plan's pharmacy network from its Health Plan Management System (HPMS) submission. Results of CMS' and HFS' reviews, as well as NORC's signature page review and contract verification phone calls for Medicare providers, facilities, and pharmacies were sent to each health plan. If a health plan had missing or unsigned signature pages, the health plan was asked to either resubmit these pages or to submit a cover memorandum stating that the given provider/facility/pharmacy had been removed from the health plan's network table. Additionally, health plans with signature page deficiencies were asked to submit new, additional provider/facility/pharmacy signature pages to further ensure the health plan had an adequate network in place.

The intent of the pre-enrollment validation process is to confirm that policies and procedures that were reviewed during the desk review or that were discussed as part of the site visit were being operationalized prior to health plan marketing. This included making sure that staff were being hired in accordance with staffing plans, staff were being trained on the topics required by the Demonstration prior to marketing, and key scripts contained accurate and sufficient information. This portion of the review process also provided health plans a final opportunity to submit corrected documentation to meet the desk review criteria.

HSAG collaborated with CMS and HFS to assist with the MMAI readiness reviews by exchanging health plan-specific care management/care coordination staffing and training information and conducting validation of certain aspects of the MMAI provider network as described below.

HCBS Provider Analysis

HSAG conducted a review of the MMAI HCBS provider network using the list of required services described in the contract. In addition, HSAG completed an analysis of the network based on the following HCBS contract standard:

> For Providers of each of the following Covered Services under a HCBS Waiver, ICPs must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participants in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the Participants, unless the Department grants ICP an exception.[6-1]

The analysis or the provider network included the following HCBS service providers:

- Adult Day Care
- Homemaker/In-Home Services
- Day Habilitation
- Home-delivered Meals
- Home Health Aides
- Nursing Services
- Occupational Therapy
- Speech Therapy
- Physical Therapy

To conduct these analyses, HSAG worked with HFS to obtain sufficient data to calculate the minimum required access standard. In the absence of health plan-specific utilization data, HSAG conducted and analyzed the historical FFS utilization for the HCBS providers. HSAG de-duplicated the utilization file to identify the number of each type of HCBS service provider by county and then compared the number of contracted HCBS providers for each health plan by county. HSAG provided eight samples of MMAI HCBS provider files to CMS for validation surveys.

Skilled Nursing Facility (SNF) Analysis

Using Quest Analytics software, HSAG evaluated the network standard for each MMAI health plan of two SNFs within 15 miles. Quest Analytics software takes the duration of travel time or physical distance between members enrolled in the HCBS Waiver program and the addresses of the nearest SNF and compares them to the required access standard. Members with addresses outside the State were not included in the calculation of the percentage of members within the

[6-1] State of Illinois. Furnishing Health Services in an Integrated Care Program by a Managed Care Organization. Contract No. 2013-24-004.

time/distance standards. However, providers in adjoining states were included in the analyses. HSAG used the percentage of members who are within a certain time/distance standard of their nearest providers to determine a health plan's level of compliance with CMS requirements. To conduct these analyses, HSAG used the health plan's provider files along with HFS-prepared, estimated enrollment files. HSAG provided eight time/distance analyses of SNFs and behavioral health providers for the MMAI Program contracted health plans.

Behavioral Health Provider Analysis

Using Quest Analytics software, HSAG evaluated the network standard for contracted MMAI BH providers of 30 miles/30 minutes (urban) or 60 miles/60 minutes (rural) for each health plan. Quest Analytics software takes the duration of travel time or physical distance between members enrolled in the HCBS Waiver program and the addresses of the nearest BH provider and compares them to the contract access standard. Members with addresses outside the State were not included in the calculation of the percentage of members within the time/distance standards. However, providers in adjoining states were included in the analyses. HSAG used the percentage of members who are within a certain time/distance standard of their nearest providers to determine the level of compliance with State requirements. To conduct these analyses, HSAG used the health plan-specific provider files along with HFS-prepared, estimated enrollment files.

Additional Provider Analysis

In addition, HSAG analyzed the total number of PCPs, specialists, hospitals, and long-term acute care (LTAC) facilities in the network of each health plan serving MMAI Program members.

CCE Readiness Reviews

HFS awarded six provider groups contracts to become part of the Illinois Care Coordination Innovations Project. The provider groups chosen formed CCEs to coordinate and deliver services to seniors and adults as well as children with complex conditions using holistic, cost-efficient approaches. The primary objective of HSAG's readiness reviews was to evaluate implementation by the CCEs of their care coordination programs and readiness to provide services. Table 6.3 details the CCE readiness review activities conducted in SFY 2014, as well as the "go live" date for each CCE which indicates when the CCE began accepting enrollment for the CCE program..

Table 6.3—CCE Operational Readiness Reviews

Operational Readiness Reviews			
Program	**CCEs**	**Date of Review**	**Go Live Date**
CCE	Together4Health (T4H)	July 8–9, 2013	December 1, 2013
	Be Well Partners in Health (Be Well)	July 11–12, 2013	February 1, 2014
	Lurie Children's Hospital of Chicago CCE (Lurie)	April 28–29, 2014	September 8, 2014
	NextLevel Health (NextLevel)	May 29–30, 2014	July 25, 2014
	Order of St. Francis (OSF) HealthCare System	June 12–13, 2014	None*
	La Rabida Children's Hospital (La Rabida)	July 8–9, 2014	September 8, 2014

*OSF opted out of participation in the CCE program prior to implementation.

Scope of CCE Readiness Reviews

HSAG conducted a desk review, site visit, and supporting care coordination systems review to evaluate if the CCEs demonstrated appropriate knowledge of CCE contract requirements and systems preparedness in the following key operational areas:

- Governance Structure, Scope of Collaboration, and Leadership
- Populations and Providers
- Care Coordination Model
- Health Information Technology (HIT)
- Critical Incidents and Grievances

Due to the expedited implementation time frame of this program, the pre-implementation review was conducted prior to the execution of the CCE contracts with HFS.

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 CCEs were

required to submit thorough documentation in the operational areas listed above. 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, utilization, 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.

Pre-Implementation Operational Readiness Review Findings

The information below is a summary of the readiness review activities for the CCE program implementation. The background information for CCE was submitted to HSAG by the CCEs in their pre-on-site review documents.

Together4Health (T4H)

The mission of **T4H** is to be a regional community health home safety network that supports vulnerable people, including those living with chronic and multiple medical, mental health, and substance use conditions, those living in poverty, those experiencing homelessness, those who are unemployed and underemployed, and those with limited access to services due to cultural or language barriers. **T4H** is committed to going outside its walls to find and link the people it serves to a full range of services that improve and support the health of the overall community.

Findings

HSAG conducted an on-site pre-implementation readiness review for **T4H** on July 8–9, 2013. Following the pre-implementation readiness reviews, **T4H** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting CCE enrollment in December 1, 2013.

Governance Structure, Scope of Collaboration, and Leadership

T4H had an operating agreement in place that described the ways in which the Board of Management (BOM) would be accountable to members of **T4H** and authorize the contract with **T4H**'s management company, Heartland Health Outreach, Inc. (HHO), and monitor its performance.

For Governance requirements, **T4H** was required to follow up on the below items after the pre-implementation review.

- Execute the draft **T4H** CCE Network Participation Agreement upon contract signature with HFS.
- Complete the business associate agreements with each of the CCE partners.
- Finalize the **T4H** organizational chart.
- Finalize the structure of the **T4H** community health home hubs.

Populations and Providers

The population that **T4H** CCE will serve includes seniors with disabilities, including those with serious mental illness.

The **T4H** 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.

For the Population and Providers requirements, **T4H** was required to develop methods to ensure the adequacy of the provider network to meet the medical/specialty/and ancillary needs of members.

Care Coordination Model

T4H's care coordination model is designed to coordinate an enrollee's primary, acute, and chronic physical health services; mental healthcare and substance use treatment; and long-term community-based services and supports. The care model is designed to care for those participants who are most vulnerable with complex and chronic physical, mental, and social conditions that

lead to poor health and well-being. Each care coordination team includes a community health worker, nurse care coordinator, and mental health care coordinator, organized by regional hubs (North, West, and South). Each hub is supported by a care coordination assistant. The team will be supervised by hub managers with leadership and supervision from the program director and oversight by the medical director.

After the pre-implementation review, **T4H** was required to follow up on the below items for the Care Coordination Model:

- Complete revisions and development of the Quality Management Plan following implementation of the CCE.
- Revise the Care Coordination Model program description and policies and procedures to include all requirements of the CCE program requirements.
- Revise the care coordination staff training program to include the requirements of the CCE care coordination model of care.
- Develop policies and procedures for the Coordinated Care Team (CCT) oversight and communication to include:
  - Ongoing communication and oversight of the CCT including physician (medical and behavioral) oversight and the director of care coordination.
- Develop a testing, implementation, and training work plan for the care coordination system.

Health Information Technology

At the time of the on-site pre-implementation review, **T4H** was in the process of selecting a care coordination system. **T4H** had released an RFP to selected vendors and discussed plans to select a system in summer 2013, implementation in third and fourth quarter 2013, and go live in first quarter 2014. **T4H** described establishing a system capable of data analytics providing support for clinical decision support, quality reporting, care coordination, and business intelligence. **T4H** provided draft content for the proposed member website.

After the pre-implementation review, **T4H** was required to follow up on the below items for the HIT requirements:

- Ensure all partners are registered for the Illinois Health Information Exchange (ILHIE) Direct Secure Messaging software.
- Establish ongoing communication with HFS to obtain encounter data to assist with reporting and outcome data.
- Continue to work on strategies to develop performance measure data reporting capabilities.

Be Well Partners in Health (Be Well)

Be Well originated in 2009 when MADO Healthcare began speaking with Neumann Family Associates about moving clients from residential care (MADO) to community-based group homes (Neumann). The purpose of this collaboration was to support persons who were able to transition from a larger Intermediate Care Facility (ICF) to a smaller living situation. Methodist Hospital of Chicago has been connected to Neumann since 2002 when the hospital developed a small inpatient unit designed to meet the needs of developmentally disabled clients who lived in group homes (community integrated living arrangement [CILA]), who were mentally ill, and who required short-term hospitalization for symptom management. Neumann's Medical Director, Robert Jespersen, is also the medical director of this unit and is one of the two **Be Well** medical directors. Sharon Sidell, the CCE's executive director, has been the administrative director of the Behavioral Medicine Department at Methodist since 1999 and developed the Behavioral Medicine Department at Norwegian American Hospital in 2006. These two safety-net hospitals cater exclusively to the seriously mentally ill population.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Be Well** on July 11–12, 2013. Following the pre-implementation readiness reviews, **Be Well** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting CCE enrollment in February 2014.

Governance Structure, Scope of Collaboration, and Leadership

Be Well is governed by a Board of Directors comprised of two members of each of the four partnering organizations. Theresa Garate, president and CEO of Neumann Family Services, is the ongoing Board liaison to the executive director. **Be Well** is in the process of forming a Medical Advisory Board, a Professional Advisory Board, and a Consumer Advisory Board. The senior staff includes the executive director, utilization review/quality assurance specialist (Century PHO), clinical director, engagement and enrollment specialist, finance specialist and training/evaluation specialist.

The **Be Well** partner organizations were identified as MADO Healthcare, Bethany Homes/Methodist Hospital, Norwegian American Hospital, and Neumann Family Services. The **Be Well** Board of Directors is comprised of two members of each partner organization. The Board voted to offer the executive director position to Sharon Sidell, PhD (who was representing Methodist Hospital).

After the pre-implementation review, **Be Well** was required to follow up on the items below for governance:

- Finalize the structure, roles, and responsibilities of the Medical Advisory Board, Professional Advisory Board, and the Consumer Advisory Board.
- Complete revisions and development of the Quality Management Plan following implementation of the CCE.
- Develop a description of recruitment, meeting frequency, and membership for the Consumer Advisory Board.

Populations and Providers

Be Well's primary focus for enrollment is the serious mental illness (SMI) population, with an initial focus on engagement of individuals involved with partner organizations and those attributed and auto-assigned to **Be Well** by HFS.

Providers in the **Be Well** network were in one of the following categories: hospitals, FQHCs, individual providers, residential partners, in-network residential, associate providers, and service/supply vendors.

For the Populations and Providers requirements, **Be Well** was required to follow up on the items below after the pre-implementation review.

- Identify the internal process for loading the proprietary file and tracking membership for the CCE program.
- Identify an internal process to identify and report members who are health home-eligible.
- Continue to update the stationary and mobile health home locations.

Care Coordination Model

The **Be Well** care model is designed to assist members and families to self-manage their health conditions and related psychosocial problems more effectively, coordinate care among multiple health and community providers, bridge gaps in care, and ensure that members receive the appropriate level of care. The care model is provided by a collaborative team (nurse, social worker, or professional counselor, advocate) with the member/family, the member's PCP/psychiatrist, and other health and community providers involved in the member's care.

After the pre-implementation review, **Be Well** was required to follow up on the items below for the Care Coordination Model requirements:

- Revise the training program for the CCT to ensure all elements of the care coordination model of care are included.
- Revise the Care Coordination Model program description and policies and procedures to include all requirements of the CCE program requirements.

- Develop policies and procedures for CCT oversight and communication.

Health Information Technology

At the time of the on-site pre-implementation readiness review, **Be Well** was in the process of contracting with Streamline Healthcare Solutions for the SmartCare package, which is a CCE electronic record and can also be used as an electronic medical record (EMR) database.

After the pre-implementation review, **Be Well** was required to follow up on the items below for the HIT requirements:

- Develop a testing, implementation, and training work plan for the Streamline and SmartCare programs.
- Obtain HFS approval for use of the SmartCare Web messaging software. Schedule a demonstration of the SmartCare Web software for HFS.
- Establish a process for implementation of the ILHIE Web messaging software as an interim step prior to implementation of the SmartCare Web messaging software.

Lurie Children's Hospital of Chicago CCE (Lurie)

The Ann & Robert H. Lurie Children's Hospital of Chicago is uniquely qualified to serve as the lead entity for this CCE. Lurie Children's is the largest provider of pediatric Medicaid services in Illinois and one of the largest providers of pediatric subspecialty care in the United States. The CCE engages new primary care, mental health, dental, and social support partners. To deepen the capacity to serve children and adolescents with medical complexity, the CCE also engages a care coordination firm who works to link together the wide range of services, to reduce redundancies and delays in care, and to provide ongoing support and education to the children and families served by the **Lurie** CCE. The model is supported by a care coordination fee and a shared savings model with the State, with important built-in incentives for the PCPs and a results-oriented focus for distributing shared savings to CCE collaborators. The **Lurie** CCE specifically tailors care coordination efforts and staffing based on what the data have indicated for the target population, which suggests four care coordination tracks:

- Track 1: Complex, Co-Occurring Mental Health Diagnosis
- Track 2: Primary Developmental Condition Diagnosis
- Track 3: Complex, LOW Service Use
- Track 4: Complex, HIGH Service Use

Care coordination services are delivered to children and their families under a contract with CHS. CHS is experienced in developing and managing medical home networks for state Medicaid programs, with a special focus on dual-eligible populations and children with medically complex needs. CHS is based in Florida and currently operates in five states. CHS has created state-of-the-art care coordination software, called Consensus, which will be part of the IT integration process for **Lurie**.

Findings

HSAG conducted an on-site pre-implementation readiness review for **Lurie** on April 28–29, 2014. Following the pre-implementation readiness reviews, **Lurie** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting CCE enrollment in September 2014.

Governance Structure, Scope of Collaboration, and Leaders

The **Lurie** Children's Health Partners Care Coordination, LLC (LCHPCC) Advisory Board and Committees agreement described the governance and structure of the CCE. Children's Hospital of Chicago Medical Center was described as the sole member of LCHPCC and as such will provide the overall governance for LCHPCC and will take or approve any and all necessary actions on

behalf of LCHPCC, including but not limited to committing LCHPCC to contractual relationships and financial commitments. LCHPCC is led by its executive director and medical director who are responsible for the LCHPCC.

After the pre-implementation review, **Lurie** was required to follow up on the items below for the Governance requirements:

- Finalize and execute the operating agreements between Lurie Children's Health Partners Care Coordination, LLC (LCHPCC) and partner organizations following signature of the HFS contract.
- Continue execution of the business associates agreements (BAAs). Submit a copy of the agreements to HFS/HSAG when complete.

Populations and Providers

Lurie Children's Hospital's employed providers (primary care providers, behavioral health providers, pediatric subspecialists, pediatric dentists, and a hospital) will comprise the provider network for the CCE. In addition, **Lurie** has engaged a wide array of additional hospitals, primary care providers, community-based mental health providers, and social service providers to participate as partners.

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

- Submit the final Network Provider Development and Management Plan once the HFS contract is signed.
- Continue development of the delegation agreement and responsibilities of the delegate and oversight by LCHPCC. Include the following requirements in the agreement:
  - Fraud, abuse, and waste reporting—vendor notification of LCHPCC of all fraud, waste, and abuse reports, who in turn will notify HFS.
  - Critical incident reporting—include notification of LCHPCC and HFS.
  - Define meeting frequency between LCHPCC and CHS to review delegated activities.

Care Coordination Model

The Lurie Care Coordination Program was developed to encompass elements of traditional disease management and case management programs and included assessment, planning, facilitation, education, and advocacy for resources and services to meet the member's needs, goals, and preferences. The Care Coordination Program recognized: (1) the need for a high level of member engagement; (2) that socioeconomic stressors identification and mitigation is an essential foundation for change; and (3) that the coordination process must involve collaboration between the member, key providers, community-based resources, the care coordinator, and other

stakeholders identified by the member. Care coordination core processes included assessment, planning, facilitation and advocacy, monitoring, and modification to meet an individual's needs.

The Lurie Children's Health Partners' model for care coordination for children with complex medical needs is built on the Wagner Chronic Care Model. This model has been shown to be effective in the delivery and coordination of care for children with complex medical needs. The effectiveness of the model rests on three major elements, which are all built into Lurie Children's Health Partners: (1) informed, activated patients, (2) prepared, proactive practice team, and (3) well-integrated services.

Lurie had a subcontract with CHS to conduct all care coordination activities. HSAG reviewed the subcontract with CHS and the oversight and monitoring **Lurie** had in place to monitor performance of the subcontractor.

After the pre-implementation review, **Lurie** was required to follow up on the items below for the Care Coordination Model requirements:

- Continue to develop the performance metrics LCHPCC will use to evaluate effectiveness of the Care Coordination Model. Include the selected metrics in the quality program description and Care Coordination Model program description.
- Develop a process work flow that clearly demonstrates LCHPCC oversight of the delegate CHS, including frequency of operational meetings.
- Submit the Care Coordination Model staff training program.
- Continue development of the LCHPCC/CHS Care Coordination Model and submit updates when changes are made to the model.

Health Information Technology

At the time of the readiness review, **Lurie** was working on access rights to Epic, the EMR software used by Lurie Children's hospital, for the subcontractor CHS to document care coordination activities.

After the pre-implementation review, **Lurie** was required to follow up on the items below for the HIT requirements:

- Continue development of connectivity between the Concensus system and the FQHCs, and update the implementation timeline with progress of development.
- Develop a schematic that demonstrates the data flow of the enrollment file from CHS to LCHPCC. Include processing of the care coordination claims data (CCCD) file in the data flow.

- LCHPCC and CHS will continue development of the provider management system (ECHO). Include development and testing of the system in the implementation timeline and forward a link to the portal site when operational.

NextLevel Health (NextLevel)

In the spirit of collaboration and to effectively manage the health and wellness of enrollees on the West Side and Southwest Side of Chicago, NextLevel Health Partners (NLHP) and the Illinois Coordinated Care Partnership (ICCP) have joined together to achieve a professionally managed and fully integrated health delivery network. By fostering strong partnerships, redefining care workflows, and adopting a holistic approach to the management of health needs, the joint venture will provide an invaluable opportunity to bring together best-in-class practices and models to coordinate care for vulnerable individuals living within chronically underserved communities, namely seniors and persons with disabilities (SPD) on the West Side and Southwest Side of Chicago.

Findings

HSAG conducted an on-site pre-implementation readiness review for **NextLevel** on May 29–30, 2014. Following the pre-implementation readiness reviews, **NextLevel** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting CCE enrollment in July 2014.

Governance Structure, Scope of Collaboration, and Leaders

NextLevel described that the Board of Directors will guide the overall direction and strategy for **NextLevel** health plan. At the time of the readiness review **NextLevel** was in the process of finalizing the business and collaborator agreements with its partners. The governance structure overview described the role, function and composition of the Board of Directors.

After the pre-implementation review, **NextLevel** was required to follow up on the items below for the Governance requirements:

- Finalize and execute the business agreements between **NextLevel** and the partner organizations following signature of the HFS contract.
- Finalize the business agreement, collaborator agreement, and the business associate agreements.

Populations and Providers

The proposed priority populations (i.e., members) to be served by **NextLevel** include: (1) ACA adults; and (2) SPD, including but not limited to those receiving LTSS waiver services, those living in long-term care facilities, as well as those with SMI. **NextLevel** will cover the geographical areas

of the West Side and Southwest Side of Chicago and will service members over a span of 16 Chicago area ZIP codes: 60607, 60608, 60609, 60612, 60616, 60622, 60623, 60624, 60629, 60632, 60638, 60639, 60644, 60647, 60651, and 60652.

After the pre-implementation review, **NextLevel** was required to follow up on the items below for the Populations and Providers requirements:

- Develop a policy and procedure that describes how **NextLevel** will monitor the provider network as described in Section 5.2.3 of the HFS contract.
- Develop methods to monitor access to behavioral health and substance abuse providers.
- Develop a training plan for informing all providers about the CCE model of care.

Care Coordination Model

NextLevel's care coordination model is designed to provide care coordination services across the continuum of care through a community-based approach to improve health outcomes of the members and serve as the members' health home. Designed around the needs of the priority population to be served, **NextLevel**'s approach facilitates the delivery of coordinated, integrated, and co-located health services to meet the medical/physical, behavioral, functional, and social services needed by this vulnerable population. **NextLevel** defines "care coordination" as a "Member-centered, assessment-based interdisciplinary approach integrating healthcare and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care." **NextLevel** augments the role of the primary care provider with an interdisciplinary care approach via an ICT to improve the health and quality of life for members with complex health conditions through advocacy, encouraging self-management techniques where appropriate, and empowering through education to improve the members' understanding of their condition(s).

After the pre-implementation review, **NextLevel** was required to follow up on the items below for the Care Coordination Model requirements:

- Revise the Care Model program description to include all CCE contract requirements.
- Submit a copy of the Care Coordination Model training for the provider sites.
- Submit a training outline for the ICT on the Virtual Health software.
- Develop and submit a policy that clearly describes the oversight and monitoring of the timelines for completion of the HRS, HRA, and enrollee care plans. Add to HRA, HRS Enrollee Care Plan policy and procedure.
- Submit a copy of the training curriculum for the ICT.

Health Information Technology

NextLevel Health has established a strategic partnership with Virtual Health®, an advanced, cloud-based patient engagement and population management platform supporting a range of customizable care and analytic functionalities. The Virtual Health platform positions **NextLevel** to amplify care coordination efforts through a cloud-based technology platform, thus empowering a provider with point-of-care mobility to send and receive near-real-time information and updates regarding the member's health needs and status, facilitating the appropriate care decisions among the care team. Virtual Health® provides a feature-rich platform base which allows providers of all types, members and members' families, caregivers, and/or authorized representatives to log in to the system and view pertinent, protected information relevant to them.

After the pre-implementation review, **NextLevel** was required to follow up on the items below for the HIT requirements:

- Develop and submit a contingency plan if **NextLevel** does not have the Virtual Health® software installed and operating prior to accepting enrollment.
- Continue development of connectivity between Virtual Health® and Evolve software to enhance integration of medical and behavioral health.
- Continue development of connectivity for sharing of real-time ED and inpatient admissions between the hospitals and provider sites.

Order of St. Francis (OSF) Healthcare System

OSF HealthCare System (OSF) is redesigning its clinical care model to improve the "Triple Aim" for all patients. The goal is to transform how care is delivered throughout the entire continuum of care to provide high-quality, patient-centric care that better meets the needs of patients. **OSF** believes that all persons entrusted to its care should be cared for in a team-based, patient-centric medical home environment. **OSF** has 51 NCQA-recognized level 3 medical homes. All **OSF** care managers are trained using the Johns Hopkins Guided Care course and receive internal onboarding, mentoring, continuing education, and peer-to-peer support. The **OSF** commitment to transforming care and providing coordinated care extends beyond primary care and includes dedicated care coordination in selected specialty care, skilled nursing facilities, and acute care facilities. **OSF** is building a coordinated network of longitudinal care managers and episodic case managers, each an expert within their domains, interconnected into a structured, comprehensive network. This will support the patients as they move to and from physician practices; acute care facilities; and home health, hospice, and/or palliative care services. This collaboration between care managers and other case/care managers within the system ensures proactive navigation and smooth transitions to improve the health of patients and populations, enhance the patient experience, and help reduce the total cost of care. Care managers are embedded in **OSF** practices and supported by a centralized structure which will maintain expertise in social services, behavioral health, and transportation. Care managers collaborate with the child, family, and provider to develop care plans in a standardized manner to include patient and family goals, preferences, barriers, depression screening, unaddressed social needs, and follow-up plans. These care plans are given to the patient and family to carry with them, are sent to the PCP, and are widely available at all points of care throughout **OSF** within the Epic electronic health record (EHR).

Findings

HSAG conducted an on-site pre-implementation readiness review for **OSF** on June 12–13, 2014. Following the pre-implementation readiness reviews, **OSF** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. **OSF** chose not to participate in the CCE program following the initial readiness review.

Governance Structure, Scope of Collaboration, and Leaders

OSF, acting in the capacity of a CCE for Children with Complex Medical Needs (CCMN), had several documents in place that described the CCE's governance structure. **OSF** maintained an organizational chart for the CCE and included a description regarding the role of the lead entity, key affiliates, and other system partners in their response to the solicitation to the Department of Healthcare and Family Services (HFS). The CCE maintained articles of incorporation and corporate bylaws.

After the pre-implementation review, **OSF** was required to follow up on the items below for the Governance requirements:

- Update and revise as necessary all policies and procedures following execution of the contract with HFS. Submit revised policies once complete.
- Submit the governance documents/articles of incorporation and corporate bylaws for the CCMN program.

Populations and Providers

OSF had established participation of various specialty providers to deliver direct care to enrollees. **OSF** produced a listing of providers that included PCPs, hospitals, pediatric specialist providers, behavioral health providers, and dental providers.

After the pre-implementation review, **OSF** was required to follow up on the items below for the Populations and Providers requirements:

- Continue development of connectivity with the FQHC for sharing information.
- Monitor the behavioral health referrals to ensure appropriate access to behavioral health services due to the shortage of providers (a resource link was developed to address this need).

Care Coordination Model

OSF maintained a set of policies and procedures that described the CCE's approach to care coordination and commitment to assuring access to medically necessary services. The **OSF**'s Care along Continuum policy described coordination of care efforts across treatment settings through the establishment of a care plan and sharing of information. The Admission, Discharge, Transfer Planning policy provided staff direction in the handling of transfers across providers. The CCE's Patient Care Assessment, Screening, and Reassessment policy detailed a comprehensive set of assessments to be completed in providing care to enrollees and the required timelines for completion. The policies did not specifically address the delivery of medically necessary services to children, including those with complex medical needs.

OSF will use the EMR Epic for documentation of care coordination services. Epic is used throughout the **OSF** system including provider practices and hospitals.

After the pre-implementation review, **OSF** was required to follow up on the items below for the Care Coordination Model requirements:

- Continue development of the comprehensive assessment for children with complex conditions with input from the sub-specialty providers.

- Develop a Care Coordination Model program description and policies and procedures to include all requirements of the CCE program.
- Submit the care coordination model training program guidelines

Health Information Technology

OSF completed a review of current technology capacity among its collaborators including PCP, pediatric specialist, dental provider, and hospital communication capabilities. PCPs, pediatric specialists, and hospitals were using Epic, the **OSF** EMR with full inpatient and outpatient connectivity. Dental providers were using either the EMR or an established paper system of communication deemed adequate by the CCE. **OSF** was linked directly to the Central Illinois Health Information Exchange (CIHIE) since January 2013. The CCE will also use the connection developed between CIHIE and ILHIE to facilitate data exchanges and has full capacity to query CIHIE.

- For the HIT requirements, **OSF** was required to submit the testing file for the patient roster.

La Rabida Childrens Hospital (La Rabida)

Under the auspices of the hospital's Board of Trustees and president and CEO, La Rabida Care Coordination is led by an executive director experienced in healthcare management, program and leadership development, and community service. Day-to-day program direction is provided by a clinical director with both pediatric and neonatal intensive care experience and a deep background in case and disease management, including the development and supervision of site-based case management programs such as **La Rabida**'s program. The medical director's role is currently filled on an interim basis, so that **La Rabida** could obtain medical expertise combined with expertise in program design, Medicaid programs, data systems, and analytics. Questions specifically requiring pediatric medical expertise can be referred to the hospital's own pediatric specialists. The medical director's role will shift to pediatric leadership as the program's design needs recede.

The care coordination model proposed by **La Rabida** is initially one of geographically co-located services on the La Rabida Children's Hospital campus. It is designed as a "one-stop shop" to address the health and social service needs of CCE enrollees. **La Rabida** was the first hospital in Illinois and the only pediatric hospital in the State with NCQA Patient-Centered Medical Home (PCMH) recognition.

Findings

HSAG conducted an on-site pre-implementation readiness review for **La Rabida** on July 8–9, 2014. Following the pre-implementation readiness reviews, **La Rabida** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting CCE enrollment in September 2014.

Governance Structure, Scope of Collaboration, and Leaders

La Rabida had articles of incorporation and draft bylaws that described the governance and leadership of the CCE. The CCE will be governed by the La Rabida Children's Hospital Board. A CCE Advisory Board representing collaborating organizations and other key stakeholders being developed at the time of the readiness reviews.

After the pre-implementation review, **La Rabida** was required to follow up on the items below for the Governance requirements:

- Finalize the CCE bylaws and submit an executed copy following contract signature.

- Develop and submit a description of the oversight committees. The description should include at a minimum the composition, roles, and responsibilities of the committees (including the consumer advisory board).

Populations and Providers

La Rabida Hospital includes an acute care center, pediatric sub-specialty services, hospital services, a wide array of relevant health and social service programming, and a robust Care Management/Care Coordination Program. La Rabida Children's Hospital has also established relationships with collaborators on behalf of the CCE to supplement current services to ensure adequate specialty, diagnostic, behavioral health, and specialty dental services for **La Rabida** CCE enrollees.

For the Populations and Providers requirements, **La Rabida** was required to continue development of partnerships with dentists and behavioral health providers.

Care Coordination Model

La Rabida's vision for care coordination has been informed by several decades of experience in assessing and striving to meet service needs and coordination challenges of children with complex medical needs. **La Rabida**'s vision emphasizes a thorough risk assessment of the patient/family or guardian including medical and social issues; risk assignment; assignment of the patient/family to one care coordinator with whom an ongoing relationship is established; proactive and regular outreach based on risk assignment; the use of technology to improve transition care; and the development, monitoring, and updating of the care plan in care coordination to facilitate access to services (in this case for children and families/guardians of children with complex medical needs) that will maximize health outcomes in the most cost-effective manner. This includes not only access to and actual receipt of traditional healthcare services but also support/wrap-around services critical for good health.

La Rabida will deliver care coordination services through a consolidated, center-based program. Offering services in one location facilitates access and engagement, communication between various partners and stakeholders, and environmental safety which are especially important given the complex issues associated with complex medical conditions. Each patient has his or her own individualized care plan, which is the result of a collaborative effort between the patient, families/guardians, and the **La Rabida** care team led by the patient's physician. The care coordinator, embedded within the primary care practice, will help patients and their guardians navigate the resources and services necessary to ensure the successful execution of the care plan. Patients will have access to primary care services in an NCQA-recognized PCMH, and access to center-based dentistry, mental health and family support provided by partner organizations, as well as an array of additional services offered by La Rabida Children's Hospital's collaboration with the patient/family.

La Rabida had a subcontract in place with Automated Health Systems (AHS) for member call center and initial risk screenings for enrollees. As part of the readiness review HSAG reviewed the delegation agreement and the scope and implementation of the contracted activities.

After the pre-implementation review, **La Rabida** was required to follow up on the items below for the Care Coordination Model requirements:

- Develop a process flow that demonstrates the activities of the care coordination team beginning with the initial telephonic outreach (four-question screening tool).
- Develop a process flow that demonstrates the communication with the Medical Home Network (MHN)/provider office and the care coordination team; for example appointment schedule, risk assessment, and care planning.
- Revise the care coordination model description to include all CCE contract requirements.

Health Information Technology

La Rabida described plans to establish a patient portal within the first year of the program. The goal of the patient portal will be to enhance patient and family communication, the administration of satisfaction surveys, and automated reminders.

For the pre-implementation review, **La Rabida** was required to follow up on the items below for the HIT requirements:

- Continue development of connectivity between provider partner sites.
- Evaluate the SyntraNet productivity reporting to consider inclusion of outreach efforts for "hard-to-reach enrollees."

Ongoing Monitoring

Based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews, HSAG recommended that HFS approve all of the reviewed CCEs to proceed with enrollment in the designated service areas, with continued monitoring in designated improvement areas as determined for each CCE. HSAG and HFS continued to monitor the CCEs to ensure progress toward the improvement areas.

Upon completion of the on-site activities, all deficiencies from the desk review and site visits were identified, and the CCEs were required to remedy each deficiency prior to program implementation. HSAG and HFS used a standardized monitoring tool to document follow-up on any elements that required remediation and monitored corrective actions until successfully completed.

Once enrollment began, the CCEs were required to submit monthly reports monitoring care coordination and staffing. Ongoing feedback was provided by HSAG and HFS to the health plans following review of the required reports.

Staffing and Training

As the CCEs implemented their programs, HFS needed to monitor staffing and training to ensure the CCEs were hiring and adequately training qualified staff to meet the requirements. As a method of consistent tracking, HSAG developed a staffing/training workbook which the CCEs were required to submit monthly. The spreadsheet required CCEs to submit the names, qualifications/license, position, hire date, and training dates of each staff member.

CCE Care Coordination Reporting

At the request of HFS, HSAG also developed a Care Coordination Reporting Template. The CCEs were required to complete and submit the report monthly to HFS/HSAG. The report captured each CCE's monthly enrollment; tracked the number/percentage of high risk health screenings that had been completed; and displayed the percentage of members in the high-, medium-, and low-risk stratifications in both a monthly and cumulative format. The template also indicated the number/percentage of comprehensive assessments and enrollee care plans the CCE had completed. HFS used this report to track if the CCEs were meeting the requirements for completing health risk screens, risk stratification, comprehensive assessments, and enrollee care plans. This information kept HFS informed as to the effectiveness of the CCEs in being able to reach and engage their enrollees into care coordination.

ACE Readiness Reviews

An ACE was a new model of care coordination passed by the General Assembly in May 2013, and signed into law on July 22, 2013 (Public Act 98-104). This model coordinates a network of Medicaid services for children and their family members (initially), as well as ACA Medicaid adults. The State sought a redesigned healthcare delivery system that would provide integrated and accountable care, improve health outcomes, and enhance patient access. HSAG's readiness review was designed to evaluate implementation by the ACEs of their care coordination programs and readiness to provide services. Table 6.4 details the ACE readiness review activities conducted in SFY 2014, as well as the "go live" date for each ACE which indicates when the ACE began accepting enrollment for the ACE program..

Table 6.4—ACE Operational Readiness Reviews

Operational Readiness Reviews			
Program	**ACEs**	**Date of Review**	**Date of Go Live**
ACE	Advocate Accountable Care (Advocate)	April 17–18, 2014	July 28, 2014
	Better Health Network (Better Health)	April 23–24, 2014	September 8, 2014
	Illinois Partnership for Health, Inc. (IPH)	April 30–May 1, 2014	July 21, 2014
	SmartPlan Choice	May 8–9, 2014	August 11, 2014
	MyCare Chicago (MyCare)	May 20-21, 2014	September 8, 2014
	Loyola University Health System (Loyloa)	June 9–10, 2014	September 8, 2014
	HealthCura	June 30–July 1, 2014	September 8, 2014

Scope of the ACE Readiness Reviews

HSAG conducted a desk review, site visit, and network review to evaluate if the ACEs demonstrated appropriate knowledge of ACE contract requirements and systems preparedness in the following key operational areas.

- Organization and Governance
- Care Coordination Model
- Provider Network
- Subcontracts and Delegation
- Enrollee Information
- Complaints and Grievances
- HIT

The ACE readiness review tools included the global ACE model requirements but also focused on each ACE's proposed care coordination model as described in the RFP response. The ACEs were required to submit thorough documentation in the operational areas listed above. HSAG reviewed these areas to determine those that required additional focus during the on-site review. During the on-site readiness review, HSAG conducted ACE staff interviews to obtain further information to determine the ACE'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 ACE receiving enrollment. The ACEs 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 ACEs 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.

Following the on-site pre-implementation readiness reviews, HFS and HSAG worked with the ACEs to meet the pre-implementation requirements. In an email from HFS prior to enrollment, the ACEs were notified that member enrollment had been approved in response to the initial readiness review process; however, continued approval of enrollment was subject to ongoing monitoring of the following areas: (1) care model staffing capacity and training, (2) monitoring of care coordination activities through record reviews, (3) member call center capacity and metric reporting, (4) provider network capacity, and (5) IT capabilities as enrollment increases and/or expansion into additional counties/service areas occurs.

ACE Care Model Descriptions

This section provides a brief description of each ACE's organizational structure and care coordination model. This background information for ACEs was submitted to HSAG by the CCEs in their pre-on-site review documents.

Advocate Accountable Care (Advocate)

Advocate was established as an ACE in July 2014. Enrollees have been supported by a robust care management program and a progressive care model based on the existing infrastructure of Advocate Physician Partners.

The **Advocate** care management program seeks to manage the highest-risk patients in the population in order to reduce avoidable admissions/readmissions/emergency room (ER) visits through patient activation, enhanced access to medical and behavioral health, and improved condition control. **Advocate**'s PCMH initiative is creating a more comprehensive approach to care management. Patients are broadly categorized into segments of high-risk, rising-risk, and low-risk and may move between risk categories over time based on new diagnoses, gaps in care, and utilization. Health risk-assessment tools and risk-stratification tools help inform the care team about which patients may benefit from various programs, interventions, and a stronger link with their PCP. The **Advocate** PCMH initiative supports offices to leverage the full potential of their EMR, the Center Disease Registries, and the role of each member of the care team to contribute to high-quality, efficient patient care. The outpatient care management staff assigns a care manager to the highest-risk patient population. One-hundred percent of patients enrolled in complex care

management have a shared care plan. This staff works from the physician-directed treatment plan to provide inter-visit management by ensuring care plan implementation, removing barriers to care, supporting patient self-management, and serving as a trusted bridge between the patient and care team. The **Advocate** complex care management program has three distinct high-risk populations: medical/behavioral, maternity, and pediatric.

HSAG conducted an on-site pre-implementation readiness review for **Advocate** on April 17–18, 2014. Following the pre-implementation readiness reviews, **Advocate** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in July 2014.

Better Health Network (BHN)

BHN's care coordination model is an enrollee-engaging, accountable, bilingual and culturally competent, person-centered, consumer-driven integration of medical services related to primary care, specialist care, and behavioral healthcare. The model, founded on accessible, geographically dispersed anchor medical sites, FQHCs, and physician offices, thoroughly identifies enrollee health status via a comprehensive HRA. Enrollees choose a PCP who will service as their medical home. Medical homes provide all PCP services and are supported by integrated care teams and health information technology. A highly qualified clinical leadership and care team whose expertise as leading clinicians and industry experts develop and improve research and data-driven HRAs, disease management, and workforce training. The model provides primary, specialist, education, and prevention care services, as well as community-based services and services that are available 24 hours a day, seven days a week. The care team's role is to mitigate access barriers to receiving necessary care and intervention and coordinate all services and information sharing through regular meetings, health technology resources, and real-time access to medical records. The care coordinator will be the team member primarily responsible for interfacing with the patient, PCP, specialist, and OB/GYN (if needed), as well as social service provider and behavioral specialist. The care coordinator must commit the time and energy required to facilitate implementation of all facets of the care plan including engaging family members to provide supportive services such as assistance with activities of daily living, child care, and transportation to and from follow-up care appointments.

HSAG conducted an on-site pre-implementation readiness review for **BHN** on April 23–24, 2014. Following the pre-implementation readiness reviews, **BHN** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in September 2014.

HealthCura

HealthCura is led by Access Community Health Network (ACCESS), a critical safety net provider organization with a long history of providing healthcare to Medicaid beneficiaries, and a leader in delivering high-quality, culturally appropriate care in communities with the highest need. ACCESS has a 20-year history of responding directly to community need by providing community-based care to underserved communities. In 1991, ACCESS was incorporated as a FQHC organization. ACCESS is one of the largest FQHC networks in the country with an annual budget of $117 million. ACCESS' ability to manage large initiatives that reach deep into the community to address the needs of high risk patients provides a strong platform for the **HealthCura** network.

HSAG conducted an on-site pre-implementation readiness review for **HealthCura** on June 30 and July 1, 2014. Following the pre-implementation readiness review, **HealthCura** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in September 2014.

Illinois Partnership for Health, Inc. (IPH)

Through the use of PCPs and their respective care teams embedded at the practice level (e.g., nurse case managers, social workers, licensed practical nurses (LPNs), registered nurses (RNs), patient navigators), "Founders" are responsible for coordinating and managing all clinical, social, and behavioral health needs within a PCMH model framework. The Founders will be responsible for the majority of care management and care coordination, resulting in the Founders hiring and managing to meet new and existing care coordinator staffing needs. Additionally, the Founders will leverage the medical home model to assist in supporting care management and care coordination needs, especially for the low-risk enrollees. The Founder care teams will be responsible for managing all high-, medium-, and low-risk enrollee care needs to ensure seamless care coordination and care management across **IPH**. As part of this process, the Founders have identified an opportunity to leverage their relationship with Health Alliance to initiate certain aspects of the administrative components of the care management process. Health Alliance will act as a vendor that provides initial care coordination support services collaboratively with the Founders, specifically, handling enrollment/disenrollment, conducting welcome calls for defined members, assisting enrollees in identifying a PCP, initiating intake assessments, risk stratification, and generating reports when applicable. Thereafter, Health Alliance will work closely with the Founder care teams to ensure the smooth transition of patients to the appropriate Founder organization for all care coordination and care management needs. Additionally, and similar to health systems nationwide, Founders will be able to outsource and leverage Health Alliance as a vendor for complex case management support for rare, high-risk conditions such as transplants or AIDS, when appropriate.

HSAG conducted an on-site pre-implementation readiness review for **IPH** on April 30 through May 1, 2014. Following the pre-implementation readiness reviews, **IPH** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in July 2014.

Loyola University Health System (Loyola)

The **Loyola** model of care will be driven by the following innovations:

- Interprofessional team model with a physician as the lead in the medical home versus the traditional medical model.
- Group clinics for moderate and high risk patients to teach and learn versus individual patient visit, which also breaks down disparities.
- Use of technology during and between visits to manage health longitudinally versus episodic contact when a patient needs medical attention and comes in for a unique clinic visit or goes to the ED.
- Partnerships with the health and social service providers within the community versus standalone operation.
- New role for community health worker as a trusted health coach versus use of a professional medical practitioner.
- Engagement of health professional students to assist patients with adoption of technology and assist in managing maintenance to plans of care in the community setting versus health professional students as observers of care.

The patients with the highest health risks identified through the HRA or referral from their clinical care team will receive care coordination from a care coordinator, as well as through their medical home and have access to a community health worker when needed.

HSAG conducted an on-site pre-implementation readiness review for **Loyola** on June 9–10, 2014. Following the pre-implementation readiness reviews, **Loyol**a continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in September 2014.

MyCare Chicago (MyCare)

MyCare began operation on September 8, 2014. The healthcare providers who came together to form **MyCare** saw great value in a collaboration with high quality providers to improve access to services, reduce costs, and provide improved coordination of care. **MyCar**e brought together three safety net hospitals, five FQHCs, one FQHC "look-alike," and a significant network of

primary care physicians, behavioral and substance abuse care providers, and specialty physicians. The members of **MyCare** had worked together for many years but hoped that by forming an ACE they would be able to provide even more comprehensive care to their patients, to provide additional services, and to maximize the strengths of all of the members. The combination of hospitals and FQHCs provided a large primary care base to create access to primary care. The specialty networks of employed physicians and other independent specialists created access to high quality specialty services, and the hospitals and Community Counseling Centers of Chicago provided access to the behavioral health services needed by **MyCare**'s clients.

HSAG conducted an on-site pre-implementation readiness review for **MyCare** on May 20–21, 2014. Following the pre-implementation readiness reviews, **MyCare** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in September 2014.

SmartPlan Choice

SmartPlan Choice delegates the vendors Presence Health Partners (PHP) (for PHP providers) and **Apex Healthcare, Inc.** (**Apex)** (for IPA-designated providers) with conducting comprehensive health risk assessments for medium- and high-risk patients. PHP is required to monitor ED utilization rates as a proxy to access to care and seven-day follow-up post hospitalization to ensure appropriate provider access and availability. PHP provides access to individualized care plans, monitors patient transitions between different specialists, and identifies additional social and community supports when needed. PHP works with a variety of state and community-based social services within the targeted geographic region which provide critical services to the FHP/ACA population.

HSAG conducted an on-site pre-implementation readiness review for **SmartPlan Choice** on May 8–9, 2014. Following the pre-implementation readiness reviews, **SmartPlan Choice** continued to work with HSAG to complete follow-up on all items identified in the SFY 2014 Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in August 2014.

Delegated Entities Readiness Review

Apex

Three of the ACEs, **MyCare**, **BHN**, and **SmartPlan Choice**, delegated their call center activities to **Apex**. HSAG performed a delegated entity readiness review for **Apex** on June 5, 2014, which included the delegation activities for all three ACEs. UI Health Plus also delegated call center activities to **Apex**, but that agreement was not in place at the time of the on-site review.

In the review, HSAG interviewed **Apex** staff on the following elements for all three ACEs: the enrollment file, HIPAA and confidentiality, quality assurance reporting, staffing and training, member and provider service lines, and the exchange of information between **Apex** and each of the ACEs. During the review **Apex** provided a demonstration of the call center system.

SmartPlan Choice also delegated care coordination to **Apex** for members who were assigned to a PCP through the Independent Physician Alliance of Illinois. During that portion of the review, HSAG reviewed the care coordination activities delegated to **Apex**. **Apex** was to document directly into **SmartPlan Choice**'s care coordination system, the Crimson Care Management System.

Follow-up items from the on-site review included revisions to each of the delegation agreements to clearly define responsibilities and reporting requirements; additions to the demographic fields for alternative contact information and responsible party; information technology (IT) schematic demonstrating the flow of data within the **Apex** system; policy for handling enrollee transportation requests; and staffing grid identifying full-time equivalent (FTE) staff dedicated to each of the ACEs. Follow-up for **SmartPlan Choice** included Crimson Care Connect Software training for **Apex** staff.

FHN

MyCare and **BHN** delegated their care management activities to **FHN**. HSAG performed a readiness review for **FHN** on June 3, 2014, which included the delegation activities for all three ACEs.

In the review, HSAG interviewed **FHN** staff on the following elements for all three ACEs: care model, identification of enrollees for care coordination, health risk screening, health risk assessments, enrollee care plans, predictive modeling, case load assignment tracking and monitoring, and staffing and training for each of the ACEs. HSAG also reviewed the HIPAA and cultural competency training; tracking of fraud, waste, and abuse; tracking of grievance and appeals; processing of the panel roster; provider and CCCD files; and provider network services. **FHN** provided a demonstration of the case management system, CCMS.

At the time of the review, **FHN** did not have a predictive modeling system in place; follow-up was conducted for this item, which revealed that the item was completed after the on-site review. Other follow-up items included revisions to each of the delegation agreements clearly defining responsibilities and reporting requirements; timeline for testing the patient roster, provider file, and CCCD file; flowcharts for handling grievances; training for fraud, waste, and abuse, cultural competency, and HIPAA; and a staffing grid identifying FTEs dedicated to each of the ACEs.

Findings and Conclusions

Based on the readiness review activities, reporting, and responses to the findings, HSAG recommended that HFS approve all of the reviewed ACEs to proceed with enrollment in the designated service areas, with continued monitoring in designated improvement areas as determined for each ACE. HSAG and HFS continued to monitor the ACEs to ensure progress toward the improvement areas and to ensure they had sufficient resources and operational capacity to serve further enrollment.

Upon completion of the on-site activities, all deficiencies from the desk review and site visits were identified, and the ACEs were required to remedy each deficiency prior to program implementation. HSAG and HFS used a standardized monitoring tool to document follow-up on any elements that required remediation.

ACE Staffing and Qualifications Review

The ACE Contract [6-2]with HFS did not contain specific staffing ratio guidelines but stated that the "Contractor shall expand its staffing over the term of the Contract in direct relationship to the Contractor's growth in enrollment and risk stratification of Enrollees" (Section 5.7.5.5). The contract also stated that each interdisciplinary care team "shall consist of clinical and non-clinical staff whose skills and professional experience will complement and support each other in the oversight of each Enrollee's needs" (5.7.5.6), with higher-level needs enrollees "assigned to Care Coordinators with clinical backgrounds such as registered nurses, licensed clinical social workers, rehabilitation specialists, or other relevant clinical backgrounds, such as counselors" (Section 5.7.5.1).

HFS contracted with HSAG to conduct reviews to ensure ACEs had adequate staffing to serve ACE members and that the staff was appropriately qualified. HSAG provided each of the ACEs with a staffing template in order to monitor the hiring of staff members for both care coordination and call center departments. The care coordination template included these fields: Name, County/State of Residence, Position, Date Hired, Education, Experience, Training Dates, FTE equivalent, and whether the staff member was from a delegated entity. The call center template included these fields: Name, Position, Languages Spoken, Date Hired, FTE equivalent, Training Dates, and whether the staff member was from a delegated entity. The reports were initially submitted and monitored biweekly starting prior to the ACEs going live in July 2014 and continued after implementation. In April 2015, these reports were required on a monthly submission schedule and continue to be submitted monthly by the ACEs.

[6-2] State of Illinois. Furnishing Health Services in an Integrated Care Program by a Managed Care Organization. Contract No. 2013-24-004.

HCBS CMS Waiver Record Reviews

Introduction

SP II of the ICP was implemented in February 1, 2013. This package includes nursing facility services and the care provided through some of the HCBS waivers operating in Illinois (excluding Developmentally Disabled/DD waiver services). Nursing facility services are long-term care services covered by the Department for Medicaid-eligible residents and include SNFs and ICFs).

HCBS waivers allow participants to receive nontraditional services in the community or in their own homes, rather than being placed in an institutional setting. Illinois currently operates nine HCBS waivers, five of which will be included in SP II. ICP enrollees in the five regions have their waiver services administered through an ICP health plan to coordinate more effectively and meet the total needs of the participant. The health plans will have specific quality improvement responsibilities and are required to comply with the HCBS CMS Performance Measure Waiver requirements.

In SFY 2014, HFS contracted HSAG to review health plan compliance with the HCBS Waiver measures for each ICP health plan to monitor the quality of services and supports provided to the HCBS Waiver program enrollees.

The following ICP health plans were reviewed during the 2013–2014 reporting year: **Aetna**, **Community Care Alliance of Illinois** (**CCAI**), **Health Alliance**, **IlliniCare**, **Meridian**, and **Molina**.

The following HCBS Waiver programs were included in the CMS Performance Measures record reviews:

- Persons with Physical Disabilities (PD)
- Persons with HIV/AIDS (HIV)
- Persons with Brain Injury (BI)
- Persons who are Elderly (Aging)
- Persons in a Supportive Living Facility (SLF)

An overall summary of the record review process and results are provided below, and additional details about the HCBS Waiver reviews can be found in the SFY 2014 *HCBS Waiver CMS Performance Measures Record Reviews Summary of Findings and Recommendations Report*.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

A two-step protocol for selecting a statistically valid, representative sample of waiver enrollees was developed to account for small waiver population sizes in some of the ICP health plans. Based on enrollment data received from HFS, HSAG first determined the appropriate sample size by ICP and by waiver. Next, the appropriate sample size by waiver program based on the ICP distribution was determined. Once the required sample sizes were determined, the larger of the two sample sizes from each ICP-waiver combination was used to generate the final sample size. For example, **Aetna**'s sample size for its Aging waiver program was 155 cases, while the Aging waiver program's sample size for **Aetna** was 126 cases. The final sample size in this example was 155 cases—the larger of the two samples. This approach ensured that the minimum required confidence level (95 percent) and margin of error (5 percent) were maintained when the samples were combined. Additionally, a 10 percent oversample based on the proportional distribution of enrollees across ICP health plans was selected. Table 6.5 below displays the SFY 14 record review sample size by ICP health plan and waiver program. The statewide sample for all waivers was 1,509. On-site record reviews for SFY 2014 began in March 2014 and were completed in August 2014.

Table 6.5—CMS Waiver Performance Measures Sampling

ICP Health Plan	Eligible Population	Sample Size	Oversample		Waiver Program				
			5%	10%	Aging	BI	HIV	PD	SLF
Aetna	1,750	393	20	39	155	56	28	129	25
IlliniCare	2,147	424	21	42	162	74	25	131	32
Meridian	396	200	10	20	41	16	9	132	2
Molina	364	191	10	19	52	18	5	110	6
Health Alliance	335	184	9	18	50	17	7	103	7
CCAI	167	117	6	12	25	5	2	85	0
Statewide Total	**5,159**	**1,509**	**76**	**150**	**485**	**186**	**76**	**690**	**72**

Development of a Web-Based Abstraction Tool and Reporting Database

An electronic web-based abstraction tool and reporting database were developed by HSAG to collect and store the data gathered during on-site record reviews. The information required to complete the record review tool data fields was abstracted from each ICP health plan's case management system and used to generate reports of findings. The automated tool included all waiver performance measures gathered from the review of records, as well as ICP contract

requirements. The tool was modeled after the current tool used by the State to monitor the FFS population to ensure all waiver enrollees are monitored in a similar manner.

Interrater Reliability (IRR)

Interrater reliability was conducted by the HSAG senior project manager for all reviewers conducting ICP health plan reviews. The senior project manager reviewed 100 percent of each reviewer's records the first week in the field. An accuracy rate of 95 percent was required. If a reviewer scored less than 95 percent, the senior project manager communicated with the reviewer and the correction was made. Each week, 10 percent of each reviewer's records across waivers were reviewed to ensure the reviewer was maintaining an accuracy rate of 95 percent. Feedback between the senior project manager and the reviewer was ongoing. If the accuracy rate fell below 95 percent, retraining was conducted. A Microsoft Excel workbook was used to record the accuracy scores of all reviewers.

CMS Performance Measures Description

Table 6.6 provides a description of each CMS performance measure, including the identification of waiver-specific measures.

Table 6.6—CMS Waiver Performance Measure Descriptions

Measure #	Measure Description
26C	BI, HIV, PD Waivers—The personal assistant evaluation is completed and in the record at the time of the most recent assessment/reassessment.
31D	The most recent care plan includes all enrollee goals as identified in the comprehensive assessment.
32D	The most recent care plan includes all enrollee needs as identified in the comprehensive assessment.
33D	The most recent care plan includes all enrollee risks as identified in the comprehensive assessment.
35D	The most recent care plan includes signature of enrollee (or representative) and case manager, and dates of signatures.
	The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.
36D	PD Waiver—The case manager made annual contact with the enrollee or there is valid justification in record.
	HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record. (prior to March 2014) The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record. (after March 2014)

Measure #	Measure Description
	BI Waiver—The case manager made valid contact with the enrollee at least 1 time a month, or valid justification is documented in the enrollee's record.
37D	PD, HIV, and Elderly Waivers—The most recent care plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
	PD, HIV, and Elderly Waivers—The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
	BI Waiver—The most recent care plan is in the record and completed in a timely manner. (Completed within 6 months from review date)
	BI Waiver—The most recent service plan is in the record and completed in a timely manner. (Completed within 6 months from review date)
38D	The service plan was updated when the enrollee needs changed.
	The care plan was updated when the enrollee needs changed.
39D	The most recent care plan includes the type, amount, and frequency of services (including the number of hours each task is to be provided per month).
	The most recent service plan includes the type, amount, and frequency of services (including the number of hours each task is to be provided per month).
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
49G	BI, HIV, PD Waivers—The most recent care plan includes the name of the backup personal assistant (PA) service (if receiving PA).
	Additional Requirement
II.A.6	The score of the most recent Mini-Mental State Examination/MMSE/Determination of Need (DON) totals 29 points.

Summary of Overall Record Review Findings

Table 6.7 and Table 6.8 display the overall waiver performance measure findings by ICP health plan and by performance measure. **Meridian** had findings in four of the 11 applicable performance measures, while the number of findings for the remaining ICP health plans varied from seven to 12 findings across the performance measures. **Aetna** and **Health Alliance** demonstrated 50 percent or greater noncompliance with six of the 12 performance measures. **FHN** demonstrated 50 percent or greater noncompliance with five of the 11 applicable performance measures. Both **IlliniCare** and **Molina** demonstrated 50 percent or greater noncompliance with three of the applicable performance measures. No immediate concerns related to health, safety, or welfare were discovered during the on-site record reviews.

Table 6.7—Waiver Performance Measure Findings

Health Plan Name	Overall Record Review Findings
Aetna Better Health (ABH)	Findings in 11 of 12 performance measures
Community Care Alliance of Illinois (CCAI)	Findings in 11 of 12 performance measures
Health Alliance Medical Plans, Inc. (HAMP)	Findings in 7 of 12 performance measures
IlliniCare Health Plan, Inc. (IHP)	Findings in 12 of 12 performance measures
Meridian Health Plan, Inc. (MHP)	Findings in 4 of 11 performance measures
Molina Healthcare of Illinois, Inc. (MHI)	Findings in 10 of 12 performance measures

Table 6.8—Waiver Performance Measure Findings

Performance Measure Findings Across Managed Care Plans Percent Noncompliant by Measure						
PM #	ABH	CCAI	HAMP	IHP	MHP	MHI
26C	55%	N/A	0%	23%	N/A	0%
31D	36%	3%	4%	28%	0%	19%
32D	69%	99%	5%	21%	0%	17%
33D	34%	3%	3%	15%	0%	14%
35D	100%	94%	98%	99%	3%	54%
36D	16%	5%	12%	12%	3%	9%
37D	0%	14%	2%	1%	0%	1%
38D	60%	50%	100%	30%	0%	N/A
39D	100%	98%	82%	93%	0%	32%
41D	7%	36%	77%	3%	1%	66%
42G	6%	3%	63%	4%	1%	67%
49G	89%	100%	51%	62%	0%	27%

Figure 6.1 and Figure 6.2 display the overall performance compliance and noncompliance ranking by ICP health plan. **Meridian** achieved an overall 99 percent compliance ranking across all measures for all waivers, while the remaining ICP health plans' performance varied with compliance rankings from 69 to 55 percent. **Aetna** and **CCAI** had the lowest overall performance ranking of 55 percent.

Figure 6.1—Comparison of CMS Waiver Performance Measure Overall Compliance Ranking

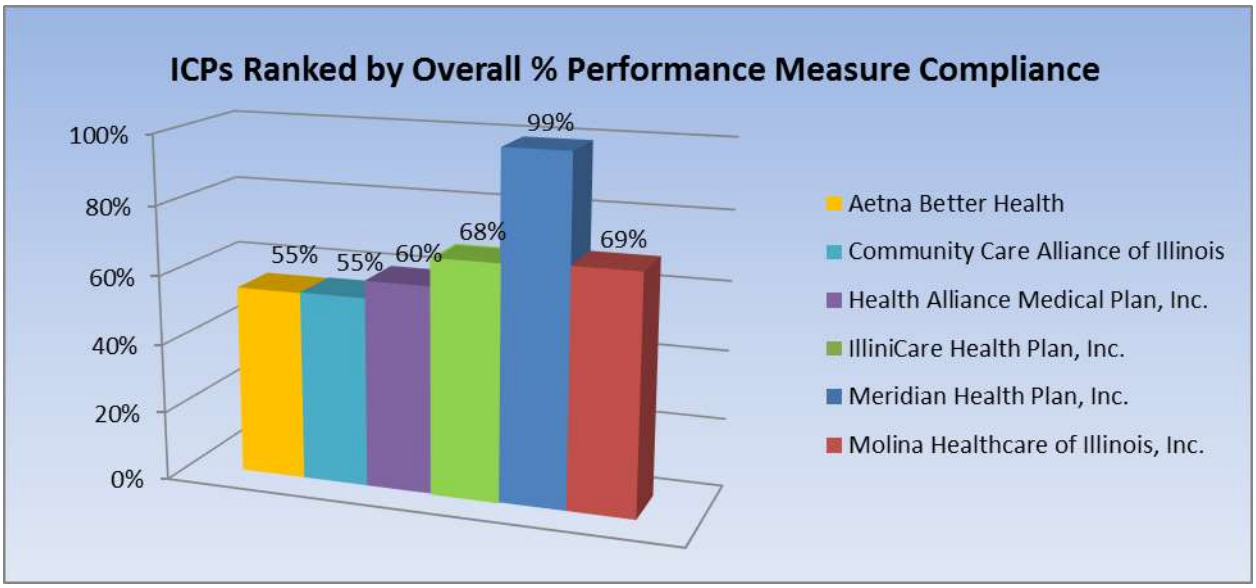
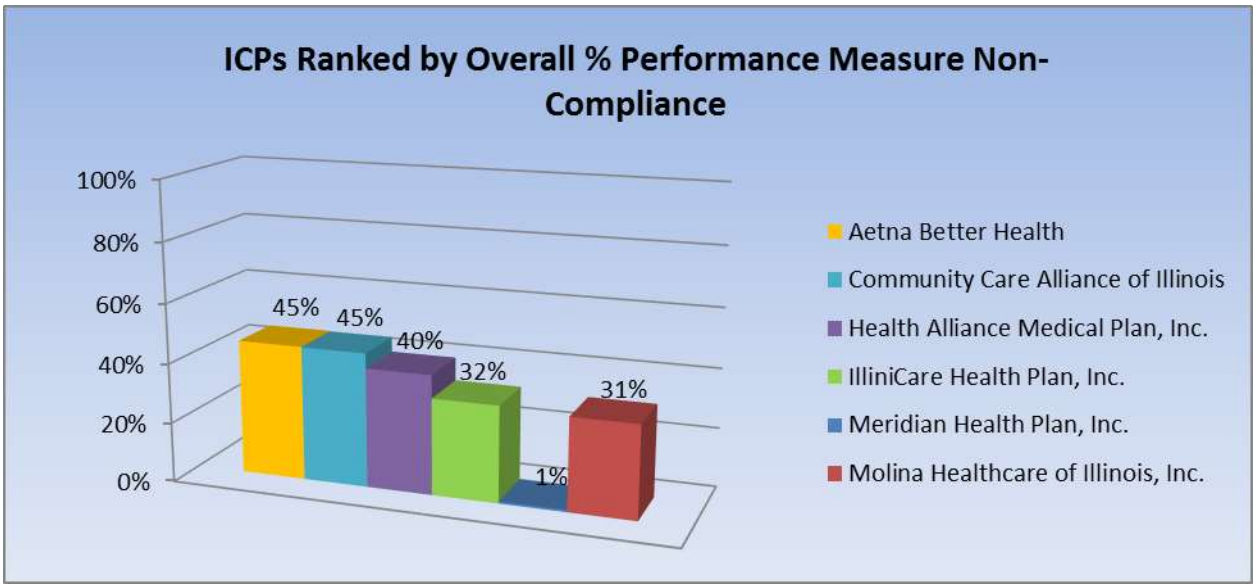


Figure 6.2—Comparison of CMS Waiver Performance Measure Overall Noncompliance Ranking



The FY 14 CMS Performance Measures Record Reviews identified significant noncompliance with documentation of care coordination activities for five of the six ICP health plans reviewed. HFS and the ICP health plans received a report of findings subsequent to each on-site record review. **Meridian** outperformed all ICP health plans, with an overall compliance ranking of 99 percent.

The ICP health plans were required to remediate the noncompliance findings and implement performance improvement strategies to improve the quality of care management/care

coordination activities for the HCBS Waiver enrollees. Compliance with remediation of these findings continued to be monitored by the EQRO through review of timeliness of completion of remediation actions within 30, 60, and 90 days as required by CMS and HFS.

Table 6.9 identifies the measures that demonstrated the highest noncompliant findings across the waiver types and ICP health plans.

Table 6.9—Waiver Performance Measures With Highest Noncompliance

Measure #	Measure Description	# of ICP Health Plans
32D	The most recent care plan includes all enrollee needs as identified in the comprehensive assessment.	5 of 6
35D	The most recent care plan includes signature of enrollee (or representative) and case manager, and dates of signatures.	6 of 6
	The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.	
38D	The care plan was updated when the enrollee needs changed	4 of 5
	The service plan was updated when the enrollee needs changed.	
39D	The most recent care plan includes the type, amount, and frequency of services (including the number of hours each task is to be provided per month).	5 of 6
	The most recent service plan includes the type, amount, and frequency of services (including the number of hours each task is to be provided per month).	
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers.	6 of 6
42G	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.	6 of 6
49G	BI, HIV, PD Waivers—The most recent care plan includes the name of the backup personal assistant (PA) service (if receiving PA).	5 of 6

Findings from the record reviews identified that, with the exception of one ICP health plan, findings of noncompliance with performance measure requirements occurred in seven out of nine of the 12 performance measures across the ICP health plans.

Remediation

All noncompliance findings were documented in the remediation tracking database. ICP health plans received training on the use of the database and were required to remediate individual record review findings within the required 30-, 60-, and 90-day time frames. HSAG and HFS monitored ICP compliance with completion of all remediation actions.

In addition, HSAG identified additional systemic remediation recommendations to address the findings of the record reviews which included suggestions related to case manager training,

oversight and monitoring of case manager/care coordination resources and activities, and case management systems and processes.

Overall Recommendations for Improvement

HSAG identified the following systemic remediation recommendations to address the findings of the record reviews.

Case Manager Training

- Conduct immediate training and/or retraining of case managers/care coordinators to ensure staff understand the CMS Waiver Performance Measure documentation requirements. Training should focus on the deficiencies identified as a result of the record reviews.
- Training should include education on person-centered care planning, which will provide case managers the tools necessary to engage enrollees in the care planning process.
- Training/retraining of case managers should occur within 60 days of receipt of the record review findings report.
- Training must be documented in the remediation tracking database.
- HFS should ensure ongoing input and training for the ICP health plans from the waiver agencies.

Oversight and Monitoring of Case Manager/Care Coordination Resources and Activities

- Conduct ongoing evaluation of staffing resources to ensure sufficient capacity to manage the case management/care coordination activities of the HCBS Waiver enrollees.
- Develop and implement an oversight process to ensure case manager records are reviewed to facilitate compliance with CMS performance measure requirements.
- Develop and implement a process to evaluate case manager performance in areas such as enrollee satisfaction; percentage of enrollee goals met; compliance with enrollee contact standards; informing enrollees of how and to whom to report abuse, neglect, and exploitation; service plan updates when enrollee needs change, etc.
- Implement internal processes to monitor remediation actions to ensure timely remediation of record review findings.

HCBS ICP Health Plan Staffing and Qualifications Review

Introduction

Section 1915(c) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive certain requirements in Medicaid law in order for states to provide HCBS to meet the needs of individuals who choose to receive their long-term care services and supports in

their home or community, rather than in an institutional setting. These programs serve a variety of targeted populations groups, such as BI, HIV, PD, ELD and SLF.

CMS requires HFS to provide quality oversight of state Medicaid managed care plans that provide HCBS Waiver services. HFS contracted HSAG to conduct an annual review of the HCBS Waiver programs' compliance with qualifications by waiver type, related experience, FTE allocation, caseload assignments, annual training, and training curriculum. The review was designed to assess if the health plans serving the HCBS population were meeting the Waiver Care Coordination/Case Management Staffing, Qualifications, Training, and Caseload requirements.

Methodology

During the reporting year, HSAG worked with HFS to develop review criteria and an evaluation tool to standardize the review process as well as a project timeline for conducting the staffing and training reviews. To collect the staffing and training information, HSAG developed a standardized data collection tool (Staffing, Qualifications and Training Workbook). Each health plan was required to complete the information requested within the data collection tool and submit it to the HSAG File Transfer Protocol (FTP) website. Upon receipt, HSAG reviewed the tool for completeness and return it to the health plan if information was missing that was necessary to the analysis of the data. If a health plan did not submit necessary documentation, HSAG contacted the health plan. This communication ensured the health plans were aware that documentation was outstanding and needed to be submitted as required. HSAG then reviewed the educational qualifications, related experience, annual training hours, FTE allocation, and caseloads of the health plan's care coordinators serving the HCBS Waiver population against the CMS HCBS program requirements. In addition to staffing allocations, the review assessed caseload requirements to ensure each care coordinator responsible for enrollees with varying risk levels had an overall caseload that met requirements for case limits and case mix. Finally, to evaluate if the health plans met HCBS training requirements, the number of annual training hours completed by HCBS Waiver staff, the HCBS Waiver Training Curriculum, and the employee training sign-in sheets were reviewed. To track this documentation, HSAG developed an HCBS Training Requirements Review Tool.

Conducting the Review

During this reporting year, HSAG conducted the HCBS Staffing and Qualifications Review as part of the pre-implementation readiness reviews and continued to monitor the ICP health plans staffing and training via the methods described above throughout the year.

Provider Network Capacity Validation—All Programs

HSAG was contracted to conduct a provider network analysis of the health plans' provider networks as a key component of the pre-implementation readiness reviews. The network analysis allows HFS to evaluate the provider networks across the health plans using a consistent and standardized approach. For these reviews, each health plan is required to submit a provider file that includes all contracted and credentialed providers within the network. HSAG analyzes the provider network using the following provider types:

- Primary Care Providers
- Specialty Providers
- Facilities
- Hospitals
- Behavioral Health Providers
- Skilled Nursing Facilities

HSAG also conducted a review of the HCBS Provider Network using the list of required services described in the *State of Illinois Furnishing Health Services in an Integrated Care Program by a Managed Care Organization* contract. Additional HCBS provider types were included in this analysis.

The analysis included a review of the number and types of providers by county for the contracted service areas. If provided by the health plan, HSAG also conducted a review and analysis of the provider network in contiguous counties for each of the contracted service areas.

HSAG assessed the data for the following to ensure consistency and accuracy:

- Duplicate entries—Providers may be counted more than once if they offer the same service at two or more sites, or two or more services at the same site.
- Lack of standardization of provider types and specialties—Health plans were required to report a prescribed list of provider types, facilities, hospitals, and HCBS services.
- Providers contracted, credentialed, and loaded in the network database—Health plans were required to complete the contracting and credentialing processes before loading providers and facilities in the database.
- Comparison to external resources—Provider, facility, HCBS, and/or HCBS services were compared to external resources, such as https://data.illinois.gov/, to compare the providers and services reported by the health plans to those potentially available for possible contracting.

Following analysis of the data, HSAG reviewed the results with HFS and the health plan. HSAG presented the provider, facility, hospital, and HCBS service distribution per county and reported any data integrity issues as well as identified any network deficiencies. Health plans were also made

aware of any required actions to correct issues or deficiencies and whether subsequent resubmissions of provider network data were required.

Validation of Encounter Data

Introduction

Encounter data are detailed information regarding the services provided to Medicaid clients enrolled in capitated managed care. Health plans that contract with the Illinois Department of Healthcare and Family Services (HFS) to provide Medicaid services are required to maintain health information systems. These systems must be able to collect data on Medicaid clients, provider characteristics, and services using encounter data or other state-specified methods. Health plans are required to ensure that data received from Medicaid providers are accurate and complete.[7-1]

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

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

During state fiscal year (SFY) 2014, HFS contracted with its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc.(HSAG), to conduct an encounter data validation (EDV) study. The goal of the study was to assess the degree of data file completeness, accuracy, and timeliness across two health plans in order to provide insight into the quality of HFS' overall encounter data system.

[7-1] Department of Health and Human Services, OIG. *Medicaid Managed Care Encounter Data: Collection and Use.* May 2009.

Encounter Data Requirements

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

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

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

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

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

Once the format is correct, HFS then performs the second level of review. This second review is for standard claims processing edits. These edits include, but are not limited to, the following: correct provider numbers, valid enrollee numbers, valid procedure and diagnosis codes, and cross checks to assure provider and enrollee numbers match the name on file. The acceptable error rate of claims processing edits of the encounter data provided by the contractor shall be determined by HFS. Once an acceptable error rate has been achieved, as determined by HFS, the contractor is instructed that the testing phase is complete and those data must be sent in production.

Production. Once the contractor's testing of data specified above is completed, the contractor will be certified for production. Once certified for production, the contractor continues to submit encounter date in accordance with these requirements. HFS will continue to review the encounter data for correct format and quality. The contractor shall submit as many files as necessary, in a time frame agreed upon by HFS and the contractor, to ensure all encounter data are current. At

the sole discretion of HFS, HFS may pull the contractor out of production and back to the testing protocol if warranted due to poor quality.

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

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

Conducting the Review

To assess the overall quality of encounter data submitted to HFS by **Aetna Better Health** (**Aetna**) and **Meridian Health Plan, Inc.** (**Meridian**), HSAG evaluated HFS' encounter data across three dimensions: completeness, accuracy, and timeliness. EDV metrics evaluated the quality of data at both the encounter file and field levels. Based on the Centers for Medicare & Medicaid Services (CMS) Protocol,[7-2] the following objectives were evaluated in this study:

- Identify the degree to which encounters are being submitted and accepted into HFS' encounter data system, as well as the extent to which key encounter data elements are present in the data.
- Determine the degree to which encounter data elements contain accurate values.
- Evaluate the timeliness of encounter data submissions.

Encounter file completeness was evaluated by assessing general utilization metrics (i.e., volume and costs by encounter type) and encounter acceptance rates. Completeness was also evaluated at the encounter data element level by determining the percentage of key data fields that were populated with values. In collaboration with HFS, HSAG selected the key fields for inclusion in this analysis. All claims/encounter data types (i.e., institutional, professional, and pharmacy) were examined.

Encounter data accuracy was evaluated at the data element level by analyzing the percentage of values populated in key data elements that contained the expected values (i.e., valid ICD-9 codes in the diagnosis fields). Accuracy was also evaluated through age- and gender-specific discrepancy analyses of diagnoses and procedures (e.g., male members with an encounter for pregnancy). Finally, by comparing the date of service to the encounter processing date by HFS, HSAG was

[7-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4 Validation of Encounter Data Reported by the MCO*. Protocol 4. 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.

able to evaluate the timeliness of encounter data submissions. This represents another critical element of overall encounter data completeness.

Encounter Data Source

Based on the approved scope of work, HSAG worked with HFS' encounter data unit and the Decision Support System (DSS) vendor to develop the data submission requirements for conducting the EDV study. Once finalized, the data submission requirements were submitted to HFS to guide the extraction and collection of study data. Data were requested for professional, institutional, and pharmacy encounter records with beginning dates of service between January 1, 2013, and December 31, 2013 for the two plans included in the EDV study. In addition to the file specifications, the data submission requirements included information on the required data elements, which was based on the Core Coordination Claims Data (CCCD) format. HSAG requested HFS to provide other supporting data files related to member enrollment, member demographics, and providers associated with the encounter files.

Once received, HSAG conducted a preliminary review of the data. Any outstanding questions were discussed with HFS and later resolved. The analyses presented in this results brief were calculated using the administrative encounter data extracted from the State's data warehouse.

Conclusions and Recommendations

Conclusions

Outlined below are the key conclusions based on the preliminary analysis of the quality of HFS' encounter data:

- Acceptance Rates: While the overall encounter acceptance rates were above 90 percent in July and August 2014 for both health plans, the acceptance rate for **Aetna**'s institutional encounters was less than 55 percent from June to August 2014.
- Encounter Volume: While the total member months in 2013 were similar for **Aetna** and **Meridian**, **Aetna**'s encounter volume was much higher for each of the three claim types. Further analyses showed that the main reason for the difference was that the average encounters per member per month (PMPM) for the Integrated Care Program (ICP) was much higher than that for the Voluntary Managed Care (VMC) program and approximately 95 percent of **Meridian**'s member months were for the VMC program in 2013.
- Completeness and Accuracy: For the selected key data elements in each claim type, all or nearly all records had values present and all or nearly all values present were valid. This finding indicated that once the encounter data were accepted by HFS, the encounter data were generally complete and accurate.

- Reasonableness: More than 96 percent or more of all inpatient, outpatient, and professional encounters with age-specific and gender-specific diagnosis, Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS) codes were appropriate.
- Timeliness: In general, professional encounters were submitted and processed by HFS in a timely manner. For both health plans, less than 60 percent of pharmacy encounters had been processed by HFS within 120 days of the dates of service, which suggests an opportunity for improvement.
- Cost Analysis: The average cost PMPM for **Aetna** was higher than **Meridian**'s average cost PMPM. This was mainly because approximately 95 percent of **Meridian**'s members were enrolled in the VMC program in 2013, while nearly all of **Aetna**'s members were enrolled in the ICP. The ICP is for seniors and persons with disabilities whose recipients seem to utilize services more often and use more expensive services such as inpatient, outpatient, and ambulatory surgical treatment.

Recommendations

Based on the findings from the administrative analyses of HFS' encounter data, HSAG recommends the following:

- HFS should work with **Aetna** to improve its acceptance rate for the institutional encounters.
- HFS should work with **Aetna** to determine the reason(s) why multiple DCNs had been assigned to the professional services that occurred on the same day for the same member and from the same provider.
- When monitoring the monthly encounter volume, the criteria for the ICP and VMC program should be different. In addition, encounters PMPM may be a better monitoring metric than the monthly encounter counts, especially during the program start-up period, since the number of members enrolled each month generally varies greatly.
- For inpatient encounters, the percentage of records with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure codes present for **Aetna** was 48.9 percent, which was nearly 30 percentage points lower than **Meridian**. HFS may want to investigate the reason(s) for this difference.
- HFS should work with both health plans to identify the barriers for the pharmacy encounter submission so that HFS can obtain the pharmacy data in a timely manner. In addition, there is room for HFS and **Aetna** to work together to improve the timeliness of the institutional encounters.
- When monitoring the cost PMPM, the criteria for the ICP and VMC program should be different. In addition, cost PMPM may be a better monitoring metric than the monthly cost,

especially during the program start-up period, since the number of members enrolled each month generally varies greatly.

- Currently there are no data elements in the encounter data (in monthly claims care coordination data [CCCD] format) to indicate whether **Meridian**'s encounters were from the ICP or VMC program. Since encounter data monitoring metrics for the two programs will be different, HFS should consider adding a data element to indicate to which program the encounter belongs.
- During the preliminary data review stage, HSAG worked with HFS to clarify which health plan some of the institutional encounters were associated with since HSAG could not use the "PayeeID" field to assign them. This issue was solved by an extra crosswalk file HFS provided. Since more health plans will be coming on board for the managed care programs, HFS should consider implementing changes to prevent this issue from recurring.
- The encounter data extracted for this EDV study were in the CCCD format. HSAG noticed that the data element "ProcCd" in the procedure file contained the CPT/HCPCS codes for the professional encounters and the ICD-9-CM procedure codes for the inpatient encounters. In addition, the data element "Revenue HCPCS" (Healthcare Common Procedure Coding System) in the revenue file contained the CPT/HCPCS codes for the inpatient/outpatient encounters. Since this file structure may confuse the clients using this file layout, HFS should consider clarifying this potential issue (i.e., update the CCCD Data Dictionary) or making changes to the CCCD file layout for those data elements.
- Currently, data element "MCO Payment Amount" was not populated for the pharmacy encounters in the CCCD layout. HFS should continue its effort to obtain values for this data element.

Study Limitations

When evaluating the findings presented in this report, it is important to understand the following limitations associated with this study:

- The findings from this study were for the encounters with beginning dates of service in calendar year 2013 and from **Aetna** and **Meridian**; therefore, the findings may not be applicable to other MCOs or for a different study period.
- Current Illinois law requires HFS to withhold the reporting of substance abuse and human immunodeficiency virus (HIV)-related data from CCCD. Therefore, no encounters related to substance abuse and HIV were included in this EDV study. In addition, dental, long-term care, and mental health encounters were also not included in this EDV study since none of them were available for the data extraction in July 2014.

- The findings from this assessment provided a series of baseline results and established a foundation for reporting and monitoring activities.

Validation of State Performance Measures for Primary Care Case Management (PCCM)/Children's Health Insurance Program Reauthorization Act (CHIPRA)

Introduction

HFS contracts with HSAG to conduct annual validation of performance measures for the PCCM Program, the ICP, and CHIPA.

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 2.0, September 2002 (the CMS Performance Measure Validation Protocol)*. HSAG also uses the *National Committee for Quality Assurance (NCQA) manual, HEDIS 2013 Compliance Audit: Standards, Policies and Procedures, Volume 5*.

Conducting the Review

The primary objectives of the performance measure validation (PMV) process are to:

- Evaluate the processes used to collect the performance measure data by HFS.
- Determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.

HFS identifies the performance measurement period for validation for each program for the reporting year. HFS opts to use selected NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as non-HEDIS performance measures designed specifically for the PCCM, ICP, and CHIPRA programs. The set of performance measures selected by HFS differs by program, but many of the measures that are classified as non-HEDIS measures are very similar to existing or retired HEDIS measures.

Pre-Audit Activities

HSAG requests that HFS submit an Information Systems Capabilities Assessment Tool (ISCAT); source code for each performance measure and any additional supporting documentation necessary to complete the audit; and a list of the measures under the scope of the audit. A conference call is conducted to answer questions and prepare for the audit.

Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of these data:

- **ISCAT**: HFS was responsible for completing and submitting the ISCAT document to HSAG. Upon receipt, HSAG conducted a cursory review of the ISCAT to ensure that HFS completed all sections and included all needed attachments. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used the information in the ISCAT to complete the review tools, as applicable.
- **Source code (programming language) for performance measures:** HSAG requested source code (computer programming language) from HFS for all performance measures. HSAG source code reviewers completed a line-by-line code review and evaluation of program logic flow to ensure compliance with State measure definitions. The source code reviewers identified areas of deviation and shared them with HFS for adjustment. The source code reviewers also informed the audit team of any deviations from the measure specifications so the team could evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- **Supporting documentation**: HSAG requested documentation and data queries that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for follow-up.

Reporting

To validate the performance measures, data from various sources, including provider data, claims/encounter systems, and enrollment data, must be audited. The auditor scrutinizes these processes and makes a determination as to the validity of the data collected. HSAG uses a variety of audit methods, including analysis of computer programs, primary source verification, and staff member interviews to determine a result for each measure.

Focused Review

Insourcing of Delegated Functions

Behavioral Health (BH) Insourcing

During the reporting year, **Harmony** notified HFS that the health plan had made a business decision to insource BH services from the delegated vendor, Magellan, back into health plan operations. HFS requested that HSAG conduct a focused review to evaluate **Harmony**'s readiness to transition BH services from Magellan to **Harmony**'s corporate office.

Conducting the Review

This focused review consisted of establishing regular calls with **Harmony** to communicate the documentation needed to complete the BH insourcing review, desk review of required documents, and follow-up of any outstanding items identified during the desk review. HSAG, in collaboration with HFS, conducted the desk review to evaluate contract requirements in the following key operational areas:

- BH Network Capacity
- Care Management/Care Coordination
- Crisis Plans
- Utilization Management

The review consisted of establishing regular calls with the health plan to communicate the documentation needed to complete a BH insourcing review, desk review of required documents, and follow-up of any outstanding items identified during the desk review.

To assess the adequacy of the BH network, **Harmony** was required to submit a network data file to HSAG that contained a list of all contracted BH provides within the **Harmony** service areas. HSAG analyzed the network data to assess the number and types of BH providers by counties within the **Harmony** service area. **Harmony**'s member and provider notification letters were also reviewed by HSAG and approved by HFS to ensure the change of BH providers and services was communicated to the enrollees. HSAG also reviewed the policies and procedures pertinent to the contract requirements for BH services and assessed if **Harmony**' care management/care coordination resources were sufficient and staff appropriately qualified to manage and coordinate services for enrollees with BH needs. Finally, HSAG reviewed **Harmony**'s policies/procedures and available resources to ensure sufficiency to handle any behavioral healthcare requests for services and denials of care based on medical necessity (including having appropriately qualified physicians, healthcare practitioners, or pharmacists available for review).

Findings

Based on the review described above, HSAG recommended that HFS approve **Harmony**'s insourcing of BH services as of December 1, 2013, with continued monitoring in designated improvement areas as determined by the review.

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, HSAG assists and attends HFS' on-site quarterly meetings with the health plans 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 Medicaid 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 health plans' 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 health plans and HFS to ensure timely completion of those items. HSAG provides status updates to HFS so it can track health plan progress on completing follow-up items.

Technical Assistance (TA) to HFS and Health Plans

TA to HFS

Technical assistance is one of the activities identified by CMS that EQROs can provide to state Medicaid agencies as well as health plans.

HSAG has provided a variety of technical assistance to HFS that has led to quality outcomes. This includes technical assistance in the following areas: PIPs, grievance and appeals process, care

management/care coordination programs, CAHPS sampling and development of CAHPS supplemental questions, pay-for-performance (P4P) program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS Waiver program requirements, and much more.

Specific examples of technical assistance topics conducted to assist HFS in SFY 2014 are described below.

Development of Performance Measures

Throughout SFY 2014, HSAG continued to assist HFS in developing performance measures that would meet the unique demands of the Family Health Plans/Affordable Care Act (FHP/ACA) health plans, Care Coordination Entities (CCEs), Accountable Care Entities (ACEs), and Medicare-Medicaid Alignment Initiative (MMAI) health plans. HSAG worked collaboratively with HFS to identify and develop performance measures specific to each of the programs and the populations they currently serve as part of the care coordination expansion.

HSAG has provided technical assistance in the development and selection of performance measures in the following areas:

- HEDIS, HEDIS-like, and State-defined measure recommendations.
- Developing a rate reporting workbook for collection and reporting of the HEDIS, HEDIS-like, and State-defined rates for the VMC and ICP health plans.
- Developing and updating performance measure specifications for HEDIS-like and State-defined performance measures (*Performance Measures Resource Manual for Adults and Seniors with Disabilities Manual).*
- Assisting HFS with methodologies for establishing performance improvement benchmarks for the HEDIS and non-HEDIS performance measures.
- Developing validation tools for the MMAI program care goals and Americans with Disabilities Act (ADA) performance measures.

Network Capacity Reporting

HSAG produced over 50 ad hoc network capacity reports for HFS during SFY 2014. The reports were requested by HFS throughout the ICP expansion process, and during the readiness and implementation processes of the MMAI health plans and ACEs. The reports included a range of topics, from samples of HCBS and BH providers for the MMAI health plan readiness reviews to a specific zip code analysis in Cook County for implementation of the ICP.

Some of the reports were requested in order to provide information to CMS prior to implementation of the MMAI program. HSAG provided eight samples of MMAI HCBS provider

files to CMS for validation surveys as well as eight time/distance analyses of skilled nursing facilities (SNFs) and BH providers for the MMAI health plans.

At the request of HFS, HSAG wrote numerous reports that provided analyses which focused on an area of concern, such as the following examples:

- Analysis of HFS utilization data for HCBS providers in Greater Chicago and Central regions.
- Analysis of the number of primary care providers (PCPs), specialists, and acute inpatient hospitals contracted with ICP health plans serving the Greater Chicago region.
- Comparative analysis of ICP health plan networks for contracted HCBS providers in the Central Region.
- Comparative analysis of MMAI health plan networks for HCBS providers in the Central Region.
- Analysis of contracted SNFs in the Central region.
- Analysis of the children's hospitals in Illinois and St. Louis, Missouri.
- A report describing the provider network review process.

HSAG also developed multiple reports during the reporting year to monitor the continued development of provider networks in each of the Medicaid managed care regions. Ad hoc reports that were produced for HFS included:

- Analyses of the contracted HCBS providers in Greater Chicago and Central Illinois for MMAI program.
- Analyses of the total number of PCPs, specialists, hospitals, and long-term acute care (LTAC) facilities in the networks of each health plan participating in the MMAI program.
- Analyses of the contracted SNFs for each ICP health plan.
- Comparative analyses of seven health plans' contracted PCPs, specialists, hospitals, facilities, pharmacies, HCBS, and BH providers in ZIP code zones in Cook County.
- Comparative analyses of the contracted provider network for ICP health plans in the Greater Chicago and Central regions.
- Analyses of the number of community mental health centers (CMHCs) affiliated with ACEs.

Care Coordination Expansion Map

Given the significant expansion occurring during the 2013–2014 reporting year, HFS requested HSAG to design a graphical depiction that could be shared with stakeholders to document expansion efforts. As a result, HFS and HSAG created the Care Coordination Expansion Map, which demonstrates which health plans are operating in regions across the State of Illinois, and in which programs those plans participate. HFS used the map to inform stakeholders and legislators of expansion progress, and was displayed publicly on the HFS website. In addition to the initial development of the map, HSAG provided ongoing technical assistance to periodically update the

map to reflect up-to-date expansion. The most recent version of the expansion map can be found at: http://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys Sampling Methodology

HFS requested that HSAG develop a proposed sampling methodology for conducting CAHPS surveys of adult Medicaid beneficiaries enrolled in ICP health plans including **Aetna** and **IlliniCare**.

The sampling methodology was developed to meet 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. The sampling plan was designed to report at the waiver level by conducting a simple random sample and targeted oversample at this level.

In SFY 2014, HSAG conducted meetings to review the CAHPS sampling methodology with ICP health plans and their CAHPS vendors for inclusion of the waiver populations in the survey.

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 to meet 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 health plans for inclusion in their CAHPS surveys.

The following supplemental questions were developed for the waiver population and approved by NCQA:

- Did you receive the services you needed when you needed them? (Waiver PM 34D)
- Did you receive all the services listed in your plan of care?(Waiver PM 40D)
- Were you treated well by your direct support staff? (Waiver PM 47G)

University of Illinois at Chicago (UIC)—Independent Evaluation of the Integrated Care Program

HFS contracted with UIC to conduct an independent evaluation of the ICP. UIC released the SFY 2014 report which presented results through the third year of the ICP's implementation. The SFY

2014 UIC report included the transition period to Service Package II services covered by the ICP health plans which included long-term services and supports. HSAG worked extensively with UIC and HFS to assist UIC with the evaluation process. HSAG conducted meetings with HFS throughout SFY 2014 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 provider network data validation and performance measures. In 2013, HFS expanded HSAG's responsibilities to include ongoing monitoring of the development and maintenance of the ICP health plan provider networks. HSAG worked with HFS and the ICP health plans to standardize the format to be used to report the number of signed providers in their networks. HSAG created standardized provider categories for the ICP health plans to use in reporting their providers, instituted an active protocol to detect and minimize duplications of providers, and expanded reporting to include counts of providers by counties within the ICP. As a result, the UIC team was able to obtain extensive provider network data from HSAG. The team used the HSAG Network Capacity Reports for December 2013 and December 2014 in the study's analysis of provider networks. HSAG also evaluated both ICP health plans for their performance on two sets of the three quality indicators including P4P measures and the non-P4P HEDIS measures for Service Package 1 (SP1). In addition, for the first time, HSAG evaluated the quality of Service Package 2 (SP2) in 2014. Reports for outcome measures for both SP1 and SP2 were received and used for analysis by the research team. At the request of HFS, HSAG will continue to support the UIC evaluation process through the provision of reports and data.

TA to Health Plans

HSAG has worked with HFS and the health plans 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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services for children; perinatal care, postpartum care, and depression screening for women; and care coordination following hospitalizations by linking enrollees to community resources.

HSAG understands the importance of providing ongoing and specific technical assistance to each health plan, 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 health plans 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 health plans 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 to assist the health plans in SFY 2014 are described below.

Conducting PIPs

HSAG conducts ongoing technical assistance with the health plans to provide training in the PIP activities identified below to ensure that the health plans' PIPs are designed, conducted, and reported in a methodologically sound manner.

- 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

PIP Training

HFS is requiring all health plans serving FHP/ACA and ICP members to participate in a new BH collaborative PIP (BH PIP). During this reporting year, HSAG conducted a training session to discuss how the health plans are to collaborate on development of the BH PIP. The collaborative process and sample study questions were reviewed during the training, and the health plans were asked to begin identifying staff members to be assigned to the BH PIP. The health plans will then work with HFS and HSAG to develop the study question and indicators. The BH PIP is scheduled to begin development in SFY 2015, with baseline measurement occurring in SFY 2016.

CCEs Reporting

HSAG provided a Care Coordination Report (CCR) Template. The purpose of this report was to track the number of health risk screenings, comprehensive assessments, and care plans completed for each client enrolled within a CCE program. Based on the information collected within this report, HFS was able to assess whether or not the CCE was successful in completing the initial steps of the newly developed care coordination model program. While monitoring these reports, HSAG observed discrepancies in the way each of the CCEs were completing the templates. Technical calls between HFS and the CCEs were scheduled to provide uniform instructions on completing this report. After several discussions with the CCEs, HFS redeveloped the CCR and continued to collect and monitor the data submitted within the report.

CCE Annual Report Outline

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. Assistance was provided through 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.

Contract Language

CCE

Technical assistance for the CCE program 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.

ACE

Technical assistance for the ACE program included researching and reviewing contract language and standards, and assisting with development of performance measures. HSAG consulted the ACEs on the risk stratification process, development of health risk screening tools, and overall assistance with implementation with their care coordination programs.

Consumer Satisfaction Surveys

Objectives

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) 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 Better Health** (**Aetna**), **Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), **IlliniCare Health Plan, Inc.** (**IlliniCare**), and **Meridian Health Plan, Inc.** (**Meridian**) were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. Results for all five plans were forwarded to Health Services Advisory Group, Inc. (HSAG), for analysis. The CAHPS results are presented by program type, with **FHN**, **Harmony**, and **Meridian** under Voluntary Managed Care (VMC), and **Aetna** and **IlliniCare** under the Integrated Care Program (ICP).

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their healthcare experiences.

Technical Methods of Data Collection and Analysis

Voluntary Managed Care Organizations (VMCOs)

For **FHN**, **Harmony**, and **Meridian** the adult Medicaid and child Medicaid populations were surveyed. The Myers Group administered the CAHPS surveys on behalf of **FHN** and **Harmony**. Morpace administered the CAHPS surveys on behalf of **Meridian**.

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**, **Harmony**, and **Meridian** used a mixed methodology for data collection, which included both mail and telephone surveys for data collection, and offered the surveys in English or Spanish.

ICP Health Plans

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 mail and telephone surveys for data collection, and offered the surveys in English or Spanish.

Survey Measures for CAHPS

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 healthcare. 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). The National Committee for Quality Assurance (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, if available, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. **Meridian**'s results were not available when the minimum reporting threshold of 100 respondents was not met for a CAHPS measure; therefore, **Meridian**'s measures with fewer than 100 respondents are denoted in the tables as Not Available (NA).

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 three categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2) "Not At All," "A Little," "Some," and "A Lot" or (3) "No" and "Yes." For 2014, 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 "A Lot" or "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 2013 to 2014. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points from 2013 to 2014.[8-1] Additionally, for **FHN**, **Harmony**, **Meridian**, **Aetna**, and **IlliniCare**, a substantial

[8-1] 2014 represents the first year **Meridian** administered the standard CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys to its adult and child populations. Therefore, the 2014 Adult and Child CAHPS results presented in this report for **Meridian** represent baseline results, and 2013 CAHPS results are not available for comparisons.

difference is noted when a measure's rate is 5 percentage points higher or lower than the 2014 NCQA CAHPS top-box average.

Due to changes to the *Shared Decision Making* composite measure, comparisons to NCQA CAHPS national averages could not be performed for this measure for 2014.

Plan-specific Findings and Comparisons

VMCOs

Family Health Network

Adult Medicaid

The Myers Group collected 408 valid surveys from the eligible **FHN** adult Medicaid population of 2,198 members from January through May 2014, yielding a response rate of 18.6 percent. The overall NCQA target number of valid surveys is 411, though this is not a requirement or reporting threshold. **FHN**'s 2013 and 2014 adult Medicaid CAHPS top-box percentages are presented in Table 8.1.

Table 8.1—FHN Adult Medicaid CAHPS Results

	2013 Top-Box Percentages	2014 Top Box Percentages
Composite Measures		
Getting Needed Care	78.0%	69.0%
Getting Care Quickly	74.8%	73.2%
How Well Doctors Communicate	90.0%	87.9%
Customer Service	89.8%+	84.1%
Shared Decision Making	50.7%+	55.7%+
Global Ratings		
Rating of All Health Care	48.3%	47.0%
Rating of Personal Doctor	58.6%	62.7%
Rating of Specialist Seen Most Often	60.4%+	69.4%+
Rating of Health Plan	47.8%	56.9%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Indicates the 2014 top-box rate is substantially below the 2014 NCQA CAHPS national average.

A comparison of **FHN**'s 2013 results to its 2014 results revealed that **FHN**'s rates increased for four measures: *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. The rate increases were substantial for *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. However, a comparison of **FHN**'s 2013 results

to its 2014 results revealed that **FHN**'s rates decreased for five measures: *Getting Needed Care, Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care*. The rate decreases were substantial for *Getting Needed Care* and *Customer Service*. **FHN** scored substantially below the 2014 NCQA CAHPS top-box national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Child Medicaid

The Myers Group collected 530 valid surveys from the eligible **FHN** child Medicaid population from January through May 2014, yielding a response rate of 19.6 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2013 and 2014 child Medicaid CAHPS top-box percentages are presented in Table 8.2.

Table 8.2—FHN Child Medicaid CAHPS Results

	2013 Top-Box Percentages	2014 Top Box Percentages
Composite Measures		
Getting Needed Care	73.8%	75.7%
Getting Care Quickly	77.8%	76.6%
How Well Doctors Communicate	88.7%	91.3%
Customer Service	85.1%	84.1%
Shared Decision Making	55.9%+	48.1%+
Global Ratings		
Rating of All Health Care	55.8%	58.9%
Rating of Personal Doctor	70.9%	73.9%
Rating of Specialist Seen Most Often	58.1%+	64.3%+
Rating of Health Plan	57.3%	65.8%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Indicates the 2014 top-box rate is substantially below the 2014 NCQA CAHPS national average.

A comparison of **FHN**'s 2013 results to its 2014 results revealed that **FHN**'s rates increased for six measures: *Getting Needed Care, How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. The rate increases were substantial for two measures: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. However, rates for three measures decreased from 2013—*Getting Care Quickly*, *Customer Service*, and *Shared Decision Making*; of these, the decrease was substantial for *Shared Decision Making*. In comparison to NCQA national averages, **FHN** scored substantially below the 2014 NCQA CAHPS top-box national average on four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

Harmony Health Plan

Adult Medicaid

The Myers Group collected 549 valid surveys from the eligible **Harmony** adult Medicaid population from January through May 2014, yielding a response rate of 20.6 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2013 and 2014 adult Medicaid CAHPS top-box percentages are presented in Table 8.3.

Table 8.3—Harmony Adult Medicaid CAHPS Results

	2013 Top-Box Percentages	2014 Top Box Percentages
Composite Measures		
Getting Needed Care	71.3%	69.8%
Getting Care Quickly	73.8%	74.3%
How Well Doctors Communicate	87.2%	88.7%
Customer Service	83.5%	86.9%
Shared Decision Making	54.0%	48.1%
Global Ratings		
Rating of All Health Care	43.1%	36.6%
Rating of Personal Doctor	51.3%	55.3%
Rating of Specialist Seen Most Often	52.0%+	57.5%+
Rating of Health Plan	37.2%	38.8%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Indicates the 2014 top-box rate is substantially below the 2014 NCQA CAHPS national average.

A comparison of **Harmony**'s 2013 results to its 2014 results showed an increase in rates for six measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, *Rate of Specialist Seen Most Often*, and *Rating of Health Plan*. A substantial increase was displayed in only one of these measures, *Rating of Specialist Seen Most Often*. Three measures showed a decrease in rates from 2013 to 2014: *Getting Needed Care*, *Shared Decision Making*, and *Rating of All Health Care*. The decrease in rates was substantial for two of these measures, *Shared Decision Making* and *Rating of All Health Care*. **Harmony** scored substantially below the 2014 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 539 valid surveys from the eligible **Harmony** child Medicaid population from January through May 2014, yielding a response rate of 18.4 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2013 and 2014 child Medicaid CAHPS top-box percentages are presented in Table 8.4.

Table 8.4—Harmony Child Medicaid CAHPS Results

	2013 Top-Box Percentages	2014 Top Box Percentages
Composite Measures		
Getting Needed Care	73.6%	72.6%
Getting Care Quickly	79.5%	74.8%
How Well Doctors Communicate	89.4%	89.3%
Customer Service	86.5%	85.7%
Shared Decision Making	54.7%+	52.7%+
Global Ratings		
Rating of All Health Care	55.8%	55.4%
Rating of Personal Doctor	69.7%	70.6%
Rating of Specialist Seen Most Often	70.7%+	70.0%+
Rating of Health Plan	43.6%	55.9%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Indicates the 2014 top-box rate is substantially below the 2014 NCQA CAHPS national average.

A comparison of **Harmony**'s 2013 results to its 2014 results showed an increase in rates for two measures: *Rating of Personal Doctor* and *Rating of Health Plan*. Only one of these measures, *Rating of Health Plan*, demonstrated a substantial increase. **Harmony**'s rate decreased from 2013 to 2014 for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care,* and *Rating of Specialist Seen Most Often*. None of these measures showed a substantial decrease. **Harmony** scored substantially below the 2014 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*.

Meridian Health Plan

Adult Medicaid

Morpace collected 490 valid surveys from the eligible **Meridian** adult Medicaid population from January through May 2014, yielding a response rate of 28.3 percent. The overall NCQA target

number of valid surveys is 411. It is important to note that 2014 represents the first year **Meridian** participated in the CAHPS surveys; therefore, the 2014 rates represent a baseline assessment of adult members' satisfaction with **Meridian** as measured through the CAHPS survey. **Meridian**'s 2014 adult Medicaid CAHPS top-box percentages are presented in Table 8.5.

Table 8.5—Meridian Adult Medicaid CAHPS Results

	2014 Top-Box Percentages
Composite Measures	
Getting Needed Care	85.0%
Getting Care Quickly	84.1%
How Well Doctors Communicate	89.8%
Customer Service	92.3%
Shared Decision Making	54.4%
Global Ratings	
Rating of All Health Care	56.7%
Rating of Personal Doctor	66.4%
Rating of Specialist Seen Most Often	73.4%
Rating of Health Plan	62.0%
Indicates the 2014 top-box rate is substantially above the 2014 NCQA CAHPS national average.	

Meridian scored substantially above the 2014 NCQA CAHPS top-box national averages on three measures: *Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

Child Medicaid

Morpace collected 480 valid surveys from the eligible **Meridian** child Medicaid population from January through May 2014, yielding a response rate of 29.4 percent. The overall NCQA target number of valid surveys is 411. It is important to note that 2014 represents the first year **Meridian** participated in the CAHPS surveys; therefore, the 2014 rates represent a baseline assessment of parents'/caretakers' satisfaction of child members enrolled in **Meridian** as measured through the CAHPS survey. **Meridian**'s 2014 child Medicaid CAHPS top-box percentages are presented in Table 8.6.

Table 8.6—Meridian Child Medicaid CAHPS Results

	2014 Top-Box Percentages
Composite Measures	
Getting Needed Care	82.6%
Getting Care Quickly	89.8%
How Well Doctors Communicate	93.1%
Customer Service	93.0%
Shared Decision Making	52.5%
Global Ratings	
Rating of All Health Care	65.6%
Rating of Personal Doctor	74.1%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	75.7%

NA indicates there were fewer than 100 respondents for a CAHPS measure and results were not available for this measure.

Indicates the 2014 top-box rate is substantially above the 2014 NCQA CAHPS national average.

Meridian scored substantially above the 2014 NCQA CAHPS top-box national averages for two measures: *Customer Service* and *Rating of Health Plan*.

VMCO Comparisons

Adult Medicaid

Table 8.7 presents the 2014 adult Medicaid CAHPS results for **FHN**, **Harmony**, and **Meridian**.

Table 8.7—2014 Adult Medicaid CAHPS Results

	FHN	Harmony	Meridian
Composite Measures			
Getting Needed Care	69.0%	69.8%	85.0%
Getting Care Quickly	73.2%	74.3%	84.1%
How Well Doctors Communicate	87.9%	88.7%	89.8%
Customer Service	84.1%	86.9%	92.3%
Shared Decision Making	55.7%+	48.1%	54.4%
Global Ratings			
Rating of All Health Care	47.0%	36.6%	56.7%
Rating of Personal Doctor	62.7%	55.3%	66.4%
Rating of Specialist Seen Most Often	69.4%+	57.5%+	73.4%
Rating of Health Plan	56.9%	38.8%	62.0%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). 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 showed that **Meridian** outperformed **FHN** and **Harmony** on eight of the nine CAHPS measures. For *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, and *Rating of Health Plan*, **Meridian** scored substantially higher than both **FHN** and **Harmony**. For *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*, **Meridian** scored substantially higher than **Harmony**. For 2014, **FHN** had the lowest rates among the three health plans for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. **FHN** also had the highest rate among the three plans on one measure, *Shared Decision Making*, and scored substantially higher than **Harmony** for this measure. For 2014, **Harmony** did not outperform **FHN** or **Meridian** on any of the measures and showed the lowest rates for five measures: *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Child Medicaid

Table 8.8 presents the 2014 child Medicaid CAHPS results for **FHN**, **Harmony**, and **Meridian**.

Table 8.8—2014 Child Medicaid CAHPS Results

	FHN	Harmony	Meridian
Composite Measures			
Getting Needed Care	75.7%	72.6%	82.6%
Getting Care Quickly	76.6%	74.8%	89.8%
How Well Doctors Communicate	91.3%	89.3%	93.1%
Customer Service	84.1%	85.7%	93.0%
Shared Decision Making	48.1%+	52.7%+	52.5%
Global Ratings			
Rating of All Health Care	58.9%	55.4%	65.6%
Rating of Personal Doctor	73.9%	70.6%	74.1%
Rating of Specialist Seen Most Often	64.3%+	70.0%+	NA
Rating of Health Plan	65.8%	55.9%	75.7%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NA indicates that there were fewer than 100 respondents and results were not available for the CAHPS measure.

A comparison of **FHN**'s, **Harmony**'s, and **Meridian**'s results show that **Meridian** outperformed **FHN** and **Harmony** on seven of the CAHPS 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 Health Plan*. Furthermore, **Meridian** scored substantially higher than both **FHN** and **Harmony** on five of these seven measures. **FHN** scored lowest among the health plans on two measures (*Customer Service* and *Shared Decision Making*) and scored lower than **Harmony** on one measure (*Rating of Specialist Seen Most Often*), but it did not score highest on any of the CAHPS

measures.[8-2] **Harmony** scored lowest among the three health plans on six measures and outperformed **FHN** and/or **Meridian** on two measures: *Shared Decision Making* and *Rating of Specialist Seen Most Often*.

ICP Health Plans

Aetna Better Health

Adult Medicaid

CSS collected 505 valid surveys from the eligible **Aetna** adult Medicaid population from February through May 2014, yielding a response rate of 39.9 percent. The overall NCQA target number of valid surveys is 411. **Aetna**'s 2013 and 2014 Adult Medicaid CAHPS top-box percentages are presented in Table 8.9.

Table 8.9—Aetna Adult Medicaid CAHPS Results

	2013 Top-Box Percentages	2014 Top Box Percentages
Composite Measures		
Getting Needed Care	75.6%	78.6%
Getting Care Quickly	76.8%	76.6%
How Well Doctors Communicate	89.7%	87.8%
Customer Service	80.2%	82.9%
Shared Decision Making	48.2%	55.0%
Global Ratings		
Rating of All Health Care	46.4%	44.0%
Rating of Personal Doctor	57.1%	59.1%
Rating of Specialist Seen Most Often	63.1%	59.7%
Rating of Health Plan	42.1%	47.9%
Indicates the 2014 top-box rate is substantially below the 2014 NCQA CAHPS national average.		

From 2013 to 2014, **Aetna** showed rate increases for five of the nine measures, including *Getting Needed Care, Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Two measures displayed a substantial increase: *Shared Decision Making* and *Rating of Health Plan*. **Aetna** scored more than 5 percentage points below the 2014 NCQA CAHPS top-box national average for three measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

[8-2] **Meridian** had fewer than 100 respondents for the *Rating of Specialist Seen Most Often* global rating measure and was not able to report a rate for this measure; therefore, only **FHN**'s and **Harmony**'s scores could be compared.

IlliniCare Health Plan

Adult Medicaid

The Myers Group collected 543 valid surveys from the eligible **IlliniCare** adult Medicaid population from January through May 2014, yielding a response rate of 32.8 percent. The overall NCQA target number of valid surveys is 411. **IlliniCare**'s 2013 and 2014 Adult Medicaid CAHPS top-box percentages are presented in Table 8.10.

Table 8.10—IlliniCare Adult Medicaid CAHPS Results

	2013 Top-Box Percentages	2014 Top Box Percentages
Composite Measures		
Getting Needed Care	76.3%	78.6%
Getting Care Quickly	80.7%	78.8%
How Well Doctors Communicate	90.2%	91.1%
Customer Service	84.3%	87.7%
Shared Decision Making	49.5%	46.9%
Global Ratings		
Rating of All Health Care	48.3%	46.8%
Rating of Personal Doctor	62.3%	61.7%
Rating of Specialist Seen Most Often	61.4%	67.1%
Rating of Health Plan	46.1%	52.6%

Five out of nine measures for **IlliniCare** showed an increase in rates from 2013 to 2014: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Two measures showed a substantial increase—*Rating of Specialist Seen Most Often* and *Rating of Health Plan*. Four measures showed rate declines—*Getting Care Quickly, Shared Decision Making*, *Rating of All Health Care*, and *Rating of Personal Doctor*; however these decreases were not substantial.

ICP Health Plan Comparisons

Adult Medicaid

Table 8.11 presents the 2014 adult Medicaid CAHPS results for **Aetna** and **IlliniCare**.

Table 8.11—2014 Adult Medicaid CAHPS Results

Measure Name	Aetna	IlliniCare
Composite Measures		
Getting Needed Care	78.6%	78.6%
Getting Care Quickly	76.6%	78.8%
How Well Doctors Communicate	87.8%	91.1%
Customer Service	82.9%	87.7%
Shared Decision Making	55.0%	46.9%
Global Ratings		
Rating of All Health Care	44.0%	46.8%
Rating of Personal Doctor	59.1%	61.7%
Rating of Specialist Seen Most Often	59.7%	67.1%
Rating of Health Plan	47.9%	52.6%

Aetna scored substantially higher than **IlliniCare** on one measure, *Shared Decision Making*. **IlliniCare** scored higher than **Aetna** on seven measures: *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*. For *Rating of Specialist Seen Most Often*, **IlliniCare** scored substantially higher than **Aetna**.

Conclusions and Recommendations—VMCOs

The following provides a summary of the CAHPS survey findings for **FHN**, **Harmony**, and **Meridian**. 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 of the health plan's CAHPS results to NCQA national averages.

Conclusions

Family Health Network

Based on **FHN**'s 2014 adult and child Medicaid CAHPS results, **FHN** has several areas that can be improved. **FHN** should focus on those areas for which rates were below CAHPS national averages and had also decreased from 2013 to 2014.

For the adult Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care*.

For the child Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Care Quickly* and *Customer Service*.

Harmony Health Plan

Based on **Harmony**'s 2014 adult and child Medicaid CAHPS results, **Harmony** should focus on those areas for which rates were below CAHPS national averages and had also decreased from 2013 to 2014.

For the adult Medicaid population, **Harmony** showed a decrease in rates and scored substantially lower than the CAHPS national average for *Getting Needed Care* and *Rating of All Health Care*. 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 areas of *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

Meridian Health Plan

Based on its 2014 adult and child Medicaid CAHPS results, **Meridian** should focus on those areas for which rates were only slightly above or below CAHPS national averages.

For the adult Medicaid population, **Meridian** did not have any measures with rates that fell below the 2014 NCQA CAHPS national averages. However, the rate for *How Well Doctors Communicate* was only slightly higher than the CAHPS national average. As such, **Meridian** should focus on improving in this area.

For the child Medicaid population, **Meridian** should focus on improving performance in the areas of *Getting Needed Care* and *Rating of All Health Care* since the rates for these measures were below the CAHPS national averages.

Recommendations for VMCOs

Based on **FHN**'s, **Harmony**'s, and **Meridian**'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 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.

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.

How Well Doctors Communicate

- Health plans can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Further, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.
- Often, health information is presented to patients in a way that is too complex and technical, which can result in patient nonadherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Providing training for healthcare workers on how to use these materials with their patients and ask questions to gauge patient understanding can also help improve patients' level of satisfaction with provider communication. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.
- Health plans could consider hiring interpreters who serve as full-time staff members at provider offices with a high volume of non-English-speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationships between the patient and family members with their physician.

Customer Service

- An evaluation of current health plans' call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- Health plans could consider implementing a training program to meet the needs of their unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member

encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they return to the job.

- Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

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 Specialist Seen Most Often

- Health plans could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.
- Health plans could create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

- Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Further, the local provider is more involved in the consultation process and more informed about care the patient is receiving.

Conclusions and Recommendations—ICP Health Plans

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.

Conclusions

Aetna Better Health

For the adult Medicaid population, **Aetna** should focus on the measures which showed the least improvement from 2013 to 2014: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

IlliniCare

For the adult Medicaid population, **IlliniCare** showed a decrease in rates for *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Personal Doctor*. **IlliniCare** should focus on improving the rates for these measures.

Recommendations

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 both health plans. Each health plan should evaluate these general recommendations in the context of its own operational and 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.

Shared Decision Making

- Health plans should encourage skills training in shared decision making for all physicians. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process, ensuring that physicians understand the importance of taking each patient's values into consideration, and understanding patients' preferences and needs.
- Health plans can provide physicians with literature and materials to encourage shared decision making between physicians and patients. Materials such as healthcare goal-setting handouts and forms can assist physicians in facilitating the shared decision making process with their patients. Health plans can also provide members with pre-structured question lists to assist members in asking all the necessary questions so the appointment is as efficient and effective as possible.

How Well Doctors Communicate

- Health plans can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Further, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.
- Often, health information is presented to patients in a way that is too complex and technical, which can result in patient nonadherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms

and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Providing training for healthcare workers on how to use these materials with their patients and ask questions to gauge patient understanding can also help improve patients' level of satisfaction with provider communication. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.

- Health plans could consider hiring interpreters who serve as full-time staff members at provider offices with a high volume of non-English-speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationships between the patient and family members with their physician.

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 Specialist Seen Most Often

- Health plans could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.
- Health plans could create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

- Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Further, the local provider is more involved in the consultation process and more informed about care the patient is receiving.

Access to Care Measures

HEDIS Measures	MER	FHN	HAR	All MCOs*	National Medicaid HEDIS 2013 Percentiles				
					10th	25th	50th	75th	90th
Children's Access to PCPs									
Children's Access to PCPs (12–24 Months)	98.50%	85.91%	89.98%	88.91%	92.37%	95.51%	96.89%	97.84%	98.49%
Children's Access to PCPs (25 months–6 Years)	95.36%	71.52%	76.47%	75.66%	82.76%	86.37%	89.39%	91.29%	93.60%
Children's Access to PCPs (7–11 Years)	97.00%	74.34%	75.63%	76.31%	83.43%	87.77%	90.88%	93.26%	95.25%
Adolescent's Access to PCPs (12–19 Years)	97.24%	74.25%	77.70%	77.51%	81.35%	86.09%	89.58%	91.85%	93.77%
Adults' Access to Preventive/Ambulatory Care									
20–44 Years of Age	87.08%	63.85%	70.38%	68.92%	68.53%	77.34%	82.33%	85.27%	88.32%
45–64 Years of Age	87.98%	65.66%	71.23%	70.25%	79.52%	84.55%	87.51%	90.41%	91.17%
***These rates represent the weighted averages.**									

	National Medicaid HEDIS 2013 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Prevention and Screening for Children and Adolescents

HEDIS Measures	MER	FHN	HAR	All MCOs**	National Medicaid HEDIS 2013 Percentiles				
					10th	25th	50th	75th	90th
Prevention and Screening for Children and Adolescents									
Childhood Immunizations—Combo 2	85.68%	71.06%	70.60%	72.02%	65.97%	70.44%	76.89%	81.74%	85.40%
Childhood Immunizations—Combo 3	83.37%	65.97%	66.44%	67.60%	61.95%	66.08%	72.88%	78.30%	83.32%
Lead Screening in Children	88.45%	78.24%	78.84%	79.35%	36.57%	58.50%	72.26%	82.24%	86.96%
Appropriate Testing for Children with Pharyngitis	52.23%	20.20%	34.15%	31.42%	50.84%	60.82%	70.30%	77.97%	85.09%
*Well-Child Visits in the First 15 Months (0 Visits)**	0.00%	1.62%	3.76%	2.47%	3.55%	2.13%	1.22%	0.73%	0.29%
Well-Child Visits in the First 15 Months (6+ Visits)	90.46%	51.39%	56.57%	57.27%	49.7%	55.95%	65.16%	70.90%	77.44%
Well-Child Visits (3–6 Years)	88.44%	71.06%	68.06%	70.14%	60.81%	67.40%	72.26%	78.51%	82.08%
Adolescent Well-Care Visits	74.58%	48.61%	49.77%	50.33%	37.27%	41.72%	48.18%	57.40%	65.45%
Immunizations for Adolescents	70.26%	53.47%	58.33%	57.38%	50.93%	58.06%	68.59%	77.08%	85.64%
Human Papillomavirus Vaccine for Female Adolescents	48.60%	16.90%	14.81%	16.75%	9.80%	14.12%	17.85%	22.14%	27.25%
Weight Assessment and Counseling—BMI (Total)	58.33%	60.65%	38.19%	46.38%	22.87%	37.96%	52.31%	69.68%	80.24%
Weight Assessment and Counseling—Nutrition (Total)	64.35%	59.72%	59.49%	59.87%	31.02%	47.45%	59.11%	67.91%	75.18%
Weight Assessment and Counseling—Physical Activity (Total)	37.73%	52.31%	54.86%	52.99%	20.92%	34.55%	46.23%	55.26%	64.72%

*** Lower rates indicate better performance for this measure. The percentiles have been reversed to be consistent with the color coding.**

****These rates represent the weighted averages.**

	National Medicaid HEDIS 2013 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

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	88.89%	52.67%	42.99%	46.53%	41.72%	46.54%	51.53%	57.85%	62.88%
Cervical Cancer Screening	80.65%	64.50%	72.73%	70.26%	47.22%	58.99%	66.38%	71.91%	76.64%
Chlamydia Screening (16–20 Years of Age)	46.90%	59.35%	44.13%	48.96%	41.05%	46.94%	53.82%	59.35%	66.38%
Chlamydia Screening (21–24 Years of Age)	71.28%	67.71%	56.60%	61.17%	51.52%	58.98%	64.29%	70.68%	73.45%
Chlamydia Screening (Combined Rate)	62.13%	63.78%	50.15%	55.11%	46.22%	51.18%	57.25%	63.42%	68.81%
Maternity-Related Measures									
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	0.86%	29.63%	12.79%	18.35%	27.39%	13.83%	8.27%	4.24%	2.32%
Frequency of Ongoing Prenatal Care (81–100% of Visits)	92.72%	29.17%	42.09%	42.24%	36.25%	50.97%	64.70%	73.97%	80.12%
Timeliness of Prenatal Care	94.03%	57.64%	70.00%	67.56%	70.59%	79.85%	85.88%	89.72%	92.82%
Postpartum Care	78.46%	44.44%	48.37%	49.99%	50.69%	57.91%	63.99%	70.20%	73.83%
*** Lower rates indicate better performance for this measure. The percentiles have been reversed to be consistent with the color coding.**									
****These rates represent the weighted averages.**									

	National Medicaid HEDIS 2012 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Chronic Conditions/Disease Management Measures

HEDIS Measures	MER	FHN	HAR	All MCOs**	National Medicaid HEDIS 2012 Percentiles				
					10th	25th	50th	75th	90th
Adult BMI Assessment	84.69%	NA	71.69%	72.27%	48.73%	62.53%	72.02%	78.71%	84.39%
Chronic Conditions/Disease Management									
Medication Management for Asthma—Total, 50%	94.31%	52.13%	44.32%	51.47%	40.74%	44.83%	50.94%	56.37%	61.66%
Medication Management for Asthma—Total, 75%	83.74%	29.41%	21.46%	29.74%	19.20%	22.17%	27.65%	32.89%	38.71%
Use of Appropriate Medications for Asthma—Total	92.86%	85.59%	84.73%	85.72%	77.30%	80.47%	84.64%	87.61%	89.76%
Controlling High Blood Pressure	78.50%	42.58%	50.00%	49.57%	44.77%	50.00%	56.20%	62.97%	69.55%
Diabetes Care (HbA1C Testing)	94.37%	74.29%	75.61%	75.94%	75.91%	79.23%	83.21%	87.32%	90.97%
*Diabetes Care (Poor HbA1c Control)**	73.24%	62.26%	56.76%	59.29%	59.48%	52.58%	43.02%	35.76%	31.14%
Diabetes Care (Good HbA1c Control)	23.94%	29.48%	34.59%	32.43%	34.58%	39.80%	48.57%	53.77%	58.64%
Diabetes Care (Eye Exam)	63.38%	72.88%	25.50%	42.99%	37.14%	44.37%	54.43%	62.46%	67.64%
Diabetes Care (LDL-C Screening)	91.55%	58.96%	59.20%	60.46%	66.79%	71.03%	76.28%	80.54%	83.52%
Diabetes Care (LDL-C Level <100 mg/dL)	29.58%	17.22%	20.62%	19.85%	21.76%	27.90%	34.69%	40.03%	43.80%
Diabetes Care (Nephropathy Monitoring)	88.73%	67.45%	72.73%	71.62%	69.76%	75.00%	79.28%	82.74%	85.85%
Diabetes Care (BP < 140/90)	67.61%	54.48%	58.54%	57.55%	45.67%	53.74%	60.93%	68.17%	74.55%

*** Lower rates indicate better performance for this measure. The percentiles have been reversed to be consistent with the color coding.**

****These rates represent the weighted averages.**

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Mental/Behavioral Health Measures

HEDIS Measures	MER	FHN	HAR	All MCOs*	National Medicaid HEDIS 2012 Percentiles				
					10th	25th	50th	75th	90th
Mental/Behavioral Health									
Follow-up After Hospitalization for Mental Illness—7 Days	41.94%	54.20%	61.68%	57.66%	21.33%	31.28%	44.65%	54.80%	68.79%
Follow-up After Hospitalization for Mental Illness—30 Days	65.59%	61.58%	69.80%	66.75%	38.29%	56.83%	65.75%	75.62%	81.98%
Antidepressant Medication Management—Effective	65.96%	46.82%	39.50%	43.81%	45.12%	48.30%	51.49%	56.17%	61.03%
Antidepressant Medication Management—Continuation	53.19%	29.48%	25.97%	29.21%	28.13%	32.07%	35.32%	40.17%	45.86%
***These rates represent the weighted averages.**									

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

ICP Non-Pay-for-Performance Rates for Reporting Year 2014															
Measure ID	Measure Description	Original Baseline Rates	QISMC Target Goal	Aetna						IlliniCare					
				Aetna 2013 Rate	2014 QISMC Goal	Aetna 2014 Rate	2014 QISMC Goal Status	Change from Baseline to 2014	Overall Result Baseline to 2014	IlliniCare 2013 Rate	2014 QISMC Goal	IlliniCare 2014 Rate	2014 QISMC Goal Status	Change from Baseline to 2014	Overall Result Baseline to 2014
	Access to Care Measures (Percentages)														
ADV	Annual Dental Visit	**23.92%**	**31.53%**	23.15%	31.53%	Retired	NA	NA	NA	20.47%	31.53%	Retired	NA	NA	NA
IIHR	Inpatient Hospital 30-Day Readmission Rate*	**8.31%**	**7.48%**	7.91%	7.12%	8.55%	Not Met	0.24%	**Declined**	12.82%	7.48%	11.72%	Not Met	3.41%	**Declined**
IIMR	Inpatient Mental Hospital 30-Day Readmission Rate*	**24.20%**	**21.78%**	23.34%	21.00%	23.93%	Not Met	-0.27%	**Improved**	27.61%	21.78%	25.28%	Not Met	1.08%	**Declined**
SAAP	Access to Member's Assigned PCP	**NA**	**NA**	NA	NA	50.26%	NA	NA	**NA**	NA	NA	51.44%	NA	NA	**NA**
	Preventive Care Measures (Percentages)														
ICCI	Care Coordination–Influenza Immunization	**9.92%**	**18.93%**	13.08%	21.77%	14.09%	Not Met	4.17%	**Improved**	10.72%	19.64%	12.03%	Not Met	2.11%	**Improved**
SCOL	Colorectal Cancer Screening	**NA**	**NA**	NA	NA	30.82%	NA	NA	**NA**	NA	NA	36.81%	Not Met	NA	**NA**
BCS	Breast Cancer Screening	**NA**	**NA**	NA	NA	46.09%	NA	NA	**NA**	NA	NA	47.58%	Not Met	NA	**NA**
CCS	Cervical Cancer Screening	**40.81%**	**46.73%**	31.87%	46.73%	43.85%	Not Met	3.04%	**Improved**	37.55%	46.73%	43.39%	Not Met	2.58%	**Improved**
ABA	Adult BMI Assessment	**NA**	**NA**	NA	NA	70.58%	NA	NA	**NA**	NA	NA	68.98%	Not Met	NA	**NA**
	Appropriate Care Measures (Percentages)														
MPM	Annual Monitoring for Patients on Persistent Medications—ACEI or ARBs	**86.00%**	**87.40%**	89.59%	90.63%	89.89%	Not Met	3.89%	**Improved**	89.21%	90.29%	90.66%	**Met**	4.66%	**Improved**
MPM	Annual Monitoring for Patients on Persistent Medications—Digoxin	**81.46%**	**83.32%**	94.04%	94.64%	86.81%	Not Met	5.35%	**Improved**	91.61%	92.45%	93.37%	**Met**	11.91%	**Improved**
MPM	Annual Monitoring for Patients on Persistent Medications—Diuretics	**86.60%**	**87.94%**	89.38%	90.45%	89.97%	Not Met	3.37%	**Improved**	89.66%	90.69%	91.71%	**Met**	5.11%	**Improved**
MPM	Annual Monitoring for Patients on Persistent Medications—Anti-convulsants	**74.49%**	**77.04%**	80.72%	82.65%	81.21%	Not Met	6.72%	**Improved**	78.77%	80.90%	80.21%	Not Met	5.72%	**Improved**
MPM	Annual Monitoring for Patients on Persistent Medications—Total	**84.12%**	**85.71%**	87.84%	89.05%	88.24%	Not Met	4.12%	**Improved**	87.67%	88.90%	89.33%	**Met**	5.21%	**Improved**
CDC	Comprehensive Diabetes Care—HbA1c Testing (DD Population)	**79.05%**	**81.15%**	80.26%	82.24%	83.95%	Met	4.90%	**Improved**	79.03%	81.15%	70.97%	Not Met	-8.08%	**Declined**
	Behavioral Health Measures (Percentages)														
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	**NA**	**NA**	80.89%	NA	81.29%	NA	NA	**NA**	70.97%	NA	76.20%	Not Met	NA	**NA**
IBHR	Behavioral Health Risk Assessment Completed within 60 Days of Enrollment	**NA**	**NA**	24.89%	NA	24.03%	NA	NA	**NA**	27.70%	NA	44.42%	Not Met	NA	**NA**
IBHR	Follow-up Completed within 30 Days of Positive BHRA	**NA**	**NA**	29.41%	NA	20.45%	NA	NA	**NA**	38.77%	NA	7.87%	Not Met	NA	**NA**
IET	Alcohol and Other Drug Dependence Treatment—Initiation	**45.71%**	**51.14%**	51.53%	56.38%	44.29%	Not Met	-1.42%	**Declined**	53.56%	58.21%	49.69%	Not Met	3.98%	**Improved**
IET	Alcohol and Other Drug Dependence Treatment—Engagement	**8.97%**	**18.07%**	6.12%	18.07%	7.75%	Not Met	-1.22%	**Declined**	5.00%	18.07%	6.68%	Not Met	-2.29%	**Declined**
FUH	Follow-Up After Hospitalization for Mental Illness, 7-Day follow-up	**34.67%**	**41.20%**	25.93%	41.20%	26.19%	Not Met	-8.48%	**Declined**	23.03%	41.20%	39.49%	Not Met	4.82%	**Improved**
	Utilization Measures (Per 1,000 Member Months)														
AMB	Ambulatory Care—ED Visits (DD Population)*	**112.06**	**100.85**	46.36	41.72	50.66	Not Met	-61.40	**Improved**	NR	100.85	41.95	**Met**	-70.11	**Improved**
IDER	Dental ED Visits*	**11.37**	**10.23**	0.80	0.72	0.97	Not Met	-10.40	**Improved**	0.73	0.65	0.76	Not Met	-10.61	**Improved**
	Inpatient Utilization (Per 1,000 Member Months)														
IPU	Inpatient Utilization—General Hospital/Acute Care: Total Inpatient Discharges	**40.35**	**NA**	27.65	NA	23.43	NA	-16.92	**NA**	27.32	NA	24.83	NA	-15.52	**NA**
IPU	Inpatient Utilization—General Hospital/Acute Care: Total Medicine Discharges	**28.95**	**NA**	19.34	NA	15.93	NA	-13.02	**NA**	19.29	NA	16.89	NA	-12.06	**NA**
IPU	Inpatient Utilization—General Hospital/Acute Care: Total Surgery Discharges	**10.78**	**NA**	7.79	NA	7.05	NA	-3.73	**NA**	7.61	NA	7.51	NA	-3.27	**NA**
IPU	Inpatient Utilization—General Hospital/Acute Care: Total Maternity Discharges	**0.62**	**NA**	0.66	NA	0.57	NA	-0.05	**NA**	0.57	NA	0.59	NA	-0.03	**NA**
	Mental Health Utilization Inpatient and Outpatient (Percentages)														
MPT	Mental Health Utilization—Any Services Total	**25.04%**	**NA**	22.92%	NA	25.61%	NA	0.57%	**NA**	16.84%	NA	16.70%	NA	-8.34%	**NA**
MPT	Mental Health Utilization—Inpatient Total	**6.11%**	**5.50%**	5.62%	5.06%	8.49%	Not Met	2.38%	**Declined**	4.20%	3.78%	5.36%	Not Met	-0.75%	**Improved**
MPT	Mental Health Utilization—Intensive outpatient/partial Hospitalization Total	**2.74%**	**NA**	0.24%	NA	0.20%	NA	-2.54%	**NA**	0.12%	NA	0.15%	NA	-2.59%	**NA**
MPT	Mental Health Utilization—Outpatient Total	**23.32%**	**30.99%**	21.03%	30.99%	21.55%	Not Met	-1.77%	**Declined**	15.19%	30.99%	14.39%	Not Met	-8.93%	**Declined**
	Long Term Care (Per 1,000 Member Months)														
IUTI	Long Term Care Urinary Tract Infection Admission Rate*	**2.17**	**1.95**	0.42	1.95	1.04	Met	-1.13	**Improved**	0.48	1.95	0.42	**Met**	-1.75	**Improved**
IBPR	Long Term Care Bacterial Pneumonia Admission Rate*	**2.42**	**2.17**	0.76	2.17	1.01	Met	-1.41	**Improved**	0.83	2.17	1.48	**Met**	-0.94	**Improved**
IPPU	Long Term Care Prevalence of Hospital Acquired Pressure Ulcers*	**NA**	**NA**	NA	NA	0.00	NA	NA	**NA**	NA	NA	0.97	NA	NA	**NA**
	Member Movement (Percentages)														
IMWS	Movement of Members—Started and Ended in Community	**NA**	**NA**	NA	NA	82.59%	NA	NA	**NA**	NA	NA	79.84%	NA	NA	**NA**
IMWS	Movement of Members—Started and Ended in HCBS (LTSS)	**NA**	**NA**	NA	NA	78.91%	NA	NA	**NA**	NA	NA	74.45%	NA	NA	**NA**
IMWS	Movement of Members—Started and Ended in LTC	**NA**	**NA**	NA	NA	80.95%	NA	NA	**NA**	NA	NA	73.41%	NA	NA	**NA**
IMWS	Movement of Members—Total Medicaid Members with No Movement	**NA**	**NA**	NA	NA	82.12%	NA	NA	**NA**	NA	NA	78.93%	NA	NA	**NA**
IMWS	Movement of Members–No Longer Enrolled	**NA**	**NA**	NA	NA	14.47%	NA	NA	**NA**	NA	NA	17.67%	NA	NA	**NA**

ICP Pay for Performance Rates for Reporting Year 2014																		
Measure ID	Measure Description	Original Baseline Rate	Original Target Goal	Aetna							IlliniCare						
				2013 Rate	New Target Goal	2014 Rate	Change 2014-2013	Change Status 2014-2013	2014 Goal Status	2014 Overall Status	2013 Rate	New Target Goal	2014 Rate	Change 2014-2013	Change Status 2014-2013	2014 Goal Status	2014 Overall Status
	Access / Utilization of Care																
IAPE	Ambulatory Care Follow-up with a Provider within 14-Days of ED Visit	40.25%	46.23%	40.92%	46.83%	42.24%	1.32%	Improved	NOT MET	NOT MET	40.11%	46.23%	40.28%	0.17%	Improved	NOT MET	NOT MET
IAPI	Ambulatory Care Follow-up with a Provider within 14-Days of Inpatient Discharge	46.85%	52.17%	54.10%	58.69%	52.87%	-1.23%	Declined	NOT MET	NOT MET	50.96%	55.86%	54.50%	3.54%	Improved	NOT MET	NOT MET
AMB	Ambulatory Care–ED Visits (**Per 1,000 Member Months**)*	178.23	160.41	76.93	69.24	75.69	-1.24	Improved	NOT MET	NOT MET	80.55	72.50	74.93	-5.62	Improved	NOT MET	NOT MET
ADV	Annual Dental Visit—DD Population	36.01%	42.41%	38.94%	Retired	Retired	NA	NA	NA	NA	28.12%	Retired	Retired	NA	NA	NA	NA
	Comprehensive Diabetes Care (CDC)			**The CDC Measure Requires a Goal Status of MET for 2 of #1-3, and 1 of #4-5**													
CDC	1. HbA1c Testing	77.13%	79.42%	83.39%	85.05%	85.62%	2.23%	Improved	MET	MET	79.69%	81.72%	85.42%	5.73%	Improved	MET	NOT MET
CDC	2. Nephropathy Monitoring	75.42%	77.88%	80.47%	82.42%	80.53%	0.06%	Improved	NOT MET		82.78%	84.50%	85.65%	2.87%	Improved	MET	
CDC	3. LDL-C Screening	75.63%	78.07%	80.84%	82.76%	83.63%	2.79%	Improved	MET		75.50%	78.07%	80.56%	5.06%	Improved	MET	
SCDC	4. Statin Therapy (80% of Eligible Days)	40.85%	46.77%	41.21%	47.09%	48.86%	7.65%	Improved	MET		38.32%	46.77%	42.11%	3.79%	Improved	NOT MET	
SCDC	5. ACEI / ARB Therapy (80% of Eligible Days)	38.38%	44.54%	40.40%	46.36%	51.88%	11.48%	Improved	MET		38.10%	44.54%	41.67%	3.57%	Improved	NOT MET	
	Congestive Heart Failure (CHF)			**The CHF Measure Requires a Goal Status of MET for 2 of #1-3**													
ICHF	1. ACEI / ARB Therapy 80% of the Time	32.40%	39.16%	44.61%	50.15%	55.81%	11.20%	Improved	MET	MET	36.48%	42.83%	39.41%	2.93%	Improved	NOT MET	NOT MET
ICHF	2. Beta Blockers 80% of the Time	30.40%	37.36%	68.90%	72.01%	88.07%	19.17%	Improved	MET		78.70%	80.83%	81.69%	2.99%	Improved	MET	
ICHF	3. Diuretics 80% of the Time	34.47%	41.02%	42.65%	48.39%	55.97%	13.32%	Improved	MET		42.86%	48.57%	45.14%	2.28%	Improved	NOT MET	
	Coronary Artery Disease (CAD)			**The CAD measure requires a Goal Status of MET for 2 of #1-4**													
ICAD	1. Cholesterol Testing	76.01%	78.41%	77.52%	79.77%	78.70%	1.18%	Improved	NOT MET	MET	74.72%	78.41%	79.79%	5.07%	Improved	MET	MET
ICAD	2. Statin Therapy 80% of the Time	42.74%	48.47%	45.75%	51.18%	53.90%	8.15%	Improved	MET		43.38%	49.04%	47.48%	4.10%	Improved	NOT MET	
ICAD	3. ACEI / ARB Therapy 80% of the Time	36.59%	42.93%	40.88%	46.79%	50.96%	10.08%	Improved	MET		37.69%	43.92%	39.37%	1.68%	Improved	NOT MET	
PBH	4. Persistence of Beta-Blocker Treatment After a Heart Attack	35.00%	41.50%	86.00%	87.40%	93.33%	7.33%	Improved	MET		87.80%	89.02%	96.43%	8.63%	Improved	MET	
	Pharmacotherapy Management of COPD Exacerbation (PCE)			**The PCE Measure Requires a Goal Status of MET for 2 of #1-3**													
PCE	1. Systemic Corticosteroid Dispensed Within of 14-days of the Event	62.08%	65.87%	69.97%	72.97%	69.21%	-0.76%	Declined	NOT MET	NOT MET	72.37%	75.13%	77.11%	4.74%	Improved	MET	NOT MET
PCE	2. Bronchodilator Dispensed Within 30-days of the Event	78.13%	80.32%	89.47%	90.52%	89.40%	-0.07%	Declined	NOT MET		90.79%	91.71%	89.88%	-0.91%	Declined	NOT MET	
SPR	3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD	29.67%	36.70%	NA	36.70%	NA	NA	NA	NA		NA	36.70%	NA	NA		NA	
	Behavioral Health																
FUH	Follow-up After Hospitalization for Mental Illness (FUH)—30-day Follow-up	55.42%	59.88%	44.03%	59.88%	49.59%	5.56%	Improved	NOT MET	NOT MET	40.90%	59.88%	55.11%	14.21%	Improved	NOT MET	NOT MET
AMM	Antidepressant Medication Management—Acute	52.05%	56.85%	55.44%	59.90%	76.99%	21.55%	Improved	MET	MET	49.31%	56.85%	50.82%	1.51%	Improved	NOT MET	NOT MET
AMM	Antidepressant Medication Management—Continuation	41.52%	47.37%	47.67%	52.90%	64.52%	16.85%	Improved	MET	MET	36.11%	47.37%	36.07%	-0.04%	Declined	NOT MET	NOT MET
***Lower rates are considered better for this measure.**																	

ACA ..... Affordable Care Act
ACE ..... Accountable Care Entity
ADA ..... Americans with Disabilities Act
AOD ..... Alcohol and Other Drug
BBA ..... Balanced Budget Act of 1997
BH ..... Behavioral Health
BHRA ..... Behavioral Health Risk Assessment
BMI ..... Body Mass Index
BOD ..... Board of Directors
CAD ..... Coronary Artery Disease
CAHPS ..... Consumer Assessment of Healthcare Providers and Systems
CAQH ..... Council for Affordable Quality Healthcare
CCA ..... Care Coordination Alliance
CCCD ..... Care Coordination Claims Data
CCE ..... Care Coordination Entity
CCHHS ..... Cook County Health and Hospital System
CCIP ..... Chronic Care Improvement Program
CCMN ..... Children with Complex Medical Needs
CCMS ..... CareEnhance Clinical Management Software
CDC ..... Comprehensive Diabetes Care
CFR ..... Code of Federal Regulations
CHF ..... Congestive Heart Failure
CHIP ..... Children's Health Insurance Program
CHIPRA ..... Children's Health Insurance Program Reauthorization Act
CHOW ..... Community Health Outreach Worker
CIC ..... Critical Incident Committee
CIHIE ..... Central Illinois Health Information Exchange
CILA ..... Community Integrated Living Arrangement
CIS ..... Client Information System
CMHC ..... Community Mental Health Center
CMPD ..... Case Management Program Description
CMS ..... Centers for Medicare & Medicaid Services
COPD ..... Chronic Obstructive Pulmonary Disease
CORE ..... Consolidated Outreach and Risk Evaluation
CPG ..... Clinical Practice Guidelines

CQI ..... Continuous Quality Improvement
CRG ..... Clinical Risk Grouping
CSS ..... Center for the Study of Services
DCFS ..... Department of Children and Family Services
DCG ..... Diagnostic Cost Grouper
DD ..... Developmental Disability
DHS ..... Department of Human Services
DIS ..... Division of Information Systems
DoA ..... Department on Aging
DPH ..... Department of Public Health
DSCC ..... Division of Specialized Care for Children
DSS ..... Decision Support System
EDV ..... Encounter Data Validation
EDW ..... Enterprise Data Warehouse
EHR ..... Electronic Health Record
EIS ..... Executive Information System
EPSDT ..... Early and Periodic Screening, Diagnosis, and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ESP ..... Education and Scoring Program
FFS ..... Fee-for-Service
FHP ..... Family Health Plan
FQHC ..... Federally Qualified Health Center
FTE ..... Full-Time Equivalent
FTP ..... File Transfer Protocol
H2H ..... Hospital to Home
HCBS ..... Home and Community Based Services
HEDIS ..... Healthcare Effectiveness Data and Information Set
HFS ..... The Illinois Department of Healthcare and Family Services
HIPAA ..... Health Insurance Portability and Accountability Act
HMO ..... Health Maintenance Organization
HPL ..... High Performance Level
HPMS ..... Health Plan Management System
HRS ..... Health Risk Screening
HSAG ..... Health Services Advisory Group
HSD ..... Health Services Delivery
ICF ..... Intermediate Care Facility
ICP ..... Integrated Care Program
ICT ..... Integrated Care Team

IDSS.....Interactive Data Submission System
IDPA.....Illinois Department of Public Aid
IHC.....Illinois Health Connect
ILCS.....Illinois Compiled Statutes
IPA.....Independent Physician Association
IRR.....Interrater Reliability
IS.....Information Systems
IT.....Information Technology
LOCUS.....Level of Care Utilization System
LTAC.....Long-Term Acute Care
LTSS.....Long-Term Services and Supports
MAC.....Medical Advisory Committee
MCCN.....Managed Care Community Network
MCO.....Managed Care Organization
MCS.....Managed Care System
MMAI.....Medicare-Medicaid Alignment Initiative
MMCO.....Medicare-Medicaid Coordination Office
MMIS.....Medicaid Management Information System
MPL.....Minimum Performance Level
MRR.....Medical Record Review
NB.....No Benefit
NCPDP.....National Council for Prescription Drug Programs
NCQA.....National Committee for Quality Assurance
OCR.....Optical Character Recognition
P4P.....Pay-for-Performance
PCCM.....Primary Care Case Management
PCE.....Pharmacotherapy Management of COPD Exacerbation
PCMH.....Patient-Centered Medical Home
PCP.....Primary Care Physician
PDSA.....Plan-Do-Study-Act
PHI.....Protected Health Information
PIP.....Performance Improvement Project
PMPM.....Per Member Per Month
PMV.....Performance Measure Validation
POSM.....Participant Outcomes and Status Measures
QA.....Quality Assurance
QAPI.....Quality Assessment and Performance Improvement
QI.....Quality Improvement
QIC.....Quality Improvement Committee

QIP ..... Quality Improvement Project
QISMC ..... Quality Improvement System for Managed Care
QM ..... Quality Management
SFY ..... State Fiscal Year
SHCN ..... Special Health Care Needs
SLF ..... Supportive Living Facility
SMI ..... Serious Mental Illness
SNF ..... Skilled Nursing Facility
SPD ..... Seniors and Persons with Disabilities
SSI ..... Supplemental Security Income
TCV ..... Transitional Care Visit
TPL ..... Third Party Liability
UM ..... Utilization Management
UMBH ..... Utilization Management Behavioral Health
VMC ..... Voluntary Managed Care
VMCO ..... Voluntary Managed Care Organization