

Division of Medical Programs



2021-2024

Comprehensive Medical Programs

Quality Strategy



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Section 1. Quality Framework



Purpose

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



Mission

HFS is committed to improving lives by addressing social and structural determinants of health, by empowering customers to maximize their health and well-being, and by maintaining the highest standards of program integrity on behalf of Illinoisans. HFS is committed to making equity the foundation of quality improvement.



Objectives

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



Goals

Better Care

1. Improve population health.
2. Improve access to care.
3. Increase effective coordination of care.

Healthy People/Healthy Communities

4. Improve participation in preventive care and screenings.
5. Promote integration of behavioral and physical healthcare.
6. Create consumer-centric healthcare delivery system.
7. Identify and prioritize reducing health disparities.
8. Implement evidence-based interventions to reduce disparities.
9. Invest in the development and use of health equity performance measures.
10. Incentivize the reeducation of health disparities and achievement of health equity.

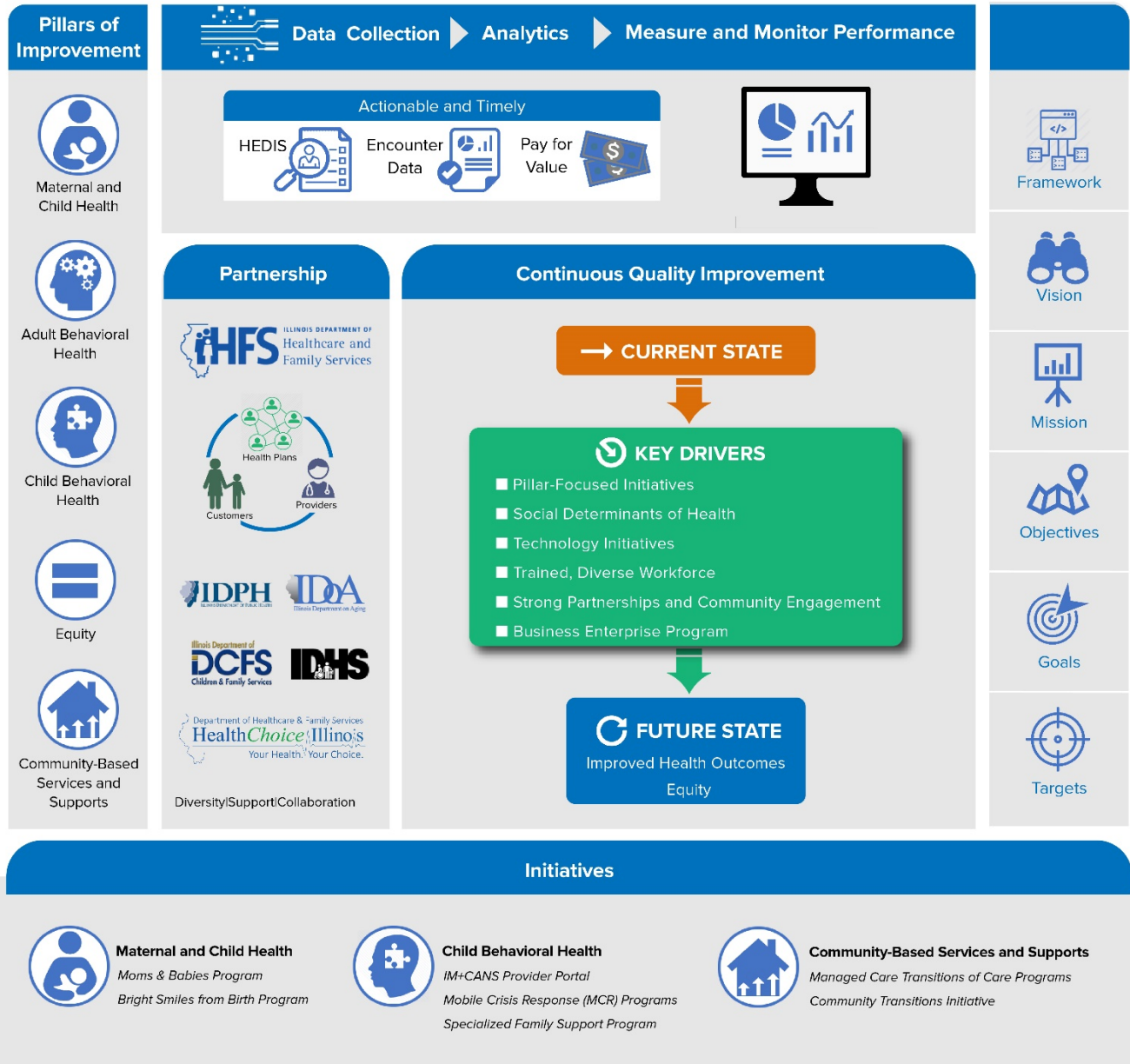
Affordable Care

11. Transition to value- and outcome-based payment.
12. Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

Roadmap for Quality Framework



Illinois Department of Healthcare and Family Services Comprehensive Medical Programs Quality Strategy



Vision for Improvement—Program Goals



Improve Maternal and Infant Health Outcomes

- Reduce preterm birth rate and infant mortality
- Improve the rate and quality of postpartum visits
- Improve well-child visits rates for infants and children
- Increase immunization rates for infants and children



Improve Behavioral Health Services and Supports for Adults

- Improve integration of physical and behavioral health
- Improve transitions of care from inpatient to community-based services
- Improve care coordination and access to care for individuals with alcohol and/or substance use disorders



Improve Behavioral Health Services and Supports for Children

- Improve integration of physical and behavioral health
- Improve transitions of care from inpatient to community-based services
- Reduce avoidable psychiatric hospitalizations through improved access to community-based services
- Reduce avoidable emergency department visits by leveraging statewide mobile crisis response



Increase Preventive Care Screenings—Use Data to Identify Target Areas in Priority Regions where Disparities in Optimal Outcomes are the Highest

- Focus on health equity



Serve More People in the Settings of Their Choice

- Increase the percentage of older adults and people receiving institutional care (nursing facilities) to home- or community-based programs to maximize the health and independence of the individual

The vision for improvement and program goals are inclusive of the populations served by Medicaid, including women and infant health, consumers with behavioral health needs, consumers with chronic conditions, and healthy children and adults with a central focus on health equity. The HFS Quality Strategy framework prioritizes equity across all program goals as the ultimate aim for improvement efforts by analyzing data to strategically pinpoint improvement needs.

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

various populations and working to mitigate negative impacts. In the pursuit of equity, HFS will identify appropriate equity tools to assess the effectiveness of its programs. A key component of equity is incorporating enterprises that are culturally competent with the capability of mitigating challenges across the continuum of healthcare, including the social and structural determinants of health. The State of Illinois' Business Enterprise Program is an integral part of addressing equity, and the goals of the program will be incorporated in how quality is measured.

Section 2. Introduction

Scope

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

The Quality Strategy is designed to foster the delivery of the highest-quality, most cost-effective services possible by establishing a framework for ongoing assessment and the identification of potential opportunities for healthcare coordination and improvement. See Section 1 for further details.

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

Managed Care Expansion

Statewide

In 2018, HFS expanded its managed care program, HealthChoice Illinois, to cover all counties in Illinois. The rebooted program was designed to enhance care while managing costs to keep the program sustainable in coming years. Expansion included continued efforts to streamline administration, include tools to measure and promote success, and incorporate a coordinated care system that addresses the total health history and needs of each customer such as built-in enhancements for care coordination, quality measures, and whole-person care.

In 2020, HFS' obtained a 1915(b) Waiver to include populations of children with complex health and social service needs in HealthChoice Illinois (see Section 6 for more details).

Six Medicaid managed care health plans (health plans) serve Medicaid customers statewide, including Aetna Better Health (Aetna), Blue Cross Blue Shield of Illinois (BCBSIL) also known as Blue Cross Community Health Plan, CountyCare Health Plan (CountyCare), MeridianHealth (Meridian), Molina HealthCare of Illinois (Molina), and YouthCare.

Transforming Medical Assistance

In the summer of 2019, the Governor enacted a Medicaid overhaul (Senate Bill 1321) to increase the timeliness of applications, redeterminations, and payments to providers; decrease the number of Medicaid claims denials; and to expand transparency throughout the program. Aggressive action before and after has been undertaken through a broad range of strategies to bring down the unacceptable Medicaid backlog that built up over a number of years under previous administrations. The Department has been working closely with key stakeholders, including healthcare associations, hospitals, and other providers that rely heavily on Medicaid to improve efficiencies around billing,

payment, administration, and other systems so that the Department can serve our customers efficiently and effectively.

In addition to addressing backlogs, among the areas of managed care enhancements and reforms addressed by SB 1321 are reimbursement for stays beyond medical necessity, expedited payments, timely payment interest penalties, dispute resolution process, claims rejection/denial management, timely filing extension for eligibility errors, provider effective dates, provider directory updates, operational standardization, medical loss ratios, and value-based payment models. SB 1321 passed with bipartisan support and forms a central part of the Department's wide-ranging improvements and enhancements of Medicaid managed care.

Response to COVID-19 Challenges

In 2020, the coronavirus disease 2019 (COVID-19) swept across our nation leaving in its devastating wake millions of individuals, including Medicaid enrollees, without access to services or protection against the virus. The State immediately jumped into action. HFS pursued numerous flexibilities related to eligibility, coverage, benefits, provider participation, and billing to simplify processes and directly address customers' sudden and dramatically changing healthcare needs during the COVID-19 public health emergency (PHE). While HFS had the authority to implement some flexibilities immediately, including many telehealth flexibilities, the majority required approval from the federal Centers for Medicare & Medicaid Services (CMS) through waivers or state plan amendments (SPAs).

The changes and flexibilities implemented included, but were not limited to, the following: giving the State presumptive eligibility authority and expanding presumptive eligibility for children and pregnant women to up to two times per calendar year (CY); prior authorization requirement suspensions; post-screenings for Preadmission Screening and Resident Review (PASRR); physical signature requirement flexibilities that allow for modes of communication for telehealth that may not be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA); provider payments for care in alternate settings; long-term care nurse aid training and certification flexibilities; cost increases for services provided to Home- and Community-Based Services (HCBS) Waiver customers; and reimbursements to encounter rate clinics for virtual check-ins and e-visits outside of their encounter rates. Additionally, HFS amended the health plan contract to cover COVID-19 diagnoses and treatment by non-network providers, added a risk corridor to address the impact of COVID-19 on the utilization of covered services, and allowed initial health plan enrollment through direct auto-assignment to make care coordination service available to customers sooner.

Due to the impact of the pandemic on the health plans' abilities to collect medical record data for hybrid measures, National Committee for Quality Assurance (NCQA) and HFS authorized health plans to rotate measure rates (i.e., report the health plans' Healthcare Effectiveness Data and Information Set [HEDIS®]²⁻¹ 2019 rates in place of the HEDIS 2020 rates) for the hybrid measures.

Building on its investments to fight against the COVID-19 public health and medical emergency, HFS modified the 2020 pay-for-performance (P4P) framework to reinvest in strategies that mitigate the impact of the virus. HFS determined that its quality metrics would be affected in unprecedented ways

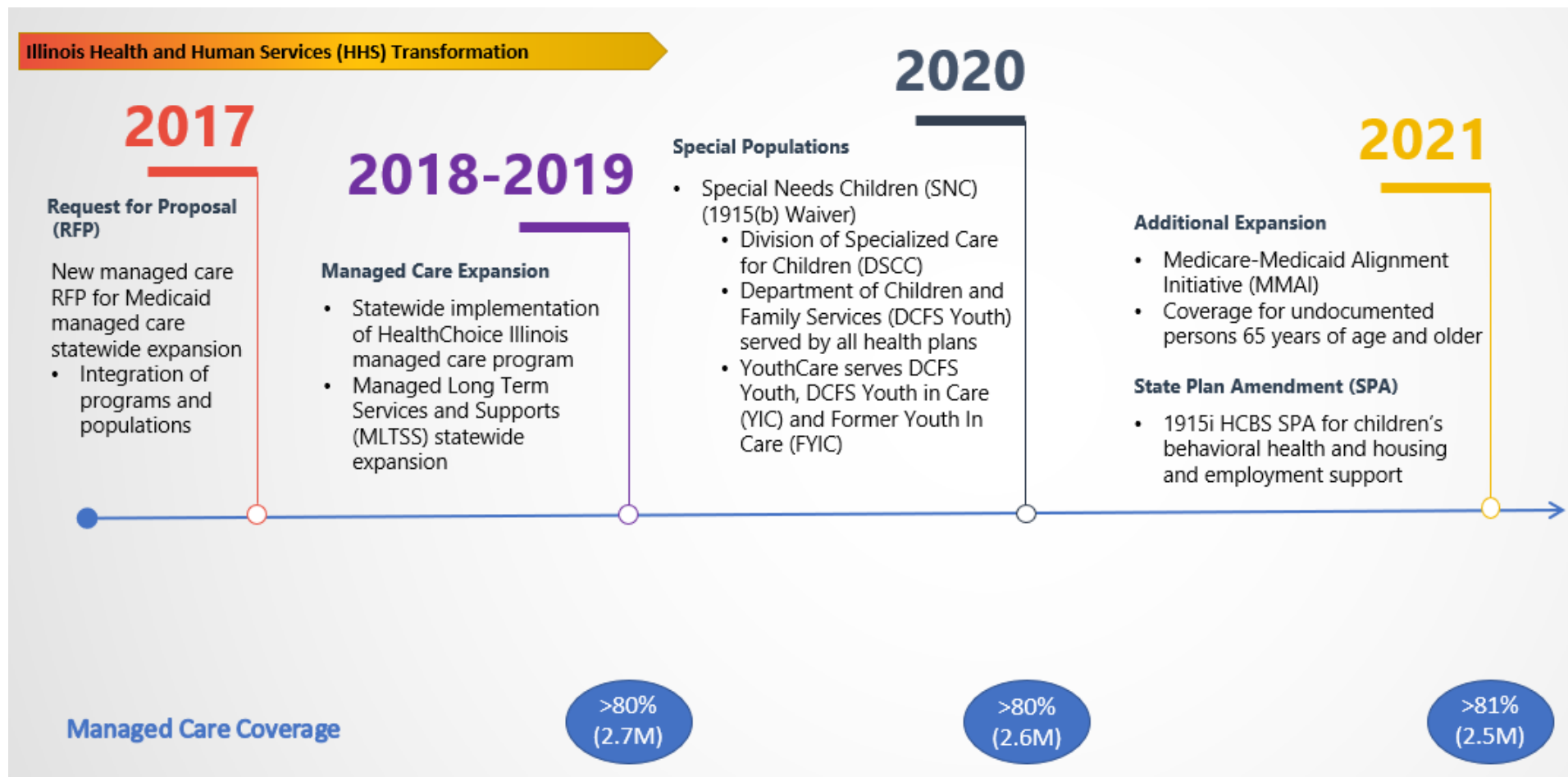
²⁻¹ HEDIS is a registered trademark of the National Committee for Quality Assurance.

because of changes in utilization associated with the pandemic. Rather than relying on performance metrics disrupted by the pandemic, HFS asked the health plans to submit proposals for how they would invest the funding into Illinois communities. Approximately \$100 million of the P4P quality payments was reinvested, as additional capital, into community organizations and providers across Illinois. Investments were directed with a lens toward equity and the greatest impact for organizations and providers that were not already receiving other support. Nearly half of the total redirected quality payments were spent in disproportionately impacted areas.

Health plans invested in critical services and initiatives to help Medicaid customers and providers during the pandemic, such as increasing reimbursement rates for behavioral health providers; expanding telehealth capabilities and infrastructure; contracting with vendors and community-based organizations owned by minorities, women, and people with disabilities to increase community engagement in African American and Latin communities which were the hardest hit by the pandemic; providing technology assistance; extending housing benefits; and providing food and funding to school-based health centers.

Managed Care Timeline

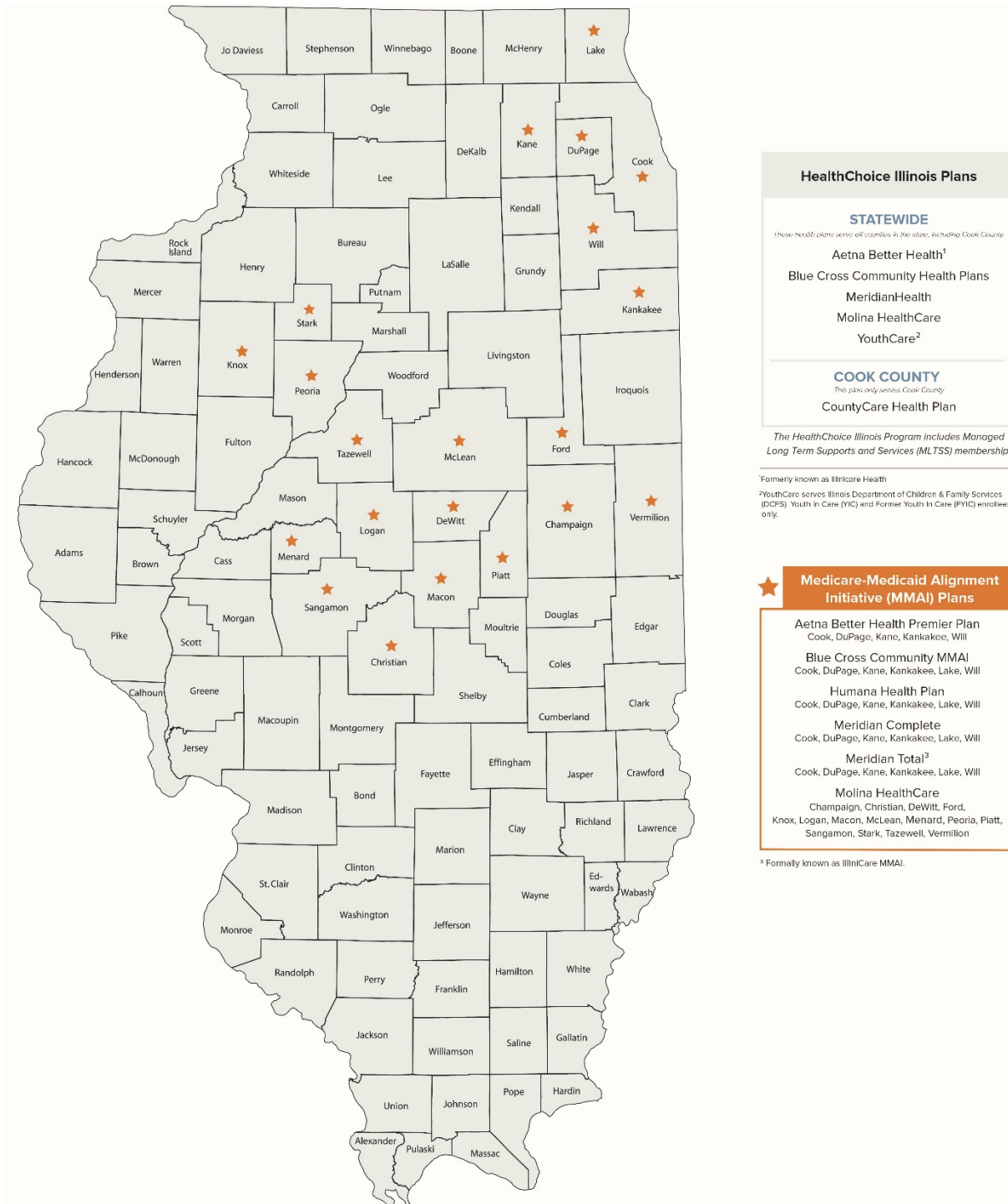
Figure 2-1—Managed Care Timeline



Managed Care Expansion Map

This map graphically displays the Medicaid Reform Care Coordination Expansion in Illinois as of September 2020.

Figure 2-2—HealthChoice Illinois Managed Care Program Map



Managed Care Programs

HFS medical programs pay for a wide range of health services, provided by thousands of medical providers throughout Illinois. 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, as authorized under the Illinois Insurance Code (215 ILCS 106/1 et seq.) and Title XXI of the Social Security Act, the State Children’s Health Insurance Program (SCHIP).

Most people who enroll are covered for comprehensive services, including but not limited to doctor visits and dental care, well-childcare, 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.

With managed care statewide expansion, most Medicaid customers in Illinois are served through HealthChoice Illinois. HealthChoice Illinois health plans provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system.

Populations/services covered include:

- Families and children eligible for Medicaid through Title XIX or Title XXI (Children’s Health Insurance Program).
- Affordable Care Act expansion Medicaid-eligible adults.
- Medicaid-eligible adults with disabilities who are not eligible for Medicare.
- Medicaid-eligible older adults who are not eligible for Medicare.
- Dual-eligible adults who are receiving long term services and supports (LTSS) in an institutional care setting or through a HCBS Waiver, excluding those receiving partial benefits who are enrolled in the Illinois Medicare-Medicaid Alignment Initiative (MMAI), or are subject to other exclusions.
- Special needs children, defined as customers under the age of 21 who are eligible for Medicaid through Supplemental Security Income (SSI), DSCC, or a disability category of eligibility.
- Children in the care of the Department of Children and Family Services (DCFS Youth), including those formerly under this care who have been adopted or who entered a guardianship.
- Managed Long Term Services and Supports (MLTSS) and waiver services (including the Elderly Waiver, Supportive Living Program, and Division of Rehabilitation Services).

However, the MMAI program continues to operate under a separate three-way contract between HFS, CMS, and the health plans. Statewide expansion is scheduled for 2021.

Managed Care Enrollment

HealthChoice Illinois provides comprehensive healthcare coverage to more than 2.3 million Illinoisans. Enrollment figures as of June 2020 are displayed in Table 2-1. More detailed enrollment, including enrollment by health plan, by gender and age, and by ethnicity can be found in Appendix B.

Table 2-1—Illinois Medicaid Enrollment

Program Type	June 2020 Enrollment
HealthChoice Illinois	2,592,122
MLTSS	60,502
MMAI	51,592
Total Customers	2,704,216

Quality Management Structure

The **Bureau of Managed Care** administers and monitors HFS’ managed care/care coordination programs. The **Bureau of Quality Management** is purposed to improve healthcare quality for HFS customers in Illinois. Together, these bureaus work to administer initiatives and programs to help customers improve their health status by ensuring the highest-quality, most cost-effective services possible to meet their needs, including disease management, hospital quality and utilization management, interfaces between primary care and behavioral health, as well as ongoing assessment and analysis of potential opportunities for healthcare coordination and improvement. The Quality Strategy establishes clear aims, goals, and objectives to drive improvements in care delivery and health outcomes as well as metrics by which progress will be measured.

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

The bureaus are also responsible for oversight, monitoring, and evaluation of quality assurance to ensure health plans are in compliance with State standards, federal regulations, and contract requirements. HFS monitors each health plan’s compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via its internal quality management program and on-site reviews of compliance with various quality assessment/improvement standards. HFS’ external quality review organization (EQRO), Health Services Advisory Group, Inc., conducts compliance reviews at least once every three years. The purpose of the reviews is to determine a health plan’s understanding and application of federal regulations and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during an on-

site evaluation. The reviews include an assessment of each plan's quality improvement structure. This structure is necessary in facilitating quality improvement of performance measures and performance improvement projects (PIPs), which measure each health plan's performance in achieving quality goals and objectives identified in the Quality Strategy. The report enables the health plans to implement improvement interventions to correct any areas of deficiency. The report also helps HFS determine each health plan's compliance with the contract and identify contractual areas that need to be modified or strengthened to ensure that a health plan complies with the standards and can achieve the goals and objectives identified in the Quality Strategy.

HFS routinely conducts quality driven meetings to discuss progress/outcomes, facilitate staff education, promote equity initiatives, and promote quality-related information specific to health plan performance.

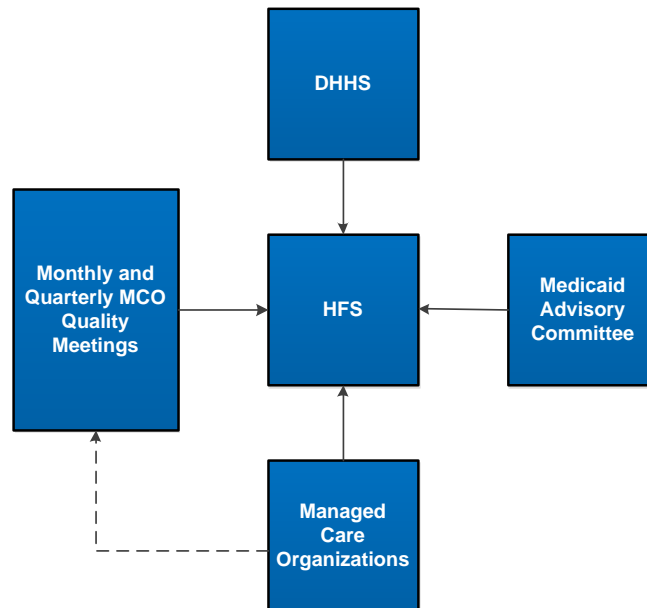
HFS holds monthly conference calls and quarterly meetings with health plans to provide a forum for discussion of quality of care and outcomes for Illinois Medicaid customers. During these meetings, HFS and health plan staff review and discuss performance measure results, PIP results, and whether the quality improvement outcomes align with the Quality Strategy goals and objectives. The meetings shall include representatives from the Managed Care Organization Quality Team, Bureau of Quality Management, Bureau of Managed Care, and other units who have a vested interest in the topic being discussed. The representatives will discuss quality objectives and policies and procedures, as well as provide resources and guest speakers to discuss outcomes and evidence-based interventions. Quarterly Monitoring Reports are submitted to the Bureau of Quality Management for review and discussion during the Quarterly Quality Meeting. These quarterly reports shall include data relative to the quality measures identified, member and provider outreach, and any new initiatives related to the quality measures. In an effort to align health plan reporting, a template was created identifying general and specific reporting instructions to provide essential guidance to effectively compare performance. Further, the health plans are required to present information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome obstacles that impede performance.

HFS is committed to the delivery of equitable access of its programs and services removing disparate impact on its customers by ensuring each population gets what they need to thrive. HFS will work with service providers, vendors, and contractors to institute approaches that prioritize equity and remove conditions and barriers to achieve optimal outcomes for customers. HFS further commits to engaging with customers who will have input in decision-making and opportunities to assist in advancing racial equity. HFS is committed to making equity the foundation of everything it does.

HFS meets with the health plans independently for monthly operations meetings and quarterly business reviews (QBRs) to monitor plan performance. Each plan is asked to provide HFS with a presentation on its recent activities and developments. These meetings serve as an interactive environment for open communication between health plans and HFS. This time also provides the opportunity for the health plans to ask any operational questions or receive assistance from HFS. HFS is interested in seeing what works well for the health plans, what needs improvement, any planned future developments, and what HFS can do to help. On-site visits enhance HFS' ability to oversee the health plans and build relationships with plan leadership. As the quarterly operations meetings progress, HFS is anticipating an overall presentation of each health plan's latest data, achievements, and issues/concerns. In addition, the Medicaid Advisory Committee (MAC) advises HFS with respect to

policy and planning related to the health and medical services provided under HFS’ medical programs pursuant to federal Medicaid requirements established at 42 CFR §431.12. The MAC consists of up to 15 members, at least five of whom must be consumers or advocates. The MAC meets six times a year and currently has five subcommittees: Quality Care, Public Education, Pharmacy, Health Equity, and Telemedicine. The subcommittees are supported by workgroups.





Figure 2-3—Illinois HFS Quality Strategy Organizational Structure



Contracting for Managed Care

Right Care, Right Time, Right Place

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

 <h3>Paying for Value</h3> <p>Evidence-based practices in service delivery to move from fee-for-service (FFS) to value-based payment. HFS is focusing on helping with treatment of high-volume, costly, high-risk, and preventable conditions. Risk and performance must be tied to reimbursement to continue to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes.</p>	 <h3>Care Coordination</h3> <p>Public Act 96-1501 required that at least 50 percent of all Medicaid recipients eligible for full benefits would be enrolled in care coordination, which means the deliberate organization of patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.²⁻² As of January 2021, over 70 percent of managed care customers are enrolled in care coordination.</p>
 <h3>1915(b) Waiver Programs</h3> <p>To extend the benefits of managed care, HFS obtained 1915(b) or 1915(c) Waivers to include the following populations in HealthChoice Illinois:</p> <ol style="list-style-type: none"> 1. Managed Long Term Services and Supports. 2. Home- and Community-Based Services. 3. Special Needs Children, including children from the DSCC Core Program and DCFS Youth. 	 <h3>Tech Integration</h3> <p>When the IMPACT initiative is fully implemented, HFS’ state-of-the-art technology platform serving a single statewide managed care system will allow for efficient and effective reporting, analytics, and timely decision making which enhances program integrity and increases efficiency while reducing costs.</p>

²⁻² Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination. Publication No. 04(07)-0051-7, June 2007. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/clinic/tp/caregaptp.htm>. Accessed on: October 17, 2012.

Goals and Objectives

To support health equity and HFS’ mission and to drive progress in the five pillars of improvement, HFS restructured its P4P program in 2020.

P4P Baseline Measures

Collection of baseline rates for the P4P program begins in measurement year (MY) 2019 (reporting year [RY] 2020) for the following P4P measures.

Better Care

Pillar: Adult Behavioral Health

1. *Follow-Up After Hospitalization for Mental Illness (FUH)*
 - 7-Day
 - 30-Day
2. *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*
 - 7-Day
 - 30-Day

Pillar: Child Behavioral Health

1. *Follow-Up After Hospitalization for Mental Illness (FUH)—6–17 years of age stratification*
 - 7-Day
 - 30-Day
2. *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—6–17 years of age stratification*
 - 7-Day
 - 30-Day

Pillar: Maternal and Child Health

1. *Prenatal and Postpartum Care (PPC)*
 - *Timeliness of Prenatal Care*
 - *Postpartum Care*
2. *Childhood Immunization Status (CIS)—(Combo 3)*

Healthy People/Healthy Communities

Pillar: Equity

1. *Breast Cancer Screening (BCS)*
2. *Cervical Cancer Screening (CCS)*
3. *Controlling High Blood Pressure (CBP)*
4. *Adults’ Access to Preventive/Ambulatory Health Services (AAP)*

Pillar: Community-Based Services and Supports

Measures for this pillar are included as reporting measures until baseline rates and health plan performance on the measures are established

Reporting Measures

HFS has also identified a portion of the P4P withhold to incentivize the reporting of the following measures that will be incorporated as P4P measures in subsequent years.

Better Care

Pillar: Adult Behavioral Health

1. *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*
 - 7-Day
 - 30-Day
2. *Pharmacotherapy for Opioid Use Disorder (POD)*

Pillar: Child Behavioral Health

1. *Mobile Crisis Response Services That Result in Hospitalization*
2. *Visits to the Emergency Department Visit for Behavioral Health Services That Result in Hospitalization*
3. *Overall Number and Length of Behavioral Health Hospitalizations*
4. *Number of Repeat Behavioral Health Hospitalizations*

Pillar: Maternal and Child Health

1. *Well-Child Visits in the First 30 Months of Life (W30)*
2. *Child and Adolescent Well-Care Visits (WCV)*
3. *Annual Dental Visit (ADV)—Age Groups: 2–3 years, 4–6 years, 7–10 years, 11–14 years, 15–18 years, and 19–20 years*
4. *Childhood Immunization Status (CIS)—(Combo 10)*

Healthy People/Healthy Communities

Pillar: Equity

1. HIV Viral Load Suppression
2. Gap in HIV Medical Visits
3. Prescription of HIV Antiretroviral Therapy

Pillar: Community-Based Services and Supports

1. LTSS Comprehensive Care Plan and Update
2. Successful Transition after Long-Term Care Stay

Development and Review of the Quality Strategy

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

Developing a Quality Strategy

HFS obtains input from customers and stakeholders as well as the MAC in drafting and revising the Quality Strategy.

Review

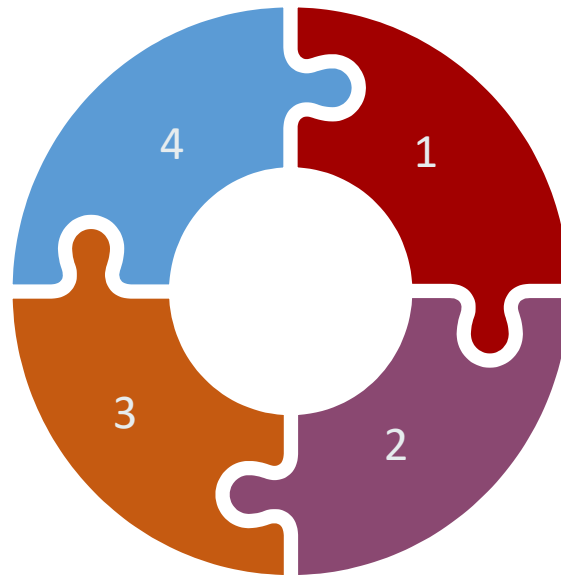
HFS reviews and updates the Quality Strategy as needed, but no less than every three years. Reviews include evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. Results of reviews are made available on HFS' website.

Public Comment

The Quality Strategy is shared with stakeholders for public comment. HFS takes recommendations into consideration before submitting the strategy to CMS for review.

Updates

Updates are made as necessary based on health plan performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the Medicaid program. HFS considers statewide expansion or the addition of new programs/delivery systems as significant changes that necessitate updates to the Quality Strategy. HFS submits the Quality Strategy to CMS as required and makes the strategy available on its website required by §438.10(c)(3).



Additional Information

For more information about HealthChoice Illinois, visit:

<https://enrollhfs.illinois.gov/news/healthchoice-illinois>.

For additional information about Medicaid programs, eligibility, enrollment, and HFS, visit:

<https://www.illinois.gov/hfs/MedicalClients/Pages/default.aspx>.

Section 3. Assessment

Assessing and Improving the Quality of HealthCare and Services

As required in CFR §438.340, this section describes HFS’ strategies for assessing and improving the quality of healthcare and services furnished by its Medicaid managed care health plans. Table 3-1 summarizes HFS’ assessment strategies for each federal regulation designated in CMS’ Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule) as requirements of HFS’ Quality Strategy.³⁻¹

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.334	Adopt a Medicaid managed care quality rating system in accordance with CMS requirements.	HFS implemented the HealthChoice Illinois Plan Report Card. This quality rating system (QRS) helps customers pick the health plan that is best for them by showing each plan’s performance in providing care and services to its customers for specific measures in key performance areas. HFS produces a statewide report card and a Cook County report card, both of which are available online. See Appendix C. In 2021, HFS will evaluate its QRS to determine if revisions are needed based on the revised Quality Strategy and alignment to the new P4P program. HFS will also revise its QRS to comply with the minimum set of mandatory performance measures in CMS’ MAC QRS framework when it is published.
§438.340(b)(1)	State-defined quantitative network adequacy standard and availability of services standards. Validation of health plan network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and §438.206.	Provider Network Capacity Reviews conducted by the EQRO include the types of providers specified in §438.68 as well as LTSS providers. Quarterly monitoring is conducted for HealthChoice Illinois and LTSS. As specified in §438.68(b)(iv), HFS defines specialists in whatever way is deemed most appropriate for their programs. Network Capacity Readiness Reviews to monitor the capacity of each health plan’s provider network in the expansion counties, including LTSS providers.

³⁻¹ Medicaid.gov. Medicaid and CHIP Managed Care Final Rule. Available at: <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>. Accessed on: November 3, 2020.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		<p>Annual Time and Distance Annual Analysis implemented by HFS and conducted by the EQRO to evaluate the degree to which health plans are complying with the time and distance network standards as outlined in the model Medicaid contract.</p> <p>Geographic Distribution Tables and Maps must be generated by health plans to plot enrollee and network provider locations by ZIP Code and analyze the information, considering the prevalent modes of transportation available to enrollees, enrollees’ ability to travel, and enrollees’ ability to be in an office setting. The results must be reported to HFS as requested.</p> <p>Access and Availability Surveys implemented by HFS and conducted by the EQRO to evaluate appointment availability and after-hours access among the health plans’ networks by utilizing secret shopper telephone surveys for primary care providers (PCPs), obstetricians/gynecologists (OB/GYNs), dental and specialty providers. Health plans are also required to monitor appointment availability as part of their access and availability plan.</p> <p>Monitoring of Other Network Adequacy Indicators is contractually required by health plans including: enrollee and provider complaints related to access; call center requests from enrollees, providers, advocates, and external organizations for help with access; and the percentage of completely open primary care provider panels versus the percentage open only to existing patients.</p>
§438.340(b)(1)	Examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	<p>HFS requires health plans to incorporate practice guidelines that meet nationally recognized standards and that:</p> <ul style="list-style-type: none"> • Are based on valid, reliable clinical evidence. • Consider the needs of enrollees. • Are adopted in consultation with network providers. • Are reviewed and updated periodically as appropriate. <p>All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, and shall be adopted by the contractor’s quality improvement plan (QAP) Committee with sources referenced and guidelines documented in the contractor’s QAP.</p>

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
§438.340(b)(3)(i)	Description of the quality metrics and performance targets to measure the performance and improvement of each health plan.	HFS collects quarterly Managed Care Organization Performance Reporting (MPR) data from all health plans. QBR thresholds are set for a variety of metrics in the categories of New Enrollee Screening and Assessments, Enrollee Engagement: Risk Stratification, and Provider and Enrollee Service Call Center. A range of other metrics are collected quarterly, and HFS will continue to set QBR thresholds for these metrics, including enrollee plans of care, maternity dental services, enrollee grievances and appeals, claims, prior authorizations, and provider disputes.
§438.340(b)(3)(i)(i)	Mandatory PIPs.	HFS implemented the Institute for Healthcare Improvement’s (IHI’s) rapid-cycle performance improvement approach for PIPs in 2019, which places a greater emphasis on improving outcomes using quality improvement science. HFS requires HealthChoice Illinois health plans to conduct PIPs and MMAI health plans to conduct QIPs. HFS selects PIP topics based on its goals and areas identified for improvement. In the rapid-cycle process, each health plan is tasked with designing small tests of change (interventions) to implement in real-work settings and then studying the impact to determine which interventions may be effective and which may need to be modified, replaced, or eliminated. This results in a variety of health plan-specific interventions that are reported each year, when applicable, in HFS’ External Quality Review Technical Report.
§438.340(b)(4)	Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered by the health plans.	HFS contracted with its EQRO to perform the external quality review (EQR) activities newly required by the Final Rule. See the “External Quality Review” section.
§438.340(b)(5)	A description of the State’s Transition of Care (TOC) policy.	HFS requires health plans to manage TOC and continuity of care for new enrollees and for enrollees moving from an institutional setting to a community living arrangement. Health plans are required to submit a TOC Plan to HFS initially and when there are updates to the plan. HFS requires health plans to implement a quality improvement plan to address the EQR recommendations to improve the effectiveness of care transitions. To comply with §438.62, HFS account managers oversee the implementation of health plans’ quality improvement plan for improving TOCs and monitor progress through weekly and quarterly meetings with the health plans. In addition, all health plans are required to participate in a TOC PIP.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		<p>Under the new Community Transitions Initiative (CTI), HealthChoice Illinois plans may receive incentive payments for the successful transition of customers living in skilled nursing facilities and specialized mental health rehabilitation facilities.</p>
<p>§438.340(b)(6)</p>	<p>State’s plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status.</p>	<p>HFS developed the following new goals for its Quality Strategy to focus improvement efforts on the reduction of health disparities:</p> <ol style="list-style-type: none"> 1. Identify and prioritize reducing health disparities. 2. Implement evidence-based interventions to reduce disparities. 3. Invest in the development and use of health equity performance measures. 4. Incentivize the reduction of health disparities and achievement of health equity. <p>P4P measures have been selected to evaluate performance in the following categories: Male, Female, African-American, and Hispanic.</p> <p>HFS identifies the race, sex, age, ethnicity, disability status, primary language spoken, and waiver type for each Medicaid beneficiary and provides this information to the health plans at the time of enrollment. The Illinois Client Enrollment Broker (CEB) transmits an enrollment file containing race/ethnicity and primary language of each enrollee to the health plans monthly. Health plans are required to develop and implement a cultural competency plan, offer appropriate foreign language versions of all beneficiary materials, and develop member materials which can be easily understood at a sixth-grade reading level. The plan is submitted to HFS for approval. Health plans are required to offer trainings to health plan staff and network providers.</p> <p>Health plans are required to monitor network provider compliance with Americans with Disabilities Act (ADA) requirements. The health plans also make ADA access information available in the online and hard copy provider directory.</p> <p>Health plans are required to proactively attempt to hire staff who reflect the diversity of enrollee demographics. Plan staff are required to complete linguistic and cultural competence training upon hire and no less frequently than annually.</p> <p>Health plans are required to have a process to verify subcontractors’ and provider network’s compliance with the health plans’ Cultural Competency Plan.</p>

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		Health plans are required to collaborate with community-based organizations to address social determinants of health, assess beneficiary needs, formulate collaborative responses, and evaluate outcomes for community health improvement and eliminating health disparities.
§438.340(b)(7)	Appropriate use of intermediate sanctions for health plans.	HFS sets forth the right to impose civil money penalties, late fees, and performance penalties (collectively, “monetary sanctions”), and other sanctions, on health plans for failure to substantially comply with the terms of the contract with HFS. Sanctionable events are included in the Medicaid model contract.
§438.340(b)(9)	State’s mechanisms to identify persons who need LTSS or persons with special healthcare needs and specify those mechanisms in the Quality Strategy.	<p>HFS has had a mechanism in place since 2012 to identify persons who need LTSS services and children with special healthcare needs using a program code in the enrollment file. HFS requires health plans to have specific mechanisms in place to identify individuals who need LTSS services or have special healthcare needs.</p> <p>Health plans are required to have a full-time LTSS program manager who oversees the LTSS program and acts as a liaison among LTSS statewide agency liaisons. HFS requires health plans to conduct comprehensive assessments for individuals in need of LTSS as well as special healthcare needs by qualified service coordinators.</p> <p>To assess satisfaction of customers with special needs, HFS added supplemental questions to the health plan Consumer Assessment of Healthcare Providers and Systems (CAHPS®)³⁻² surveys that include the HCBS population as well as adults with mental health conditions. Questions covering children with special healthcare needs were added to the HFS statewide CAHPS survey.</p> <p>HFS defines special healthcare needs children as children under the age of 21 who are eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 <i>et seq.</i>) or Medicaid-eligible and eligible to receive benefits pursuant to Title XVI of the Social Security Act. Children with special healthcare needs (CSHN) also include Medicaid-eligible children under the age of 21 who receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 <i>et seq.</i>) via the Division of Specialized Care for</p>

³⁻² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Table 3-1—HFS Strategies to Assess and Improve the Quality of HealthCare and Services

42 CFR	Summary of Requirement	HFS Strategy
		<p>Children (DSCC) or other such entity that the Department may designate for providing such services and CSHN as specified in Section 1932 (a)(2)(A) of the Social Security Act.</p> <p>HFS requires health plans to have a special healthcare needs plan to conduct timely identification and screening, comprehensive assessments, and appropriate case management services. Compliance is reviewed by HFS' EQRO. HFS monitors quality and appropriateness of services for customers with LTSS and special healthcare needs through compliance monitoring activities and regular review of health plan reporting.</p> <p>Health plans are required to have a consumer advisory board. Health plans are required to identify a liaison who will be a consumer advocate for high-needs children. The individual is responsible for internal advocacy for these enrollees' interests, including input in policy development, planning, decision-making, and oversight.</p>
§438.340(b)(10)	Nonduplication of mandatory activities with Medicare or accreditation review.	HFS requires all health plans to obtain NCQA accreditation . All six health plans have obtained NCQA accreditation. HFS will consider conducting a nonduplication review of mandatory activities now that all HealthChoice Illinois plans have achieved NCQA accreditation.

National Performance Measures

Core Measure Sets

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

HFS includes a number of core set measures in its quality monitoring program and requires health plans to report results, as listed below. Measures with an asterisk are included in the revised P4P program.

Adult Core Set

- *Cervical Cancer Screening**
- *Chlamydia Screening in Women Ages 21 to 24*
- *Breast Cancer Screening**
- *Prenatal and Postpartum Care: Postpartum Care**
- *Controlling High Blood Pressure**
- *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control*
- *HIV Viral Load Suppression**
- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older**
- *Use of Pharmacotherapy for Opioid Use Disorder**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence**
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H—Adult Version**

Child Core Set

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Childhood Immunization Status**
- *Well-Child Visits in the First 30 Months of Life**
- *Immunizations for Adolescents*
- *Child and Adolescent Well-Care Visits**
- *Prenatal and Postpartum Care: Timeliness of Prenatal Care**
- *Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17**
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items**

State Monitoring

Monitoring System

As required in CFR §438.66, this section describes HFS’ monitoring system which addresses all aspects of the managed care program, including the performance of each health plan in the areas designated in the CFR, as summarized in Table 3-2. The table also indicates areas that are included as key indicators in health plan scorecards. Scorecards are a key component of HFS’ monitoring system, developed to depict health plan performance on key metrics and performance indicators. The scorecards are reviewed quarterly. See the scorecard example in Appendix C.

Table 3-2—HFS Monitoring System


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

Table 3-2—HFS Monitoring System



42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		<p>and resolved in compliance with the portal resolution timeframes to encourage communication between the two entities and to ensure fair resolution of disputes. HFS tracks and reports the volume of complaints received and resolved to each health plan as part of the QBR process and will be developing complaint trend reports to post on the portal home page beginning in 2021.</p> <p>Health plans are required to have a provider complaint resolution process which is linked to the HFS resolution portal for provider education efforts.</p>	
<p>§438.66(b)(3)</p>	<p>Claims management.</p> 	<p>Health plans are required to submit the following claims and encounter management reports:</p> <ul style="list-style-type: none"> • Monthly encounter data report. • Monthly adjudicated claims inventory summary. • Monthly pharmacy claims monitoring report. • Quarterly report of percent of denied or rejected claims. 	<p>An enrollment and claims system review was conducted during 2017 as part of the HealthChoice Illinois program readiness reviews.</p>
<p>§438.66(b)(4)</p>	<p>Enrollee materials and customer services, including the activities of the beneficiary support system.</p> 	<p>All enrollee materials must be approved by HFS initially and as revised.</p> <p>Enrollee service call center reporting metrics are monitored through the scorecard and quarterly health plan reporting in the MPR and QBR processes.</p> <p>HFS offers a variety of avenues for an individual to receive education and enrollment assistance under its beneficiary support system, including an enrollment call center that provides education and</p>	<p>The readiness and administrative reviews include a review of enrollment materials and review of service level agreement (SLA) reporting for the member services for each health plan.</p>

Table 3-2—HFS Monitoring System

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

Table 3-2—HFS Monitoring System


42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(8)	<p>Medical management, including utilization management and case management.</p>  <p>Key Scorecard Indicator</p>	<p>Care Management Care management and disease management program descriptions are submitted initially and as revised.</p> <p>Health plans are required to submit the following monthly and quarterly reports:</p> <ul style="list-style-type: none"> • Monthly care coordination effectiveness summary report. • Annual care gap plan. • Quarterly outreach summary report. • Quarterly enrollee engagement metrics. • Transition of care plan, initially and as revised. • Care management metrics are also monitored through the scorecard. <p>Utilization Management Health plans are required to submit the following monthly utilization management (UM) reports:</p> <ul style="list-style-type: none"> • Monthly prior authorization report. • Monthly utilization management report, pharmacy utilization monitoring report, psychotropic review report, and drug utilization report. • Utilization metrics are also monitored through the scorecard. 	<p>The readiness and administrative reviews include utilization management and care management program requirements and case file reviews. The EQRO also conducts a care management/care coordination (CM/CC) staffing, qualifications, and training review to review the educational qualifications, related experience, annual training hours, full-time equivalency (FTE) allocation, and caseloads of CM/CC staff serving the Medicaid managed care population against state-selected requirements.</p>

Table 3-2—HFS Monitoring System


42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(9)	Program integrity.	Health plans are required to submit the following program integrity reports: <ul style="list-style-type: none"> • Quarterly fraud and abuse report. • Annual certification to confirm compliance of each contractor and its subcontractors. • Recipient verification procedure, initially, annually, and as revised. • Fraud, Waste, and Abuse (FWA) compliance plan. 	Review of the FWA compliance plan, reporting, training, and mechanisms in place to detect FWA is conducted during readiness and administrative reviews.
§438.66(b)(10)	Provider network management, including provider directory standards. 	Monthly provider directory attestation reports. Quarterly review of health plan network capacity status. Provider metrics are also monitored through the scorecard.	Review of provider contracts for the following provider types: ancillary, facility, federally qualified health center (FQHC), hospital, physician hospital organization (PHO), and provider. The EQRO reviews a template contract against 15 elements to determine compliance with requirements. A review of the health plan provider complaint resolution process is conducted during the readiness review. Compliance with provider directory standards is reviewed during the readiness and administrative reviews.

Table 3-2—HFS Monitoring System




42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
§438.66(b)(11)	<p>Availability and accessibility of services, including network adequacy standards.</p>  Key Scorecard Indicator	<p>Health plans are required to submit the following weekly and monthly provider network reports:</p> <ul style="list-style-type: none"> • Weekly PCP, hospital, and affiliated specialist file (CEB Provider File). • Monthly provider network file (complete). • Provider site closures/terminations notification (as each occurs). • Network access metrics are also monitored through the scorecard. 	<p>Biannual provider network monitoring for HealthChoice Illinois and LTSS.</p> <p>Biannual network provider capacity reviews.</p> <p>Network capacity reviews as part of administrative and readiness reviews.</p> <p>Ad hoc network capacity analysis.</p> <p>Review of health plan provider access and appointment availability audit results to assess health plans' monitoring of provider compliance with appointment availability and after-hours access standards.</p> <p>Annual analysis of time/distance standards for specific network providers including PCPs, OB/GYNs, behavioral health, specialists, hospitals, pharmacy, and adult and pediatric dental.</p>
§438.66(b)(12)	<p>Quality improvement.</p>  Key Scorecard Indicator	<p>Health plans are required to submit the following quarterly and annual reports:</p> <ul style="list-style-type: none"> • A Quality Assessment and Performance Improvement (QAPI) program description annually and evaluate the effectiveness of the QAPI program as indicated in the annual Quality Assurance, Utilization Review, and Peer Review (QA/UR/PR) Report/Program Evaluation. • Adult and child CAHPS results are reported in the health plan's annual QAPI evaluation report. 	<p>Review of the QAPI program description and annual QAPI evaluation report.</p> <p>Administrative, readiness, and focused reviews.</p> <p>PIPs.</p> <p>The EQR report includes the results of the CAHPS surveys, quality measures, and all EQR mandatory and optional activities conducted during the preceding 12 months.</p>

Table 3-2—HFS Monitoring System

42 CFR	Summary of Requirement	HFS Monitoring	EQRO Monitoring
		<ul style="list-style-type: none"> Quarterly HEDIS measure rates report. Submission of QA/UR/PR committee meeting minutes at the request of HFS. 	
§438.66(b)(13)	<p>Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program.</p> 	<p>Health plans are required to submit the following critical incident reports:</p> <ul style="list-style-type: none"> Health plans are required to submit policies and procedures for processing critical incidents, initially and as revised. Monthly critical incident detail report and quarterly critical incidents summary report. Critical incident metrics are monitored through the scorecard. The EQRO also submits the following reports as a result of monitoring of critical incidents and health, safety, and welfare (HSW). EQR HSW reports identified during quarterly record reviews. Quarterly summary of HSW reports. 	<p>Quarterly record review of plan compliance with the HCBS CMS performance measures.</p> <p>Review of HSW concerns during quarterly record reviews and review of health plan remediation actions.</p> <p>Quarterly critical incident monitoring through case file reviews and follow up on findings and remediation actions.</p> <p>Annual review of LTSS care management qualifications, training, and caseload requirements.</p> <p>Review of compliance with critical incident reporting during administrative reviews.</p>
§438.66(b)(14)	<p>All other provisions of the contract, as appropriate.</p>	<p>See the section on health plan reporting below.</p>	<p>See the “External Quality Review” section.</p>

Health Plan Reporting

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

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

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

Reporting is required monthly, quarterly, and annually as demonstrated in the reporting tables found in Attachment XIII (Required Deliverables, Submissions, and Reporting) of the health plan contract as included in Appendix H.

The MMAI program has specific federal reporting requirements that can be reviewed at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Illinois.html>.

Using Monitoring Data to Improve Performance

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

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

Monitoring Through Readiness Reviews

As required in CFR §438.66(d), HFS assesses the readiness of each contracted health plan as follows:

- Prior to the State implementing a managed care program, whether the program is voluntary or mandatory.
- When the specific health plan entity has not previously contracted with the State.
- When any health plan currently contracting with the State will provide or arrange for the provision of covered benefits to new eligibility groups.

HFS ensures that readiness reviews are:

- Initiated at least three months prior to the effective date of the events described above.
- Completed in sufficient time to ensure smooth implementation of an event described above.
- Submitted to CMS for CMS to make a determination that the contract or contract amendment is approved.

HFS also ensures that readiness reviews include both a desk review of documents and on-site reviews as required by federal regulations and assess the ability and capacity of the health plan to perform satisfactorily in all the applicable areas outlined in CFR §438.66(d)(4).

HFS' Monitoring of Quality Assessment and Performance Improvement (QAPI) Programs

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

- QA/UR/PR plan with overview of goal areas
- Major initiatives to comply with the State Quality Strategy
- Quality improvement and workplan monitoring
- Contractor network access and availability and service improvements, including access and utilization of dental services
- Cultural competency
- FWA monitoring
- Population profile
- Improvements in CM/CC and clinical services/programs

- Effectiveness of care coordination model of care
- Effectiveness of quality program structure
- Summary of monitoring conducted including issues or barriers addressed or pending remediation
- Comprehensive quality improvement workplans
- Chronic health conditions
- Behavioral health (includes mental health and substance use disorder services)
- Dental care
- Discussion of the health education program
- Member satisfaction
- Enrollee safety
- FWA and privacy and security
- Delegation

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

External Quality Review

HFS contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, the EQRO conducts the mandatory and optional EQR activities as set forth in 42 CFR §438.358. The EQRO performs services in accordance with 42 CFR and the Balanced Budget Act of 1997. To see the 2020–2021 EQR workplan, see Appendix F.

Mandatory EQR Activities

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

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(i)	Validates PIPs in accordance with §438.330(b)(1) to determine if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and beneficiary satisfaction.
§438.358(b)(1)(ii)	Validates performance measures. Conducts NCQA HEDIS Compliance Audits ^{TM3-2} and performance measure validation (PMV) audits in accordance with §438.330(b)(2). For a list of healthcare and quality of life measures included in the HealthChoice Illinois contract, see Appendix G.
§438.358(b)(1)(iii)	<p>Conducts a review, at least every three years, to determine health plan compliance with federal standards (subpart D) and the QAPI requirements described in §438.330. HFS' EQRO conducts a variety of types of compliance reviews including:</p> <ul style="list-style-type: none"> • Administrative Reviews and Remediation <ul style="list-style-type: none"> ○ To determine health plan compliance with various quality assessment/improvement standards in 18 areas of compliance (as listed in Appendix H). • Readiness Reviews and Remediation <ul style="list-style-type: none"> ○ To evaluate, prior to client enrollment, whether a health plan's internal organizational structure, health information systems, staffing, and oversight are sufficient to enroll customers. • HCBS Record Reviews and Remediation <ul style="list-style-type: none"> ○ In accordance with CMS requirements, quarterly on-site record reviews of a statistically valid sample, weighted by waiver type, are conducted by the EQRO. All record review findings and remediation of findings are tracked in the record review database. Annual reviews of HCBS staffing, experience, qualifications, FTEs, and caseload assignments are conducted on all health plans that provide services to HCBS Waiver customers. See a list of CMS HCBS Waiver performance measures in Appendix I. • Critical Incident/HSW Reviews and Remediation <ul style="list-style-type: none"> ○ To audit health plan processes for identifying and resolving Critical Incident/HSW concerns by conducting case file reviews.

³⁻² NCQA HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(b)(1)(iv)	<p>Validates managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) network adequacy to comply with requirements set forth in §438.68. The EQRO conducts a biannual review of the provider network, annual time/distance analysis of selected providers to evaluate compliance with time/distance standards requirements, and appointment availability surveys to evaluation compliance with appointment standards and after-hours access for customers.</p> <p>HFS' EQRO also conducts an analysis of the health plans' provider networks as a key component of pre- and post-implementation readiness reviews to evaluate the progress of each health plan in contracting with a sufficient number of providers to establish network capacity in the expansion areas.</p>
§438.364	<p>Produces an annual EQR technical report and submits to the State in accordance with the CFR requirements. The EQRO works with HFS to follow up on EQR recommendations by building and monitoring EQR recommendations, quality improvement plans, and corresponding implementation plans with each health plan. See Appendix J.</p>

Optional EQR Activities

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

42 CFR	Summary of EQRO Activity to Meet Federal Requirements
§438.358(c)(1)	<p>Validates encounter data reported by health plans. Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates; however, these data must be valid, complete, and accurate.</p>
§438.358(c)(2)	<p>Validates and administers consumer surveys of quality of care. Each year, the health plans are required to independently administer a consumer satisfaction survey for both adults and children as applicable to the programs they cover. The EQRO administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. The EQRO summarizes the health plan and statewide data and includes the results of the CAHPS surveys in the annual EQR technical report.</p>
§438.358(c)(3)	<p>Validates performance measures for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Program using the CMS protocol. The primary objectives are to evaluate the processes used to collect the performance measure data by HFS and determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.</p>
§438.358(c)(5)	<p>Conducts studies on quality that focus on an aspect of clinical or nonclinical services at a point in time. The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of health plan customers.</p>
§438.358(c)(6)	<p>Assists with the development and production of the quality rating of health plans report card consistent with §438.334.</p>

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

Section 4. State Standards

HFS' contracts with HealthChoice Illinois health plans include the standards for access, structure and operations, and quality measurement and performance improvement as specified in 42 CFR Part 438 Subpart D.

Access Standards

Standards for HealthChoice Illinois related to access can be found in Article 5 of the model contract, including Section 5.7 (Provider Network) and Section 5.8 (Access to Care Standards).

A detailed crosswalk between the CFR requirements for access standards and HFS' contract references can be found in Appendix H.

Structure and Operations Standards

Standards for HealthChoice Illinois related to structure and operations can be found in Article 5 of the model contract. A detailed crosswalk between the CFR requirements for structure and operations standards and HFS' contract references can be found in Appendix H.


Measurement and Improvement Standards

Standards for HealthChoice Illinois related to measurement and improvement can be found in Article 5 of the model contract. A detailed crosswalk between the CFR requirements for measurement and improvement standards and HFS' contract references can be found in Appendix H.

Section 5. Improvement and Interventions

Continuous Quality Improvement

HFS recognizes that having standards is a first step in promoting safe and effective healthcare. In order to ensure that standards are followed, HFS regularly monitors the health plans and managed care programs. HFS is also committed to ongoing assessment and identification of opportunities for improvement to ensure delivery of the highest-quality, most cost-effective services. Based on the results of the assessment and monitoring activities outlined in sections 3 and 4 of this report, Illinois has implemented comprehensive approaches for continuous quality improvement with the goal of improving healthcare outcomes to all customers enrolled in a Medicaid program. HFS’ major, overarching strategies for improvement are described below.

Scorecards and Claims Analysis	<p>Scorecards are developed to depict health plan performance on key metrics and performance indicators. See the example in Appendix C. Health plans use the scorecards to assist in developing action plans for improvement. In addition, MCO hospital claims processing and payment performance analysis is conducted twice a year.</p>	<p>HFS restructured management to add a new layer of Medicaid oversight. Each health plan is assigned an HFS account manager. Weekly meetings and monthly operations meetings are conducted to follow up on action plans.</p> <p>HFS also developed an Account Manager inbox so all requests and responses flow through one channel and are tracked across health plans.</p>	Account Managers
Quarterly Business Reviews (QBRs)	<p>QBRs are conducted with all health plans to review scorecards, discuss trends in performance, identify barriers, share best practices, and promote continuous improvement.</p>	 <p>HFS account managers track the progress of health plan implementation of CAPs developed in response to administrative and readiness reviews, network monitoring, and HCBS record reviews.</p>	Corrective Action Plans (CAPs)
EQR Recommendations	<p>HFS has developed a phased process for the State and health plans to follow up on recommendations from the annual EQR process. See an example of EQR recommendations, quality improvement plan, and implementation plan in appendices J and K.</p>	<p>To provide feedback and analysis on the health plans’ compliance with HSW and critical incident (CI) requirements, HFS’ EQRO conducts quarterly reviews of HSW/CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Health plans are required to complete remediation of any findings.</p>	Health, Safety, and Welfare (HSW) and Critical Incidents

Quality Improvement Interventions

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

Pillar	Initiatives
Maternal and Child Health	<p>The HFS Illinois Moms & Babies Program covers insurance for moms during the course of their pregnancy and for 60 days postpartum. It provides screening and coverage for postpartum depression as well as any medical complications that can arise. Additionally, moms can sign up for the “text4baby” program that provides them with advice on infant care and postpartum issues. The State of Illinois also has a Section 1115 Waiver pending which would extend coverage for postpartum care for women to one year. Research indicates that infants and children with mothers who are insured are more likely to receive adequate medical care.</p> <p>Based on low rates of breast and cervical cancer screening according to electronic case reporting (eCR) reports, particularly in Black and Hispanic populations, HFS added P4P measures in the equity pillar for both topics.</p> <p>HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), developed a statewide Bright Smiles from Birth Program that uses web-based training to educate physicians, nurse practitioners, and FQHCs on how to perform oral health screenings, assessments, and fluoride and varnish applications in both the FFS and managed care delivery system. The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care, and studies confirm that fluoride varnish applications are effective in reducing early childhood caries in young children. See http://www.brightsmilesfrombirth.org for more information.</p> <p>DCFS Youth are now served by HealthChoice Illinois.</p>

Pillar	Initiatives
<p>Adult and Child Behavioral Health</p>	<p>Illinois’ 1915(i) Home- and Community-Based Services (HCBS) State Plan Amendment will add new community behavioral health services to the Illinois Medicaid service array for a targeted population of individuals who meet specified needs-based eligibility criteria. HFS will work closely with health plans on the implementation of new services.</p> <p>In 2020, HFS launched the IM+CANS Provider Portal to collect and manage data from the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) instrument. The IM+CANS serves as HFS’ standardized mental health assessment and treatment plan for community behavioral health providers. The IM+CANS Provider Portal will provide HFS with the clinical data necessary to better track outcomes for customers receiving community behavioral health services.</p> <p>As the State’s Medicaid infrastructure began to evolve through the introduction of care coordination and managed care service delivery systems, the State’s approach to crisis response has also evolved. Many of the children and youth who are experiencing a mental health crisis and whose care requires public funding are now being served by Mobile Crisis Response (MCR) programs administered and funded by the health plans. MCR features centralized intake via the Crisis and Referral Entry System (CARES) and access to face-to-face crisis intervention services. HFS actively works with health plans to ensure coordination and continuity across the crisis response systems.</p> <p>The Specialized Family Support Program (SFSP) launched in April 2017 pursuant to the Custody Relinquishment Prevention Act 20 ILCS 540. It is a collaborative effort between HFS, DCFS, Department of Human Services (DHS), Department of Juvenile Justice (DJJ), Department of Public Health (DPH), and the Illinois State Board of Education (ISBE). The SFSP is designed to identify the behavioral health needs of youth at risk of custody relinquishment and to link them to appropriate services.</p> <p>In July 2018, HFS began its implementation of a five-year Section 1115 Demonstration Waiver to establish a series of behavioral health pilot projects, with a strong focus on piloting substance use disorder treatment services not covered under the Illinois Medicaid State Plan.</p> <p>HFS plans to develop measures that will gauge the success of behavioral health/medical integration to help direct adjustments and needed resources.</p> <p>HFS is enhancing the validation of the behavioral health provider network through the addition of a time/distance analysis of the behavioral health network. State activities are currently being planned to focus on telemedicine.</p>

Pillar	Initiatives
<p>Equity</p>	<p>Supplemental CAHPS questions are added to the health plan adult surveys to obtain input on the satisfaction with HCBS services, including satisfaction with direct support staff and receipt of waiver services.</p> <p>HFS’ Quality Care Subcommittee has assigned a workgroup to assess racial or ethnic disparity in LTSS programs and recommend strategies for equality and quality of services for LTSS customers throughout Illinois.</p> <p>Health plans are required to have a member advisory committee with a reasonable representation of LTSS customers.</p> <p>HealthChoice Illinois and CountyCare were selected as one of seven teams nationwide to work together to reduce health disparities as customers of the Advancing Health Equity (AHE) Learning Collaborative that launched on October 2, 2019. The AHE Learning Collaborative is a component of the Advancing Health Equity: Leading Care, Payment, and Systems Transformation program funded by the Robert Wood Johnson Foundation. The AHE Learning Collaborative is based at the University of Chicago and conducted in partnership with the Institute for Medicaid Innovation and the Center for Health Care Strategies. The AHE Learning Collaborative convenes the seven teams over the course of two years to design integrated payment and healthcare delivery reforms to reduce health disparities. The teams will also address social determinants of health as part of their efforts and generate best practice and policy recommendations for national dissemination.</p>
<p>Community-Based Services and Supports</p>	<p>Supplemental CAHPS questions are added to the health plan adult surveys to obtain input on the satisfaction with HCBS services, including satisfaction with direct support staff and receipt of waiver services.</p> <p>HFS’ Quality Care Subcommittee has assigned a workgroup to assess racial or ethnic disparity in LTSS programs and recommend strategies for equality and quality of services for LTSS customers throughout Illinois.</p> <p>Health plans are required to have a member advisory committee with a reasonable representation of LTSS customers.</p> <p>On October 1, 2020, HFS, in partnership with DHS and the University of Illinois at Chicago’s College of Nursing, operationalized the Community Transitions Initiative (CTI). Under this initiative, HealthChoice Illinois plans may receive incentive payments for the successful transition of customers living in skilled nursing facilities and specialized mental health rehabilitation facilities (SMHRFs) as well as for thorough evaluations of customers who are ultimately determined to have an impairment so significant that transition is not in their best interest.</p>

Pillar	Initiatives
All Pillars	<p>Performance Management Initiative: Transition of Care Programs (including CM/CC)</p> <ul style="list-style-type: none"> • Increase HFS’ performance management oversight of the MCOs. • MCOs identification of top hospitals with which they are working relative to transitions of care. • MCOs will submit weekly rosters to HFS account managers identifying behavioral health inpatient admissions. • HFS account managers will have weekly discussions with the MCOs to review the roster and to understand how the MCO is actively managing transition(s) of care. <p>Performance Management Initiative: Emergency Department Utilization</p> <p>Performance Management Initiative: Executive Scorecard Performance. MedInsight metrics and MCO self-reported metrics.</p> <p>Telemedicine task force is charged with expanding the use of telemedicine within the Medicaid program.</p> <p>P4P Program. Health plans may earn payments based on performance with respect to select quality metrics that support the Quality Strategy goals. Collection of data and calculation of health plan performance against the P4P measures are in accordance with national HEDIS timelines, specifications, and benchmarks. Due to the impacts of the COVID-19 pandemic on health plans’ abilities to collect medical record data for hybrid measures, the NCQA and HFS authorized MCOs to rotate rates (i.e., report the MCOs’ HEDIS 2019 rates in place of the HEDIS 2020 rates) for hybrid measures. In addition, approximately \$100 million of the P4P quality payments was reinvested, as additional capital, into community organizations and providers across Illinois.</p> <p>HFS is working to engage customers in an advisory capacity and participation in the MAC.</p> <p>Health Plan Accreditation. Pursuant to 305 ILCS 5/5-30 (a) and (h), HFS requires that any health plan serving at least 5,000 seniors, or people with disabilities, or 15,000 customers in other populations covered by the Medical Assistance Program that have been receiving full-risk capitation for at least one year are considered eligible for accreditation and will be accredited by the NCQA within two years after the date the health plan was eligible for accreditation. The health plans must achieve and/or maintain a status of “Excellent,” “Commendable,” or “Accredited.”</p>

Health Plan Sanctions

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

Corrective/Remedial Actions

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

Health Information Technology (HIT)

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

<p>INTEGRATED ELIGIBILITY SYSTEM (IES)</p>	<ul style="list-style-type: none"> • Eligibility system used to determine eligibility for medical programs: Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF); and cash assistance for Aged, Blind, or Disabled (ABD). • In collaboration with DHS and the Department of Innovation and Technology (DoIT). • Cost of development and installation largely defrayed by enhanced 90 percent match from federal government.
<p>ILLINOIS MEDICAID PROGRAM ADVANCED CLOUD TECHNOLOGY (IMPACT)</p> <p>IMPACT'S FOUR PHASES</p>	<p>The IMPACT initiative is a multi-agency effort that modernizes HFS’ 30-year-old Medicaid Management Information System (MMIS) which was built to support a FFS Medicaid program. The MMIS supports claims processing for the HFS medical assistance programs.</p> <ul style="list-style-type: none"> • Electronic Health Records Medicaid Incentive Payment Program (eMIPP): Provides incentive payments to EPs, EHS, and critical access hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. • Web Provider Enrollment: Beginning in July 2015, providers have been required to enroll and revalidate their enrollment through the new IMPACT Web portal. • Pharmacy Benefits Management System (PBMS): Internet-based application capable of interacting with providers, manufacturers, and other stakeholders to conduct the business processes of managing the Pharmacy Services and Drug Rebate program. • Full Implementation/CoreSystem: This phase is the largest and most complex. It encompasses numerous subsystems including claims/encounters, prior approval, eligibility/enrollment, business administration, and financials. The Full Implementation/CoreSystem is projected to be completed in 2023. Once completed, the Department will have a modern, single, cloud-enabled MMIS for all Medicaid claims processing.

<p>ELECTRONIC HEALTH RECORDS (EHR) PAYMENT INCENTIVE PROGRAM</p>	<p>Section 4210 of the Health Information Technology for Economic and Clinical Health (HITECH) Act established an EHR provider incentive payment program, which allows Medicaid to pay an incentive to eligible professionals who attested to adopt, implement, upgrade, or meaningfully use certified EHR technology. In September 2011, HFS launched Illinois’ Medicaid EHR Incentive Payment Program, allowing attestations via a State Web application (now called the EHR Medicaid Incentive Payment Program [eMIPP]) from providers who had initiated the registration process on a CMS website. Since the program’s inception through December 13, 2020, HFS has awarded over \$656.2 million in incentive payments to 9,339 eligible Medicaid providers (EPs) and 174 eligible Medicaid hospitals (EHs) to encourage them to adopt, implement, or upgrade their local EHR system, with a later goal of engaging in the “meaningful use” of said technology. The State estimates that the 100 percent federally funded payments to eligible providers may exceed \$700 million over the life of the program, which continues through 2021.</p>
<p>ADMISSION, DISCHARGE, TRANSFER (ADT) INITIATIVE</p>	<p>HFS will begin an Admission, Discharge, Transfer (ADT) initiative beginning spring 2021, with a planned completion by fall 2021. ADT is a statewide data exchange platform that will deliver vital information to Illinois Medicaid providers in a timely and secure manner. The platform will send real-time ADT notifications from the admitting or discharging facility, including emergency room visits, to a patient care coordinator or primary care provider. This real-time information will improve care coordination opportunities by highlighting high utilizers of hospitals and emergency departments. The platform will also provide higher quality care and produce more successful outcomes, decrease unnecessary hospital admissions and readmissions, decrease emergency room visits, as well as outline the timeliness and type of care coordination response to notifications by end users. The ADT platform fits well into the pillar-focused initiatives of the Quality Strategy.</p>

Section 6. Delivery System Reforms

This section describes delivery system reforms made by HFS to incorporate additional services/populations into the State’s comprehensive mandatory Medicaid managed care delivery system, HealthChoice Illinois.

Special Needs Children (SNC)

To achieve optimal benefits of care coordination, enhance quality, improve outcomes, integrate physical and behavioral health, and to best manage costs without compromising quality of care or access to care, HFS obtained a 1915(b) Waiver to include populations of children with complex health and social service needs in HealthChoice Illinois. HFS defined the SNC population as individuals under the age of 19 who meet any of the following criteria:

1. Are eligible for Supplemental Security Income (SSI) under Title XVI;
2. Receive Title V care coordination services through the Division of Specialized Care for Children (DSCC) (also known as the Core Program);
3. Qualify as disabled;
4. Are under the legal custody or guardianship of the Illinois Department of Children and Family Services (DCFS) (also known as current Youth in Care); or
5. Formerly were under the legal care of DCFS and are receiving assistance through Title IV-E (also known as former Youth in Care).

All of the HealthChoice Illinois health plans were contracted to provide services for the SNC populations. Additionally, a new specialized program (YouthCare) was implemented to provide services for DCFS current and former Youth in Care.

HFS is working to develop performance measures and performance improvement projects (PIPs) applicable to this population.

Managed Long Term Services and Supports (MLTSS)

MLTSS was also incorporated in HealthChoice Illinois. Illinois’ MLTSS Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based long term services and supports (LTSS) who are not enrolled in the State’s Medicare-Medicaid Alignment Initiative (MMAI) but are eligible for both Medicare and Medicaid, unless they meet the eligibility exclusions. The State’s goals are to redesign the healthcare delivery system for dual-eligible beneficiaries with a focus on:

- Improving health outcomes, care delivery, and utilization of community-based services.
- Rebalancing its Medicaid LTSS systems from a primary reliance on nursing facility services to expanded utilization of community-based services and supports.
- Implementing Illinois Public Act 96-15013.

The State designed a program that:

- Provides beneficiaries with opportunities for involvement in all healthcare decisions and a choice for better coordination of care, as members work with a team of providers to give them the best possible healthcare.
- Incentivizes health plans to provide robust care coordination and increased utilization of community-based services through a reimbursement structure that encourages use of community-based programs and focuses on performance measurement.

When HealthChoice Illinois was implemented, all health plans began receiving MLTSS enrollment in the greater Chicago area. MLTSS services were expanded statewide to all counties when CMS approved Illinois' MLTSS Waiver amendment, effective July 1, 2019.

HFS is working to develop performance measures and PIPs applicable to this population.

Section 7. Conclusions

Evaluation of the Effectiveness of the Quality Strategy

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

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

- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvements in care and services) and trending of indicator data.
- The appropriateness of the program structure, processes, and objectives.
- The identification of program limitations.
- The evaluation of all internal activities, including quality improvement committees; task forces; recipient complaints, grievances, and appeals; and provider complaints and issues.
- Recommendations resulting from the previous year's EQR activities.
- Feedback obtained from Department leadership, health plans, the provider community, advocacy groups, Medicaid recipients, and other internal and external stakeholders.
- Recommendations for enhanced goals and objectives for the upcoming year.

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

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

Performance-Driven Revisions to Quality Strategy

Due to the HealthChoice Illinois Medicaid Managed Care Program’s statewide expansion, changes to the program, health plan performance, and the impacts of the COVID-19 pandemic, HFS revamped its P4P program in state fiscal year (SFY) 2020. Performance metrics will center on five pillars measured through an equity lens: (1) adult behavioral health, (2) children’s behavioral health, (3) maternal and child health, (4) improving opportunities for people to be treated in their communities, and (5) improving health equities around breast cancer, cervical cancer screenings, high blood pressure, and access to primary care. Each pillar has been carefully chosen to better serve the Department’s three million Medicaid customers and to ensure the best possible allocation of the State’s scarce resources.

Performance Snapshot

Quality, Timeliness, and Access Performance Measures

HFS establishes performance measure standards and monitors health plan performance on nationally recognized measure sets to evaluate health plan performance on HFS Quality Strategy goals within the Medicaid population. For a full list of HFS-required performance measures, see Appendix G. For the most recent performance results for each of the measures, see Appendix K; and for trended results by health plan for each of the performance measures, see Appendix L.

Comparison of health plan performance on these measures to minimum performance standards helps determine what percentage of new members are assigned to the plan (quality-based assignment) and the percentage of payments withheld (quality withhold). The overall health plan-specific star ratings for the 2020 (CY 2019) aggregate quality scores did not change when compared to the 2019 (CY 2018) results, with all health plans receiving three stars (i.e., the plans’ average rating was at or between the 50th and 74th percentiles). The overall rates declined for two plans (Aetna and BCBSIL and improved for three (CountyCare, Meridian, and Molina). For the most recent quality rating results, see Appendix M.

Access to Care Measures Performance

In the Access to Care domain, the HEDIS 2020 statewide average for the *Adults’ Access to Preventive/Ambulatory Health Services—Total* measure indicator fell below the 50th percentile, and the HEDIS 2020 statewide average for the *Adult BMI Assessment* measure indicator fell below the 25th percentile, indicating an area for improvement. The HEDIS 2020 statewide average for the *Annual Dental Visit* measure indicator ranked at or above the 50th percentile.

Keeping Kids Healthy Measures Performance

In the Keeping Kids Healthy domain, the HEDIS 2020 statewide average ranked above the 50th percentile for only four of nine (44.4 percent) measure rates. Despite slight increases in the rates from HEDIS 2019, the *Childhood Immunization Status* measure rates continued to fall below the 50th percentile, indicating opportunities to increase immunizations for children. Additionally, the statewide average fell below the 50th percentile for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, demonstrating opportunities for health

plans to ensure young children receive weight assessment and counseling for nutrition and physical activity during well-child visits.

Women’s Health Measures Performance

In the Women’s Health domain, the HEDIS 2020 statewide average ranked above the 50th percentile for one of the three (33.3 percent) measure rates. Conversely, the statewide average for the *Breast Cancer Screening* and *Cervical Cancer Screening* measure indicators fell below the 50th percentile, demonstrating opportunities for health plans to ensure women receive appropriate screenings.

Living With Illness Measures Performance

In the Living With Illness domain, the HEDIS 2020 statewide average exceeded the 90th percentile for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator, indicating strong performance. Conversely, the statewide average fell below the 50th percentile for four of the eight (50.0 percent) measure rates. Of note, the statewide average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked below the 50th percentile in HEDIS 2019 and HEDIS 2020 and demonstrated a slight rate decline from HEDIS 2019. The health plans should ensure beneficiaries with diabetes receive appropriate eye exams to ensure the measure rate does not continue to decline.

Behavioral Health Measures Performance

Within the Behavioral Health domain, the statewide average for HEDIS 2020 ranked at or above the 50th percentile for three of five (60.0 percent) measure rates. Conversely, the statewide average and measure rates for all six health plans ranked below the 50th percentile for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, demonstrating opportunities to ensure timely follow-up with beneficiaries after a discharge for mental illness from a hospital.

Overall Performance

Table 7-1 provides a high-level snapshot of statewide performance for HEDIS measures, compliance monitoring, PIPs, and CAHPS results for SFY 2020. The percentiles refer to national Medicaid percentiles.

Table 7-1—Performance Snapshot SFY 2020



Indicators of Performance	Overall Domain Performance		
	Quality	Timeliness	Access
HEDIS	26 Quality Measure Rates ⁱ	4 Timeliness Measure Rates ⁱⁱ	6 Access Measure Rates ⁱⁱ
Notable 	HEDIS ≥90th Percentile and Above <ul style="list-style-type: none"> 1 of 26 measure rates (3.8%) <ul style="list-style-type: none"> Statin Therapy for Patients with Diabetes—Received Statin Therapy Between the 75th and 89th Percentiles <ul style="list-style-type: none"> 1 of 26 measure rates (3.8%) <ul style="list-style-type: none"> Immunizations for Adolescents—Combination 1 Between the 50th and 75th Percentiles <ul style="list-style-type: none"> 10 of 26 measure rates (38.5%) 	Between the 50th and 75th Percentiles <ul style="list-style-type: none"> 2 of 4 measure rates (50%) <ul style="list-style-type: none"> Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total and Engagement of AOD Treatment—Total 	Between the 50th and 75th Percentiles <ul style="list-style-type: none"> 3 of 6 measure rates (50%) <ul style="list-style-type: none"> Annual Dental Visits IET—Initiation of AOD Treatment—Total and Engagement of AOD Treatment—Total
	Compliance An Evaluation of Administrative Processes & Compliance Review (Compliance Review) for a subset of standards for HealthChoice Illinois demonstrated that all health plans achieved an overall compliance score between 81–87%.		
	PIPs As approved by CMS, HFS implemented a new rapid-cycle approach for PIPs. The duration of rapid-cycle PIPs is 18 months; therefore, the two new mandatory PIPs, <i>Follow-Up After Hospitalization for Mental Illness</i> and <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> , will continue into the next fiscal year.		
	CAHPS At or Between the 50th and 74th Percentiles Adult Aggregate Results: <ul style="list-style-type: none"> How Well Doctors Communicate Customer Service Rating of All Health Care Rating of Personal Doctor Child Aggregate Results: <ul style="list-style-type: none"> How Well Doctors Communicate Rating of All Health Care Rating of Personal Doctor Rating of Specialist Seen Most Often 	No timeliness measures achieved notable performance	No access measures achieved notable performance

Table 7-1—Performance Snapshot SFY 2020

Indicators of Performance	Overall Domain Performance			
	Quality	Timeliness	Access	
HEDIS	26 Quality Measures Rates ⁱ	4 Timeliness Measures Rates ⁱⁱ	6 Access Measures Rates ⁱⁱⁱ	
 Needs Work	≤ 25th Percentile <ul style="list-style-type: none"> 5 of 26 measure rates (19.2%) <ul style="list-style-type: none"> Adult Body Mass Index (BMI) Assessment Childhood Immunization Status (CIS)—Combination 3 Controlling High Blood Pressure Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total and 30-Day Follow-Up—Total Between the 25th and 50th Percentiles <ul style="list-style-type: none"> 9 of 26 measure rates (34.6%) 	≤ 25th Percentile <ul style="list-style-type: none"> 2 of 4 measure rates (50%) <ul style="list-style-type: none"> FUH—7-Day Follow-Up—Total and 30-Day Follow-Up—Total 	≤ 25th Percentile <ul style="list-style-type: none"> 2 of 6 measure rates (33.3%) <ul style="list-style-type: none"> FUH—7-Day Follow-Up—Total and 30-Day Follow-Up—Total Between the 25th and 50th Percentiles <ul style="list-style-type: none"> Adults' Access to Preventive/Ambulatory Health Services—Total 	
	Compliance	A Compliance Review for a subset of standards for HealthChoice Illinois identified the standards of Children's Behavioral Health (CBH) Services and Subcontractual Relationships and Delegation as needing the most improvement. File reviews identified that quality improvement efforts are needed in the following areas: case management, denials, CBH, appeals, grievances, delegation, provider complaints, and provider directories. See Section 3 of this report for more details.		
	PIPs	During SFY 2020, the primary PIP activities included Module 3 and Module 4 of the process—identifying and testing interventions. At this stage, PIPs are not yet formally evaluated on the Specific, Measurable, Attainable, Relevant, Time-bound (SMART) Aim measure outcomes. The PIPs will receive a final validation status after the completed Module 4s and Module 5s are submitted to HSAG in February 2021.		
	CAHPS	At or Between 25th and 49th Percentiles <p>Adult Aggregate Results:</p> <ul style="list-style-type: none"> Rating of Specialist Seen Most Often Rating of Health Plan < 25th Percentile <p>Child Aggregate Results:</p> <ul style="list-style-type: none"> Customer Service Rating of Health Plan 	At or Between 25th and 49th Percentiles <p>Adult Aggregate Results:</p> <ul style="list-style-type: none"> Getting Care Quickly <p>Child Aggregate Results:</p> <ul style="list-style-type: none"> Getting Care Quickly 	At or Between 25th and 49th Percentiles <p>Adult Aggregate Results:</p> <ul style="list-style-type: none"> Getting Needed Care < 25th Percentile <p>Child Aggregate Results:</p> <ul style="list-style-type: none"> Getting Needed Care

- i. HEDIS results are based on the statewide weighted average (inclusive of all health plans). The Quality Measures reported for this table are those that could be compared to NCQA’s Quality Compass^{®7-1} national Medicaid percentiles for HEDIS 2019. Refer to Appendix A2 for a list of the measures and rates that are included in the quality, timeliness, and access domains. Due to changes in the technical specifications for *Prenatal and Postpartum Care* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose Testing—Total and Cholesterol Testing—Total rates)*, NCQA recommends a break in trending between 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure. Four quality measure rates (two measures) are also included in the timeliness and access domains.
- ii. Four timeliness measure rates were compared to national Medicaid percentiles for HEDIS 2019, but please note that both measures (four measure rates) are also included in the quality and access domains.
- iii. Six access measure rates were compared to national Medicaid percentiles for HEDIS 2019, but please note that two measures (four measure rates) are also included in the quality and timeliness domains.

⁷⁻¹ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Home- and Community-Based Services (HCBS) Performance

HFS’ EQRO conducts quarterly on-site reviews of HCBS Waiver beneficiary records to evaluate compliance with CMS waiver performance measures requirements. Table 7-2 provides a high-level snapshot of statewide performance for HealthChoice Illinois, MLTSS, and MMAI. More details about health plan performance on HCBS measures can be found in Appendix I.

Table 7-2—HCBS Performance SFY 2020

Health Plan	HealthChoice Illinois	MLTSS	MMAI
Aetna	NA*	NA	99%
BCBSIL	94%	94%	95%
CountyCare	89%	88%	NA
Humana	NA	NA	88%
IlliniCare Health (IlliniCare)†	93%	91%	94%
Meridian	93%	91%	92%
Molina	89%	80%	92%
NextLevel Health Partners (NextLevel)‡	89%	89%	NA

* Health plan did not serve the population.

† IlliniCare was purchased by CVS Aetna and is now referred to as Aetna Better Health, effective December 1, 2020.

‡ NextLevel ceased operations on July 1, 2020.

Three of the six HealthChoice Illinois plans averaged greater than 90 percent compliance in SFY 2020. There was a 5-percentage point difference (89 percent to 94 percent) among health plans. Three of the six plans averaged greater than 90 percent compliance for the MLTSS population in SFY 2020. There was a 14-percentage point difference (80 percent to 94 percent) among health plans for MLTSS records. Five of the six MMAI health plans averaged greater than 90 percent overall compliance in SFY 2020. There was an 11-percentage point difference (88 percent to 99 percent) among MMAI plans.

A year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG recommendations following the conclusion of SFY 2019 reviews, efforts to incorporate technical assistance received during on-site reviews, and efforts to integrate HFS guidance into internal processes.

Health Plan Annual Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) Report

The health plans are required to submit a QA/UR/PR evaluation of the quality improvement program and quality improvement activities employed by the health plan for the previous year. The health plans’ annual evaluations include trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the health plan. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring

improvement for each of the quality measures that pertain to the population. The Department requires the health plans to follow an approved outline for the report and provide an evaluation of each of the HealthChoice Illinois Managed Care Program Healthcare and Quality of Life performance measures. The Department's EQRO reviews the annual quality evaluations submitted by each plan to verify that the health plan has followed the Department's outline and stratified and reported the data according to the parameters set by the Department. HFS requires the EQRO to include recommendations and observations about the reports including the use of appendices, ability to expand on the outline provided, and success of "telling the story" of its population. The following presents overall observations and similarities among health plans:

- Most health plans have an opportunity to more successfully utilize the data and information in their attached appendices by referencing the information in their narrative report. For instance, appendices related to population assessment would be appropriate to reference in the health plan's sections related to cultural competency and care management.
- Most health plans followed the HFS outline to establish heading and subheadings in their reports, some using the outline verbatim to report the year's activities. However, the health plans have an opportunity to use the outline more as a guide for information that must be included, rather than following the outline for report setup. For instance, behavioral health utilization and PIPs are both required on the outline in different areas but could be reported together to better draw conclusions about the success of PIP efforts on utilization or to identify additional opportunities for improvement related to behavioral health utilization. Health plans should determine if the annual report would benefit from restructuring to "tell the story," which would allow the health plans to include all outline elements but in a different order set.
- HSAG noted that the health plans' reports indicate different maturity and sophistication levels of providing narrative information, drawing conclusions, or assessing data to determine success of their QI programs. Some health plans may benefit from additional direction from HFS regarding expectations for analysis and reporting.

As part of future reporting, the health plans will be required to stratify performance measure rates by race, ethnicity, and gender. After stratifying the data, the health plans will be required to identify any healthcare disparities among the groups and develop a plan for targeted interventions to reduce and/or eliminate disparities for customers and increase performance measure rates overall.

Successes

Aligning with Quality Improvement Science

In 2014, the EQRO received permission from CMS to align its PIP process with the Model for Improvement developed by Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI). The redesigned methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects health plans to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement.

Prior to implementation of the rapid-cycle PIP process, HSAG provided training to the health plans and HFS on the rapid-cycle PIP approach, components, submission process, and validation criteria. In addition to this training, HSAG conducts module-specific trainings throughout the PIP process. The module-specific trainings solely focus on the requirements of the targeted module. The health plans may also seek one-on-one individualized TA throughout the PIP process and between the initial submission and resubmission(s) of modules.

The health plans submit two state-mandated PIPs for validation, *Follow-Up After Hospitalization for Mental Illness*, with emphasis on 30-day follow-up, and *Transitions of Care—Patient Engagement After Inpatient Discharge*. Both topics are based on HEDIS measures; however, with the rapid-cycle approach, the plans use data analyses to determine a narrowed focus for each PIP. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services. The health plans continued the topics from the prior fiscal year and concluded the PIPs by December 31, 2020.

Provider Network Monitoring

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in the CMS rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol is expected to be released in the future, HFS conducts biannual network reviews of the numbers and types of network providers, time and distance validation studies, access and availability surveys, and online provider directory audits that align with current federal regulations and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect.

Biannual Network Monitoring

The EQRO produces biannual health plan-specific and comparative network reports to identify the number of provider types within each region and county. These reports also included contracted providers within state-specific contiguous counties. Any identified network gaps are communicated to HFS and the health plans. Health plans are required to respond to all identified deficiencies in writing.

Analysis and monitoring of the HealthChoice Illinois provider network verifies that the health plans are contracted with a sufficient number of required providers types within each service region.

Time/Distance Analysis

The purpose of the time and distance study was to evaluate the degree to which health plans comply with network standards outlined in the HFS—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

The study conducted in SFY 2020 validated the time and distance requirements for 22 provider categories within each health plan’s service region. The findings of the study identified that generally all health plans were compliant with the time and distance contract standards, ranging from 19 to 22 provider categories across all regions. Health plans not meeting contract standards were required to submit a corrective action plan for any provider category not meeting time and distance contract standards.

A pediatric provider study conducted in the SFY 2020 validated the time and distance between pediatric enrollees and 25 pediatric provider categories serving pediatric enrollees in the health plans’ networks. The findings of the study identified that generally all health plans were compliant with the time and distance contract standards, ranging from 21 to 25 provider categories across all regions. Health plans not meeting contract standards were required to submit a corrective action plan for any provider category not meeting time and distance contract standards.

Access and Availability Survey

HFS requested HSAG conduct access and availability secret shopper surveys of provider offices to evaluate the average time to an appointment for Illinois Medicaid enrollees. HSAG conducted two secret shopper telephone surveys. The results of the first survey of PCPs and OB/GYNs were completed in 2020. The findings of the survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling, Medicaid eligibility verification, designation with the PCP through insurance prior to appointment scheduling, and medical record review. While some barriers pose unique limitations to a secret shopper survey where caller information cannot be provided to the office (i.e., pre-registration or requiring personal information to schedule), other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments. Other findings identified that 30 percent of sampled cases for each health plan and a key nonresponse reason involved call attempts in which the provider was no longer at the location listed in the provider data. Health plans were required to follow up on the findings of the survey, and HFS will require the EQRO to conduct a provider directory review to validate the information provided to enrollees in the online provider directory.

Children’s Behavioral Health Services

In 2019, the findings of a health plan record review of children with a behavioral health diagnosis receiving care management/care coordination services identified several opportunities for improving services including: oversight of mobile crisis response providers; oversight of the crisis line vendor; communication with inpatient psychiatric facilities regarding admission and discharge information; community stabilization and integrated care teams; and establishment of Family Leadership Council meetings. In 2020, HFS required the EQRO to conduct a follow-up review to evaluate the effectiveness of the remediation actions taken to improve care management care coordination services for this population. The overall findings of the follow-up review identified improved oversight of the crisis line vendor, including improved referrals to the mobile crisis providers; improved communication and compliance by the mobile crisis providers in completion of the Illinois Medicaid Crisis Assessment Tool (IM-CAT); improved communication with high-volume inpatient psychiatric facilities for admissions and discharges; defined roles of health plan staff and mobile crisis providers to improve community stabilization activities; and established quarterly Family Leadership Council meetings to provide enrollees and families with a mechanism for input and feedback regarding its service delivery system.

Critical Incident Reporting

The EQRO conducts quarterly reviews of critical incident (CI) records to evaluate health plan compliance with CI contract requirements. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Ongoing performance is monitored through quarterly CI record reviews, health plan-specific feedback, and remediation of review findings. The CI review evaluates the health plans’ compliance with all CI requirements required by contract, State and federal statutes and regulations, and 1915(b) and 1915(c) Waiver conditions. The health plan’s quality improvement efforts taken to improve the CI reporting process has demonstrated improved compliance with the CI requirements through monitoring and oversight of the quality department to ensure compliance with CI requirements and monitoring of CIs; improved documentation of steps taken to resolve critical incidents; more thorough completion of the CI form by the staff reporting the CI and the quality department; and improved consistency and accuracy of the data universe submission for selection of the sampled cases for the monitoring reviews.

Statewide Expansion of Managed Care for Additional Populations

1915(b) Illinois Managed Long Term Services and Supports (MLTSS) Demonstration Waiver

Illinois’ MLTSS Demonstration Waiver application was approved by CMS, effective July 1, 2016 (CMS Control # IL-01.M01). Illinois’ MLTSS Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based LTSS who are not enrolled in the State’s MMAI but are eligible for both Medicare and Medicaid, unless they meet the eligibility exclusions.

MLTSS services were expanded statewide to all counties when CMS approved Illinois’ MLTSS Waiver amendment, effective July 1, 2019. The goals of the State’s MLTSS Waiver are to redesign the healthcare delivery system for dual-eligible beneficiaries, with a focus on:

- Improving health outcomes, care delivery, and utilization of community-based services.
- Rebalancing its Medicaid LTSS systems from a primary reliance on nursing facility services to expanded utilization of community-based services and supports.
- Implementing Illinois Public Act 96-1501.⁷⁻¹

HFS contracted with its EQRO to complete the access and quality of care Independent Assessment (IA) of Illinois' MLTSS Waiver. HFS also contracted with Chicago-Milwaukee Milliman, Inc. (Milliman), an independent actuarial firm, to complete the assessment of the MLTSS Waiver's cost-effectiveness.

The IA evaluated the availability of services under the MLTSS Waiver and compared it to the level of waiver services that existed prior to the waiver, if comparison information was available, to:

- Ensure that the program did not substantially impair beneficiary access to services as compared to accessibility of services prior to or without the waiver.
- Ensure that the quality of services was not less than the quality of services prior to or without the waiver.

The IA evaluation findings identified that HFS demonstrated monitoring and oversight for all areas reviewed by HSAG in this IA. HFS' processes and health plan performance are well aligned with the commitments made in the MLTSS Waiver application. These processes also demonstrated enhancements in comparison to existing Medicaid FFS processes, thereby showing the waiver ensures that beneficiary access to services and quality of care are comparable or improved in comparison to pre-waiver enrollment. While program improvement recommendations are noted in the IA report, no areas of risk or concern were identified, as both access to care and quality of care have been determined to be as effective or more effective than access to and quality of care received prior to the MLTSS Waiver.

1915(b) Special Needs Children (SNC) Waiver

Illinois' SNC 1915(b) Waiver application was approved by CMS, effective April 1, 2019, through March 31, 2021 (CMS Control # IL-02. R00.00). Statewide implementation of the program began February 1, 2020. Illinois' SNC Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries under the age of 19 who meet any of the following criteria:

1. Are eligible for Supplemental Security Income (SSI) under Title XVI;
2. Receive Title V care coordination services through the Division of Specialized Care for Children (DSCC) (also known as the CORE Program);
3. Qualify as disabled;
4. Are under the legal custody or guardianship of the Illinois Department of Children and Family Services (DCFS) (also known as Youth in Care); or
5. Formerly were under the legal care of DCFS and are receiving assistance through Title IV-E also known as former Youth in Care.

⁷⁻¹ Illinois MLTSS Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs, and FFS Selective Contracting Programs: MMA Amendment Version April 1, 2016, April 1, 2018, Revised July 10, 2018, Second Revision September 18, 2018.

The goals of the State’s Medicaid managed care program, including the SNC Waiver are to:

1. Achieve optimal benefits of care coordination.
2. Enhance quality of care and services.
3. Improve outcomes.
4. Integrate physical and behavioral health.
5. Manage costs without compromising quality of care or access to care.⁷⁻²

Pursuant to Title 42 CFR §431.55(b)(4), CMS monitors and evaluates the implementation of Medicaid managed care programs to ensure that requirements for granting federal waivers are being met. Pursuant to Section 2111(B) of the State Medicaid Manual, states must arrange for an IA of their waiver programs and submit the findings when renewing their waiver programs. CMS requires that a contractor or agency independent of the state Medicaid agency complete the assessment by evaluating access to services and care, quality of care, and cost-effectiveness of the program prior to renewal of the waiver.

HFS will utilize its EQRO to complete the access and quality of care IA of Illinois’ SNC Waiver. HFS will also utilize Milliman to complete the assessment of the MLTSS Waiver’s cost-effectiveness as required by CMS.

Medicare-Medicaid Alignment Initiative (MMAI)—Statewide Expansion

Finally, statewide expansion of the MMAI, serving customers eligible for both Medicare and Medicaid services, is scheduled for July 1, 2021.

⁷⁻² Illinois SNC Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs: Final Version, December 6, 2018.

Advanced Cloud Technology (IMPACT)

The IMPACT initiative is a multi-agency effort that modernizes HFS' 30-year-old MMIS which was built to support the FFS Medicaid program. The fourth phase, Full Implementation/CoreSystem, is the largest and most complex. It encompasses numerous subsystems including claims/encounters, prior approval, eligibility/enrollment, business administration, and financials. It is projected to be completed in 2023. Once completed, the Department will have a modern, single, cloud-enabled MMIS for all Medicaid claims processing.

Medicaid Plan Report Card

Illinois Public Act 099-0725 set forth requirements for the Medicaid quality rating system. HFS continued to publish its consumer quality comparison tool, called the HealthChoice Illinois Plan Report Card, to reflect the performance of each of the four statewide health plans and six Cook County health plans. The report card compares Illinois' health plans across six performance areas which align with Illinois' goals and pillar-focused population streams. The six performance areas include: (1) doctors' communication, (2) access to care, (3) women's health, (4) living with illness, (5) behavioral health, and (6) keeping kids healthy. Each plan is assigned up to five stars to indicate how it performs relative to other plans on each of these six measures. The information used to create the Medicaid managed care report is collected from the health plans and their customers and is reviewed for accuracy by the EQRO. The most current information from the NCQA HEDIS and CAHPS is used.

HFS produces two report cards. The Cook County report card includes an analysis of the plans that are available to Medicaid beneficiaries in Cook County. The statewide report card included an analysis of the plans that are available statewide to Medicaid beneficiaries.

A copy of the most recently published statewide report card can be found in Appendix C and at: https://www.illinois.gov/hfs/healthchoice/reportcard/Pages/statewide_sc20.aspx

A copy of the most recently published Cook County report card can be found in Appendix C and at: <https://www.illinois.gov/hfs/healthchoice/reportcard/Documents/ILHealthChoiceReportCardCookCounty.pdf>

NCQA Accreditation

Illinois amended its Public Aid Code to require Medicaid health plans to be accredited by NCQA. NCQA accreditation is a comprehensive evaluation based on results of clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures) and is a widely recognized symbol of quality. HFS believes requiring NCQA accreditation lays the framework for health plans serving Medicaid beneficiaries to improve care, enhance service, and reduce costs. As required by §438.10(c)(3), HFS makes the accreditation status of each health plan available on its website. As of September 2019, all health plans have achieved an accreditation level of "Accredited." NCQA awards an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and quality improvement.

Challenges/Opportunities

Challenges in Improving Quality of Care

Over the past few years, the Department has been faced with a number of challenges to improving quality of care. These challenges included an outdated PIP structure that focused more heavily upon documentation than achieving results, uncoordinated care, a lack of transparency, and communication between Illinois' providers and managed care entities that resulted in an uncoordinated approach to care coordination by Illinois' health plans.

These challenges are being addressed through several activities, including: the redesign of Illinois' Medicaid PIPs to incorporate data-driven approaches and rapid-cycle methods of quality improvement through alignment with the IHI model; efforts to eliminate fragmentation in the care delivery system; increasing transparency through the use of provider and managed care report cards and dashboards showing performance on key metrics; increasing the collaborative use of data; and a focusing on care coordination for managed care enrollees.

Implementing Integrated Health Homes (IHH)

In November 2020, HFS announced it was indefinitely pushing back the rollout of its IHH program due to the need to amend timelines and prioritize plans around the public health emergency prompted by COVID-19. The IHH initiative, aimed at integrating physical and behavioral health, was a key part of the State's overhaul of behavioral healthcare in Medicaid aimed at addressing social determinants of health, reducing barriers to healthcare access, and building collaborations among community groups. The state is working with the University of Illinois at Chicago on the strategic plan in an effort to change the status quo and reorient the system around people and communities.

COVID-19 Implications

HFS stays informed of recommendations from nationally recognized organizations such as the NCQA, CMS, and the National Quality Forum regarding the impact of COVID-19. HFS continues to monitor the impact of the pandemic on health plan business operations, including potential effects on performance measurement, quality, medical record data collection, access to provider offices, and a host of other related issues.

Ongoing Medicaid Quality Improvement Activities

Future Medicaid quality improvement activities will address improving services and health outcomes within the five population-focused pillars measured through an equity lens: (1) adult behavioral health, (2) children's behavioral health, (3) maternal and child health, (4) improving opportunities for people to be treated in their communities, and (5) improving health equities around breast cancer, cervical cancer screenings, high blood pressure, and access to primary care.

The Department has dedicated program staff members in quality and performance improvement to assist the health plans in optimizing the impact of improvement initiatives and in evaluating the

effectiveness of their programs. The Department’s performance and improvement staff members actively work with Illinois’ contracted health plans in order to understand their approaches to quality, identify additional areas for improvement, and spread best practices.

The Department will continue to actively support its contracted health plans in the pursuit of quality by fostering opportunities for learning and collaboration, providing coaching resources for quality improvement activities, and providing a clear vision for improving the care of Illinoisans.

Next Steps

The Department will continue looking for innovative ways of improving the health of Illinoisans through service delivery in a managed care environment. The Department is committed to promoting a system dedicated to quality over volume and will continue to foster approaches that improve the health and economic vitality of Illinoisans in an efficient and cost-effective manner. Person-centered care that empowers individuals in making their own healthcare decisions and honors personal choice will continue to be a priority. Increased methods for ensuring data sharing and transparency will help HFS achieve desired outcomes through promoting greater coordination of care, responsiveness, integrity, and accountability.

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