ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Illinois Department of Healthcare and Family Services

Division of Medical Programs

External Quality Review Annual Report

State Fiscal Year 2015

(July 1, 2014-June 30, 2015)

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1. Executive Summary

Introduction

Since June 2002, Health Services Advisory Group, Inc. (HSAG), has served as the external quality review organization (EQRO) for the Illinois Department of Healthcare and Family Services (HFS). The State Fiscal Year (SFY) 2015 Illinois External Quality Review (EQR) Technical Report describes the manner in which data from EQR activities conducted in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.358, were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to participants of the Illinois Medical Assistance Program.

Purpose of Report

The SFY 2015 EQR Technical Report provides an evaluation of the data sources reviewed by HSAG. As the EQRO, HSAG assessed the progress made in fulfilling HFS' goals for the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients for HFS-contracted health plans for the SFY 2015 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the State requirements.

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

Federal regulations at 42 CFR §438.364 call for the production by each state of a detailed technical report on EQR results. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients by HFS-contracted health plans. Information released in this technical report does not disclose the identity of any recipient, in accordance with §438.350(f) and §438.364(a)(b). This report specifically addresses the following for each EQR activity conducted:

- Objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data

In addition, this report includes an assessment of each health plan's strengths and weaknesses with respect to the quality and timeliness of, and access to, healthcare services furnished to HFS beneficiaries. The report also offers recommendations for improving the quality of healthcare services

furnished by each health plan, makes comparisons of plan performance, and describes performance improvement efforts.

Report Organization

The EQR technical report is organized as follows:

- **Section 1—Executive Summary** describes the purpose of this report and its organization, the scope of the report (mandatory and optional EQR activities), and a summary of overall conclusions and recommendations.
- **Section 2—Introduction and Background** provides the history of State Medicaid and describes its eligibility requirements, enrollment, and programs. Section 2 also describes the mandatory and optional EQR activities, goals of the Quality Strategy, the State's monitoring and compliance efforts to assess progress toward meeting Quality Strategy goals, and the process for updating the Quality Strategy.
- **Section 3—Validation of Performance Improvement Projects** (PIPs) describes the validation process and conclusions for PIPs and describes the PIP interventions and outcomes for each PIP conducted by health plans during the report period.
- **Section 4—Validation of Performance Measures** describes the validation process and conclusions for the reporting year, including a description of the assessment of the health plans' information systems. It also provides an evaluation of the health plans' ability to collect and accurately report on the performance measures and presents performance measure results for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] 2014 and trended HEDIS measures from 2012–2015.
- **Section 5—Administrative Compliance** describes the administrative compliance assessment and monitoring activities. This includes readiness reviews, care coordination staffing monitoring and evaluation, oversight activities for Home and Community-based Services (HCBS) Waiver programs, validation and monitoring of the health plans' provider networks, and a family planning focused review. For each of the activities, the report presents the objectives, technical methods of data collection and analysis, description of data obtained, and findings.
- **Section 6—Consumer Quality of Care Surveys** presents the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys and other member satisfaction surveys conducted by health plans and HFS during the report period. The results for the statewide CAHPS survey that HSAG administered on behalf of HFS for the **Illinois Medicaid** (Title XIX) and **All Kids** (Title XXI) programs are also reported.
- **Section 7—Optional EQR Activities** describes additional activities conducted by the EQRO including, ad hoc network capacity reporting, validation of State measures for Primary Care Case Management/Children's Health Insurance Program Reauthorization Act (PCCM/CHIPRA), monthly

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

and quarterly managed care meetings, Quality Strategy guidance, and technical assistance to HFS and the health plans throughout SFY 2015.

- **Appendix A**—displays the HEDIS 2015 Medicaid rates and trended rates for Family Health Plans/Affordable Care Act (FHP/ACA) health plans.
- **Appendix B**—displays the Illinois Performance Measure 2015 Medicaid rates for the Integrated Care Program (ICP).
- **Appendix C**—displays a list of acronyms that are used throughout this report.

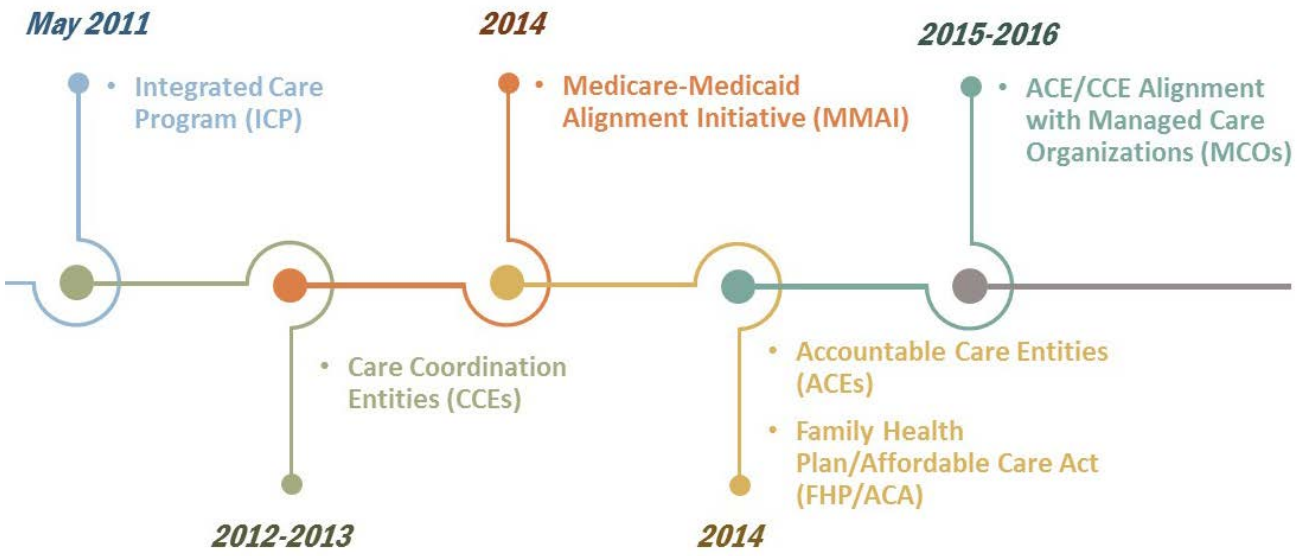
Overview of Illinois Medicaid SFY 2015

Illinois Medicaid Expansion

Effective managed care expansion was central to HFS' planning as the Department began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148). Care coordination was the centerpiece of Illinois' Medicaid reform. Initial expansion began with a focus on the most complex, expensive clients and was expanded with the development and implementation of additional managed care programs that offered the benefits of care coordination, as shown in Figure 1-1 below.

To ensure coordinated implementation of care coordination expansion, HFS created a rollout schedule identifying implementation dates for various care coordination programs, by health plan. Therefore, health plans were in varying stages of program implementation throughout SFY 2015. Results are reported accordingly.

Figure 1-1—Illinois Medicaid Expansion



Medicaid Managed Care Health Plans

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

FHP/ACA

In July 2014, Illinois transitioned from voluntary managed care (VMC) in select counties to the FHP/ACA with mandatory managed care regions that cover most of the state. Under this transition, VMC continues to be an option for clients to choose for their care coordination services within many nonmandatory counties. In this reporting year, those three health plans—**Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**)—continued to conduct mandatory activities with both the voluntary managed care population (in select, nonmandatory counties) and the new FHP/ACA population in mandatory counties. This reporting year serves as a baseline year for FHP/ACA health plans that began accepting enrollment during SFY 2015 and will initiate mandatory activities in subsequent reporting years.

HFS contracted with nine FHP/ACA health plans to provide healthcare services to Medicaid managed care beneficiaries. The table below identifies the FHP/ACA health plans and their service areas.

Table 1-1—FHP/ACA Health Plans for SFY 2015

FHP/ACA Health Plan	Counties
Aetna Better Health (Aetna)	Greater Chicago, Rockford
Blue Cross Blue Shield of Illinois (BCBSIL)	Greater Chicago
CountyCare Health Plan (CountyCare)	Cook
Family Health Network (FHN)	Greater Chicago, Rockford
Harmony Health Plan of Illinois, Inc. (Harmony)	Greater Chicago, Metro East, Jackson, Perry, Randolph, Washington, Williamson
Health Alliance Connect, Inc. (Health Alliance)	Central Illinois (N & S)
IlliniCare Health Plan, Inc. (IlliniCare)	Greater Chicago, Quad Cities, Rockford
Meridian Health Plan, Inc. (Meridian)	Greater Chicago, Central Illinois (N), Metro East, Quad Cities, Rockford, Adams, Brown, DeKalb, Henderson, Lee, Livingston, McLean, Pike, Scott, Warren, Woodford
Molina HealthCare of Illinois, Inc. (Molina)	Central Illinois (N & S), Metro East

Primary Care Case Management

As part of Illinois' care coordination expansion, Illinois Health Connect (IHC)[1-3] members in the five mandatory managed care regions began joining a managed care entity in July 2014. This means that most children, families, and newly eligible ACA adults now receive care coordination services in the five mandatory managed care regions primarily from health plans, accountable care entities (ACEs), or care coordination entities (CCEs). Counties not included in the five managed care regions will continue to include IHC as a plan choice for most individuals enrolled in the HFS medical program.

Integrated Care Program

FHP/ACA expansion provided the opportunity for additional health plans to serve the ICP population. **Aetna** and **IlliniCare** have served the ICP population since 2011, while this reporting year is the baseline year for new ICP health plans. During the reporting period, ICP beneficiaries in Illinois could choose between 10 ICP health plans. The table below identifies the ICP health plans and their counties of operation.

Table 1-2—ICP Health Plans SFY 2015

ICP Health Plan	Counties
Aetna	Greater Chicago, Rockford
BCBSIL	Greater Chicago
Cigna-HealthSpring of Illinois (Cigna)	Greater Chicago
Community Care Alliance of Illinois (CCAI)	Greater Chicago, Rockford
CountyCare	Cook
Health Alliance	Central Illinois (N & S)
Humana	Greater Chicago
IlliniCare	Greater Chicago, Rockford, Quad Cities
Meridian	Greater Chicago, Central Illinois (N), Metro East
Molina	Central Illinois (N & S), Metro East

[1-3] Illinois Primary Care Case Management (PCCM) program is called Illinois Health Connect (IHC).

Care Coordination Entities

There were nine participating CCEs during the reporting period as shown in the table below.

Table 1-3—CCEs SFY 2015

CCEs	Counties Served
Serving Adults	
Be Well Partners in Health (Be Well)	Cook (certain ZIP codes)
Choices Medicaid Care Coordination (CMCC)	Champaign, Ford, Iroquois, Vermillion
EntireCare Coordination (EntireCare)	Cook (certain ZIP codes)
My Healthcare Coordination (MHCC)	Macon, Logan, Piatt, DeWitt, Moultrie, Shelby
NextLevel Health Partners, LLC (NextLevel)	Cook
Precedence Care Coordination Entity, LLC (Precedence)	Quad Cities, Bureau, Carroll, LaSalle, Lee, Ogle, Putnam, Whiteside
Together4Health (T4H)	Cook
Serving Children	
La Rabida Children's Hospital (La Rabida)	Cook
Lurie Children's Hospital of Chicago CCE (Lurie)	Cook, DuPage, Kane, Kendall, Lake, McHenry, Will

Accountable Care Entities

There were nine participating ACEs during the reporting period as shown in the table below.

Table 1-4—ACEs SFY 2015

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

Medicare-Medicaid Alignment Initiative

There were eight participating Medicare-Medicaid Alignment Initiative (MMAI) health plans during the reporting period as shown in the table below.

Table 1-5—MMAI Health Plans SFY 2015

MMAI Health Plan	Counties
Aetna	Greater Chicago (excluding Lake)
BCBSIL	Greater Chicago
Cigna	Greater Chicago (excluding Kankakee)
Health Alliance	Central Illinois (N & S)
Humana	Greater Chicago
IlliniCare	Greater Chicago
Meridian	Greater Chicago (excluding Kankakee and Lake)
Molina	Central Illinois (N & S)

SFY 2015 External Quality Review

The EQR process consists of mandatory activities and optional activities, which are further detailed in Section 2 of this report, in addition to producing an annual EQR technical report and providing technical assistance, as needed. HSAG, as the EQRO for HFS, conducted the EQR activities and analyzed the results as described in the sections of this report. A brief summary of HSAG's assessment of performance and notable results for the July 1, 2014, through June 30, 2015 review period follows.

Summary of Findings, Conclusions, and Recommendations

As set forth in 42 CFR §438.364(a)(3), this section of the technical report includes recommendations for improving quality of healthcare services furnished by each health plan. CMS chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid managed care health plans. HSAG provides overall findings, conclusions, and recommendations regarding the health plans serving Illinois Medicaid beneficiaries during the review period for each domain of care and presents them in the annual EQR technical report.

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

- PIP results (as described in Section 3 of this report).
- Performance measure audits using National Committee for Quality Assurance's (NCQA's) standardized audit methodology (as described in Section 4 of this report).
- Administrative compliance activities including readiness reviews, HCBS oversight, and provider network validation (as described in Section 5 of this report).
- Member satisfaction survey results (as described in Section 6 of this report).
- Optional EQR activities including technical assistance to HFS and health plans (as described in Section 7 of this report).

Validation of PIPs

FHP/ACA PIPs

Three health plans—**FHN**, **Harmony**, and **Meridian**—participated in mandatory statewide PIPs focused on the following two topics:

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

The *EPSDT Screening* PIP focused on improving performance related to well-child visits and developmental screenings. During SFY 2015, all three health plans reported Remeasurement 2 data and

implemented interventions. To conduct an effective PIP, study indicators are chosen, which are quantitative or qualitative characteristics (variables) reflecting a discrete event that is to be measured. The *EPSDT Screening* PIP had seven study indicators.

Three study indicators were HEDIS measures that assessed the percentage of children who received six or more well-child visits in the first 15 months of life (Indicator 1); zero well-child visits in the first 15 months of life (Indicator 2); and, for children 3–6 years of age, one or more well-child visits during the measurement year (Indicator 7). Four study indicators assessed the percentage of children who had been screened for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their first birthday (Indicator 3); after their first birthday and on or before their second birthday (Indicator 4); after their second birthday and on or before their third birthday (Indicator 5); and in the 12 months preceding their first, second, or third birthday (Indicator 6). Results showed that all three health plans realized improvements from the prior measurement period for some, but not all, indicators. None of the improvements were statistically significant.

The primary purpose of the *Perinatal Care and Depression Screening* collaborative PIP was to determine if health plan interventions have helped to improve the rates for the perinatal HEDIS measures, along with depression screening for eligible women. The secondary purpose of this PIP is to determine potential opportunities to improve the rate of objective depression screening, along with appropriate treatment when depression is identified through screening and assessment.

A total of 16 study indicators for this PIP assessed performance on timeliness and frequency of prenatal care, completion of depression screenings during and after pregnancy, and treatment referrals for women with a positive depression screen. Results showed that from the prior measurement period, **Harmony** achieved improvement for Study Indicator 3 (frequency of ongoing prenatal care <21%) and **Meridian** achieved improvement in Study Indicators 5 and 6 for treatment or follow-up within 7, 14, and 30 days of a positive depression screen. **FHN** did not achieve improvement from the prior measurement year in any indicator. For this PIP, none of the study indicators evaluated across all three health plans achieved statistically significant improvement.

ICP PIPs

HFS required health plans delivering ICP services to participate in a mandatory, statewide PIP, *Community Based Care Coordination*. The statewide PIP focused on improving care coordination and the linkage of the member/client to ambulatory care and community services. This PIP aims to decrease readmissions within 30 days of discharge, improve care coordination during hospitalization and post-acute care discharge, and improve access to community care resources. The three study indicators assessed the percentage of high-to-moderate risk members who did not have a readmission within 30 days of an initial discharge (Indicator 1), who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge (Indicator 2), and who accessed community resources within 14 days of discharge (Indicator 3).

Statistically significant improvement from the prior measurement period was achieved by both **Aetna** and **IlliniCare** for two of the three study indicators. Both health plans reported sustained improvement from the prior measurement year in all three study indicators.

Section 3 of this report details the PIP validation process and the results of and recommendations for the PIPs conducted during the report period.

Validation of Performance Measures

FHP/ACA Performance Measure Results

For ease of review, this report organizes performance reporting by classifying performance measures into the following measure sets.

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

Results show the performance for each HEDIS measure using data collected in 2014, relative to the 2014 Quality Compass®[1-4] percentiles, displayed with the star ratings as follows:

Table 1-6—HEDIS Measure Star Ratings

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

[1-4] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Access to Care

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

Table 1-7—HEDIS Measures for Access to Care

Measure Set	HEDIS Measure
Access to Care	*Children and Adolescents' Access to Primary Care Practitioners (PCPs) (4 Measure Indicators: 12–24 Months, 25 Months–6 Years, 7–11 Years, 12–19 Years)*
	Adults' Access to Preventive/Ambulatory Care (3 Measure Indicators: 20–44 Years, 45–64 Years, Total)
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (6 Measure Indicators: Initiation—13–17 Years, 18+ Years, Total; Engagement—13–17 Years, 18+ Years, Total)

FHN's star rating was Poor for all but one of the 13 measure indicators in this category. **Harmony** also performed below the 2014 Quality Compass 25th percentile for all of the measure indicators related to child and adolescent access to PCPs and adults' access to preventive/ambulatory care. Therefore, both plans should evaluate internal policies regarding member and provider education, and quality improvement interventions and barriers, for improving these Access to Care measures. In this measure set, **Harmony** performed best in the *Initiation of AOD Dependence Treatment*, scoring a star rating of Excellent for the *13–17 Years* measure indicator and a star rating of Good for the other two initiation measure indicators. **Meridian** performed at or above the 2014 Quality Compass 50th percentiles for all measures in this measure set.

Child and Adolescent Care

The Child and Adolescent Care measures identified below fall into the Effectiveness of Care and Utilization HEDIS domains. Measures in the Effectiveness of Care domain assess prevention, screening, and appropriate care for respiratory conditions. Utilization measures provide information on well-care visits for children between the ages of 0 and 21. The following table summarizes the HEDIS measures regarding care for children and adolescents.

Table 1-8—HEDIS Measures for Child and Adolescent Care

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

Harmony's star rating was either Poor or Fair for all but three of the 13 measure indicators in this category. **Harmony**'s strongest performance in this measure set was for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, scoring at or above the 2014 Quality Compass 50th percentiles for two of the three measure indicators. This was also an area of strength for **FHN**, achieving a star rating of Good for all three measures indicators.

For *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, **FHN** achieved a Very Good star rating, while **Meridian** achieved a star rating of Excellent. **Meridian** achieved rates at or above the 2014 Quality Compass 50th percentiles on 11 of 13 measure indicators in this measure set; however, **Meridian** demonstrated rate improvements for only four measures in this measure set.

Lead Screening in Children was an area of strength across all three health plans, as they all met or exceeded the 2014 Quality Compass 50th percentiles. An area for improvement across all plans was *Childhood Immunization Status*, as all three plans' rates declined from the previous year.

Women's Health

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

Table 1-9—HEDIS Measures for Women's Health

Category	HEDIS Measure
Women's Health	*Breast Cancer Screening*
	Cervical Cancer Screening
	Chlamydia Screening in Women *(3 Measure Indicators: 16–20 Years, 21–24 Years, Total)*
	Prenatal and Postpartum Care *(2 Measure Indicators: Timeliness of Prenatal Care, Postpartum Care)*
	Frequency of Ongoing Prenatal Care *(2 Measure Indicators: <21 Percent of Expected Visits, >81 Percent of Expected Visits)*

FHN's rates were below the 2014 Quality Compass 50th percentiles for six of nine measure indicators in the Women's Health measure set. **FHN**'s performance was strongest for *Chlamydia Screening in Women*, with a star rating of Good for all three measure indicators. **Harmony**'s rates were below the 2014 Quality Compass 50th percentiles for all but one Women's Health measure indicator. **FHN** and **Harmony** should evaluate quality improvement interventions and barriers for improving the Women's Health measures.

Meridian exceeded the 2014 Quality Compass 50th percentiles for the eight measure indicators in this measure set for which it had an eligible population and outperformed the other two health plans. However, **Meridian** demonstrated rate improvements for only one measure indicator in this measure set: *Chlamydia Screening in Women—16–20 Years*.

Care for Chronic Conditions

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

Table 1-10—HEDIS Measures for Care for Chronic Conditions

Category	HEDIS Measure
Care for Chronic Conditions	*Comprehensive Diabetes Care* *(6 Measure Indicators: Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%)1, HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, BP Control (<140/90 mm Hg)*
	Controlling High Blood Pressure
	Use of Appropriate Medications for People With Asthma *(5 Measure Indicators: 5–11 Years, 12–18 Years, 19–50 Years, 51–64 Years, Total)*
	Medication Management for People With Asthma *(10 Measure Indicators: Medication Compliance 50% (5–11 Years, 12–18 Years, 19–50 Years, 51–64 Years, Total); Medication Compliance 75% (5–11 Years, 12–18 Years, 19–50 Years, 51–64 Years, Total)*

In general, Care for Chronic Conditions is a measure set needing improvement by **FHN** and **Harmony**. Both plans did not meet or exceed the 2014 Quality Compass 50th percentiles for a majority of the measure indicators. Of all the measure indicator groups, both **FHN** and **Harmony** demonstrated the strongest performance on the *Use of Appropriate Medications for People With Asthma* measure indicators. **FHN** achieved star ratings of Good or Very Good for all four of the measure indicators it had an eligible population for in this group, and **Harmony** achieved a Good star rating for the *Total* measure indicator and an Excellent star rating for the *19–50 Years* measure indicator.

For eight of the 19 measure indicators it reported, **Meridian** had less than 30 eligible cases; therefore, the rates are not presented. Health plan comparison for this measure set should be used with caution since **Meridian** reported its rates based on small population size. However, 11 of the measure indicators reported exceeded the 2014 Quality Compass 50th percentiles, including four of the six indicators reported under *Comprehensive Diabetes Care.*

Behavioral Health

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

Table 1-11—HEDIS Measure for Behavioral Health

Category	HEDIS Measure
Behavioral Health	*Follow-up After Hospitalization for Mental Illness* *(2 Measure Indicators: 7-Day and 30-Day Follow-Up)*
	Antidepressant Medication Management *(2 Measure Indicators: Effective Acute Phase Treatment, Effective Continuation Phase Treatment)*

Harmony scored below the 2014 Quality Compass 25th percentile on all of the Behavioral Health measure indicators. **FHN** scored below the 25th percentile for both *Antidepressant Medication Management* measure indicators, but the plan's star ratings for *Follow-up After Hospitalization for Mental Illness* were Good (*30-Day*) and Very Good (*7-Day*). Compared to the previous year, **FHN**'s *7-Day* measure indicator increased by nearly 11 percentage points. **Meridian**'s rates for *Follow-up After Hospitalization for Mental Illness* declined and were below the 2014 Quality Compass 50th percentile. Rates decreased for the *30-Day* measure indicator by more than 17 percentage points and by more than 10 percentage points for the *7-Day* measure indicator. Yet, **Meridian** achieved Excellent star ratings for both *Antidepressant Medication Management* measure indicators.

Performance Measure Validation Audit Results

As a result of the HEDIS 2015 compliance audit, **FHN**, **Meridian**, and **Harmony** were fully compliant with the HEDIS 2015 Technical Specifications. Medical and membership data were fully compliant with the audit standards. All HEDIS performance measures obtained a *Report* (*R*) audit designation.[1-5]

Encounter Data Completeness

The health plans were also assessed for encounter data completeness based on the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. **FHN** was able to reach at least 90 percent encounter data completeness for four measure indicators. Six measure indicators showed data completeness less than 50 percent. Although 18 measure indicators demonstrated an increase in data completeness since last year, **FHN** is still struggling to obtain complete encounter data for the measures. Continued effort to acquire encounter data is strongly encouraged.

[1-5] "Report" (R) indicates that the measure was compliant or substantially compliant with the measure specifications and there were no issues to substantially bias the performance report. Any concerns with the implementation of the specifications or data availability did not result in a significant bias in the final rate for the measure.

Harmony exceeded 90 percent data completeness for five of 23 measure indicators. In addition, **Harmony** continued to outperform **FHN** in data completeness for all but eight measure indicators. Five of the 23 measure indicators had data completeness less than 50 percent. However, when compared to the previous year's results, **Harmony**'s data completeness improved for 10 measure indicators. **Harmony** should continue to strengthen its efforts to improve submission in order to maintain the level of encounter data submission.

Meridian exceeded 90 percent data completeness for 12 measure indicators in 2015. Two measure indicators showed encounter data completeness rates below 50 percent in 2015. **Meridian** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission for the select measures that are not solely determined through administrative data.

ICP Performance Measure Results

SFY 2015 was the third year for reporting the ICP measures for **Aetna** and **IlliniCare** and the first year for reporting the ICP measures for **CCAI**, **Health Alliance**, **Meridian**, and **Molina**. For **Aetna** and **IlliniCare**, a baseline rate was established for each measure based on data prior to implementation of the ICP program, whenever possible. No plan-specific baselines were calculated for **CCAI**, **Health Alliance**, **Meridian**, and **Molina**; therefore, the baseline rates established for **Aetna** and **IlliniCare** were used to evaluate performance for the pay-for-performance measures for these ICPs.

Aetna's rates for three measure indicators represented a decline from the baseline rates. Overall, 10 rates improved, with three rates improving by more than 5 percentage points. The rates for **IlliniCare** showed that four measure indicators had a decline from the baseline rates. Overall, **IlliniCare** showed that nine rates improved, with four rates improving by more than 5 percentage points. Since this was the first year of reporting for **CCAI**, **Health Alliance**, **Meridian**, and **Molina**, no comparisons to baseline rates were made.

This was also the third year for reporting pay-for-performance measures for **Aetna** and **IlliniCare**, with **IlliniCare** demonstrating more improvement than **Aetna**. Overall, **Aetna** achieved a *Met* status for three measures, which included meeting the target goals for six of the individual rates. Twelve rates did not meet the target goals. **IlliniCare** achieved a *Met* status for three measures including 10 individual rates; the other eight rates did not meet the target goals. Both ICPs achieved a *Met* status for *Coronary Artery Disease*.

Aetna and **IlliniCare** failed to meet the target goals for the *Pharmacotherapy Management of COPD Exacerbation (PCE)* measure category. In addition, neither ICP met the target goals for, *Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit*, *Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge*, and *Ambulatory Care—ED Visits per 1,000 Member Months.*

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

This was the first year for reporting pay-for-performance measures for **CCAI**, **Health Alliance**, **Meridian**, and **Molina**. **CCAI** achieved a *Met* status for four measures, which included meeting the target goals for eight of the individual rates. Seven individual rates did not meet the target goals. **Health Alliance** achieved a *Met* status for eight measures including 13 individual rates; two individual rates did not meet the target goals. **Meridian** achieved a *Met* status for four measures, including eight individual rates; the other seven individual rates did not meet the target goals. **Molina** achieved a *Met* status for four measures, including eight individual rates; the other seven individual rates did not meet the target goals. All four ICPs reported three rates as "NA." The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* was reported as "NA" because the continuous enrollment criteria for the measure was not met. Additionally, the ICPs did not report rates for the *Comprehensive Diabetes Care—LCL-C Screening* indicator because it was retired from HEDIS 2015; therefore, it was not applicable for 2015 reporting.

Caution should be exercised when comparing the 2015 rates for **CCAI**, **Health Alliance**, **Meridian**, and **Molina** to the target goals, as the target goals were HFS' originally established baseline rates for **Aetna** and **IlliniCare**. These baseline rates have not been updated to account for more recent data availability and minimum expected improvement, or to reflect expected performance specific to these newer ICPs.

Administrative Compliance

Readiness Reviews

As described in this report, during SFY 2015, HFS expanded its managed care programs and implemented delivery system reforms to meet the goal of PA 96-1501. Through expansion efforts, 65 percent of Illinois Medicaid members enrolled in a care coordination program by June 1, 2015. Therefore, HSAG focused on working with HFS to develop and conduct the readiness review process for the FHP/ACA, CCEs, and ACEs as part of the expansion of managed care.

HSAG, in collaboration with HFS, determined the scope of the review, data collection methods, schedules, and agendas for the desk and on-site review activities. The readiness review tool included requirements that addressed operational areas necessary to service the targeted population and ensure that health plans had the system capacity needed to enroll recipients in their designated service areas.

During the reporting year, HSAG conducted readiness reviews for **Aetna**, **BCBSIL**, **Health Alliance**, and **IlliniCare** to ensure the health plans that would serve the FHP/ACA population were prepared for the rollout from voluntary to mandatory managed care. HSAG conducted a desk review, site visit, and review of supporting care coordination systems to evaluate if the FHP/ACA health plans demonstrated appropriate knowledge of FHP/ACA contract requirements and systems preparedness.

The most common areas of follow-up needed were as follows:

- Access Standards
  - Assurance of Adequate Capacity and Services

  - Coordination and Continuity of Care
- Structure and Operations Requirements
  - Enrollee Information/Enrollee Rights
- Measurement and Improvement Requirements
  - Quality Assessment and Performance Improvement Program
  - Health Information System

The CCEs of **CMCC** and **EntireCare/Southland Care Coordination Partners** (**SCCP**) were assessed to determine readiness for implementation during the reporting period to determine, prior to client enrollment, whether each CCE's internal organizational structure, health information systems, staffing, and oversight were sufficient to ensure ongoing compliance with contract requirements, quality oversight, and monitoring.

In SFY 2015, HSAG also conducted post-implementation administrative reviews of the CCEs that had previously implemented their programs: **Be Well**, **EntireCare**, **MHCC**, **Precedence**, and **T4H**. These reviews focused on the care coordination requirements in the executed contract with the State to evaluate CCEs' progress toward implementation of their models of care.

HSAG conducted a desk review, site visit, and network review to evaluate if the ACEs **CCP** and **UIH+** demonstrated appropriate knowledge of ACE contract requirements and systems preparedness. The ACE readiness review tools included the global ACE model requirements but also focused on each ACE's proposed care coordination model as described in the request for proposal (RFP) response.

HSAG also conducted a delegation readiness review for **CountyCare** and its delegate, **Medical Home Network** (**MHN**).

For all of the readiness reviews, HSAG and HFS used a standardized monitoring tool to document follow-up on any readiness review elements that required corrective action and monitored corrective actions until successfully completed. Once enrollment began, health plans, CCEs, and ACEs were required to submit monthly monitoring reports of care coordination, provider network development and capacity, and staffing.

Detailed results of all review activities can be found in Section 5, as well as a description of other compliance review activities such as staff and qualifications reviews, and provider network capacity validation activities as described below.

Care Coordination Staffing Reviews

HSAG is contracted to conduct an annual review of health plan compliance with requirements for care coordination/care management (CC/CM) staff qualifications, related experience, full-time equivalent (FTE) allocation, caseload assignments, and training. HSAG reviewed the contract requirements for care coordinators serving nonwaiver populations as well as those serving HCBS waiver populations. The data and documentation were reviewed, compared to program requirements, and scored as either "Pass" or

"Fail." If gaps were identified for health plans, HSAG requested a corrective action plan to be completed within a specified time period.

ACE/CCE Staffing Evaluation

HSAG conducted a staffing, qualifications, and training evaluation of the ACEs and CCEs to assess and monitor staffing efforts during program implementation. HSAG calculated the data to produce a dashboard which displayed the staffing trends for each ACE and CCE so that staffing ratios could easily be monitored as the ACEs and CCEs completed hiring to implement their programs. HFS and HSAG used these reports to ensure the ACEs and CCEs were complying with contract requirements for staff qualifications, training, and FTE ratios.

HCBS Waiver Oversight Activities

HCBS waivers, authorized under 1915(c) of the Social Security Act, allow the State to provide specialized, long-term care services in an individual's home or community. HFS, as the State Medicaid agency, plays a critical role in developing quality improvement systems that effectively address the health and welfare of individuals in Illinois' HCBS Waiver programs. HFS' goal is to maximize the quality of life, functional independence, health, and well-being of this population through ongoing monitoring, data analysis, and systems improvements. To continuously achieve this goal, HFS works in partnership with its operating agencies, contractors, and CMS to oversee the design and implementation of each waiver's quality improvement system. CMS requires performance measures for the six 1915(c) federal assurances and the sub-assurances associated with each. HSAG is contracted to conduct quality reviews for the HCBS Waivers included under Medicaid managed care.

HSAG conducts quarterly on-site record reviews to monitor performance on the CMS HCBS Waiver performance measures and monitor remediation and quality improvement efforts to improve performance on the measures. In addition, HSAG conducts an annual HCBS care management/coordination staffing review to monitor staffing ratios for specific waiver and program types and assesses the qualifications and training requirements specific to each waiver type. Finally, HSAG includes the HCBS provider network in its quarterly provider network validation review.

HSAG identified systematic remediation recommendations to address the record review findings in the areas of case manager training, oversight and monitoring of case manager/care coordinator resources and activities, and case management systems and processes. Recommendations included staff training on CMS Waiver Performance Measure documentation requirements and ongoing evaluation of staffing resources. Oversight processes for ensuring case manager record review and compliance with CMS requirements were recommended as well as a systemic process to ensure incorporation of all required elements in waiver service plans/care plans and timely completion of assessments. It was noted that case managers could benefit from a checklist to ensure they have the necessary information to complete required documentation. To implement systematic quality improvement initiatives, staff input and feedback as well as record review findings should be included in annual evaluations of the case management program and case management software.

Validation and Monitoring of Provider Network Capacity

HSAG evaluates and monitors progress of contracting and credentialing providers to ensure sufficient network capacity. HSAG also uses the provider network submissions to identify potential network gaps and to monitor progress toward establishing an adequate provider network for Illinois Medicaid managed care beneficiaries.

Family Planning Focused Review

To improve birth outcomes, HFS is monitoring (tracking and trending) and identifying strategies for program implementation, such as planned pregnancies/family planning; timely and risk-appropriate prenatal and postpartum care that uses evidence-based strategies; expanding birth intervals; access to smoking cessation; and access to behavioral health services, as needed. To ensure health plans, ACEs, and CCEs were complying with the updated national guidelines regarding the provision of contraceptives, HFS contracted with HSAG to conduct a review of health plan, ACE, and CCE family planning/reproductive health services policies and procedures to ensure compliance with HFS' strategy to improve birth outcomes.

Member Satisfaction Surveys

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **Aetna**, **CCAI**, **CountyCare**, **FHN**, **Harmony**, **IlliniCare**, and **Meridian** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. For the statewide **Illinois Medicaid** (Title XIX) and **All Kids** (Title XXI) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The following tables present the CAHPS measures regarding member satisfaction.

Table 1-12—CAHPS Measures for Adult and Child Medicaid

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

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

FHP/ACA CAHPS Results

A comparison of performance across the health plans shows that all plans scored at or above the 50th percentile on *How Well Doctors Communicate* compared to the 2015 NCQA HEDIS Benchmarks and Thresholds for Accreditation for the adult Medicaid population. For the adult population, all plans scored below the 25th percentile for *Getting Needed Care* and at or below the 49th percentile for *Getting Care Quickly*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

Results for the child Medicaid population showed that all three health plans scored at or above the 50th percentile for the *Customer Service* and *Rating of Personal Doctor* measures. **FHN** and **Harmony** scored below the 25th percentile for *Getting Needed Care* and *Getting Care Quickly*, while **Meridian** scored between the 50th and 74th percentile on these measures. For all four global ratings, **Meridian** scored at or above the 75th percentile for its child Medicaid population.

The FHP/ACA CAHPS results corroborated the PIP and performance measure results that indicate **FHN** and **Harmony** need improvement in access to care.

ICP CAHPS Results

A comparison of performance across the ICP health plans shows that all plans scored at or above the 75th percentile on *How Well Doctors Communicate* compared to the 2015 NCQA HEDIS Benchmarks and Thresholds for Accreditation for the adult Medicaid population. All ICP health plans scored at or above the 50th percentile for *Rating of Specialist Seen Most Often*.

Similar to the FHP/ACA results, the ICP CAHPS results show a need for improvement in access to care. All ICP health plans scored at or below the 49th percentile for *Getting Needed Care* and *Getting Care Quickly*.

CAHPS Recommendations

HSAG provided health plan-specific recommendations as well as general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was low and opportunities for improvement exist for the health plans. These recommendations are detailed in Section 6 of this report.

Optional EQR Activities

Throughout the reporting year, HSAG conducted additional EQR activities at the request of HFS such as ad hoc network capacity reporting, validation of State measures for PCCM/CHIPRA, monthly and quarterly managed care meetings, Quality Strategy guidance, and technical assistance to HFS and the health plans throughout SFY 2015. Many of these activities are ongoing or require continued monitoring. These activities are detailed in Section 7.

2. Introduction and Background

Illinois Medicaid Overview

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

HFS' Division of Medical Programs is responsible for administering the State of Illinois' Medical Assistance Programs under the provisions of the Illinois Public Aid Code (305 Illinois Complied Statutes [ILCS] 5/5 et seq.), the Illinois Children's Health Insurance Program Reauthorization Act (CHIPRA) (215 ILCS 106/1 et seq.), Covering *All Kids* Health Insurance Act (215 ILCS 170/1 et seq.), and Titles XIX and XXI of the federal Social Security Act 1932(a). As the designated Medicaid single state agency, HFS works with several other agencies that manage portions of the program—the Department of Human Services (DHS), Department of Public Health (DPH), Department of Children and Family Services (DCFS), the Department on Aging (DoA), the University of Illinois at Chicago, Cook County, and other local units of government, including hundreds of local school districts.

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

In 2011, HFS began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148), with emphasis on service delivery reforms (access to care), cost containment strategies (structure and operations), program integrity enhancements, and agency efficiencies (quality measurement improvement). PA96-1501 (also known as "Medicaid Reform") required the Department to enroll at least 50 percent of its Medicaid clients into care coordination programs by 2015. Through expansion efforts, the Department exceeded this requirement with over 60 percent of its Medicaid members enrolled in a care coordination program.

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

- Family Health Plan/Affordable Care Act (FHP/ACA)—MCOs serve adults and children, and programs for children with special healthcare needs.
- Integrated Care Program (ICP)—MCOs serve seniors and adults with disabilities.

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

In the non-mandatory managed care regions, most individuals will continue to be required to participate in the PCCM Program called Illinois Health Connect (IHC) for care coordination services. This program creates medical homes for its enrollees to make sure that primary and preventive care are provided in the best setting. IHC was the Department's first step toward implementing managed care throughout the State. In some counties, voluntary managed care organizations are also available and may be chosen for care coordination services.

Medical Programs and Eligibility

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

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

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

To be eligible for medical benefits, a person must meet certain eligibility requirements. Broadly, the categories are (1) families, children, or pregnant women, (2) aged, blind, or disabled persons, and (3) ACA adults.

- *All Kids and FamilyCare* are family health programs comprising five plans: *FamilyCare/All Kids Assist*; *All Kids Share*; *All Kids Premium Level 1*; *All Kids Premium Level 2*; and *Moms and Babies*.
- *Aid to Aged Blind and Disabled (AABD) Medical* covers seniors, persons who are blind, and persons with disabilities within income requirements.
- *ACA Adults*: Under the Affordable Care Act (ACA), adults ages 19–64 who were not previously eligible for coverage under Medicaid can now receive medical coverage.
- Through the *Department of Children and Family Services (DCFS)*, coverage is provided to children whose care is subsidized by DCFS under Title IV-E (Child Welfare) of the Social Security Act as well as children served by DCFS through its subsidized guardianship and adoption assistance programs.

- *Former Foster Care* covers young adults under age 26 who were on Medicaid when they left DCFS foster care at age 18 or later. This group is eligible for Medicaid regardless of income.

Medical coverage is provided to children through 18 years of age, parents or caretaker relatives, pregnant women, veterans, seniors, persons who are blind, persons with disabilities, and adults who qualify under the ACA. To be eligible, adults must be a U.S. citizen or a qualified immigrant, residing in Illinois. Noncitizens, ages 19 or over, who do not meet citizenship/immigration criteria may qualify for emergency medical services. Children and pregnant women must live in Illinois and are eligible regardless of citizenship or immigration status. Different income limits apply for children, pregnant women, seniors, and persons with disabilities.

Managed Care Coordination Delivery Systems

Care coordination continues to be the centerpiece of Illinois' Medicaid reform. It is aligned with Illinois' Medicaid reform law and the federal ACA. The State's overall goal in utilizing managed care and other care coordination services is to improve the lives of participants by purchasing quality health services through an integrated and coordinated delivery system that promotes and focuses on health outcomes, cost controls, accessibility to providers, accountability, and customer satisfaction.

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

The ICP initially began delivering services in two service packages. Service Package I was implemented May 1, 2011, which covered all standard Medicaid medical services, such as physician and specialist care, emergency care, laboratory and x-rays, pharmacy, mental health, and substance abuse services. Service Package II was implemented February 1, 2013, to include nursing facility services and the care provided through some of the Home and Community-Based Services (HCBS) waivers operating in Illinois (excluding Developmentally Disabled/DD waiver services).

Also in 2011, HFS launched the Care Coordination Innovations Project to test innovative models that offer risk-based care coordination through provider-organized networks organized as Care Coordination Entities (CCEs) or Accountable Care Entities (ACEs). This project worked to form alternative models of delivering care to Medicaid clients through provider-organized networks, organized around the needs of the most complex clients including seniors and persons with disabilities and children with special needs. Pursuant to P.A. 98-104, the ACEs and CCEs were required to take steps to become a licensed HMO or MCCN within 18 months of being approved and accepting enrollment as an ACE/CCE.

CCEs are a collaboration of providers that develop and implement a care coordination model that meets the State's guidelines. CCE project collaborators must include participation from hospital(s), PCPs, and

mental health and substance abuse providers. CCEs provide care coordination services using holistic, cost-efficient approaches to coordinate and deliver services to the recipients.

An ACE was a new model of care coordination created under SB26, passed by the General Assembly in May 2013, and signed into law on July 22, 2013 (Public Act 98-104). This model coordinates a network of Medicaid services for children and their family members (initially), as well as ACA Medicaid adults.

The State's focus was expanded with the development and implementation of additional managed care programs that offered the benefits of care coordination to additional Medicaid clients, including the dual eligible population, children, family members, and newly eligible ACA adults in the mandatory managed care regions.

In July 2014, Illinois transitioned from voluntary managed care in select counties to the FHP/ACA with mandatory managed care regions that cover most of the State. FHP/ACA is a mandatory program for children and their families as well as the newly eligible ACA adults. Under FHP/ACA, the State contracts with health plans to manage the provision of healthcare for FHP/ACA clients through care coordination. Under this transition, voluntary managed care continues to be an option for clients to choose for their care coordination services within many nonmandatory counties.

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

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

To meet the goals outlined above, Illinois completed its expansion of care coordination in 2015. During this expansion period, upwards of 1.5 million people on Medicaid and *All Kids* in the five mandatory managed care regions, including those individuals enrolled in IHC, were transitioned to some form of care coordination with an MCO. This means the majority of the clients currently enrolled in the Medicaid programs will receive care coordination services from MCOs implemented under the expansion period.

Enrollment

In state fiscal year (SFY) 2015, Medicaid provided comprehensive healthcare coverage to over 3 million Illinoisans and partial benefits to over 15,000 Illinoisans. On average, each month, HFS programs

covered over 1.5 million children, nearly 200,000 seniors, over 250,000 adults with disabilities, more than 600,000 other (nondisabled, nonsenior) adults, as well as over 600,000 newly eligible ACA adults. Enrollment figures for SFY 2015 are displayed in Table 2-1.

Table 2-1—Illinois Medicaid Enrollment SFY 2015

Type of Benefits	Enrollment
Comprehensive Benefits	
Children	1,516,769
Adults With Disabilities	252,313
Other Adults	631,126
Seniors	195,102
ACA Newly Eligible Adults	635,972
Total Comprehensive	**3,231,282**
Partial Benefits	
Members With Partial Benefits	16,440
Total Members	
Total Members	**3,247,722**

For additional information about Medicaid programs, eligibility, and HFS, visit the following website: https://www.illinois.gov/hfs/MedicalClients/Pages/medicalprograms.aspx.

Mandatory External Quality Review (EQR) Activities

The SFY 2015 EQR Technical Report focuses on the three federally mandated EQR activities that Health Services Advisory Group, Inc. (HSAG), performed over a 12-month period (July 1, 2014, to June 30, 2015). As set forth in title 42 of the Code of Federal Regulations (CFR) §438.352, these mandatory activities were:

- **Validation of performance improvement projects (PIPs).** As part of the SFY 2015 review, HSAG validated PIPs conducted by the health plans regarding compliance with requirements set forth in 42 CFR §438.240(b)(1).
- **Validation of performance measures.** The State contracted with HSAG to conduct a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit[2-1] of 2014 data for the health plans. The process of validating performance measures includes two elements: (1) validation of a health plan's data collection

[2-1] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

process and (2) a review of performance measure results compared with other health plans and national benchmarks. This report presents the performance measure results for the health plans.

- **Review, within the previous three-year period, to determine health plan compliance with State standards for access to care, structure and operations, and quality measurement and improvement.** HSAG conducted several compliance monitoring activities during SFY 2015 including:
  - **Readiness reviews.** HSAG worked with HFS to conduct readiness reviews for the FHP/ACA, CCEs, and ACEs as part of the expansion of managed care.
  - **Care coordination staffing reviews**. Annual review of compliance with requirements for care coordinators serving nonwaiver populations as well as those serving HCBS Waiver populations.
  - **ACE/CCE staffing evaluation**. Staffing, qualifications, and training evaluation of the ACEs and CCEs to assess and monitor staffing efforts during program implementation.
  - **HCBS Waiver programs oversight.** HSAG conducts on-site record reviews for the ICP and the MMAI to monitor performance on the HCBS Waiver performance measures. In addition, HSAG conducts an annual training and qualifications review of staff serving HCBS enrollees and monitors HCBS provider networks.
  - **Validation and monitoring of provider network capacity.** HSAG was contracted to conduct a provider network validation of the health plans' provider networks as a key component of the readiness reviews as well as ongoing, quarterly monitoring of the health plans' provider networks, including HCBS provider networks. The network analyses and validation allow HFS to evaluate the provider networks across the health plans using a consistent and standardized approach.
  - **Family planning focused review.** HFS contracted with HSAG to review health plan family planning/reproductive health services policies and procedures to ensure health plans were complying with the many updated national guidelines regarding the provision of contraceptives.

Consumer Satisfaction

- **Assessment of consumer quality of care surveys.** Each year, the health plans are required to independently administer a consumer satisfaction survey. As part of its SFY 2015 review, HSAG evaluated the results of Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys conducted by SPH Analytics, Morpace, and the Center for the Study of Services to identify trends, strengths, and opportunities for improvement.

Optional EQR Activities

- **Ad hoc provider network capacity reporting.** HSAG produced a multitude of ad hoc network capacity reports for HFS during SFY 2015 that included a range of topics and provided analyses which focused on a specific area of concern.
- **Validation of State performance measures.** HSAG conducts annual validation of performance measures for the PCCM Program, the ICP, and the Children's Health Insurance Program (CHIP) using the CHIPRA measures.

- **Monthly and quarterly managed care meetings.** HSAG meets regularly with HFS throughout the term of its external quality review organization (EQRO) contract to partner effectively and efficiently with the State, including on-site quarterly meetings with the health plans as well as monthly teleconference meetings.
- **Quality Strategy guidance.** HSAG provided guidance to HFS in the revision of its Quality Strategy. In addition to advising HFS on CMS requirements, HSAG helped HFS map out its care coordination expansion, establish performance measures, and set benchmarks to monitor the impact of program implementation.
- **Provision of technical assistance.** HSAG provides ongoing technical assistance to HFS and the health plans throughout the reporting year at the request of HFS.

Quality Strategy

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

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

In SFY 2015, HFS continued to focus on measuring progress and outcomes, and establishing thresholds for improved performance. HFS is focused on continuous quality improvement by collaborating with its partners and stakeholders in support of HFS' mission. HFS is committed to ensuring quality healthcare coverage at sustainable costs, empowering people to make sound decisions about their well-being, and maintaining the highest standards of program integrity on behalf of the citizens of Illinois. Through the review process outlined in this section, HFS used the *Centers for Medicare & Medicaid Services State Quality Strategy Tool Kit for States* (updated April 1, 2013) to update its Quality Strategy and ensure that this strategy meets the guidelines and fulfills the intended purpose—to serve as a road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting measurable goals and targets for improvement. During the review period, HFS continued revisions to the State Quality Strategy to reflect expansion efforts and programming changes.

Quality Strategy Review Process

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

practice and improved methods for quality measurement and monitoring accountability) is continuously evolving.

The process HFS uses to refine the Quality Strategy includes stakeholder involvement, including collaboration between the health plans and HFS through ongoing monthly telephonic and quarterly face-to-face meetings. The Medicaid Advisory Committee (MAC) is the primary vehicle for involving stakeholders. HFS uses feedback from MAC members and other stakeholders to make necessary revisions to the Quality Strategy. The purpose of the Quality Strategy, to be achieved through consistent application, is to ensure that quality healthcare services are delivered with timely access to appropriate covered services; coordination and continuity of care; prevention and early intervention, including risk assessment and health education; improved health outcomes; and ongoing quality improvement. HFS' goal is to measure both quality and health outcomes while continuing to work closely with stakeholders as well as sister agencies to ensure a comprehensive Quality Strategy that spans across all managed care/care coordination programs.

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

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

- Access to care and network adequacy.
- Organizational structure and operations of the managed care organizations.
- Annual HEDIS, HEDIS-like, and State-defined performance measures scores.
- CAHPS survey results.
- Audit reports.
- Quality assurance processes, including peer review and utilization review.
- Recipient complaints, grievances, and appeals, as well as provider complaints and issues.
- Preventing, detecting, and remediating critical incidents, at a minimum, on the requirements of the State for home and community-based programs.
- Collaborative performance improvement project findings.
- Success in improving health outcomes for the priority performance measures.
- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvement in care and services) and trending indicator data.
- Identification of program barriers and limitations.

- Feedback obtained from HFS leadership, health plans, the provider community, advocacy groups, Medicaid recipients, and other internal and external stakeholders that can impact recipient access to high-quality and timely care and services.
- Recommendations for the upcoming year.
- Other relevant documentation.

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

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

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

Quality Strategy Objectives

HFS' goal is to measure both quality and health outcomes while continuing to work closely with stakeholders as well as sister agencies to ensure a comprehensive Quality Strategy that spans across all care coordination programs. HFS worked with stakeholders and identified the following overarching goals for quality improvement.

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

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

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

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

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

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

Managed Care (QISMC) hybrid method. The hybrid QISMC methodology takes into consideration high performance levels (HPLs) and minimum performance levels (MPLs) and is used when HEDIS scores are above the established goals.

Evaluation of Quality Strategy

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

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

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

The results of the EQR activities such as readiness reviews, compliance reviews, validation of performance measures, and validation of non-collaborative and collaborative PIPs are used to help develop the strategic direction for HFS and the plans. In addition, HFS convenes an annual quality assurance meeting to review the Quality Strategy with stakeholders, providers, and health plans

Each year, HFS requires its EQRO to provide a written review of health plan performance in comparison to the Quality Strategy goals. This review is to include specific recommendations regarding any compliance deficits that may exist, as well as any revisions that might help the health plans improve the health outcomes of the State's Medicaid recipients. The results and recommendations of this review will be included in the annual EQR report. The Quality Strategy review process includes the following elements:

1. Review of annual results
2. Calculation of performance goals (QISMC)
3. Identification of compliance with strategic goals
4. Establishment of new/revise existing performance targets
5. Consultation with HFS on pay-for-performance (P4P) measures

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

Technical Reporting to Assess Progress in Meeting Quality Strategy Goals and Objectives

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

The areas described below are reviewed on an ongoing basis.

- Assuring the HMO has a certificate of authority (license), an approved certificate of coverage from the Illinois Department of Insurance, and an approval from DPH to provide managed care services to members.
- Assuring the MCCN meets HFS' regulatory requirements.
- Coordinating monitoring of the fiscal components of the contract that are performed by HFS' Office of Health Finance.
- Performing the initial, comprehensive readiness review and prior approval of the health plan's products and plans to comply with each aspect of the contract.
- Providing prior approval on all member and potential member written materials, including marketing materials.
- Ensuring that an information management system exists with sufficient resources to support health plan operations.
- Reviewing and providing approval (or requiring revision) on the health plan's submission of required reports or documentation on the following schedule, as appropriate: initially, as each event occurs; as revised; and monthly, quarterly, and/or annually.
- Performing on-site compliance monitoring visits, such as attendance at health plan meetings for performance reviews of quality assurance, or compliance checks, such as calling to assess after-hours availability.
- Maintaining a historical registry of marketing representatives, tracking marketing meeting schedules, handling marketing complaints, and addressing marketing concerns.

- Performing network adequacy reviews, including prior approval of primary care providers to assure that they are enrolled in, and in good standing with, the Medical Assistance Program in one of the five primary care specialties allowed in the contract.
- Monitoring physician terminations and site closures to assure appropriate transfers and network adequacy.
- Performing compliance reviews, including encounter data monitoring and utilization reporting to each health plan based on HFS' analyses of administrative data.
- Maintaining ongoing dialogue with, and providing technical assistance to, each health plan by conducting monthly conference calls and quarterly face-to-face meetings with the medical directors and quality assurance staff in a collaborative forum to coordinate quality assurance activities, identify/resolve issues and barriers, and share best practices.
- Assessing customer satisfaction through customer satisfaction surveys, problem and complaint resolution through HFS' hotline, and interaction with the member and the health plan's member services or key administrative staff members.
- Monitoring the health plan's progress toward achieving the performance goals detailed in the contract and its focus on improving health outcomes.
- Requiring quality improvement projects, corrective action plans, and sanctions for contract noncompliance when the "cure" does not occur sufficiently and/or timely, as defined by HFS.
- Monitoring the health plan's compliance with its operation of a grievance and appeals process.
- Communicating recommendations to the health plans.
- Providing oversight for the quality improvement plan.
- Contracting with and monitoring the EQRO for the provision of external oversight and monitoring of the quality assurance component of managed care.

3. Performance Improvement Projects

Validation of Performance Improvement Projects

Objectives

As part of its quality assessment and performance improvement program, the Illinois Department of Healthcare and Family Services (HFS) requires each health plan to conduct performance improvement projects (PIPs) in accordance with the Code of Federal Regulations (CFR) at 42 §438.240. The purpose of a PIP is to achieve through ongoing measurements and intervention significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving health plan processes can have a favorable effect on health outcomes and member satisfaction. Additionally, as one of the mandatory External Quality Review (EQR) activities under the Balanced Budget Act of 1997 (BBA), the State is required to validate the PIPs conducted by its contracted managed care organizations (MCOs), Integrated Care Program (ICP) health plans, and prepaid inpatient health plans. HFS contracted with Health Services Advisory Group, Inc. (HSAG), to meet this validation requirement.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measuring performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Conducting the Review

For such projects to achieve real improvements in care and member satisfaction, as well as confidence in the reported improvements, PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time period. Each PIP at a minimum must report a baseline and two annual remeasurement periods. The remeasurement study indicator results are compared to the baseline to determine if real and sustained improvement were attained.

Table 3-1—Baseline and Remeasurement Years for Each PIP

PIP Topics	FHN	Harmony	Meridian
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening	CY 2011 CY 2012 CY 2013	CY 2011 CY 2012 CY 2013	CY 2011 CY 2012 CY 2013
Perinatal Care and Depression Screening	11/06/04 to 11/05/05 11/06/05 to 11/05/06 11/06/06 to 11/05/07 11/06/07 to 11/05/08 11/06/08 to 11/05/09 11/06/09 to 11/05/10 11/06/10 to 11/05/11 11/06/11 to 11/05/12 11/06/12 to 11/05/13	11/06/04 to 11/05/05 11/06/05 to 11/05/06 11/06/06 to 11/05/07 11/06/07 to 11/05/08 11/06/08 to 11/05/09 11/06/09 to 11/05/10 11/06/10 to 11/05/11 11/06/11 to 11/05/12 11/06/12 to 11/05/13	11/06/08 to 11/05/09 11/06/09 to 11/05/10 11/06/10 to 11/05/11 11/06/11 to 11/05/12 11/06/12 to 11/05/13

CY = calendar year

Technical Methods of Data Collection and Analysis

The methodology used to implement PIPs is based on the Centers for Medicare & Medicaid Services (CMS) guidelines as outlined in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-1] Using this protocol, HSAG, in collaboration with HFS, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and evaluation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that the projects addressed all CMS PIP protocol requirements.

HSAG, with HFS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS PIP Protocol activities:

- Activity I. Select the Study Topic
- Activity II. Define the Study Question(s)
- Activity III. Select the Study Indicator(s)
- Activity IV. Use a Representative and Generalizable Study Population
- Activity V. Use Sound Sampling Techniques (if Sampling Was Used)

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

- Activity VI. Reliably Collect Data
- Activity VII. Analyze and Interpret Study Results
- Activity VIII. Implement Intervention and Improvement Strategies
- Activity IX. Assess for Real Improvement
- Activity X. Assess for Sustained Improvement

HSAG calculated the percentage score of evaluation elements met for each health plan by dividing the total elements *Met* by the total elements *Met*, *Partially Met*, and *Not Met*. Any evaluation element that received a *Not Applicable* or *Not Assessed* designation was not included in the overall score. While all elements are important in assessing a PIP, HSAG designated some elements as critical to producing valid and reliable results and for demonstrating high confidence in the PIP findings. These critical elements must be *Met* for the PIP to be in compliance. If one critical evaluation element receives a *Partially Met* score, the overall PIP validation status will be *Partially Met*. Similarly, if one critical evaluation element receives a *Not Met* score, the overall PIP validation status will be *Not Met*. HSAG's PIP Validation Tool also provides, for informational purposes, the percentage of critical elements met, which is calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*.

Managed Care

In July 2014, Illinois transitioned from voluntary managed care (VMC) in select counties to the Family Health Program/Affordable Care Act (FHP/ACA), with mandatory managed care regions that cover most of the State. Under this transition, VMC continues to be an option for clients to choose for their care coordination services within many nonmandatory counties. **Family Health Network, Inc.** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**) conducted the PIP activities presented in this section with the VMC population in the years prior to the FHP/ACA transition. In this reporting year, those health plans continued the PIP activities with both the VMC population (in select, nonmandatory counties) and the FHP/ACA population. FHP/ACA health plans that began accepting enrollment in this reporting year will initiate PIP activities in subsequent reporting years.

Findings

Table 3-2 displays the overall validation results for each activity and each stage of the *EPSDT Screening* PIP across all PIPs validated by HSAG.

Table 3-2—Combined Validation Results Across All MCOs for the *EPSDT Screening* PIP (N=3 PIPs)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic	100% 6/6	0% 0/6	0% 0/6
	II. Define the Study Question(s)	100% 3/3	0% 0/3	0% 0/3
	III. Select the Study Indicator(s)	100% 6/6	0% 0/6	0% 0/6
	IV. Use a Representative and Generalizable Study Population	100% 3/3	0% 0/3	0% 0/3
	V. Use Sound Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Reliable Collect Data	100% 13/13	0% 0/13	0% 0/13
Design Total		**100% 43/43**	**0% 0/43**	**0% 0/43**
Implementation	VII. Analyze Data and Interpret Study Results¥	85% 22/26	12% 3/26	4% 1/26
	VIII. Implement Intervention and Improvement Strategies	92% 11/12	8% 1/12	0% 0/12
Implementation Total¥		**87% 33/38**	**11% 4/38**	**3% 1/38**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	25% 3/12	50% 6/12	25% 3/12
	X. Sustained Improvement Achieved	33% 1/3	67% 2/3	0% 0/3
Outcomes Total		**27%** **4/15**	**53%** **8/15**	**20%** **3/15**
Overall PIP Results		**83%** **80/96**	**13%** **12/96**	**4%** **4/96**

¥ = The percentage total in this row does not equal 100 percent due to rounding.

Table 3-3 displays the overall validation results for each activity and each stage of the *Perinatal Care and Depression Screening* PIP across all PIPs validated by HSAG.

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

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic	100% 18/18	0% 0/18	0% 0/18
	II. Define the Study Question(s)	100% 6/6	0% 0/6	0% 0/6
	III. Select the Study Indicator(s)	100% 21/21	0% 0/21	0% 0/21
	IV. Use a Representative and Generalizable Study Population	100% 9/9	0% 0/9	0% 0/9
Design Total		**100%** **54/54**	**0%** **0/54**	**0%** **0/54**
Implementation	V. Use Sound Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Reliably Collect Data	100% 33/33	0% 0/33	0% 0/33
	VII. Implement Intervention and Improvement Strategies	100% 11/11	0% 0/11	0% 0/11
Implementation Total		**100%** **56/56**	**0%** **0/56**	**0%** **0/56**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	VIII. Analyze Data and Interpret Study Results	88% 23/26	12% 3/26	0% 0/26
	IX. Assess for Real Improvement Achieved	25% 3/12	33% 4/12	42% 5/12
	X. Assess for Sustained Improvement Achieved	0% 0/3	100% 3/3	0% 0/3
Outcomes Total¥		**63% 26/41**	**24% 10/41**	**12% 5/41**
Overall PIP Results		**90% 136/151**	**7% 10/151**	**3% 5/151**

¥ = The percentage total in this row does not equal 100 percent due to rounding.

Table 3-4—Percent of All Elements *Met*

PIP Topics	FHN	Harmony	Meridian
EPSDT Screening	80%	83%	88%
Perinatal Care and Depression Screening	91%	88%	91%

The validation scores of **FHN**, **Harmony**, and **Meridian** demonstrate stronger performance in the Design and Implementation stages for all three MCOs, indicating that each PIP was designed and implemented appropriately to measure outcomes and improvement. Opportunities for improvement continue to exist for all three MCOs in achieving real and sustained improvement as shown in Table 3-5, which indicates weaker performance in these areas.

Table 3-5—Percentage of Elements *Met* in the Outcomes Stage—Combined and by MCO

PIP Topics	Combined-All 3 MCOs	FHN	Harmony	Meridian
EPSDT Screening	27% 4/15	20% 1/5	20% 1/5	40% 2/5
Perinatal Care and Depression Screening	63% 26/41	64% 9/14	57% 8/14	69% 9/13

Table 3-5 shows the percentage of applicable evaluation elements *Met* in the Outcomes stage for **FHN**, **Harmony**, and **Meridian** individually, and all three MCOs' combined performance on the PIPs.

During state fiscal year (SFY) 2015, HSAG conducted a validation and analysis of the *EPSDT Screening* and *Perinatal Care and Depression Screening* PIPs to evaluate the MCOs' performance on the PIP indicators. The following is a result of that analysis.

Outcomes and Interventions

EPSDT Screening PIP

Background

HFS required each MCO to participate in a mandatory statewide PIP focused on EPSDT. The PIP focused on improving performance related to well-child visits and developmental screenings. These visits help to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and treatment becomes costlier. The goals of the *EPSDT Screening* PIP were to:

- Provide remeasurement results of EPSDT well-child visits and developmental screening indicators for targeting interventions and improving rates.
- Improve the quantity and quality of EPSDT examinations through a collaborative process.
- Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

Table 3-6 provides a list of the *EPSDT Screening* PIP study indicators validated for SFY 2015.

Table 3-6—EPSDT Screening PIP Study Indicators

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

Results

For the SFY 2015 validation, all three MCOs reported Remeasurement 2 data for the *EPSDT Screening* PIP. Table 3-7 displays outcomes for the *EPSDT Screening* PIP study indicators for each MCO.

Table 3-7—SFY 2015 Performance Improvement Project Outcomes for *EPSDT Screening*

Comparison to Study Indicator Results From Prior Measurement Period				
MCO	Number of Study Indicators	Improved	Statistically Significant Improvement ($p<.05$)	Sustained Improvement
FHN	7	4	0	5
Harmony	7	2	0	4
Meridian	7	2	0	6
Overall Totals	**21**	**8**	**0**	**15**

Overall, for the *EPSDT Screening* PIP, out of 21 study indicators across the MCOs, eight demonstrated improvement. Of those, none demonstrated statistically significant improvement from the prior measurement period. Fifteen study indicators demonstrated sustained improvement. For SFY 2015, **FHN** reported the percentage of children with six or more well-child visits in the first 15 months of life as 51.4 percent. **Harmony** and **Meridian** reported this measure result as 56.6 percent and 90.5 percent, respectively.

Barriers/Interventions

For the *EPSDT Screening* PIP, all three MCOs implemented interventions. **FHN** focused on provider barriers which were related to improperly completed forms and screening tools, and inaccurate billing and coding issues. In addition to the provider barriers, **FHN** noted that inaccurate member contact information led to barriers in conducting timely outreach for well-child visits. **FHN** also identified missed opportunities for developmental screening that could be conducted simultaneously with each well-child visit. **FHN**'s interventions included chart audits, follow-up provider office visits, provider education, distribution of order and sample forms to providers, and an encounter data incentive plan. Additionally, in 2014, **FHN** documented efforts to alleviate data issues to improve accuracy of billing and member contact information. For missed opportunities related to developmental screenings and well-child care, **FHN** implemented corrective action plans for all groups not meeting Healthcare Effectiveness Data and Information Set (HEDIS) goals.

Harmony and **Meridian** continued to address member, provider, and system barriers. Barriers included providers not completing screening and/or documentation of all required components for an EPSDT visit, providers' use of screening forms not recognized by Children's Health Insurance Program (CHIP) specifications, MCOs unable to reach members, and members' lack of knowledge and compliance with timely EPSDT well-child visits.

Harmony continued improvement strategies that included member, provider, and system-focused interventions. **Harmony** conducted the Harmony Hugs program, outreach, education, and home care visits to members, and made improvements to its HEDIS Inbound Care Gap program. **Harmony** implemented a care management model with emphasis on community-based care management. To educate providers, **Harmony** conducted office visits, distributed educational materials, and sent provider fax blasts. **Harmony** also developed a point of contact to address provider issues and streamlined the documentation process for the HEDIS Education and Screening Program (ESP). **Harmony**'s system-focused interventions included increasing quality improvement staff to monitor and measure rates, tracking transportation issues, partnering with Planned Parenthood, and improving data collection processes and reports.

Meridian implemented member-focused interventions including care coordination, mailing age-specific flyers with gift card incentive information, and conducting targeted outreach with parents to educate and promote preventive care for their children. In addition, **Meridian** hired a community outreach worker to visit members and assist with scheduling appointments. **Meridian** provided a developmental screening flyer to educate providers on screenings recognized by CHIP. Other provider interventions included creating age-appropriate EPSDT forms; distributing EPSDT tool kits, growth charts, and child body mass index percentiles; and providing feedback regarding the use of forms not recognized by CHIP. To make system improvements, **Meridian** incorporated historical claims data into the health plan's system to capture all visits, provided HEDIS education to staff, and used managed care system (MCS) alerts to prompt representatives to remind members of the need for regular developmental screenings.

Perinatal Care and Depression Screening PIP

Background

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

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

Table 3-8—*Perinatal Care and Depression Screening* PIP Study Indicators

Indicator	Description of Indicator
1	Timeliness of Prenatal Care (HEDIS Specifications)
2	Postpartum Care (HEDIS Specifications)
3a	Frequency of Ongoing Prenatal Care < 21%
3b	Frequency of Ongoing Prenatal Care 81%+
4	Women Who Were Screened for Depression During the Pregnancy and Prior to Delivery
4a	Women Who Were Screened for Depression Within 56 days After Delivery
4b	Women Who Were Screened for Depression During the Pregnancy and Prior to Delivery or Within 56 days After Delivery
5	Women Who Had Treatment Within 7 Days for a Positive Depression Screen
6	Women Who Had a Referral Within 7 Days for a Positive Depression Screen
7	Women Who Had Treatment or Follow-up Within 7 Days for a Positive Depression Screen
8	Women Who Had Treatment Within 14 Days for a Positive Depression Screen
9	Women Who Had a Referral Within 14 Days for a Positive Depression Screen
10	Women Who Had Treatment or Follow-up Within 14 Days for a Positive Depression Screen
11	Women Who Had Treatment Within 30 Days for a Positive Depression Screen
12	Women Who Had a Referral Within 30 Days for a Positive Depression Screen
13	Women Who Had Treatment or Follow-up Within 30 Days for a Positive Depression Screen

Table 3-9—SFY 2015 Performance Improvement Project Outcomes

MCO	Comparison to Study Indicator Results From Prior Measurement Period			
	Number of Study Indicators	Improved	Statistically Significant Improvement ($p<.05$)	Sustained Improvement
FHN	13¥	0	0	12
Harmony	16	1	0	4
Meridian	16	5	0	6
Overall Totals	**45**	**6**	**0**	**22**

¥ The MCO did not report data on Study Indicators 8, 9, and 10.

Results

Table 3-9 displays the outcomes for the *Perinatal Care and Depression Screening* study indicators for each MCO. None of the study indicators evaluated across all three MCOs achieved statistically

significant improvement. There were 22 total study indicators that demonstrated sustained improvement over the duration of the PIP.

Harmony achieved sustained improvement in four study indicators. **Harmony**'s prenatal and postpartum care rates reported in the PIP for this measurement period were 70.0 percent and 48.4 percent, respectively.

FHN achieved sustained improvement in 12 study indicators. **FHN** reported its prenatal and postpartum care rates for this measurement period as 57.6 percent and 44.4 percent, respectively.

Meridian had five study indicators that demonstrated improvement from the prior measurement period. **Meridian** achieved sustained improvement in six of the study indicators. Of the three MCOs, **Meridian** reported the highest prenatal and postpartum care rates: 94.0 percent and 78.5 percent, respectively.

Barriers/Interventions

For the SFY 2015 validation, **FHN**'s barriers for the *Perinatal Care and Depression Screening* PIP included increased enrollment, non-compliant claims/encounter data submissions, lack of provider compliance, lack of member compliance, lack of timely pregnancy notifications, and member outreach and engagement barriers due to invalid demographic data. In addition to ongoing improvement strategies that include member and provider incentives, **FHN**'s SFY 2015 interventions included hiring a maternity care coordinator, a social worker to work with Spanish-speaking members, a manager for the **FHN** Maternity Program, and three staff members to conduct member outreach. **FHN** also implemented a new health information management program, enhanced the incentive in the Brighter Beginnings Program, initiated additional direct outreach to members, implemented a new Pregnancy Notification Report, exchanged data with one laboratory vendor to improve pregnancy notifications, and educated providers on HEDIS results and missed opportunities.

Harmony reported barriers that included difficulty reaching members due to inaccurate contact information, lack of member knowledge regarding prenatal and postpartum care, provider and member lack of knowledge regarding the Harmony Hugs program, and outdated member enrollment and eligibility files. To address barriers, **Harmony** continued to implement member, provider, and system interventions. Member-focused interventions included member outreach and education in addition to enrolling members in the Harmony Hugs program. The MCO also hired an additional care coordinator to improve member engagement and enrollment in the Harmony Hugs program. Provider-focused interventions included provider outreach and education, audits, and corrective action plans for noncompliant providers. **Harmony** continued focused, clinical provider visits to the top 13 independent physician associations (IPAs). System interventions included collaborating with physician groups, partnering with Planned Parenthood, conducting a reevaluation of the Harmony Hugs program, and developing a postpartum outreach initiative process improvement plan.

Meridian continued to address barriers related to coordination of care, obtaining current member contact information, increasing member and provider knowledge, identifying pregnancy risk factors, timely billing and claims submissions, and ensuring members schedule timely care. For SFY 2015,

Meridian indicated that the population size made it difficult to prioritize barriers, which, in addition to difficulties in receiving confirmation of prenatal care, was also a barrier. Ongoing interventions included member and provider interventions, member outreach, the use of standardized screening and assessment tools, and collaboration with network providers. **Meridian** has a Maternity Care Coordination program in which staff follow the member throughout pregnancy and after delivery for 56 days to ensure appointments are kept and barriers to receiving care are addressed. The MCO targeted additional resources to address unable-to-reach members. In 2013, the Maternity Care Coordination team began receiving weekly data that highlighted members with the most time-sensitive needs for care and faxing record requests for members who were past due for prenatal or postpartum care. During Remeasurement 4, the MCO created a fax template to identify prenatal care received by members not identified via claims. The MCO was also involved in a monthly interdisciplinary HEDIS Committee that discusses and addresses barriers to success with the maternity population.

Recommendations for MCOs

The MCOs' choice of interventions, the combination of intervention types, and sequence of implementing interventions are essential to the PIP's overall success. HSAG recommends the MCOs:

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

Integrated Care Program

Community Based Care Coordination PIP

Background

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

HFS required each ICP health plan (**Aetna Better Health** [**Aetna**] and **IlliniCare Health Plan, Inc.** [**IlliniCare**]) to participate in a mandatory statewide PIP focused on improving care coordination and the linkage of the member/client to ambulatory care and community services. Through monthly and quarterly meetings, the ICP health plans developed the study question, indicators, and data sources with assistance from HSAG. The PIP focused on the relationship between care coordination, timely ambulatory care services, and readmission rates < 30 days post discharge. The study population included members stratified as high and moderate risk in order to:

- Decrease the rate of medical inpatient readmissions within 30 days of a previous admission with the same diagnoses for identified members.
- Improve health outcomes, baseline level of functioning, and quality of life.
- Promote patient-centered care.
- Foster member engagement and accountability and improve the ability to effectively manage their own health conditions.
- Realize a sustained decrease in avoidable utilization, problematic symptoms, as well as a mitigation of risk factors.
- Demonstrate sustained improvement in health outcomes and status.

The *Community Based Care Coordination* PIP had three study indicators that are outlined in Table 3-10.

Table 3-10—*Community Based Care Coordination* PIP Study Indicators

Indicator	Description of Indicator
1	The percentage of high to moderate risk members who do not have a readmission within 30 days of an initial discharge.
2	The percentage of high to moderate risk members who had two or more targeted care coordination interactions during medical hospitalization and/or post-acute care discharge.
3	The percentage of high to moderate risk members accessing community resources within 14 days of discharge.

Outcomes and Interventions

Table 3-11—PIP Outcomes for *Community Based Care Coordination*

Comparison to Study Indicator Results From Prior Measurement Period			
ICP Health Plan	Number of Study Indicators	Statistically Significant Improvement (p<.05)	Sustained Improvement
Aetna	3	2	3
IlliniCare	3	2	3
Overall Totals	**6**	**4**	**6**

Table 3-11 displays outcomes for the *Community Based Care Coordination* PIP. The PIPs had three study indicators. Both ICP health plans achieved statistically significant improvement in two of the three study indicators from the prior measurement period. All six of the study indicators across both ICP health plans were assessed for and demonstrated sustained improvement. For SFY 2015, **Aetna** reported the percentage of high-to-moderate risk members who have not had a readmission within 30 days of initial discharge as 86.0 percent, and **IlliniCare** reported this measure result as 80.0 percent.

Results

Table 3-12 displays the validation results for each activity and each stage of the *Community Based Care Coordination* PIP.

Table 3-12—PIP Validation Results Across All ICP Health Plan PIPs (N=2)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic	100% 4/4	0% 0/4	0% 0/4
	II. Define the Study Question(s)	100% 2/2	0% 0/2	0% 0/2
	III. Select the Study Indicator(s)	100% 6/6	0% 0/6	0% 0/6
	IV. Use a Representative and Generalizable Study Population	100% 2/2	0% 0/2	0% 0/2
	V. Use Sound Sampling Techniques (if sampling was used)	100% 12/12	0% 0/12	0% 0/12
	VI. Reliably Collect Data	100% 12/12	0% 0/12	0% 0/12
Design Total		**100% 38/38**	**0% 0/38**	**0% 0/38**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation	VII. Analyze Data and Interpret Study Results	100% 18/18	0% 0/18	0% 0/18
	VIII. Implement Intervention and Improvement Strategies	100% 6/6	0% 0/6	0% 0/6
Implementation Total		**100% 24/24**	**0% 0/24**	**0% 0/24**
Outcomes	IX. Assess for Real Improvement Achieved	50% 4/8	50% 4/8	0% 0/8
	X. Sustained Improvement Achieved	100% 2/2	0% 0/2	0% 0/2
Outcomes Total		**60% 6/10**	**40% 4/10**	**0% 0/10**
Overall PIP Results		**94% 68/72**	**6% 4/72**	**0% 0/72**

Table 3-13 displays the overall validation percentage for each individual ICP health plan.

Table 3-13—PIP Validation Results Across All ICP Health Plan PIPs (N=2)

PIP Topic	Aetna	IlliniCare
Community Based Care Coordination	94%	94%

Baseline and Remeasurement 1 Results

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

Figure 3-1—Aetna Care Coordination PIP Results for Study Indicator 1

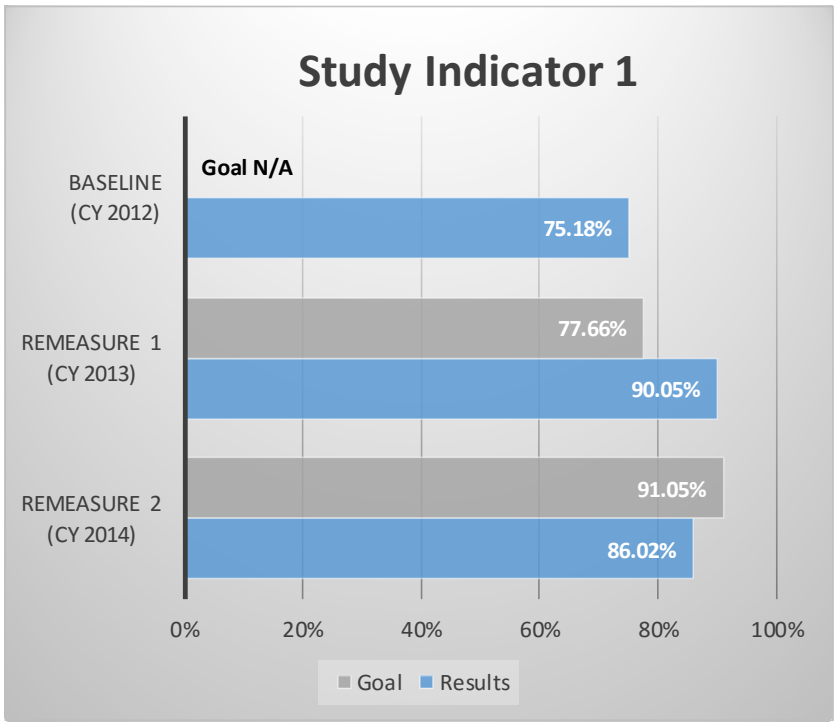


Figure 3-2—Aetna Care Coordination PIP Results for Study Indicator 2

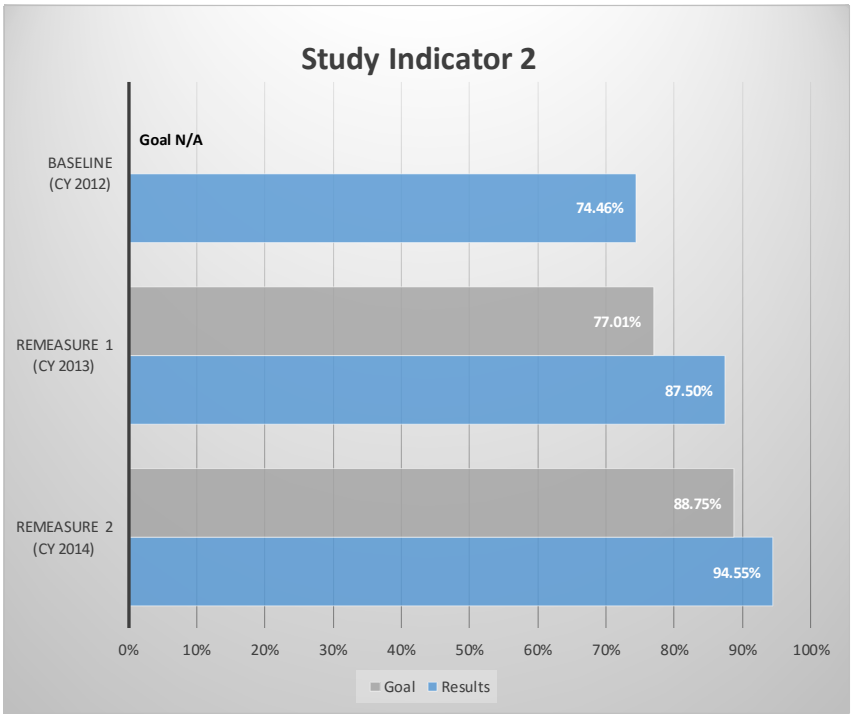


Figure 3-3—Aetna Care Coordination PIP Results for Study Indicator 3

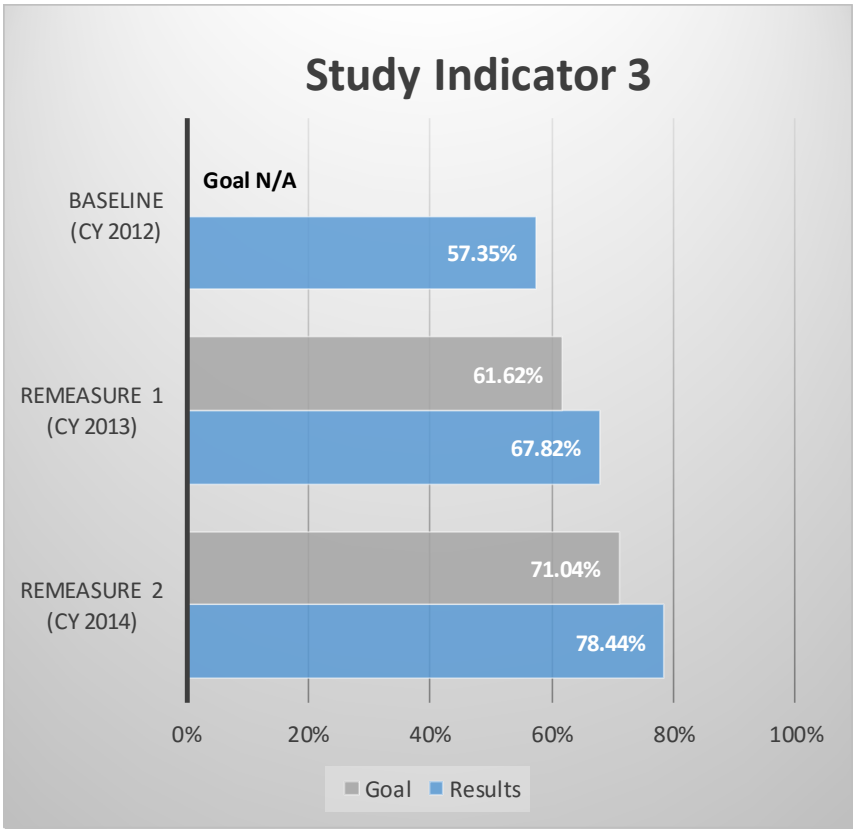


Figure 3-4—IlliniCare Care Coordination PIP Results for Study Indicator 1

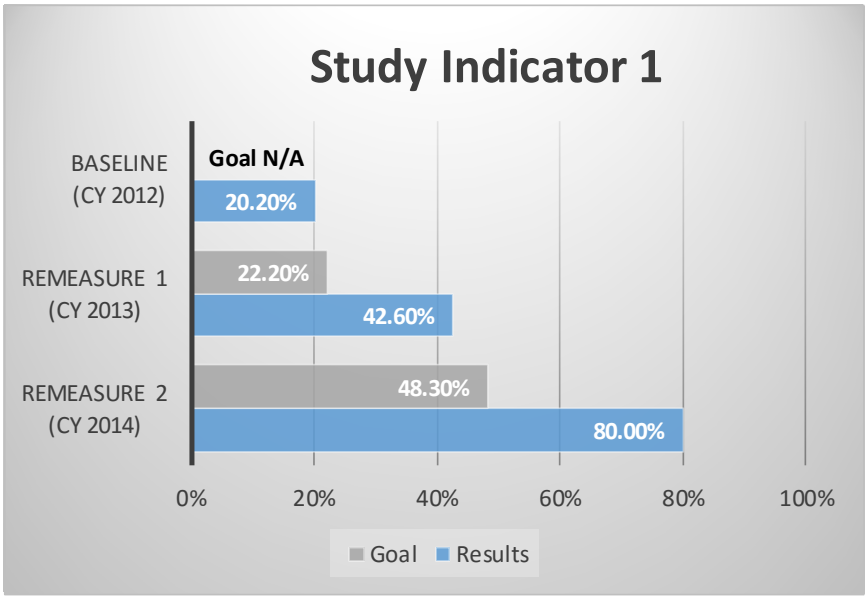


Figure 3-5—IlliniCare Care Coordination PIP Results for Study Indicator 2

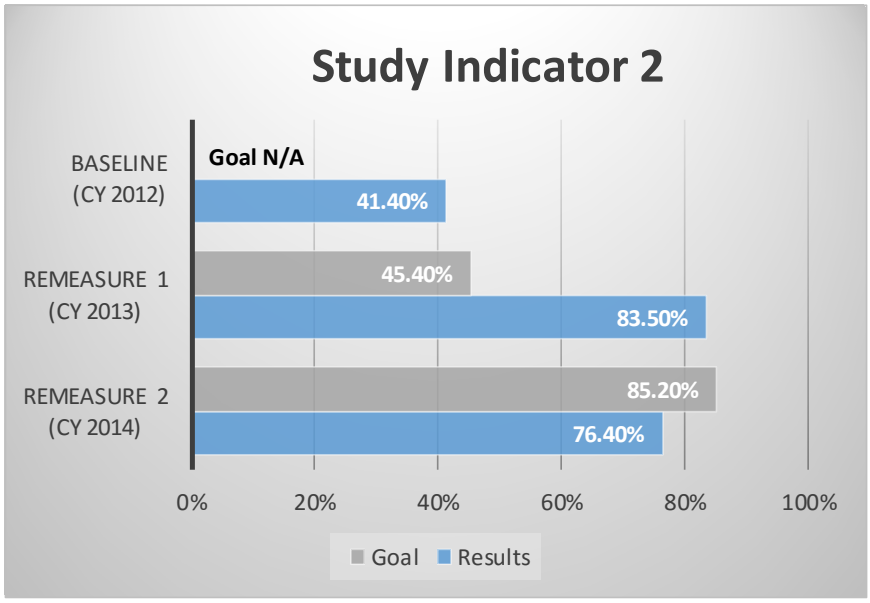
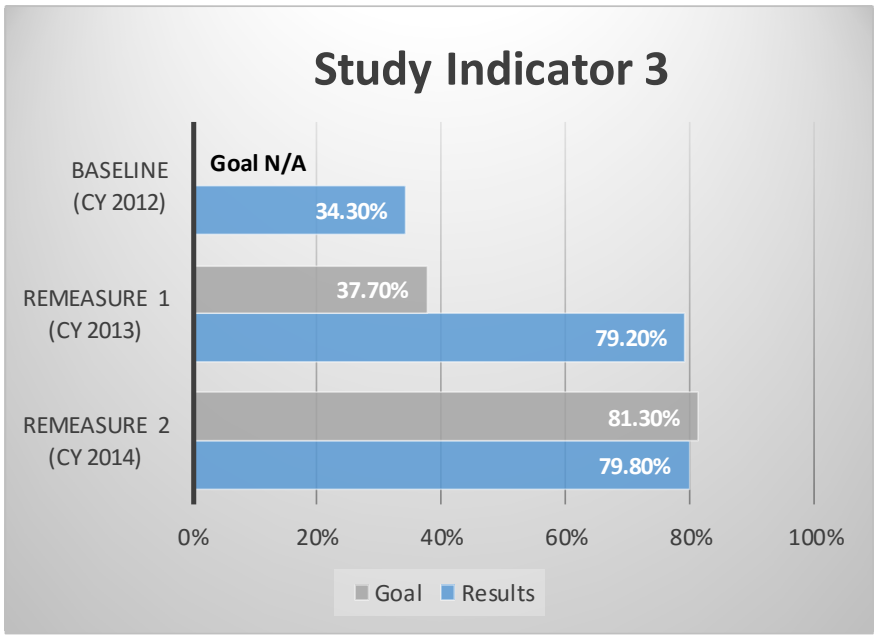


Figure 3-6—IlliniCare Care Coordination PIP Results for Study Indicator 3



Barriers/Interventions

For the *Community Based Care Coordination* PIP, both ICP health plans implemented interventions. **Aetna** continued to address barriers that included lack of timely identification of hospital discharges, subjective prioritization of cases for follow-up, lack of timely follow-up following discharge, inadequate time to assist members with discharge plans due to caseload size, unavailability of appointment time within 14 days of discharge, and member refusal to follow up with the provider. In 2015, the ICP identified additional barriers which included providers failing to recognize that authorizations for many inpatient procedures are global and include a follow-up visit, and members either receive no discharge planning or do not understand the discharge plan.

In addition to previously implemented interventions (i.e., utilization managers contacting members or hospital discharge planners to discuss care needed while the member is still in the hospital, and daily monitoring of an inpatient census for all members with readmit or Consolidated Outreach and Risk Evaluation [CORE] scores above established thresholds), **Aetna** reported the following interventions in 2014 and 2015: calling members after discharge, sharing inpatient census with three different provider groups, physicians visiting members in the home if there was no appointment scheduled and no established relationship with a PCP, and identifying any problems prior to the member being readmitted to the hospital so members can receive targeted case management.

IlliniCare continued to focus on barriers that included lack of timely notification of authorization requests and member admissions, inconsistent application of the discharge planning process, inaccurate member demographics, inconsistencies in provider contact information, members' lack of adherence to the treatment plan, the health plan's lack of access to discharge documentation, and the need for more staff education and application of best practices. In addition to previously implemented, ongoing interventions that included process changes and education initiatives, **IlliniCare** established a continuous quality improvement best practices program that incentivized teams with the best follow-up rates, sponsored an initiative to call all medical discharges within three and 10 days of discharge, developed a comprehensive central database accessible to all care coordinators, and partnered with an external organization to conduct post-discharge home visits by nurse practitioners.

Recommendations for ICP Health Plans

The ICPs' choice of interventions, the combination of intervention types, and sequence of implementing interventions are essential to the PIP's overall success. HSAG recommends that the ICP health plans:

- Evaluate the effectiveness of each intervention implemented. If the intervention is not having the desired effect, the ICP should determine how it will address these deficiencies by modifying or discontinuing interventions.
- Standardize effective process changes as well as implement new and/or enhanced interventions to sustain improvement going forward.
- Continue conducting causal/barrier analyses at least annually using quality improvement tools and prioritize barriers based on analysis results.

- Consider completing process mapping and FMEA to determine failures in processes. The ICP should rank the identified failures and address the highest-ranked failures with interventions.
- Consider testing interventions on a small scale using a quality improvement method such as PDSA. Testing interventions on a small scale reduces risk and allows the ICP health plan to maximize its resources. Changes that are successful when tested on a small scale should be considered for spread and eventually full implementation. Changes that are not successful when tested on a small scale should be abandoned and new changes developed for testing.

4. Performance Measures

Validation of Performance Measures—NCQA HEDIS Compliance Audit for MCOs—SFY 2014–2015

Objectives

This section describes the evaluation of the Managed Care Organizations' (MCOs') ability to collect and report on the performance measures accurately. The Healthcare Effectiveness Data and Information Set (HEDIS) performance measures are a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). Healthcare purchasers use these measures to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.

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

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

NCQA licenses organizations and certifies selected employees of licensed organizations to conduct performance measure audits using NCQA's standardized audit methodology. The NCQA HEDIS Compliance Audit indicates the extent to which MCOs have adequate and sound capabilities for processing medical, member, and provider information for accurate and automated performance measurement, including HEDIS reporting. The validation addresses the technical aspects of producing HEDIS data, including information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, and analytic file production.

Technical Methods of Data Collection and Analysis

The Department required that an NCQA-licensed audit organization conduct an independent audit of each MCO's measurement year (MY) 2014 data. The Department contracted with HSAG to audit **Family Health Network** (**FHN**), **Harmony Health Plan of Illinois, Inc.** (**Harmony**), and **Meridian Health Plan, Inc.** (**Meridian**). New MCOs that began accepting enrollment in this reporting year as a result of HFS' expansion efforts will be audited in subsequent reporting years. The audits were conducted in a manner consistent with the *HEDIS 2015: Volume 5, HEDIS Compliance Audit: Standards, Policies, and Procedures*. The audit incorporated two main components:

- A detailed assessment of the MCO's Information Systems (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including:
  - Computer programming and query logic used to access and manipulate data and to calculate measures;
  - Databases and files used to store HEDIS information;
  - Medical record abstraction tools and abstraction procedures used; and
  - Any manual processes employed for MY 2014 HEDIS data production and reporting.

The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

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

Table 4-1—Measures Selected for Validation

Measures
Childhood Immunization Status—Combo 3
Human Papillomavirus Vaccines for Female Adolescents
Well-Child Visits in the First 15 Months of Life—No Well-Child Visits, One, Two, Three, Four, Five, and Six or More Well-Child Visits
Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care
Developmental Screening in the First Three Years of Life
Childhood Immunization Status—Combo 3

The MCOs also reported on additional HEDIS measures that were not validated during the HSAG HEDIS audit, although the processes for collecting and calculating each measure were validated by each

plan's contracted HEDIS audit firm. The rates for these HEDIS measures are included in this report and consist of the following:

Table 4-2—Additional HEDIS Measures Reported

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

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

- Teleconference calls with MCO personnel and vendor representatives, as necessary.
- Detailed review of each MCO's completed responses to the HEDIS Record of Administration, Data Management and Processes (HEDIS Roadmap) published by NCQA as Appendix 2 to HEDIS Volume 5, and updated information communicated by NCQA to the audit team directly.
- On-site meetings in the MCOs' offices, including: staff interviews, live system and procedure documentation, documentation review and requests for additional information, primary HEDIS data source verification, programming logic review and inspection of dated job logs, computer database and file structure review, and discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.
- If the hybrid method were used, an abstraction of a sample of medical records selected by the auditors were compared to the results of the MCO's review determinations for the same records.
- If supplemental data were used, primary source verification of a sample of records were conducted from any nonstandard and member-reported databases.
- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCO.
- A variety of interviews with individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, IS director, quality management director, enrollment and provider data manager, medical records staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that provided or processed HEDIS 2015 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

Each of the audited measures reviewed by HSAG received a final audit result that were applicable to the HEDIS measures consistent with the NCQA categories listed below in Table 4-3.

Table 4-3—HEDIS Measure Audit Findings

Rate/Result	Comment
0-XXX	A rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
NR	Not Reportable. • The calculated rate was materially biased, or • The organization chose not to report the measure, or • The organization were not required to report the measure.
NA	Small Denominator. The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
NB	Benefit Not Offered. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).

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

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

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

For the discussions regarding conclusions drawn from the data for each MCO, full compliance is defined as the lack of any findings that would significantly bias HEDIS reporting by more than 5 percentage points. Additionally, when discussing rates for *Well-Child Visits in the First 15 Months of Life*, assessments are made for *No Visits* and *6 or More Visits*, as those measures are most indicative of the range of quality of healthcare. *Frequency of Ongoing Prenatal Care* is also assessed using the two categories of *<21 Percent of Expected Visits* and *≥81 Percent of Expected Visits*.

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

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

HSAG also performed a re-abstraction of records selected for MRR and compared the results to each MCO's findings for the same medical records. This process completed the medical record validation process and provided an assessment of actual reviewer accuracy. HSAG reviewed 16 records from each numerator-positive member list for each selected measure from appropriate measure groups and from the exclusions group (as determined through MRR) for measures selected for audit and MRR validation. Records were randomly selected from the entire population of MRR numerator positives identified by the MCO, as indicated on the MRR numerator listings. If fewer than 16 medical records were found to meet numerator requirements, all records were reviewed. Reported discrepancies only included "critical errors," defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa).

Plan-Specific Findings

The following Medicaid HEDIS 2015 results tables show the performance for each HEDIS measure using data collected in 2014, relative to the 2014 Quality Compass® percentiles.[4-1] The "2015 Performance Level" column illustrated in the tables assesses the MCO's performance as follows:

Table 4-4—Star Ratings

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

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

Family Health Network (FHN)

The Medicaid HEDIS 2015 rates for **FHN** are presented in Table 4-5.

Table 4-5—FHN's HEDIS 2015 Rates

	HEDIS 2015 Rate	2015 Performance Level
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	89.28%	★
25 Months–6 Years	78.85%	★
7–11 Years	79.10%	★
12–19 Years	78.55%	★
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	69.20%	★
45–64 Years	69.09%	★
Total	69.19%	★

[4-1] Quality Compass is a registered trademark of the National Committee for Quality Assurance (NCQA).

	HEDIS 2015 Rate	2015 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	40.54%	★★★
Initiation of AOD Treatment—18+ Years	28.41%	★
Initiation of AOD Treatment—Total	29.92%	★
Engagement of AOD Treatment—13–17 Years	1.35%	★
Engagement of AOD Treatment—18+ Years	3.07%	★
Engagement of AOD Treatment—Total	2.86%	★
Child and Adolescent Care		
Childhood Immunization Status		
Combination 2	65.45%	★
Combination 3	60.34%	★
Lead Screening in Children		
Lead Screening in Children	77.37%	★★★
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	61.31%	★
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	20.68%	★★★
Well-Child Visits in the First 15 Months of Life		
No Well-Child Visits[1]	2.19%	★★
Six or More Well-Child Visits	46.72%	★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	77.62%	★★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	52.31%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	31.19%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	71.78%	★★★
Counseling for Nutrition—Total	62.29%	★★★
Counseling for Physical Activity—Total	57.42%	★★★

	HEDIS 2015 Rate	2015 Performance Level
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	45.79%	★
Cervical Cancer Screening		
Cervical Cancer Screening	63.75%	★★
Chlamydia Screening in Women		
16–20 Years	56.29%	★★★
21–24 Years	63.99%	★★★
Total	60.61%	★★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	64.48%	★
Postpartum Care	46.72%	★
Frequency of Ongoing Prenatal Care		
<21 Percent of Expected Visits[1]	21.65%	★
≥81 Percent of Expected Visits	29.20%	★
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	80.78%	★★
HbA1c Poor Control (>9.0%)[1]	62.29%	★
HbA1c Control (<8.0%)	29.68%	★
Eye Exam (Retinal) Performed	49.64%	★★
Medical Attention for Nephropathy	88.56%	★★★★★
BP Control (<140/90 mm Hg)	41.36%	★
Controlling High Blood Pressure		
Controlling High Blood Pressure	42.58%	★
Use of Appropriate Medications for People With Asthma		
5–11 Years	91.79%	★★★
12–18 Years	87.92%	★★★
19–50 Years	84.03%	★★★★
51–64 Years	NA	NA
Total	87.87%	★★★★
Medication Management for People With Asthma		
Medication Compliance 50%—5–11 Years	38.41%	★

	HEDIS 2015 Rate	2015 Performance Level
Medication Compliance 50%—12–18 Years	40.66%	★
Medication Compliance 50%—19–50 Years	44.80%	★
Medication Compliance 50%—51–64 Years	NA	NA
Medication Compliance 50%—Total	41.14%	★
Medication Compliance 75%—5–11 Years	15.89%	★
Medication Compliance 75%—12–18 Years	20.88%	★★
Medication Compliance 75%—19–50 Years	20.36%	★
Medication Compliance 75%—51–64 Years	NA	NA
Medication Compliance 75%—Total	18.55%	★
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	54.90%	★★★★
30-Day Follow-Up	72.55%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	41.15%	★
Effective Continuation Phase Treatment	26.32%	★

[1] For this measure, a lower rate indicates better performance. When comparing the rates to the 2014 Quality Compass National Percentiles, percentiles were reversed (e.g., the 90th percentile became the 10th percentile).

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

FHN had 18 measure indicators with rates that met or exceeded the 2014 Quality Compass 50th percentile, including:

- One measure indicator in the Access to Care measure set.
- Seven in the Child and Adolescent Care measure set.
- Three in the Women's Health measure set.
- Five in the Care for Chronic Conditions measure set.
- Two in the Behavioral Health measure set.

Three measure indicators had fewer than 30 eligible cases (indicated by NA).

FHN had rates that fell below the 50th percentiles on 40 measure indicators, including:

- 12 measure indicators in the Access to Care measure set.
- Six in the Child and Adolescent Care measure set.
- Six in the Women's Health measure set, 14 in the Care for Chronic Conditions measure set.

- Two in the Behavioral Health measure set.

Compliance Audit Results for FHN

The HEDIS 2015 compliance audit indicated that **FHN** was in compliance with the *HEDIS 2015 Technical Specifications* (Table 4-6). Membership data supported all necessary HEDIS calculations, medical data were partially compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 4-6—FHN 2015 HEDIS Compliance Audit Results

Main Information Systems			Selected MY 2014 HEDIS Measures
Membership Data	**Medical Data**	**Measure Calculation**	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

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

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

FHN was fully compliant with IS Standard 1.0. **FHN** migrated to a new claims and encounter processing system, VIDACounter, on July 1, 2014. HSAG reviewed VIDACounter during the on-site audit and found that it met all Health Insurance Portability and Accountability Act (HIPAA) requirements for processing claims. The system only accepted standard 837 electronic claims. **FHN** also changed each of its provider contract agreements from a capitated arrangement to a fee-for-service (FFS) model. **FHN** staff indicated that the FFS model will ensure that all claims are being captured. HSAG concurred with this statement. **FHN** should see a significant benefit from the FFS model as providers are now required to submit a claim for payment. There were some concerns in the past that **FHN** was not receiving all encounters since payment was not directly attached to claims submissions. These concerns were no longer present since **FHN**'s contracts were all FFS during 2014.

FHN used the following management service organizations (MSOs) to capture claims:

1. CMSO: Used QuickCap for claims processing.
2. APEX: Used a proprietary claims processing system.
3. Lawndale: Used QuickCap for claims processing. Lawndale is a federally qualified health center (FQHC) that manages its own claims, and **FHN** reimburses for professional claims only.
4. Apogee: Used QuickCap for claims processing. Apogee is an independent practice association (IPA) that manages its own claims, and **FHN** reimburses for professional claims only.

5. NAM: Used QuickCap for claims processing. NAM is a management company that manages three IPAs, and **FHN** reimburses for professional claims only.
6. Med3000: Used EZ-CAP for claims processing. Med3000 manages two IPAs, and **FHN** reimburses for professional claims only.
7. ACME: Used QuickCap for claims processing. There are two IPAs, and **FHN** reimburses for professional claims only.

FHN had internal processes in place, including balancing claims submissions against financial reports, to substantiate the claims costs for HFS. VIDACounter was used to aggregate all data and load to Verisk Health (Verisk) software.

In addition, **FHN** performed annual oversight of its MSOs and monitored them for accuracy and timeliness. **FHN** has made significant improvements to its claims and encounter processing since the prior year's audit.

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

FHN was fully compliant with IS Standard 2.0. **FHN** migrated all of its enrollment data to a new enrollment system, VIDAbility, in July 2014. Rather than moving all of the data from the old system, **FHN** went back (as far as 2012) to all of the daily and monthly State enrollment files and recreated all of the records in VIDAbility. This ensured that all of the daily and monthly files were captured in the new enrollment system's history. **FHN** did not report any issues with the final enrollment recreation. **FHN** did report that a few files had to be redone due to errors in missing a sequential daily file; however, it was able to restore the database prior to the load and add the missing sequential daily file. HSAG randomly reviewed enrollment strings in the new system and compared them to a daily file in **FHN**'s database. HSAG found no issues. HSAG considers the process that **FHN** used to recreate the enrollment strings based on the original daily and monthly files to be a best practice.

No other changes were made in the enrollment process from the previous year. Daily and monthly files were still retrieved from the State's file transfer protocol (FTP) site and matched against the system. Members had only one unique identifier, which was provided by the State file.

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

FHN was fully compliant with IS Standard 3.0. **FHN** migrated from the legacy system to VIDAPro for provider processing. VIDAPro captured all relevant information for HEDIS measure production. Provider files contained all required fields as outlined in the HEDIS Roadmap.

Provider information was sent to the MSOs monthly, or as needed, to process claims. All MSOs were fed the provider's line of business information, provider type registered with the State, national provider identifier (NPI) number, specialty, board certification information, service location, phone and fax numbers, email address, tax identifier, and hours of operation.

HSAG reviewed **FHN**'s processes on-site and found no issues with provider processing. **FHN** has made significant improvements to its provider process since the prior year's audit.

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

FHN was fully compliant with the IS Standard 4.0 reporting process. **FHN** sampled according to the HEDIS sampling guidelines and assigned an appropriate, measure-specific oversample. Medical record pursuit and data collection were conducted by **FHN** staff using Verisk hybrid tools for the HEDIS measures. HSAG reviewed and approved the hybrid tools and corresponding abstraction instructions for the HEDIS hybrid tools. HSAG also reviewed and approved **FHN**'s proprietary tool used for collecting medical record data for the Centers for Medicare & Medicaid Services (CMS) Child Core Set measure, Developmental Screening in the First Three Years of Life. Provider chase logic was reviewed and determined appropriate across the HEDIS measures and the CMS measure.

Reviewer qualifications, training, and oversight were appropriate. Since there were no changes to **FHN**'s MRR process for HEDIS 2015 (measures or process), and **FHN** was audited by HSAG in 2014 and passed medical record review validation (MRRV), a convenience sample was not required.

FHN passed MRRV for the following measure groups:

- Group A: *Timeliness of Prenatal Care*
- Group B: *Well-Child Visits in the First 15 Months of Life—6+ Visits*
- Group C: No hybrid measures under the scope of the audit from this measure group.
- Group D: *Childhood Immunization Status—Combo 3*
- Group F: *Exclusions*
- CMS Child Core Set: *Developmental Screening in the First Three Years of Life*

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

FHN was fully compliant with IS Standard 5.0. **FHN** did not use any nonstandard supplemental data sources that contributed to the measures under the scope of the audit for HEDIS 2015. **FHN** presented HSAG with a few standard supplemental databases which did not differ from those submitted in HEDIS 2014. The standard supplemental databases included historical claims, lab data, and an immunization registry. The standard data sources were reviewed by HSAG and approved for use for HEDIS 2015 reporting.

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

This standard was not applicable to the measures under the scope of the Illinois Medicaid audit.

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

FHN was fully compliant with IS Standard 7.0. **FHN** used a SQL server database to house 35 of its source files used for HEDIS reporting. The database structure was a relational table model which contained primary and foreign keys that linked data to form unique records. The data structure was reviewed by HSAG on-site and found to be compliant. **FHN** hired new staff during 2014 that presented and demonstrated the database during the on-site audit. The demonstration included primary source verification of several member and claims records. Primary source verification also looked at the source of the record. In some instances, the records were derived from claims, so HSAG reviewed either the QNXT source or the VIDACounter system, depending on the date of service. Member records were reviewed against VIDAbility. HSAG identified no issues during the on-site audit. **FHN** staff members were exceptional at demonstrating the database and have made significant improvement since the previous year with their demonstrations and data collection processes.

FHN used Verisk to produce its HEDIS measures. Verisk is a software vendor whose HEDIS measures were certified by NCQA for HEDIS 2015. **FHN** staff members were very well versed in the Verisk tools.

HSAG reviewed and approved **FHN**'s final rates and validated that **FHN** was using the correct global unique identifiers (GUIDs) for the HEDIS measures according to Verisk's measure certification report.

Harmony Health Plan of Illinois, Inc. (Harmony)

The Medicaid HEDIS 2015 rates for **Harmony** are presented in Table 4-7.

Table 4-7—Harmony's HEDIS 2015 Rates HEDIS

	HEDIS 2015 Rate	2015 Performance Level
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	90.59%	★
25 Months–6 Years	78.33%	★
7–11 Years	79.12%	★
12–19 Years	81.29%	★
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	69.93%	★
45–64 Years	72.49%	★
Total	70.22%	★

	HEDIS 2015 Rate	2015 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	58.25%	★★★★★
Initiation of AOD Treatment—18+ Years	38.43%	★★★
Initiation of AOD Treatment—Total	41.29%	★★★
Engagement of AOD Treatment—13–17 Years	13.11%	★★
Engagement of AOD Treatment—18+ Years	5.97%	★★
Engagement of AOD Treatment—Total	7.00%	★★
Child and Adolescent Care		
Childhood Immunization Status		
Combination 2	67.64%	★
Combination 3	63.26%	★
Lead Screening in Children		
Lead Screening in Children	77.13%	★★★
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	66.83%	★★
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	18.49%	★★
Well-Child Visits in the First 15 Months of Life		
No Well-Child Visits[1]	3.46%	★
Six or More Well-Child Visits	57.53%	★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	71.39%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	44.28%	★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	41.69%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	63.02%	★★★
Counseling for Nutrition—Total	58.39%	★★
Counseling for Physical Activity—Total	55.23%	★★★

	HEDIS 2015 Rate	2015 Performance Level
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	43.62%	★
Cervical Cancer Screening		
Cervical Cancer Screening	69.55%	★★★
Chlamydia Screening in Women		
16–20 Years	45.21%	★★
21–24 Years	56.80%	★★
Total	51.46%	★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	68.37%	★
Postpartum Care	44.77%	★
Frequency of Ongoing Prenatal Care		
<21 Percent of Expected Visits[1]	11.92%	★★
≥81 Percent of Expected Visits	39.17%	★
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	75.43%	★
HbA1c Poor Control (>9.0%)[1]	63.75%	★
HbA1c Control (<8.0%)	29.68%	★
Eye Exam (Retinal) Performed	33.82%	★
Medical Attention for Nephropathy	72.75%	★
BP Control (<140/90 mm Hg)	54.74%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	44.77%	★
Use of Appropriate Medications for People With Asthma		
5–11 Years	87.53%	★
12–18 Years	85.67%	★★
19–50 Years	85.36%	★★★★★
51–64 Years	NA	NA
Total	86.21%	★★★

	HEDIS 2015 Rate	2015 Performance Level
Medication Management for People With Asthma		
Medication Compliance 50%—5–11 Years	39.78%	★
Medication Compliance 50%—12–18 Years	36.30%	★
Medication Compliance 50%—19–50 Years	43.80%	★
Medication Compliance 50%—51–64 Years	NA	NA
Medication Compliance 50%—Total	40.19%	★
Medication Compliance 75%—5–11 Years	14.25%	★
Medication Compliance 75%—12–18 Years	15.30%	★
Medication Compliance 75%—19–50 Years	21.17%	★
Medication Compliance 75%—51–64 Years	NA	NA
Medication Compliance 75%—Total	16.84%	★
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	24.86%	★
30-Day Follow-Up	37.78%	★
Antidepressant Medication Management		
Effective Acute Phase Treatment	32.42%	★
Effective Continuation Phase Treatment	16.90%	★

[1] For this measure, a lower rate indicates better performance. When comparing the rates to the 2014 Quality Compass National Percentiles, percentiles were reversed (e.g., the 90th percentile became the 10th percentile).

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

Harmony reported nine measure indicators with rates at or above the 2015 Quality Compass 50th percentiles, including:

- Three in the Access to Care measure set
- Three in the Child and Adolescent Care measure set
- One in the Women's Health measure set.
- Two in the Care for Chronic Conditions measure set.

Only two of the nine measure indicators were part of the incentive measures. Additionally, three measure indicators had fewer than 30 eligible cases (indicated by NA).

Harmony had rates that fell below the 50th percentiles on 49 measure indicators, including:

- 10 measure indicators in the Access to Care measure set.
- 10 in the Child and Adolescent Care measure set.
- Eight in the Women's Health measure set.
- 17 in the Care for Chronic Conditions measure set.
- Four in the Behavioral Health measure set.

Compliance Audit Results for Harmony

The HEDIS 2015 compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2015 Technical Specifications* (Table 4-8). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 4-8—Harmony HEDIS 2013 Compliance Audit Results

Main Information Systems			Selected MY 2014 HEDIS Measures
Membership Data	**Medical Data**	**Measure Calculation**	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

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

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

Harmony was fully compliant with IS Standard 1.0. **Harmony** continued to use the Xcelys system for its claims processing. No significant updates or changes were made during the measurement year. All relevant data fields were captured appropriately as required for HEDIS reporting. HSAG conducted a walkthrough of the claims process with **Harmony** staff during the on-site audit and determined that there were no issues with how claims were received and captured. **Harmony** had a very low volume of paper claim submissions. Any paper claim submitted was scanned and transmitted back to **Harmony** in a standard 837 format. HSAG reviewed the Incurred But Not Received (IBNR) report submitted with the Roadmap. According to the auditor's request, **Harmony** provided an updated IBNR report for the month of April, showing a complete runout of claims paid through March 2015.

Harmony continued to audit claims regularly and conducted annual desk audits of its scanning vendor to ensure policies and procedures were followed. **Harmony** had a very good auto adjudication rate, and 99.11 percent of all clean claims were processed less than 30 days from the time they were received. HSAG had no concerns with **Harmony**'s processes for processing claims processing during 2014.

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

Harmony was fully compliant with IS Standard 2.0. **Harmony** received daily and monthly files from the State for enrollments. Daily files were reconciled against the full monthly file and loaded into Xcelys. No enrollment files were manually processed, and all files were handled in HIPAA standard 834 transactions. No changes were made to the process since the prior year's audit.

HSAG confirmed with **Harmony** staff that there were no interruptions to processing the enrollment file during the measurement year. HSAG also confirmed that the assignment of member identification numbers was automatic in Xcelys but was matched prior to assignment to determine if an Xcelys identifier already existed. In the cases where a match was identified, member services reviewed to determine if the member had an existing number or if a new number needed to be assigned.

No significant changes to the Xcelys system or the enrollment process were made during 2014, and Xcelys captured all relevant fields required for HEDIS processing.

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

Harmony was fully compliant with IS Standard 3.0. **Harmony** housed all of its provider data in Xcelys following credentialing efforts. HSAG staff reviewed provider specialty assignments with **Harmony** and determined that all specialties were being captured accurately. Required data elements outlined in the HEDIS Roadmap were captured in Xcelys. There were no changes to **Harmony**'s provider data processes, including how it captured provider data. HSAG reviewed providers listed under the FQHCs to determine if individual provider information was captured in Xcelys. HSAG found **Harmony** to be compliant with the credentialing and assignment of individual providers at the FQHCs.

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

Harmony was fully compliant with the IS Standard 4.0 reporting process. **Harmony** sampled according to the HEDIS sampling guidelines and assigned an appropriate, measure-specific oversample. Provider chase logic was reviewed and determined appropriate across the hybrid measures. For HEDIS 2015, **Harmony** contracted with an MRR vendor, Altegra, for medical record pursuit and abstraction. Altegra's hybrid tools and corresponding abstraction instructions were reviewed and approved by HSAG.

Altegra's reviewer qualifications, training, and oversight were appropriate. **Harmony** conducted appropriate oversight of its vendor. Due to abstraction errors during the 2014 validation process, a convenience sample was required and subsequently passed.

Harmony passed the MRRV process for the following measure groups:

- Group A: *Timeliness of Prenatal Care*
- Group A: *Postpartum Care*
- Group B: *Well-Child Visits in the First 15 Months of Life—6+ Visits*
- Group C: There were no hybrid measures under the scope of the audit from this measure group.

- Group D: *Childhood Immunization Status—Combo 3*
- CMS Child Core: *Developmental Screening in the First Three Years of Life*

Upon validation of the *Timeliness of Prenatal Care* measure, two abstraction errors were detected. According to the NCQA MRRV protocol, a validation of a second sample was required. **Harmony** re-abstracted the *Timeliness of Prenatal Care* measure, and a second sample was validated. Due to the error type, HSAG extrapolated the findings to the *Postpartum Care* measure. Both of the second samples for the *Timeliness of Prenatal Care* and *Postpartum Care* measures passed validation. **Harmony** conducted a root cause analysis plan pertaining to the *Timeliness of Prenatal Care* errors and identified a mechanism to prevent the abstraction errors in the future. **Harmony** removed cases that involved abstraction errors from the numerator category.

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

Harmony was fully compliant with IS Standard 5.0. **Harmony** used two nonstandard supplemental data sources (IHOP and Pseudoclaims) and several standard supplemental data sources for HEDIS 2015 reporting. HSAG identified some noncritical errors in the IHOP data source that **Harmony** corrected. HSAG reviewed and approved both nonstandard data sources for use in HEDIS 2015 reporting.

HSAG did not identify any issues with **Harmony**'s standard data sources, and all standard data sources were also approved for HEDIS 2015 reporting.

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

This standard was not applicable to the measures under the scope of the Illinois Medicaid audit.

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

Harmony was fully compliant with IS Standard 7.0. During 2014, **Harmony** transformed its data warehouse platform to Green Plumb to achieve more efficient data extraction processes. The previous data warehouse often took several hours to run queries to pull data for its certified software extractions. With the implementation of Green Plumb, **Harmony** noted that queries which previously took several days to run now took merely hours. This was a significant improvement in turnaround time for data extractions. HSAG reviewed **Harmony**'s process for the implementation of Green Thumb and determined that, other than changes to the platform, there were no differences from the previous data warehouse structure. **Harmony** conducted extensive testing to ensure all data were correct and ran two parallel processes in the software to ensure the rates matched. **Harmony** continued to utilize Inovalon's software to produce its HEDIS measures. Inovalon is a software vendor whose HEDIS measures were certified by NCQA for HEDIS 2015.

HSAG reviewed and approved **Harmony**'s final rates and validated that **Harmony** was using the correct global unique identifiers (GUIDs) for the HEDIS measures according to Inovalon's measure certification report.

Meridian Health Plan, Inc. (Meridian)

The Medicaid HEDIS 2015 rates for **Meridian** are presented in Table 4-9.

Table 4-9—Meridian's HEDIS 2015 Rates 2015

	HEDIS 2015 Rate	2015 Performance Level
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	98.12%	★★★★
25 Months–6 Years	90.53%	★★★
7–11 Years	96.81%	★★★★★
12–19 Years	96.80%	★★★★★
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	83.54%	★★★
45–64 Years	90.05%	★★★
Total	85.80%	★★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	53.85%	★★★★★
Initiation of AOD Treatment—18+ Years	46.14%	★★★★
Initiation of AOD Treatment—Total	46.53%	★★★★
Engagement of AOD Treatment—13–17 Years	23.08%	★★★
Engagement of AOD Treatment—18+ Years	12.40%	★★★
Engagement of AOD Treatment—Total	12.93%	★★★
Child and Adolescent Care		
Childhood Immunization Status		
Combination 2	76.62%	★★★
Combination 3	73.61%	★★★
Lead Screening in Children		
Lead Screening in Children	84.60%	★★★★
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	73.61%	★★★
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	41.41%	★★★★★
Well-Child Visits in the First 15 Months of Life		
No Well-Child Visits[1]	0.46%	★★★★
Six or More Well-Child Visits	81.25%	★★★★★

	HEDIS 2015 Rate	2015 Performance Level
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	83.29%	★★★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	60.65%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	64.12%	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	69.21%	★★★
Counseling for Nutrition—Total	64.35%	★★★
Counseling for Physical Activity—Total	49.54%	★★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	NA	NA
Cervical Cancer Screening		
Cervical Cancer Screening	68.30%	★★★
Chlamydia Screening in Women		
16–20 Years	54.73%	★★★
21–24 Years	65.11%	★★★
Total	61.55%	★★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	90.26%	★★★★
Postpartum Care	75.41%	★★★★★
Frequency of Ongoing Prenatal Care		
<21 Percent of Expected Visits[1]	2.55%	★★★★
≥81 Percent of Expected Visits	87.94%	★★★★★
Care for Chronic Conditions		
Comprehensive Diabetes Care [2]		
Hemoglobin A1c (HbA1c) Testing	94.37%	★★★★★
HbA1c Poor Control (>9.0%)[1]	73.24%	★
HbA1c Control (<8.0%)	23.94%	★
Eye Exam (Retinal) Performed	63.38%	★★★★
Medical Attention for Nephropathy	88.73%	★★★★★
BP Control (<140/90 mm Hg)	67.61%	★★★

	HEDIS 2015 Rate	2015 Performance Level
Controlling High Blood Pressure		
Controlling High Blood Pressure	70.91%	★★★★★
Use of Appropriate Medications for People With Asthma		
5–11 Years	98.63%	★★★★★
12–18 Years	84.38%	★★
19–50 Years	NA	NA
51–64 Years	NA	NA
Total	91.41%	★★★★
Medication Management for People With Asthma		
Medication Compliance 50%—5–11 Years	84.72%	★★★★★
Medication Compliance 50%—12–18 Years	NA	NA
Medication Compliance 50%—19–50 Years	NA	NA
Medication Compliance 50%—51–64 Years	NA	NA
Medication Compliance 50%—Total	87.18%	★★★★★
Medication Compliance 75%—5–11 Years	73.61%	★★★★★
Medication Compliance 75%—12–18 Years	NA	NA
Medication Compliance 75%—19–50 Years	NA	NA
Medication Compliance 75%—51–64 Years	NA	NA
Medication Compliance 75%—Total	75.21%	★★★★★
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	31.78%	★★
30-Day Follow-Up	48.20%	★
Antidepressant Medication Management		
Effective Acute Phase Treatment	85.94%	★★★★★
Effective Continuation Phase Treatment	66.41%	★★★★★

[1] For this measure, a lower rate indicates better performance. When comparing the rates to the 2014 Quality Compass National Percentiles, percentiles were reversed (e.g., the 90th percentile became the 10th percentile).

[2] Meridian elected to rotate this measure for HEDIS 2015. Therefore, rates presented for all measure indicators are based on performance from HEDIS 2014.

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

Meridian reported 45 measure indicators with rates at or above the 2015 Quality Compass 50th percentiles, including:

- 13 in the Access to Care measure set.
- 11 in the Child and Adolescent Care measure set.

- Eight in the Women's Health measure set.
- 11 in the Care for Chronic Conditions measure set.
- Two in the Behavioral Health measure set.

Additionally, nine measure indicators had fewer than 30 eligible cases (indicated by NA).

Meridian had scores that fell below the 50th percentiles on seven measure indicators, including:

- Two measure indicators in the Child and Adolescent Care measure set.
- Three in the Care for Chronic Conditions measure set.
- Two in the Behavioral Health measure set.

Compliance Audit Results for Meridian

The HEDIS 2015 compliance audit indicated that **Meridian** was in full compliance with the *HEDIS 2015 Technical Specifications* (Table 4-10). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an *R* designation.

Table 4-10—Meridian HEDIS 2015 Compliance Audit Results

Main Information Systems			Selected MY 2014 HEDIS Measures
Membership Data	**Medical Data**	**Measure Calculation**	All of the selected HEDIS measures received an *R* audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

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

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

Meridian was fully compliant with IS Standard 1.0. HSAG reviewed **Meridian**'s internally developed claims system. **Meridian** noted that there were no significant changes to the system from the previous year. The International Classification of Diseases, Ninth Revision (ICD-9) and Current Procedural Technology (CPT) codes were updated in the system annually. **Meridian** met regularly to discuss the implementation of ICD-10 codes. Several staff members had completed training in preparation for the coding changes that will be effective in 2015.

Meridian experienced a greater than expected lag in claims processing from the previous year and attributed this to the increased enrollment from the Affordable Care Act during 2014. Claims processing

turnaround time increased to more than five days which was much higher than the previous year. At the time of the on-site visit, all claims backlogs had been rectified; therefore, HSAG did not consider this to be an issue. HSAG monitored the IBNR report to ensure the majority of claims were paid by the final refresh of administrative data. HSAG did not identify any issues with **Meridian**'s IBNR report. HSAG did not identify any additional issues during the on-site visit.

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

Meridian was fully compliant with IS Standard 2.0. **Meridian** continued to use the same processes for capturing enrollment data during the measurement year as it had the previous year. Although there was a very large increase in membership, the process seemed to run smoothly without any issues. Enrollments were still obtained from the State file daily and then reconciled with the monthly file. The increase in enrollment did not seem to slow down the process for **Meridian**, and its internal enrollment system was capable of handling the extra load with ease.

No changes were noted from the previous year other than the increase in enrollment from the Affordable Care Act.

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

Meridian was fully compliant with IS Standard 3.0. **Meridian** noted that it continued to expand its provider network to accommodate the enrollment increases. Network adequacy reviews were conducted by **Meridian** regularly to ensure there were adequate providers to provide care for the increase in membership.

Meridian appropriately captured all credentialing information from its providers and was able to capture primary and secondary specialties.

Other than primary care practitioner (PCP) expansion, there were no significant changes to the provider systems and processes from the previous year.

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

Meridian was fully compliant with the IS Standard 4.0 reporting process. **Meridian** sampled according to the HEDIS sampling guidelines and assigned an appropriate, measure-specific oversample. **Meridian** did not reduce sample sizes. Medical record pursuit and data collection were conducted by **Meridian** staff using proprietary data abstraction tools. The hybrid tools and corresponding abstraction instructions were reviewed and approved by HSAG.

Provider chase logic was reviewed and determined appropriate across the hybrid measures. Reviewer qualifications, training, and oversight by **Meridian** of its review staff were appropriate.

A full convenience sample was required since this was the first time **Meridian** reported the measures under the scope of the HSAG audit using the hybrid methodology. **Meridian** subsequently passed the full convenience sample.

Meridian passed the MRRV process for the following measure groups:

- Group A: *Postpartum Care*
- Group A: *Timeliness of Prenatal Care*
- Group B: *Well-Child Visits in the First 15 Months of Life—All Visits*
- Group C: There were no hybrid measures under the scope of the audit from this measure group.
- Group D: *Childhood Immunization Status—Combo 3*
- CMS Child Core: *Developmental Screening in the First Three Years of Life*
- Group F: *No exclusions*

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

Meridian was fully compliant with IS Standard 5.0. **Meridian** had one nonstandard supplemental database that was reviewed in March. HSAG completed the review with some questions on the dates of service location on the proof-of-service (POS) documentation. Once that issue was resolved, the database was approved for HEDIS 2015 reporting.

HSAG reviewed documentation for the three standard supplemental databases, Healthy Kids, Illinois Historical Claims, and Quest Lab. These data were exempt from primary source verification according to NCQA's guidelines. All three standard data sources were approved for HEDIS 2015 reporting.

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

This standard was not applicable to the measures under the scope of the Illinois Medicaid audit.

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

Meridian was fully compliant with IS Standard 7.0. **Meridian** continued to use internally developed source code to produce the required measures. Source code was reviewed and approved by HSAG for all measures under the scope of the audit. There was an issue with how **Meridian** was calculating the hybrid versus administrative hits in the source code. **Meridian** discovered this during the MRR validation and submitted updated source code. HSAG reviewed and approved the updated source code. There was no impact to the rates. Rather, this was an issue with bucketing hybrid versus administrative hits.

During the on-site audit, HSAG discovered **Meridian** had some external data sources that were not listed on the system integration workflow diagram. The information systems staff updated this workflow diagram to show all sources being integrated for use in the performance measures under review.

There were no significant changes in processes, and no additional issues were encountered during the on-site visit.

Plan Comparisons

This section of the report compares HEDIS performance measure results for each measure set for **FHN**, **Harmony**, and **Meridian** for HEDIS 2013, HEDIS 2014, and HEDIS 2015. HEDIS rates are compared to the respective Quality Compass 50th percentiles, as represented by the red horizontal line. As mentioned above, 2013 Quality Compass did not contain benchmarks for select measures (i.e. *Breast Cancer Screening* and *Cervical Cancer Screening* measure indicators); therefore, the 2013 HEDIS Audit Means and Percentile 50th percentile values were used for this analysis.

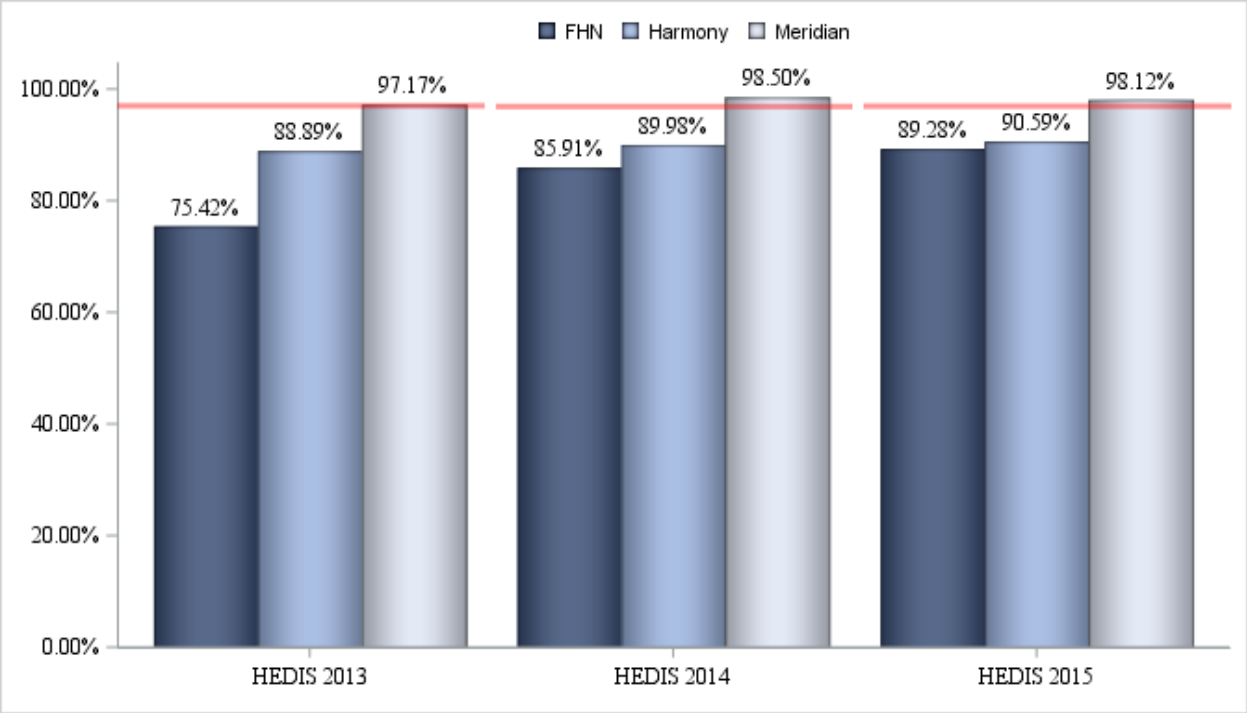
Access to Care

Children and Adolescents' Access to Primary Care Practitioners

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

Figure 4-1 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months.*

Figure 4-1—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*

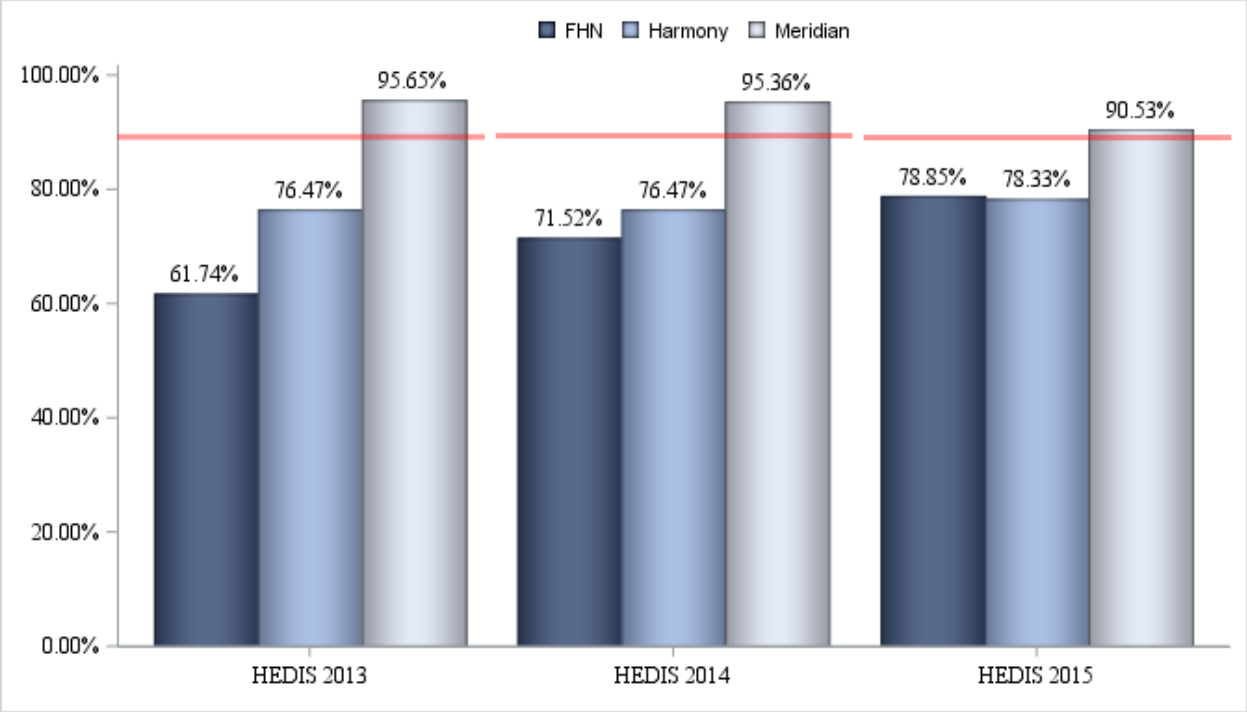


Meridian's rates from HEDIS 2013 to HEDIS 2015 consistently scored above the rates reported by **FHN** and **Harmony**. **Meridian**'s HEDIS 2014 to HEDIS 2015 rates were the only rates that were at or above the Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015. Although **FHN**'s rate increased by approximately 14 percentage points from HEDIS 2013 to HEDIS 2015, the HEDIS 2015 rate remained below the 2014 Quality Compass 50th percentile.

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

Figure 4-2 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*.

Figure 4-2—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*

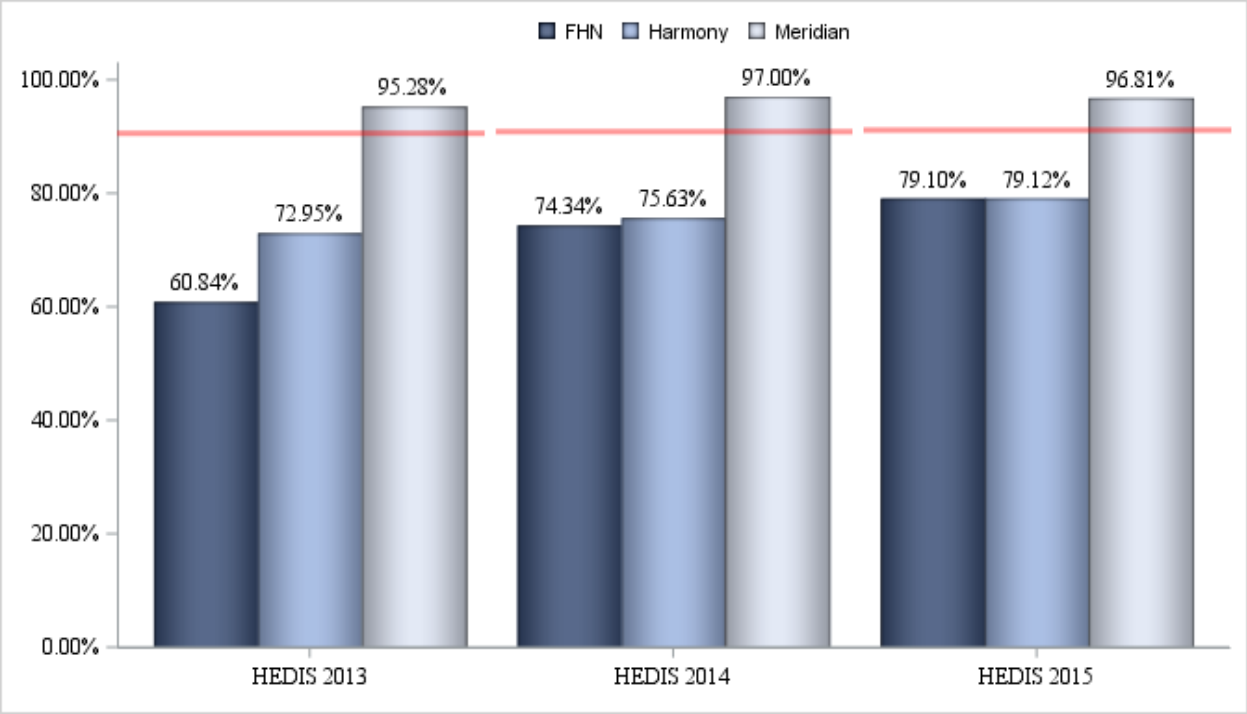


As with the previous measure, **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were also consistently at or above the Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015. As seen with the previous measure, **FHN**'s rate increased by approximately 17 percentage points from HEDIS 2013 to HEDIS 2015, but remained below the 2014 Quality Compass 50th percentile. Both **Harmony** and **FHN**'s HEDIS 2015 rates remained below the 2014 Quality Compass 50th percentile by approximately 11 percentage points.

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

Figure 4-3 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*.

Figure 4-3—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*

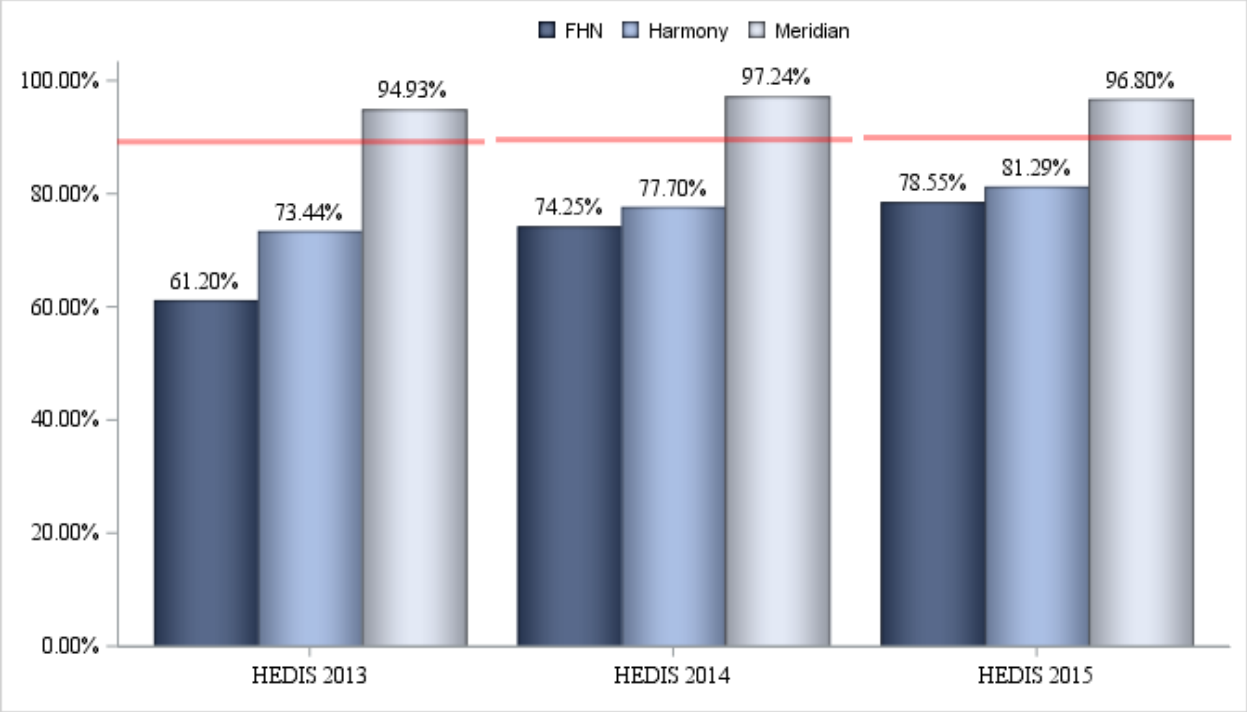


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and were at or above the respective Quality Compass 50th percentiles. **Harmony**'s rates increased by more than 6 percentage points from HEDIS 2013 to HEDIS 2015, but the HEDIS 2015 rate still fell below the 2014 Quality Compass 50th percentile. **FHN**'s rates improved each year for a total increase of approximately 18 percentage points from HEDIS 2013 to HEDIS 2015. Despite the increased rate, **FHN**'s 2015 HEDIS rate was still below the 2014 Quality Compass 50th percentile by approximately 12 percentage points.

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

Figure 4-4 presents comparative rates for *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*.

Figure 4-4—Comparison of HFS MCO Performance for *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*



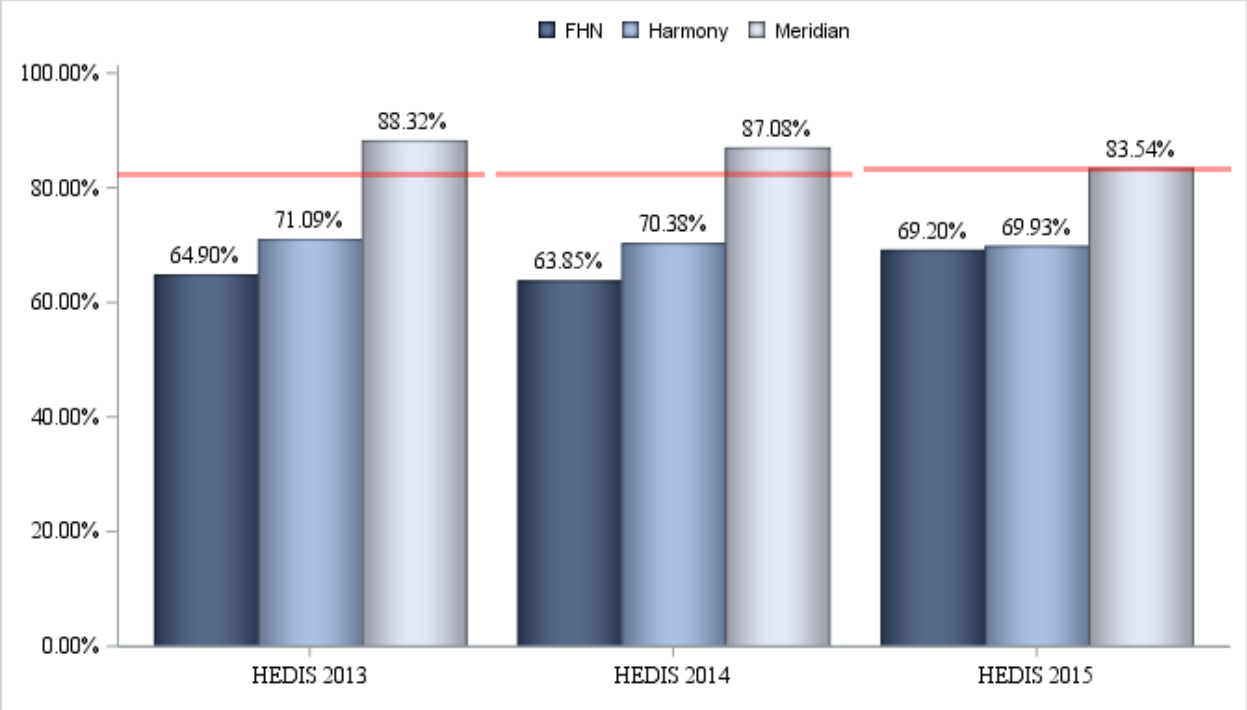
For HEDIS 2013, HEDIS 2014, and HEDIS 2015, **Meridian**'s rates consistently scored above the rates reported by **FHN** and **Harmony**, and were at or above the respective Quality Compass 50th percentiles. **Harmony**'s rates increased from HEDIS 2013 to HEDIS 2015, though **Harmony**'s HEDIS 2015 rate was still below the 2014 Quality Compass 50th percentile. **FHN**'s rates improved each year from HEDIS 2013 to HEDIS 2015 for a total increase of approximately 17 percentage points. However, **FHN**'s HEDIS 2015 rate still remained below the 2014 Quality Compass 50th percentile.

Adults' Access to Preventive/Ambulatory Health Services

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

Figure 4-5 presents comparative rates for *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*.

Figure 4-5—Comparison of HFS MCO Performance for *Adults' Access to Preventative/Ambulatory Health Services—20–44 Years*

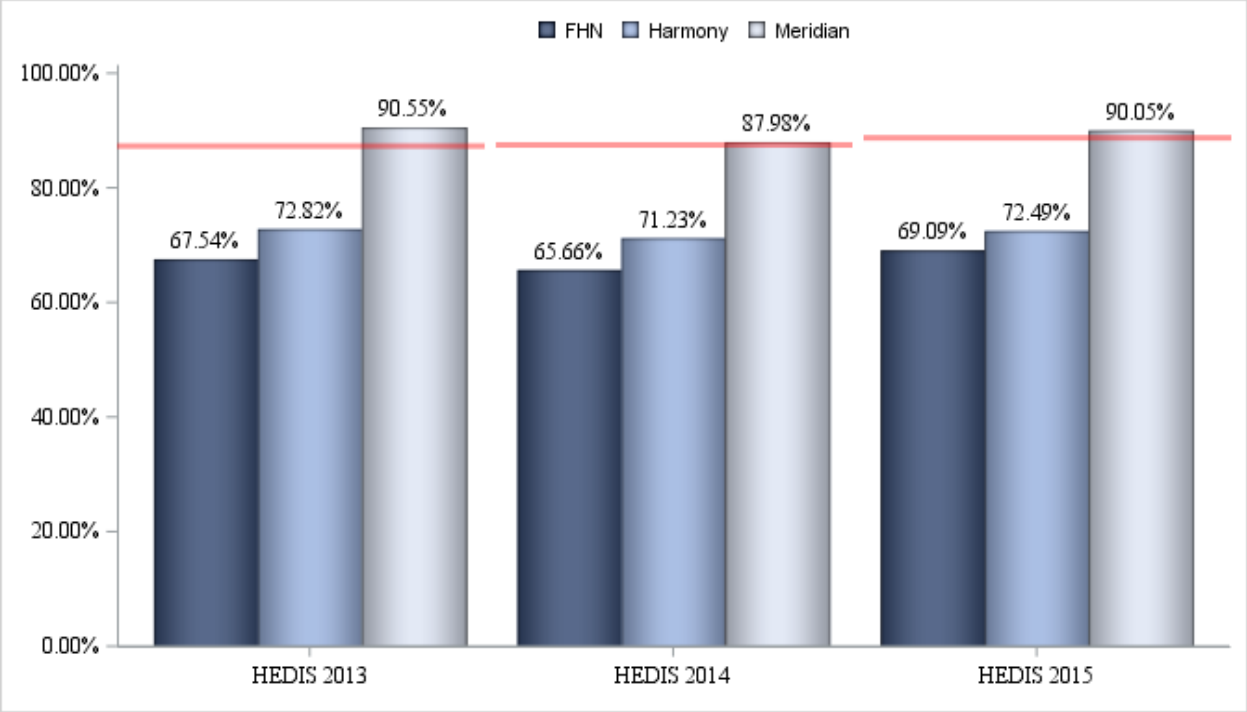


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and were at or above the Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and the HEDIS 2015 rate fell below the 2014 Quality Compass 50th percentile by approximately 13 percentage points. **FHN**'s rates for HEDIS 2013, HEDIS 2014, and HEDIS 2015 remained similar each year, and the rates for each year remained below the Quality Compass 50th percentiles.

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

Figure 4-6 presents comparative rates for *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*.

Figure 4-6—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*

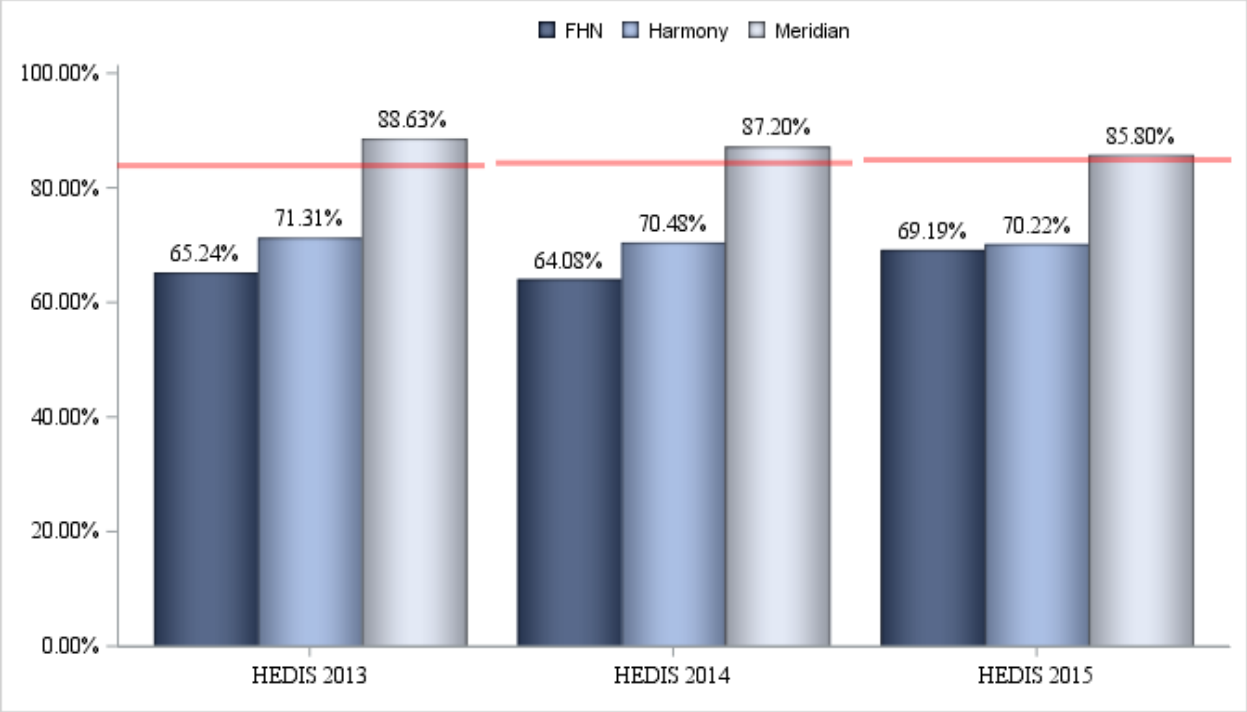


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**. Additionally, **Meridian**'s HEDIS rates were at or above the Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and remained below the Quality Compass 50th percentiles each year. **FHN**'s rates from HEDIS 2013 to HEDIS 2015 remained similar, but the HEDIS 2015 rate fell below the 2014 Quality Compass 50th percentile by almost 20 percentage points.

Adults' Access to Preventive/Ambulatory Health Services—Total

Figure 4-7 presents comparative rates for *Adults' Access to Preventive/Ambulatory Health Services—Total*.

Figure 4-7—Comparison of HFS MCO Performance for *Adults' Access to Preventive/Ambulatory Health Services—Total*



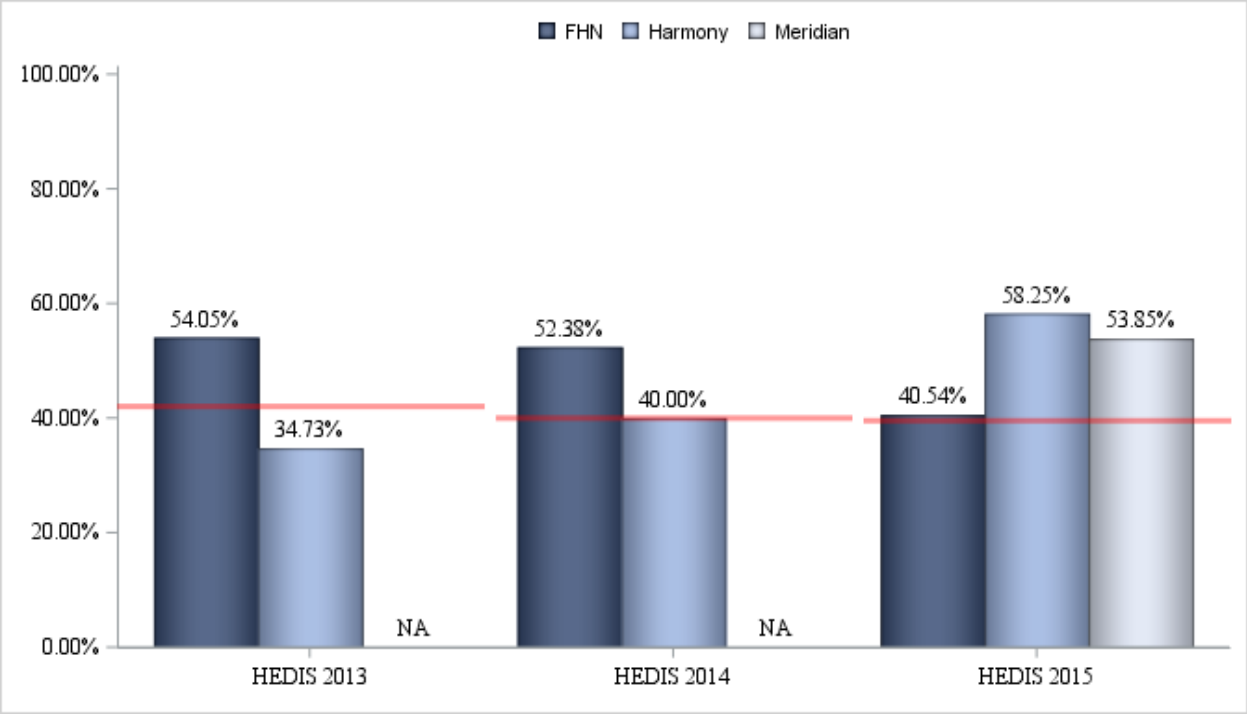
Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**. Additionally, **Meridian**'s rates scored at or above the respective Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and the HEDIS 2015 rate remained below the 2014 Quality Compass 50th percentile by approximately 15 percentage points. **FHN**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and the rates for each year remained below the Quality Compass 50th percentiles.

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

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

Figure 4-8 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—13–17 Years*.

Figure 4-8—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—13–17 Years*

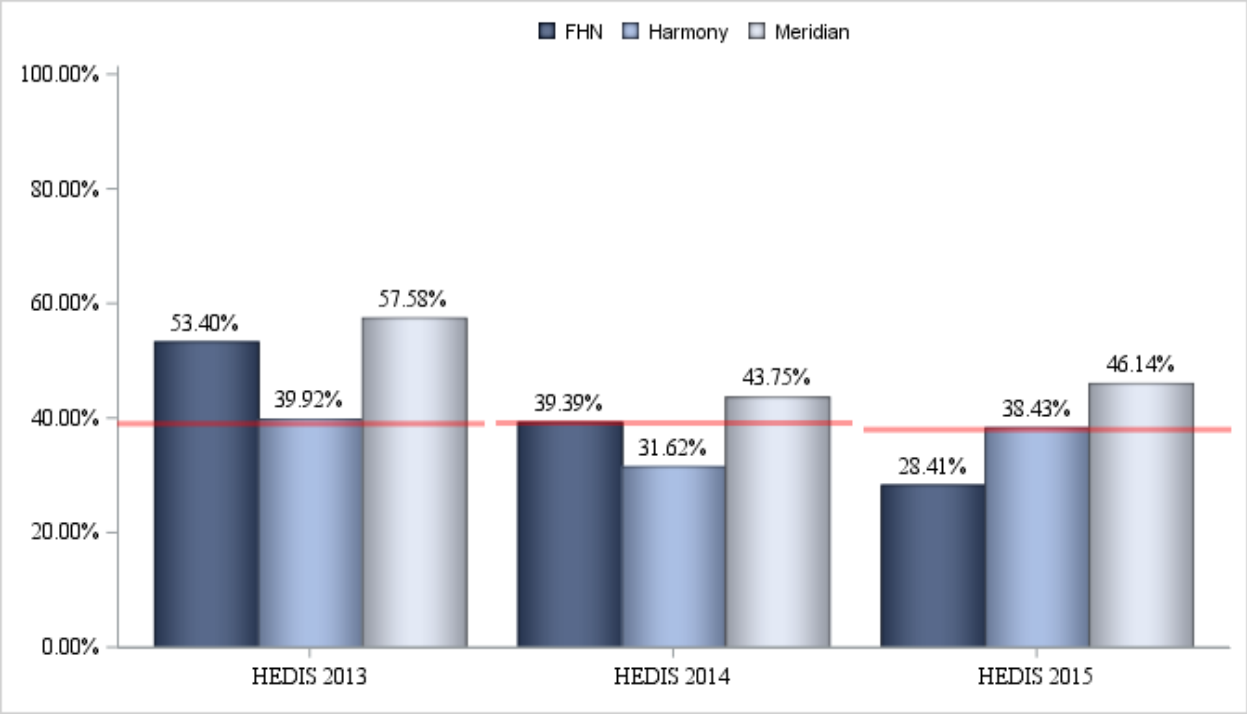


FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored at or above the Quality Compass 50th percentiles. **Harmony**'s rates increased by approximately 24 percentage points from HEDIS 2013 to HEDIS 2015. Additionally, **Harmony**'s HEDIS 2015 rate was at or above the 2014 Quality Compass 50th percentile. **Meridian**'s HEDIS 2013 and HEDIS 2014 rates were reported as NA because they had denominators that were less than 30, but **Meridian**'s HEDIS 2015 rate was at or above the 2014 Quality Compass 50th percentile.

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

Figure 4-9 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—18+ Years*.

Figure 4-9—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—18+ Years*

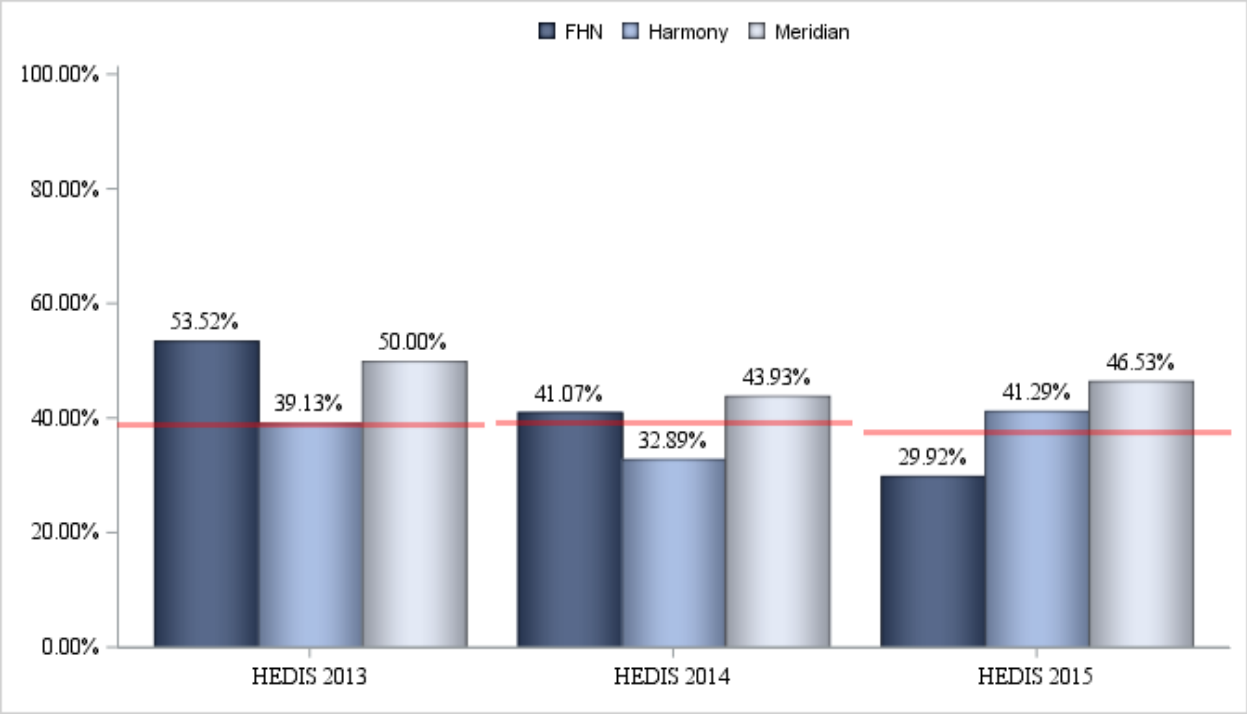


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles. Although **FHN**'s HEDIS 2013 rate was at or above the 2012 Quality Compass 50th percentile, the rate fell from HEDIS 2013 to HEDIS 2015 by approximately 25 percentage points, and the HEDIS 2015 rate also fell below the 2014 Quality Compass 50th percentile. Although **Harmony**'s HEDIS 2013 rate, which was at or above the 2012 Quality Compass 50th percentile, fell in HEDIS 2014, the HEDIS 2015 rate was at or above the 2014 Quality Compass 50th percentile.

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

Figure 4-10 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*.

Figure 4-10—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*

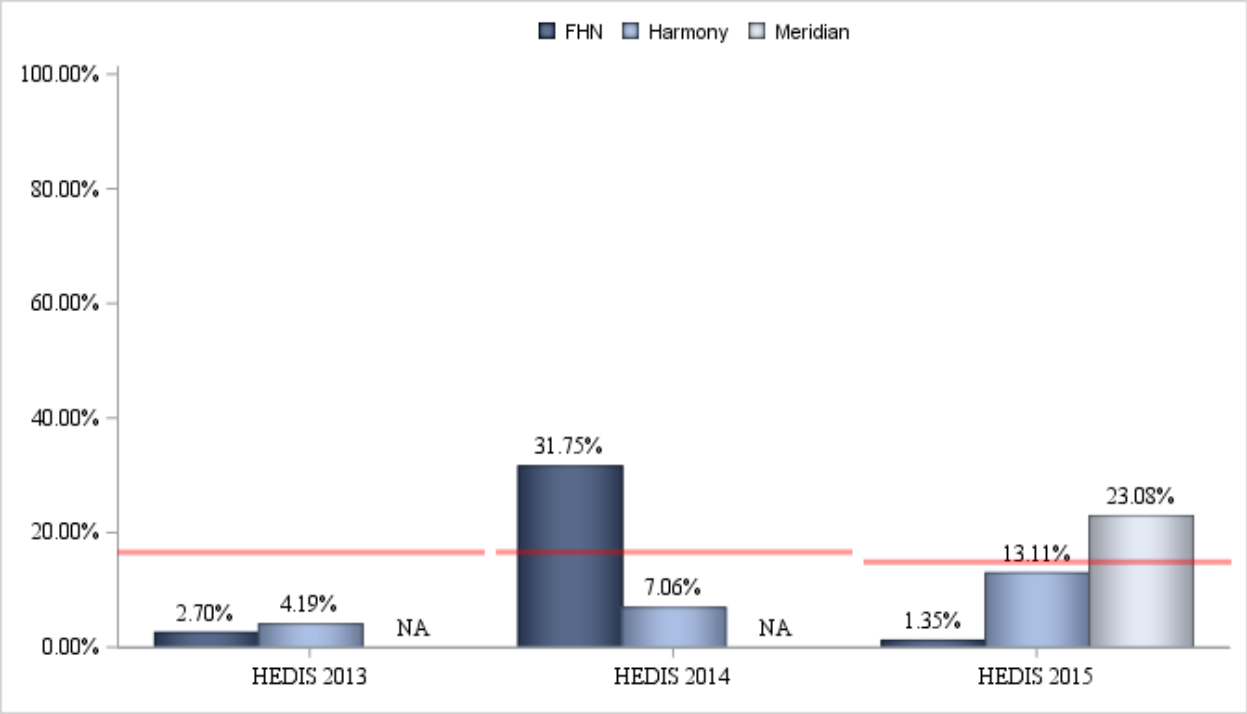


Meridian's rates scored at or above the respective Quality Compass 50th percentile in all three years. **Harmony**'s HEDIS 2015 rate improved by approximately 8 percentage points from HEDIS 2014, and **Harmony**'s HEDIS 2015 rate was at or above the 2014 Quality Compass 50th percentile. **FHN**'s HEDIS 2015 performance declined by approximately 24 percentage points from HEDIS 2013, and **FHN**'s HEDIS 2015 rate fell below the 2014 Quality Compass 50th percentile.

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

Figure 4-11 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—13–17 Years*.

Figure 4-11—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—13–17 Years*

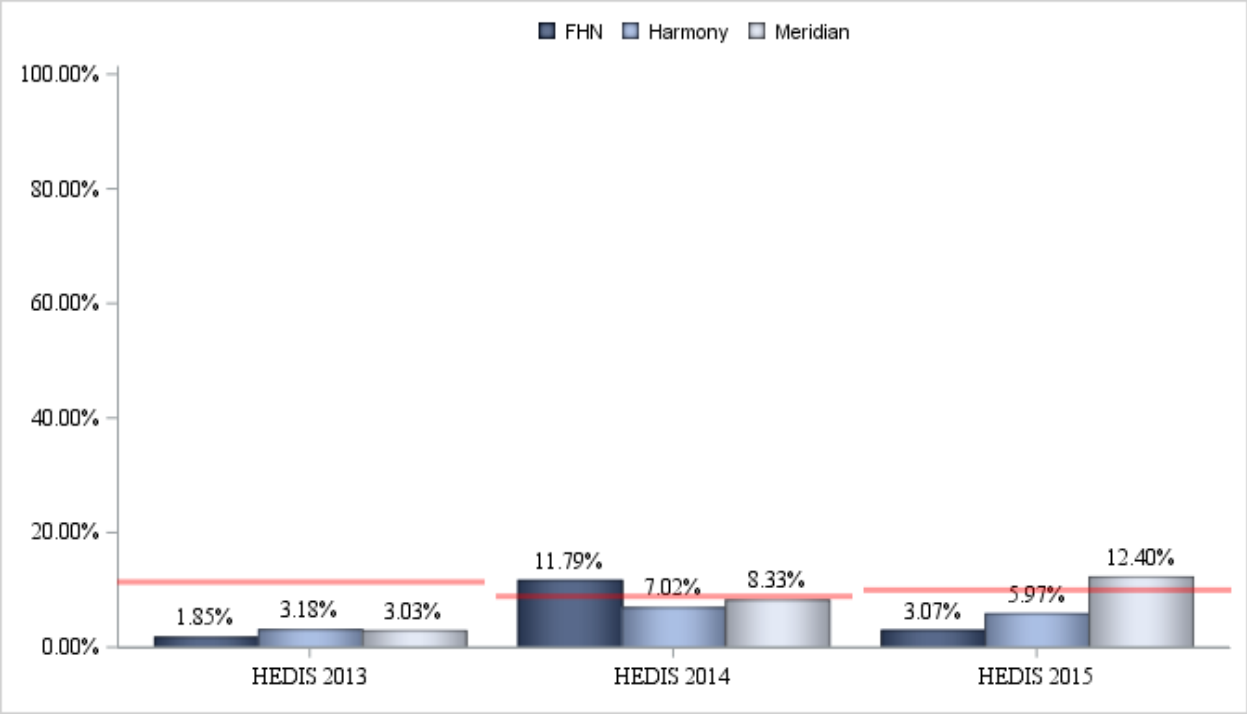


FHN's rate increased by approximately 29 percentage points in HEDIS 2014, with the HEDIS 2014 rate exceeding the 2013 Quality Compass 50th percentile. However, for HEDIS 2015, **FHN**'s rate decreased by more than 30 percentage points, falling below the 2014 Quality Compass 50th percentile. Although **Harmony**'s rate increased by approximately 9 percentage points from HEDIS 2013 to HEDIS 2015, the HEDIS 2015 rate remained below the 2014 Quality Compass 50th percentile. **Meridian**'s HEDIS 2013 and HEDIS 2014 rates were reported as NA because the rates were based on denominators of less than 30. For HEDIS 2015, however, **Meridian**'s rate was at or above the 2014 Quality Compass 50th percentile.

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

Figure 4-12 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—18+ Years.*

Figure 4-12—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—18+ Years*

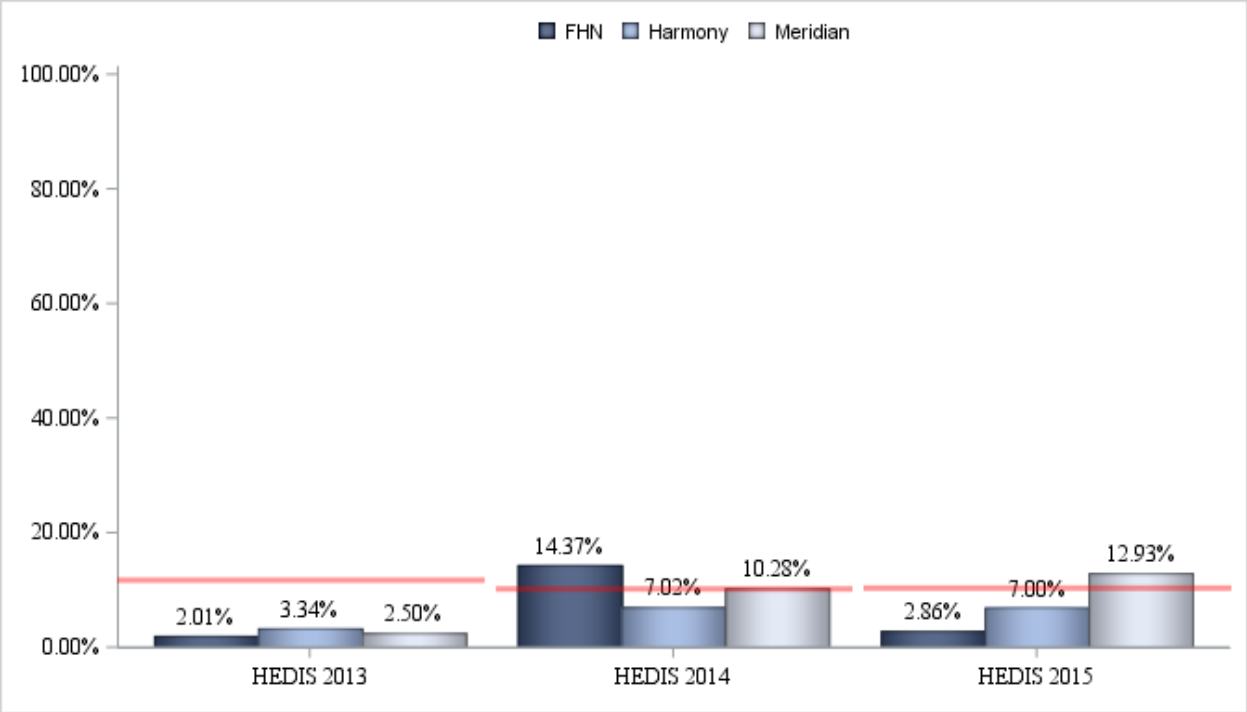


FHN's rate increased from HEDIS 2013 to HEDIS 2014, followed by a decline in performance from HEDIS 2014 to HEDIS 2015, decreasing to approximately 7 percentage points below the 2014 Quality Compass 50th percentile. Although **Harmony**'s rates increased between HEDIS 2013 and HEDIS 2014, the rates remained similar from HEDIS 2014 to HEDIS 2015, and the HEDIS 2015 rate remained below the 2014 Quality Compass 50th percentile. **Meridian**'s rate increased by 9 percentage points from HEDIS 2013 to HEDIS 2015, and **Meridian**'s HEDIS 2015 rate was at or above the 2014 Quality Compass 50th percentile.

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

Figure 4-13 presents comparative rates for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*.

Figure 4-13—Comparison of HFS MCO Performance for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*



FHN's rates from HEDIS 2013 to HEDIS 2014 increased by 12 percentage points, scoring at or above the 2013 Quality Compass 50th percentile. However, **FHN**'s HEDIS 2015 rate fell below the 2014 Quality Compass 50th percentile. **Harmony**'s rates increased from HEDIS 2013 to HEDIS 2014 and remained similar for HEDIS 2015, but the HEDIS 2015 rate remained below the 2014 Quality Compass 50th percentile. **Meridian**'s rate increased from HEDIS 2013 to HEDIS 2015 by approximately 10 percentage points, and **Meridian**'s HEDIS 2015 rate was at or above the 2014 Quality Compass 50th percentile.

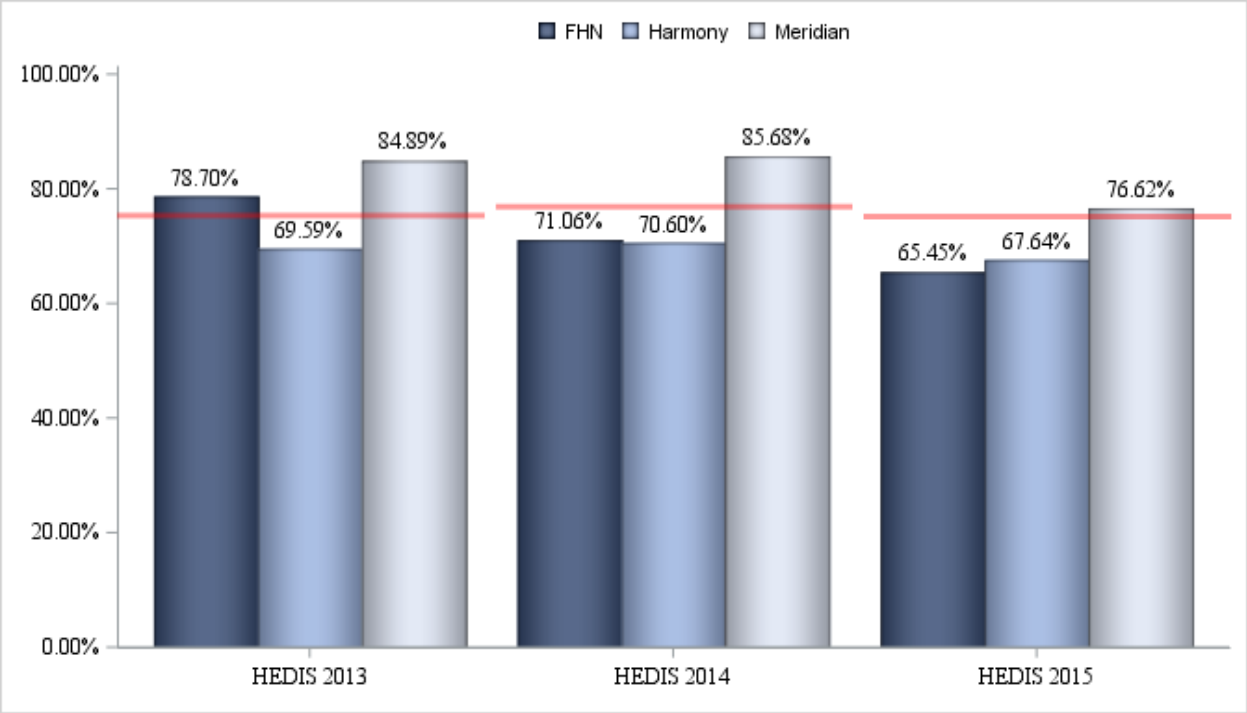
Child and Adolescent Care

Childhood Immunization Status

Childhood Immunization Status—Combination 2

Figure 4-14 presents comparative rates for *Childhood Immunization Status—Combination 2*.

Figure 4-14—Comparison of HFS MCO Performance for *Childhood Immunization Status—Combination 2*

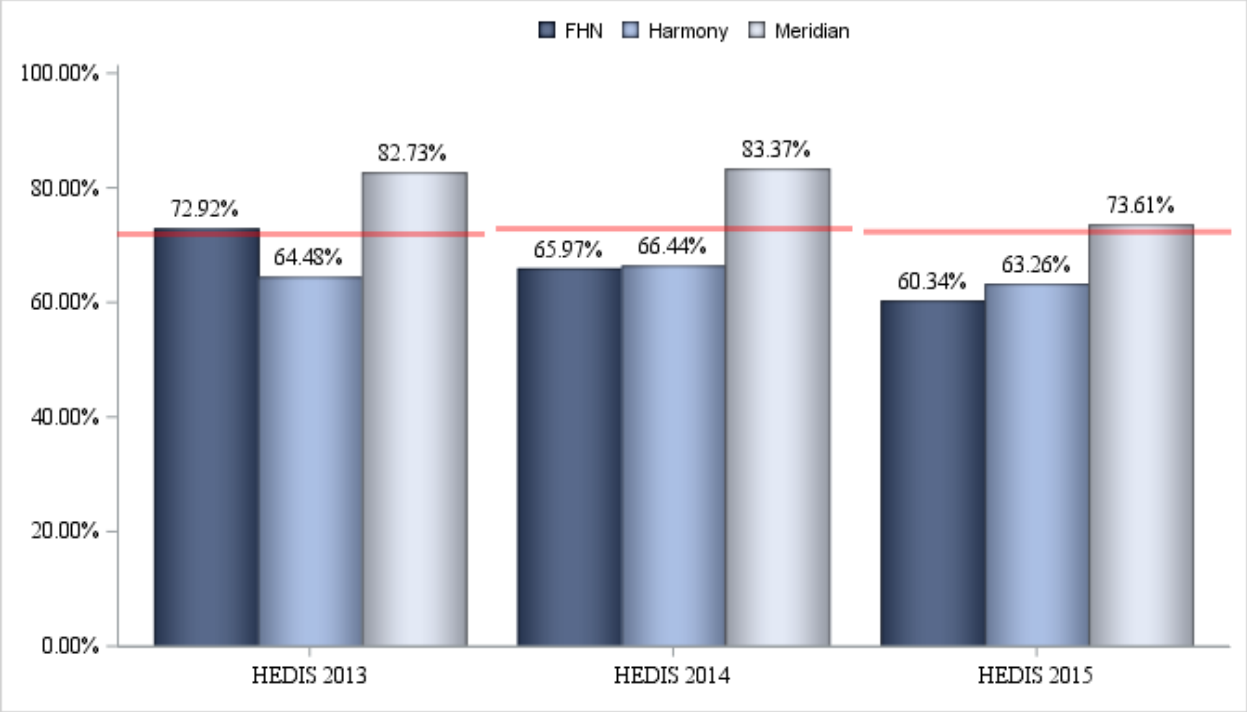


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, falling below the Quality Compass 50th percentiles each year. Although **FHN**'s HEDIS 2013 rate was at or above the 2012 Quality Compass 50th percentile, **FHN**'s HEDIS 2014 and HEDIS 2015 rates fell below the Quality Compass 50th percentiles. **FHN**'s HEDIS 2015 fell below the 2014 Quality Compass 50th percentile by approximately 10 percentage points.

Childhood Immunization Status—Combination 3

Figure 4-15 presents comparative rates for *Childhood Immunization Status—Combination 3*.

Figure 4-15—Comparison of HFS MCO Performance for *Childhood Immunization Status—Combination 3*

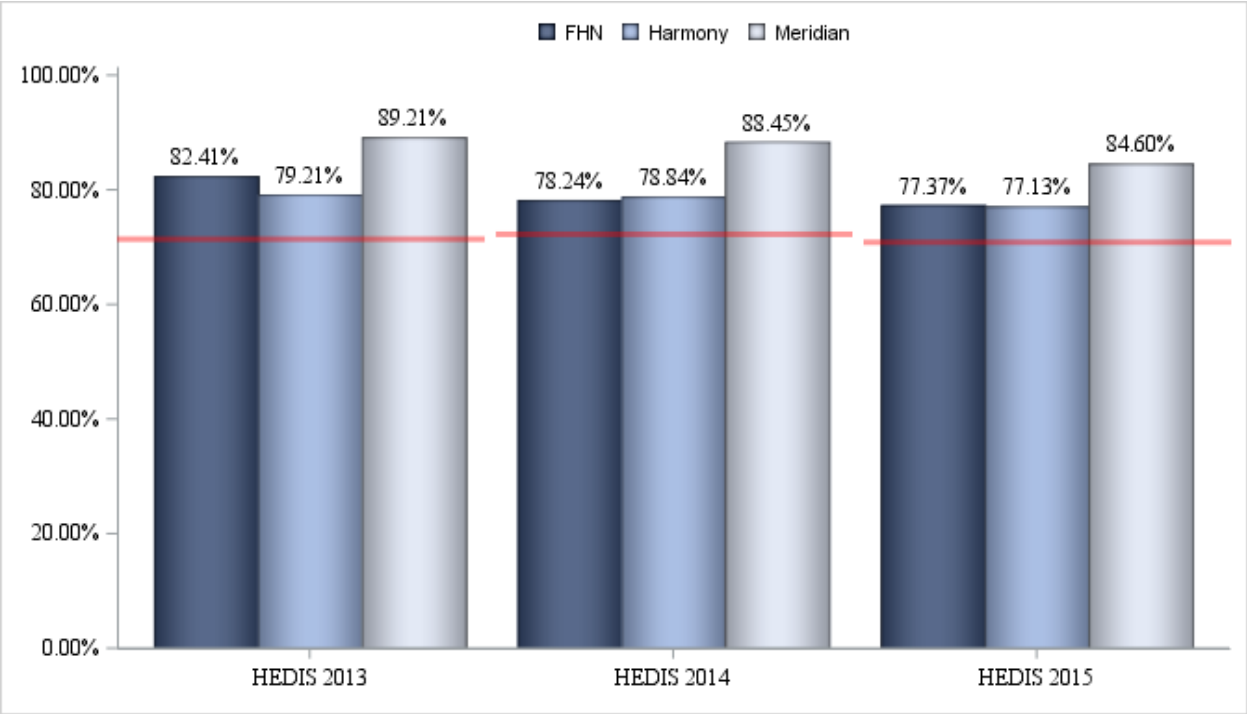


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates scored at or above the respective Quality Compass 50th percentiles each year. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and fell below the Quality Compass 50th percentiles each year. **FHN**'s HEDIS 2013 rate was at or above the 2012 Quality Compass 50th percentile, but the rates steadily decreased from HEDIS 2013 to HEDIS 2015. The HEDIS 2014 and HEDIS 2015 rates for **FHN** fell below the Quality Compass 50th percentiles.

Lead Screening in Children

Figure 4-16 presents comparative rates for *Lead Screening in Children*.

Figure 4-16—Comparison of HFS MCO Performance for *Lead Screening in Children*

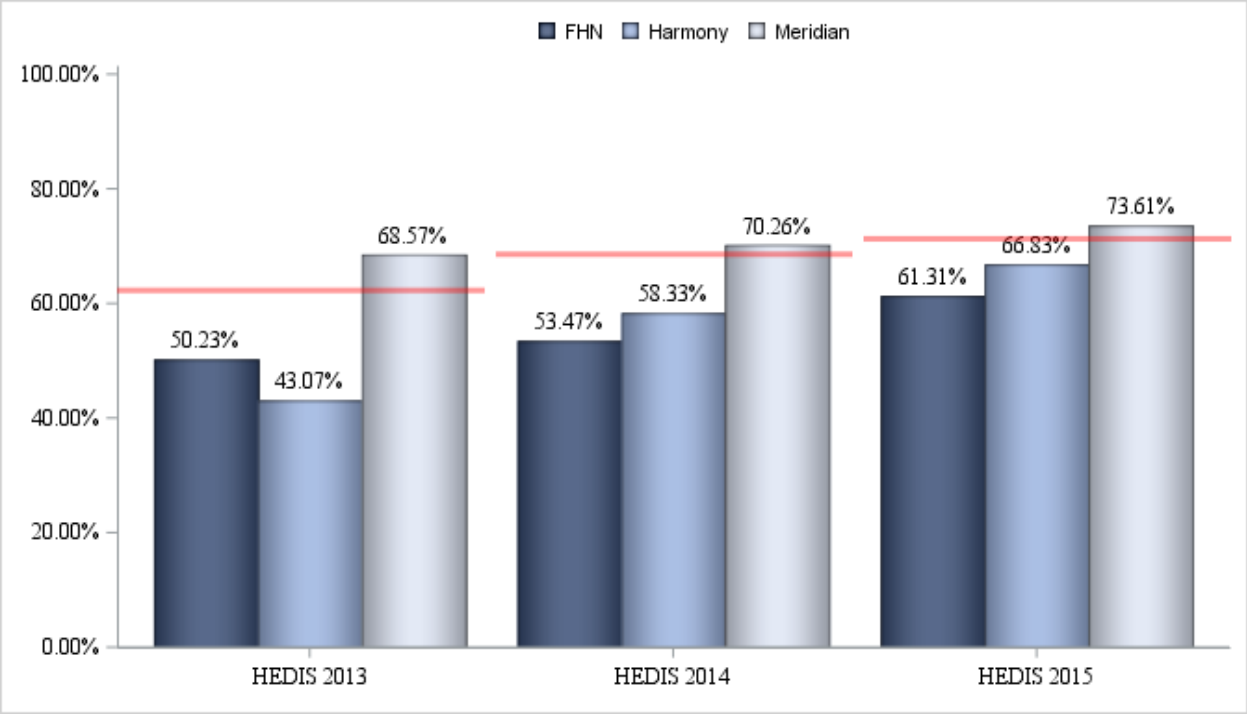


Although the rates for **FHN**, **Harmony**, and **Meridian** steadily decreased from HEDIS 2013 to HEDIS 2015, their rates for each year were at or above the Quality Compass 50th percentiles.

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

Figure 4-17 presents comparative rates for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)*.

Figure 4-17—Comparison of HFS MCO Performance for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)*

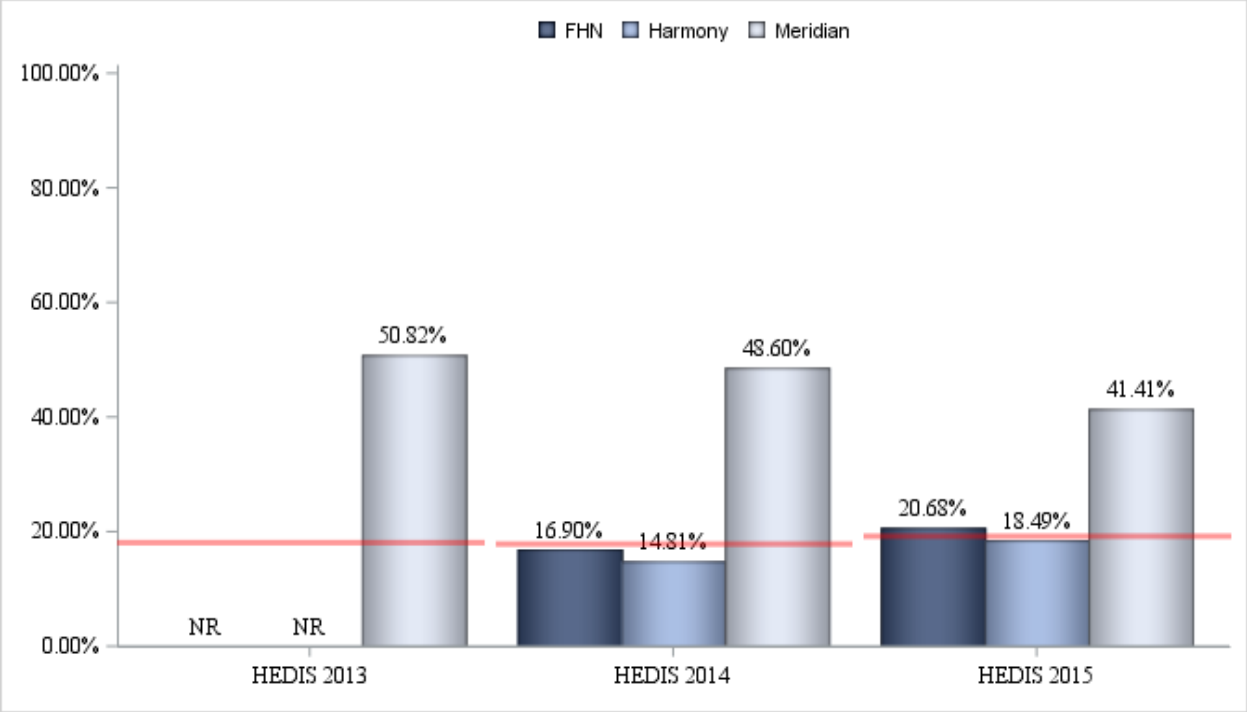


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates scored at or above the respective Quality Compass 50th percentiles each year. **FHN**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates steadily increased, but they remained below the Quality Compass 50th percentiles each year. **Harmony**'s rate improved by nearly 24 percentage points from HEDIS 2013 to HEDIS 2015, but it remained below the 2014 Quality Compass 50th percentile.

Human Papillomavirus Vaccine for Female Adolescents

Figure 4-18 presents comparative rates for *Human Papillomavirus Vaccine for Female Adolescents*.

Figure 4-18—Comparison of HFS MCO Performance for *Human Papillomavirus Vaccine for Female Adolescents*



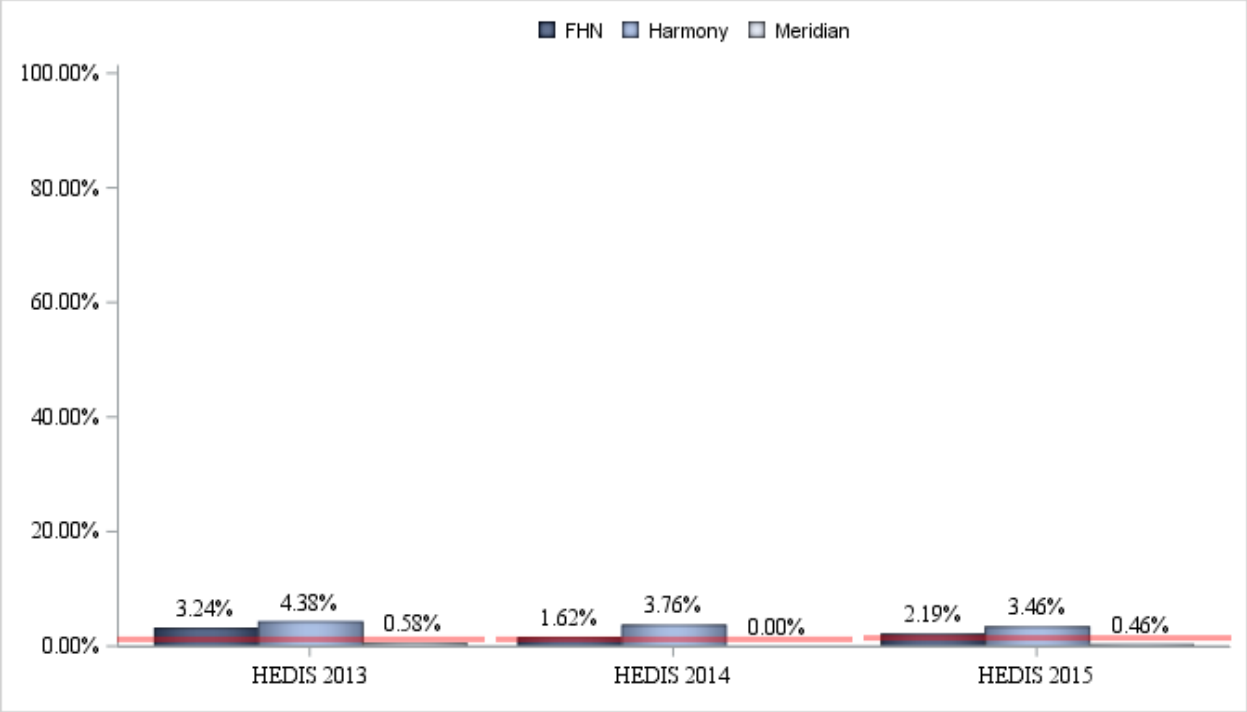
Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles. **FHN** and **Harmony**'s HEDIS 2013 rates were deemed NR. Both **FHN** and **Harmony** improved performance from HEDIS 2014 to HEDIS 2015. **FHN**'s HEDIS 2015 rate scored at or above the 2014 Quality Compass 50th percentile, while **Harmony**'s HEDIS 2015 rate remained below the 2014 Quality Compass 50th percentile.

Well-Child Visits in the First 15 Months of Life

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

Figure 4-19 presents comparative rates for *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*. **For this measure, a lower rate indicates better performance**.

Figure 4-19—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—No Well-Child Visits*

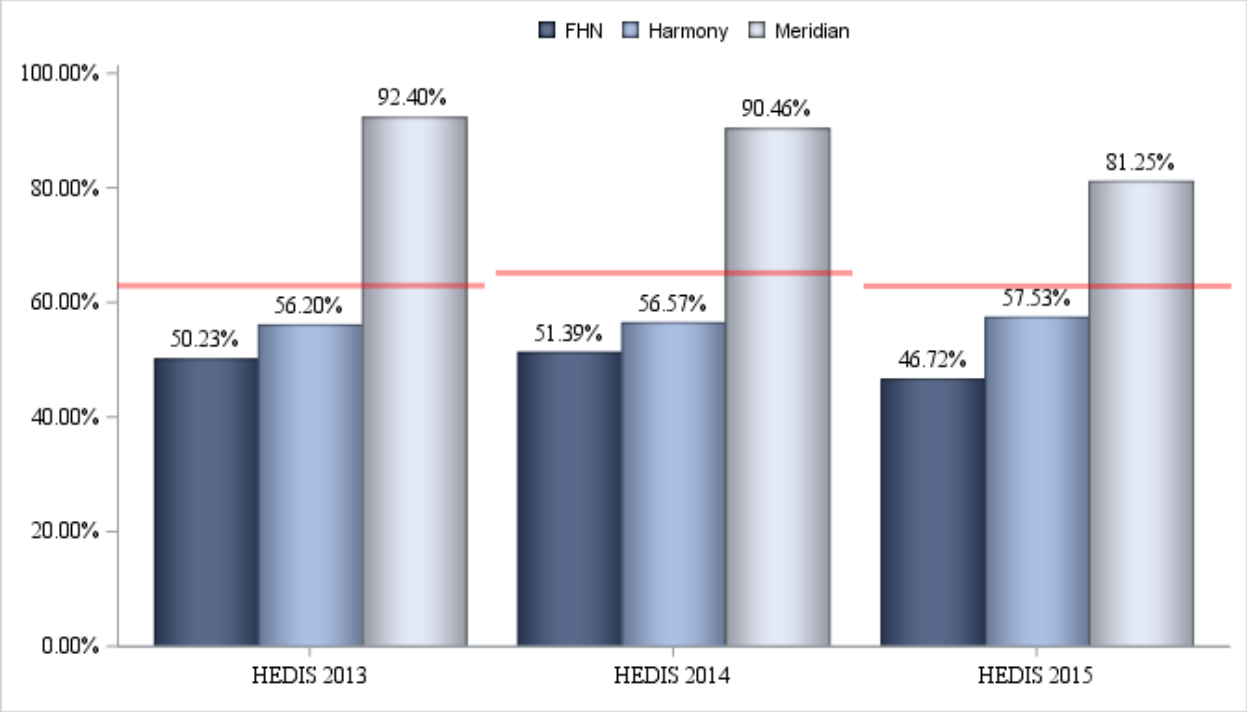


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates scored more favorably than the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates were at or better than the Quality Compass 50th percentiles each year. Both **FHN** and **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were worse than the Quality Compass 50th percentiles.

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

Figure 4-20 presents comparative rates for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*.

Figure 4-20—Comparison of HFS MCO Performance for *Well-Child Visits During the First 15 Months of Life—Six or More Well-Child Visits*

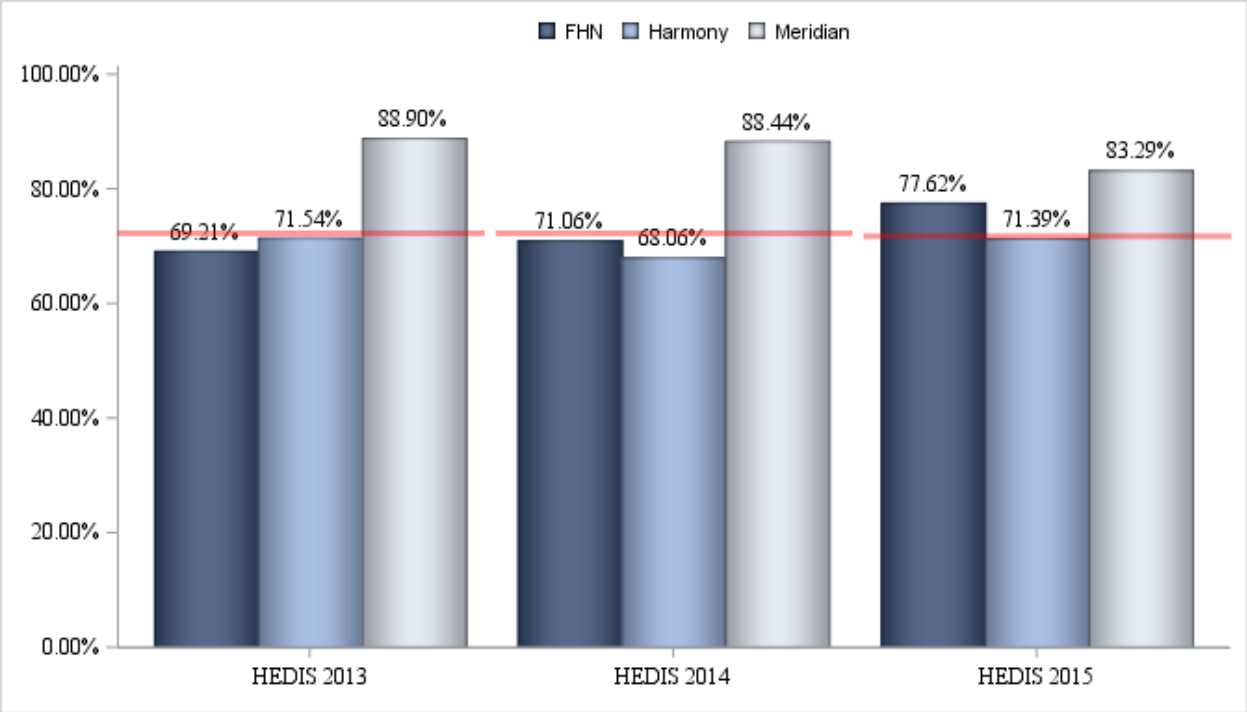


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates exceeded the Quality Compass 50th percentiles each year. **FHN**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and the rates for each year fell below the Quality Compass 50th percentiles. **Harmony**'s rates also remained similar from HEDIS 2013 to HEDIS 2015, and the rates for each year also fell below the Quality Compass 50th percentiles.

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

Figure 4-21 presents comparative rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

Figure 4-21—Comparison of HFS MCO Performance for *Well-Child Visits During the Third, Fourth, Fifth, and Sixth Years of Life*

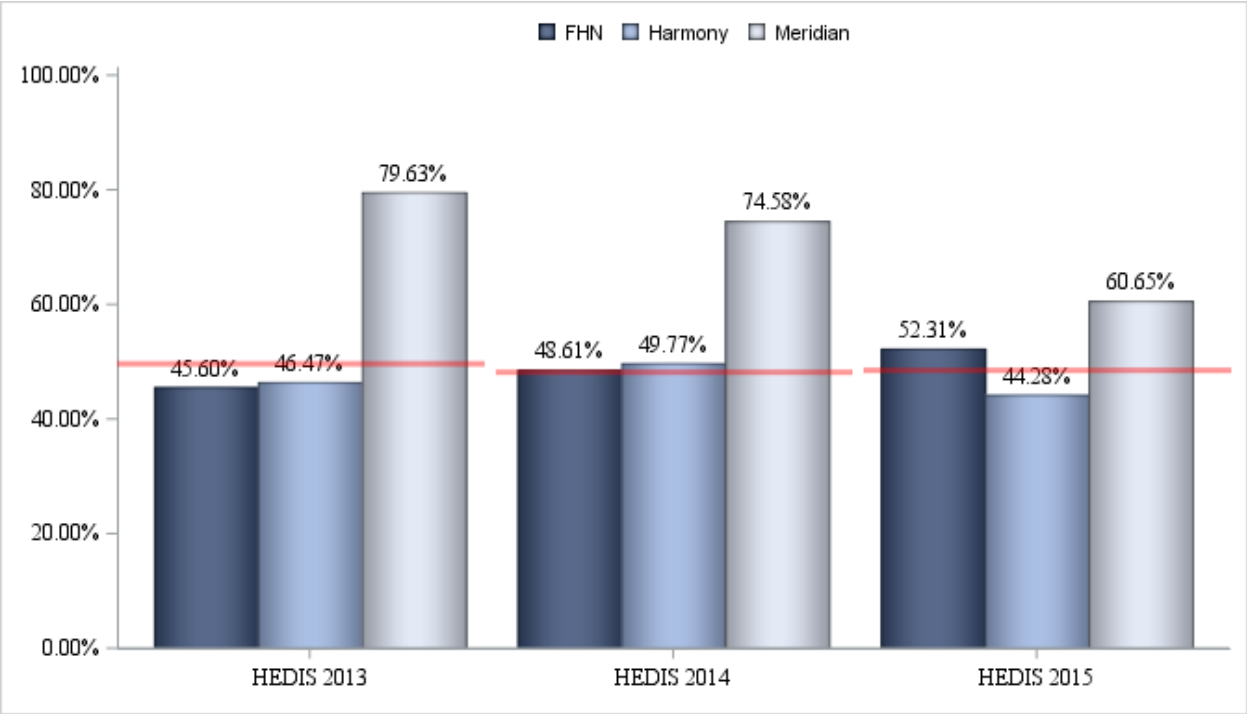


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates were at or above the Quality Compass 50th percentiles each year. **FHN**'s rates remained similar between HEDIS 2013 to HEDIS 2014, but the HEDIS 2015 rates were at or above the 2014 Quality Compass 50th percentile. **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates remained similar and fell below the Quality Compass 50th percentiles each year.

Adolescent Well-Care Visits

Figure 4-22 presents comparative rates for *Adolescent Well-Care Visits*.

Figure 4-22—Comparison of HFS MCO Performance for *Adolescent Well-Care Visits*

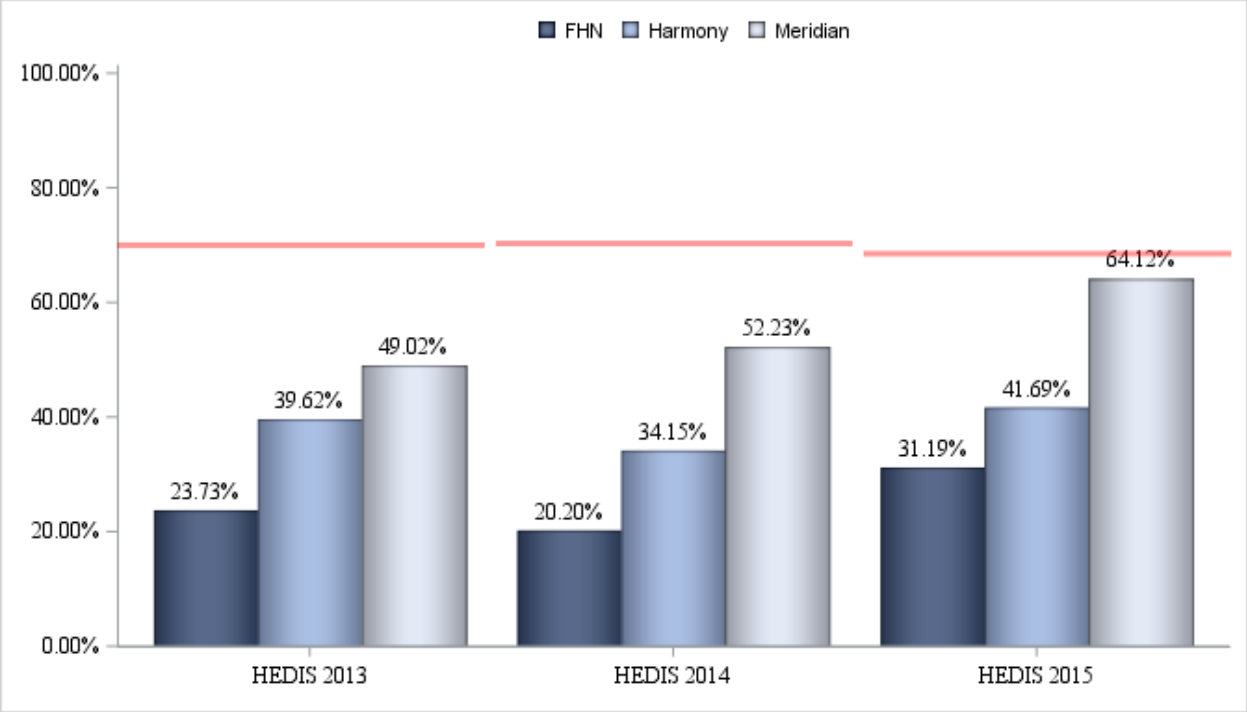


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles each year. Although **Harmony**'s HEDIS 2014 rate improved to be at or above the 2013 Quality Compass 50th percentile, the HEDIS 2015 rate declined and fell below the 2014 Quality Compass 50th percentile. **FHN**'s HEDIS 2013 to HEDIS 2015 rates steadily increased to be at or above the Quality Compass 50th percentiles for HEDIS 2014 and HEDIS 2015.

Appropriate Testing for Children With Pharyngitis

Figure 4-23 presents comparative rates for *Appropriate Testing for Children With Pharyngitis*.

Figure 4-23—Comparison of HFS MCO Performance for *Appropriate Testing for Children With Pharyngitis*



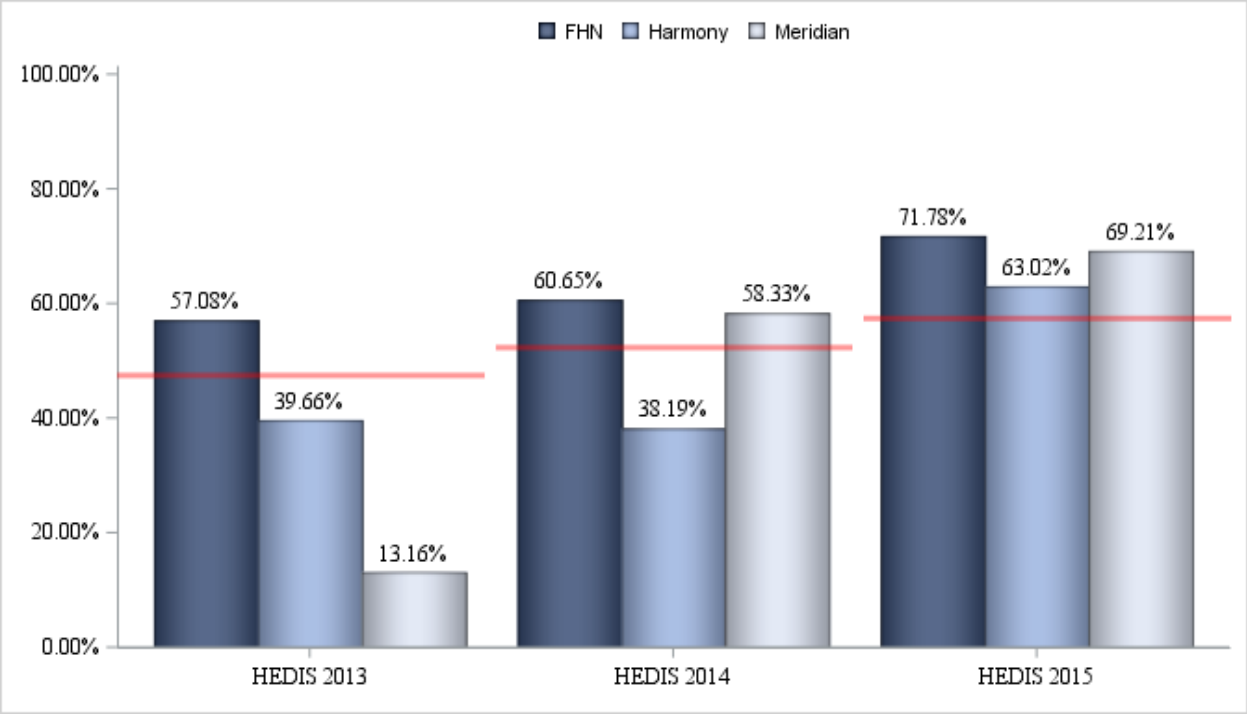
Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**. However, HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates for all three MCOs fell below the respective Quality Compass 50th percentile each year. **FHN**'s rate improved by approximately 7 percentage points from HEDIS 2013 to HEDIS 2015. **Harmony**'s performance remained similar from HEDIS 2013 to HEDIS 2015. **Meridian**'s rate improved by approximately 15 percentage points from HEDIS 2013 to HEDIS 2015.

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

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

Figure 4-24 presents comparative rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total.*

Figure 4-24—Comparison of HFS MCO Performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*

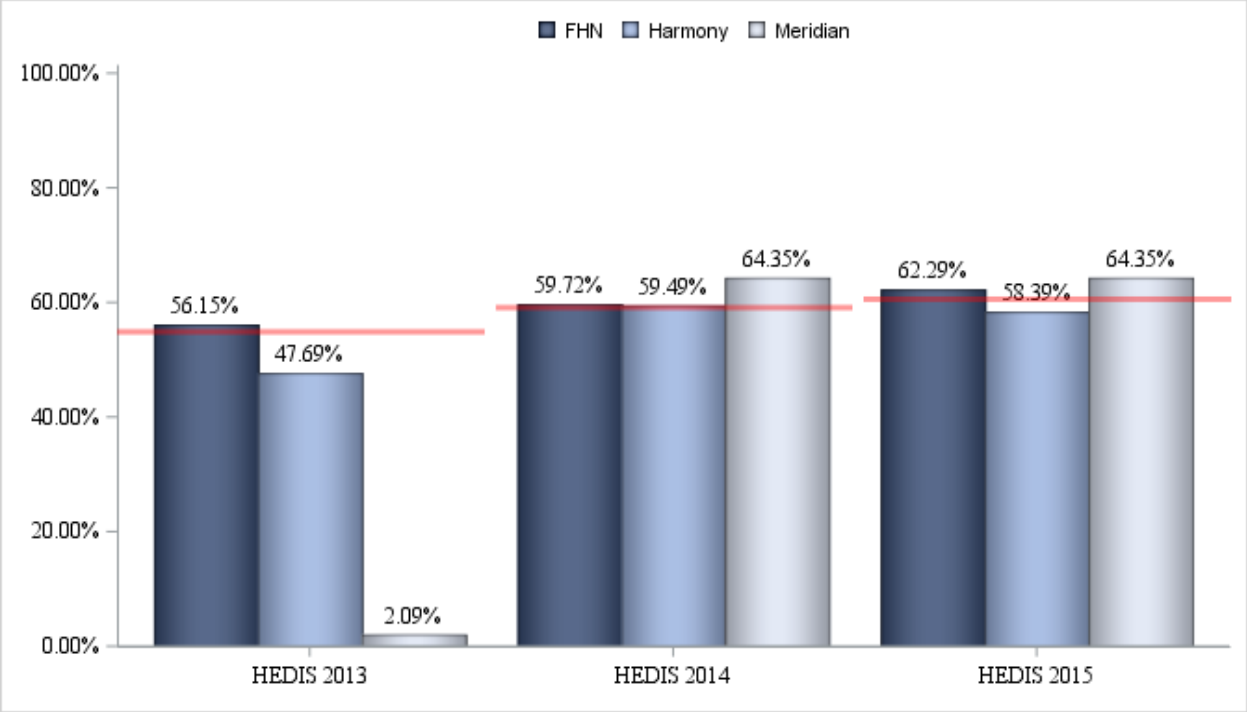


FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the respective Quality Compass 50th percentiles each year. While **Harmony**'s HEDIS 2013 and HEDIS 2014 rates remained similar and below the Quality Compass 50th percentiles, the rate increased by nearly 25 percentage points in HEDIS 2015 to be at or above the 2014 Quality Compass 50th percentile. **Meridian**'s rate increased in HEDIS 2014 and again in HEDIS 2015 by a total of approximately 56 percentage points. However, the increase in **Meridian**'s HEDIS 2014 rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. Both **Meridian**'s HEDIS 2014 and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles.

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

Figure 4-25 presents comparative rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*.

Figure 4-25—Comparison of HFS MCO Performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

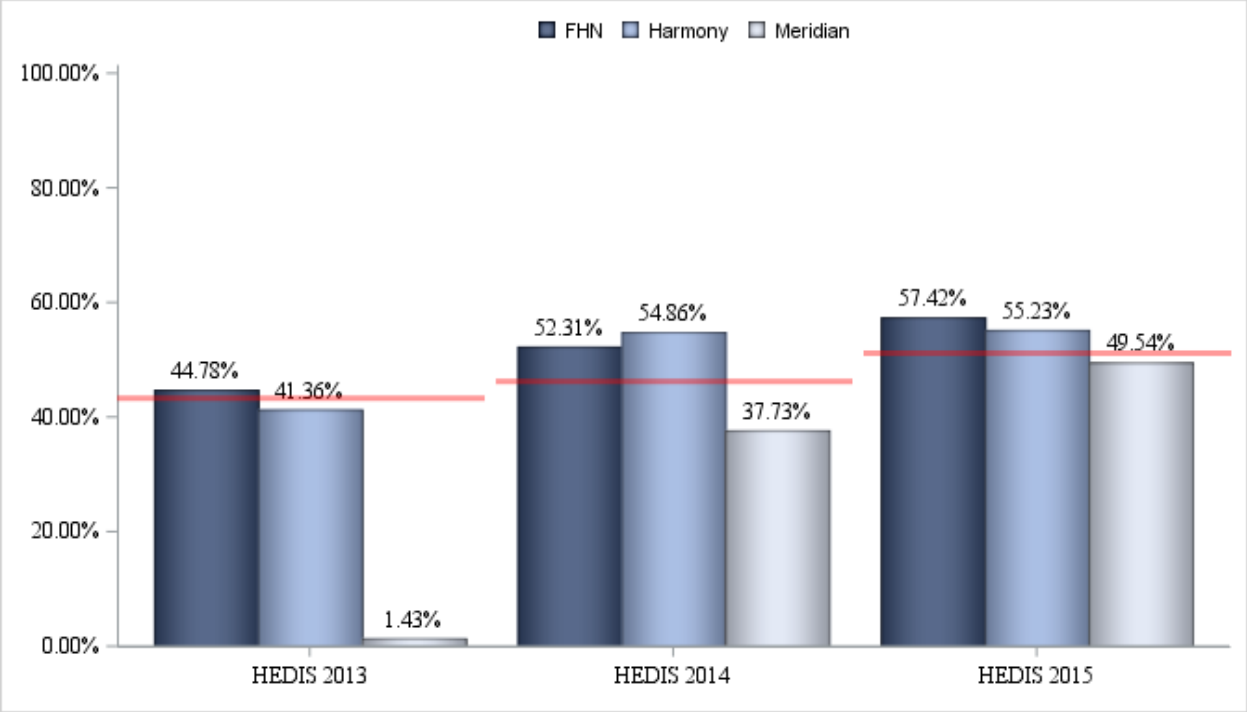


FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the respective Quality Compass 50th percentiles each year. Although **Harmony**'s HEDIS 2014 rate improved by nearly 12 percentage points, scoring at or above the 2013 Quality Compass 50th percentile, **Harmony**'s HEDIS 2015 rate decreased slightly and fell below the 2014 Quality Compass 50th percentile. **Meridian**'s HEDIS 2013 rate increased by 62 percentage points in HEDIS 2014, although the increase is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. **Meridian**'s HEDIS 2014 and HEDIS 2015 remained similar, and both rates were at or above the Quality Compass 50th percentiles.

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

Figure 4-26 presents comparative rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*.

Figure 4-26—Comparison of HFS MCO Performance for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*



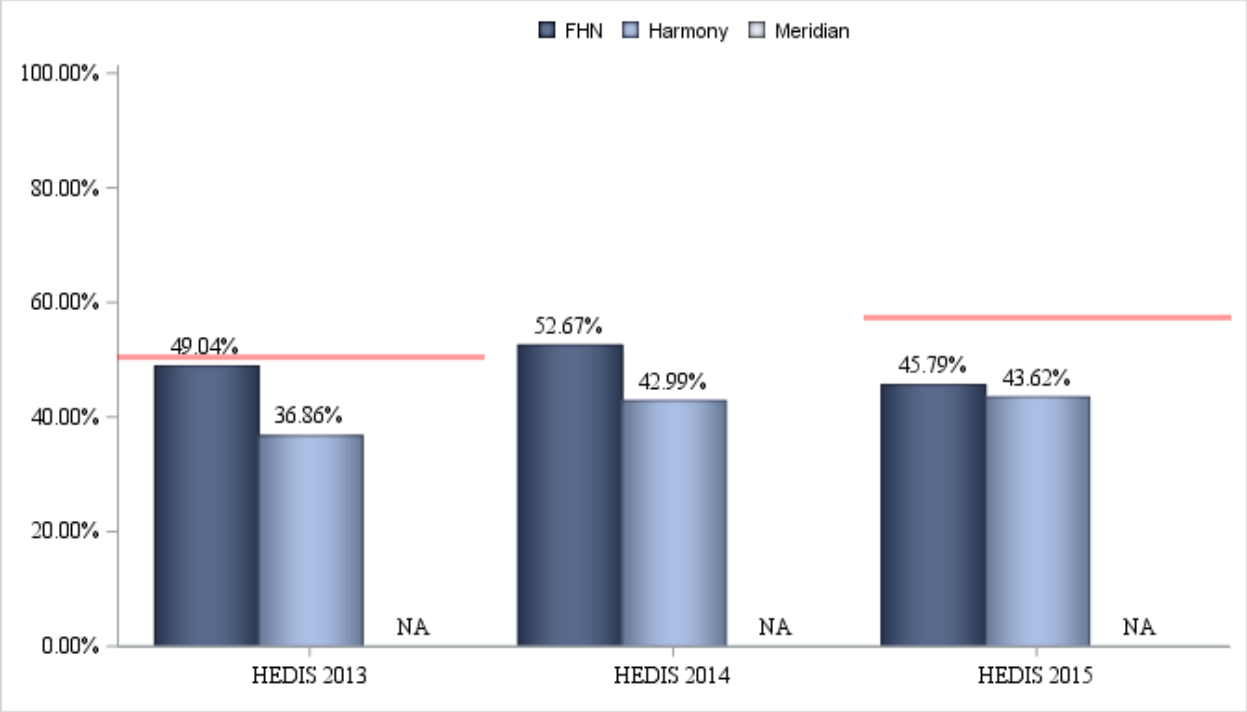
FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles. **Harmony**'s HEDIS 2013 rate steadily increased in HEDIS 2014 and HEDIS 2015 to be at or above the Quality Compass 50th percentiles. **Meridian**'s HEDIS 2013 rate increased by 36 percentage points in HEDIS 2014, although the increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. Although **Meridian**'s rates increased from HEDIS 2013 to HEDIS 2015, the rates for each year remained below the Quality Compass 50th percentiles.

Women's Health

Breast Cancer Screening

Figure 4-27 presents comparative rates for *Breast Cancer Screening*. Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 4-27—Comparison of HFS MCO Performance for *Breast Cancer Screening*

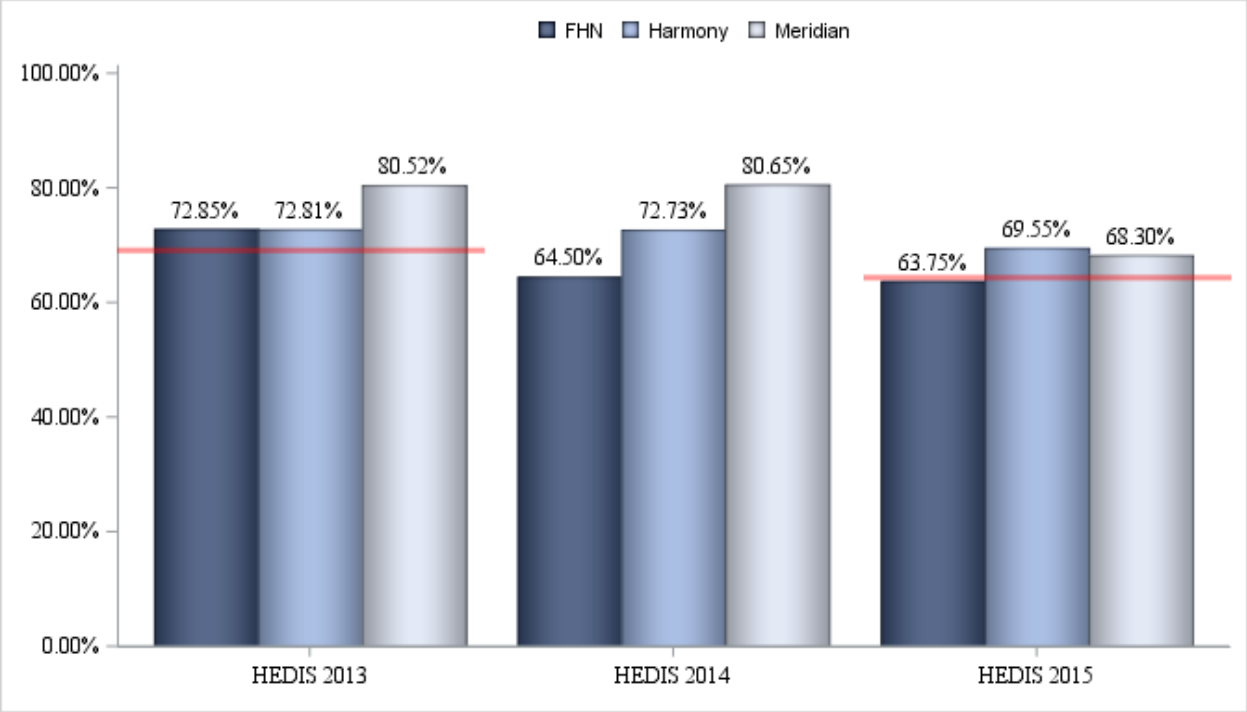


FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **Harmony**. **Harmony**'s rates steadily increased from HEDIS 2013 to HEDIS 2015, but they remained below the Quality Compass 50th percentiles, where applicable. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30.

Cervical Cancer Screening

Figure 4-28 presents comparative rates for *Cervical Cancer Screening*. Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 4-28—Comparison of HFS MCO Performance for *Cervical Cancer Screening*



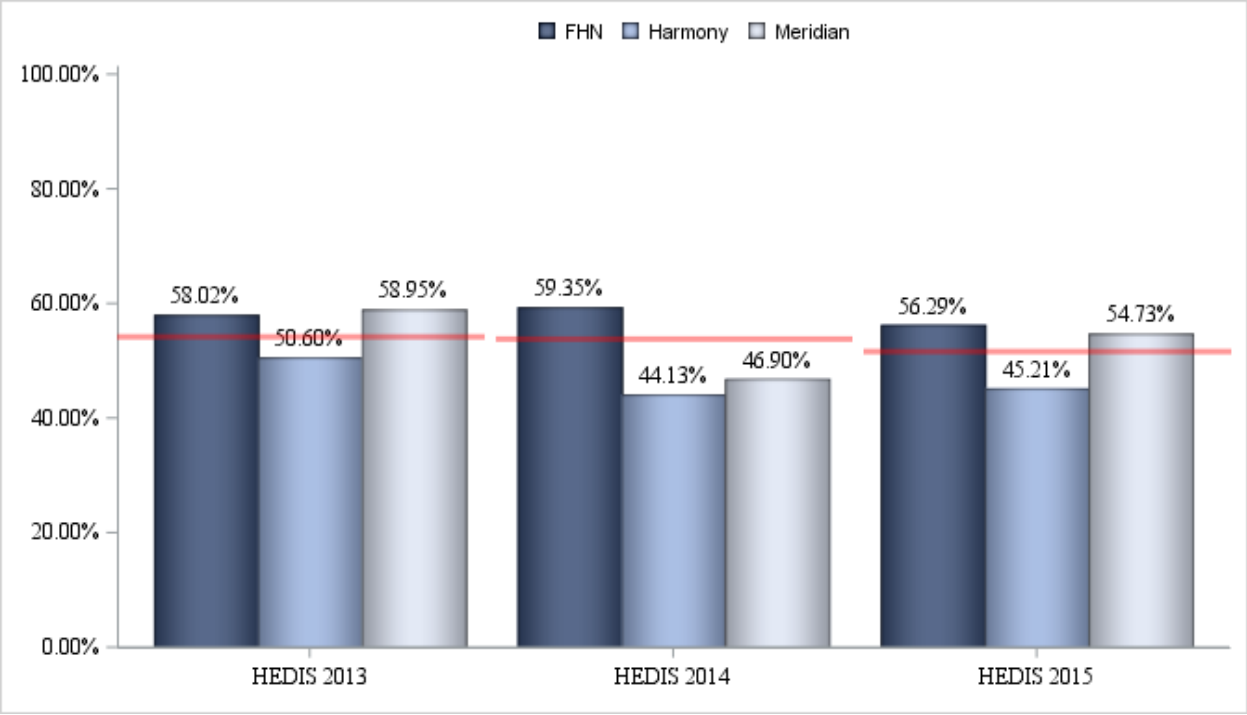
FHN's rates decreased from HEDIS 2013, where the rate was at or above the 2012 Quality Compass 50th percentile, to HEDIS 2015, where the rate fell below the 2014 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, with the HEDIS 2013 and HEDIS 2015 rates scoring at or above the Quality Compass 50th percentiles. **Meridian**'s HEDIS 2013 and HEDIS 2014 rates remained similar, while the HEDIS 2015 rate declined but still remained at or above the 2014 Quality Compass 50th percentile.

Chlamydia Screening in Women

Chlamydia Screening in Women—16–20 Years

Figure 4-29 presents comparative rates for *Chlamydia Screening in Women—16–20 Years.* Given the relatively low population for this measure, caution should be used when comparing results across MCOs.

Figure 4-29—Comparison of HFS MCO Performance for *Chlamydia Screening in Women—16–20 Years*

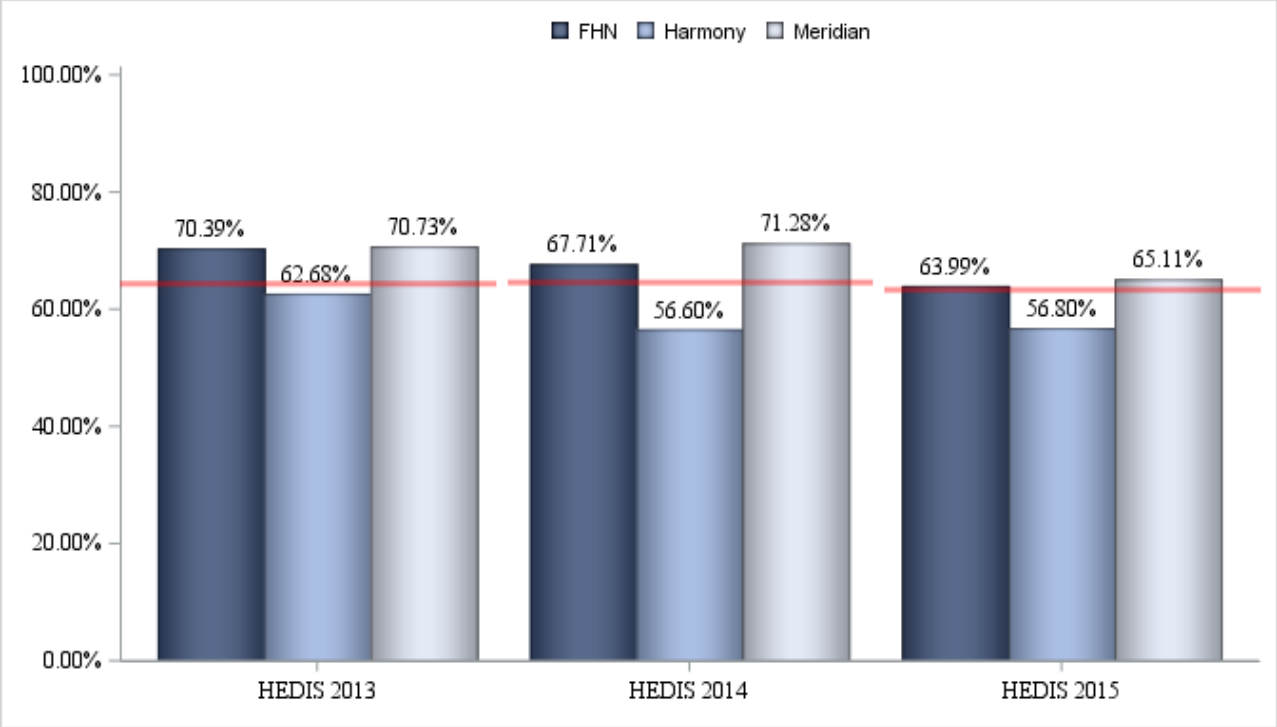


FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles each year. **Harmony**'s rates decreased by more than 6 percentage points from HEDIS 2013 to HEDIS 2014, increased slightly in HEDIS 2015, but remained below the Quality Compass 50th percentiles each year. **Meridian**'s HEDIS 2013 rate, which was at or above the 2012 Quality Compass 50th percentile, declined by approximately 12 percentage points in HEDIS 2014, where the rate fell below the 2013 Quality Compass 50th percentile. However, **Meridian**'s HEDIS 2015 increased by approximately 8 percentage points, scoring at or above the 2014 Quality Compass 50th percentile.

Chlamydia Screening in Women—21–24 Years

Figure 4-30 presents comparative rates for *Chlamydia Screening in Women—21–24 Years.*

Figure 4-30—Comparison of HFS MCO Performance for *Chlamydia Screening in Women—21–24 Years*

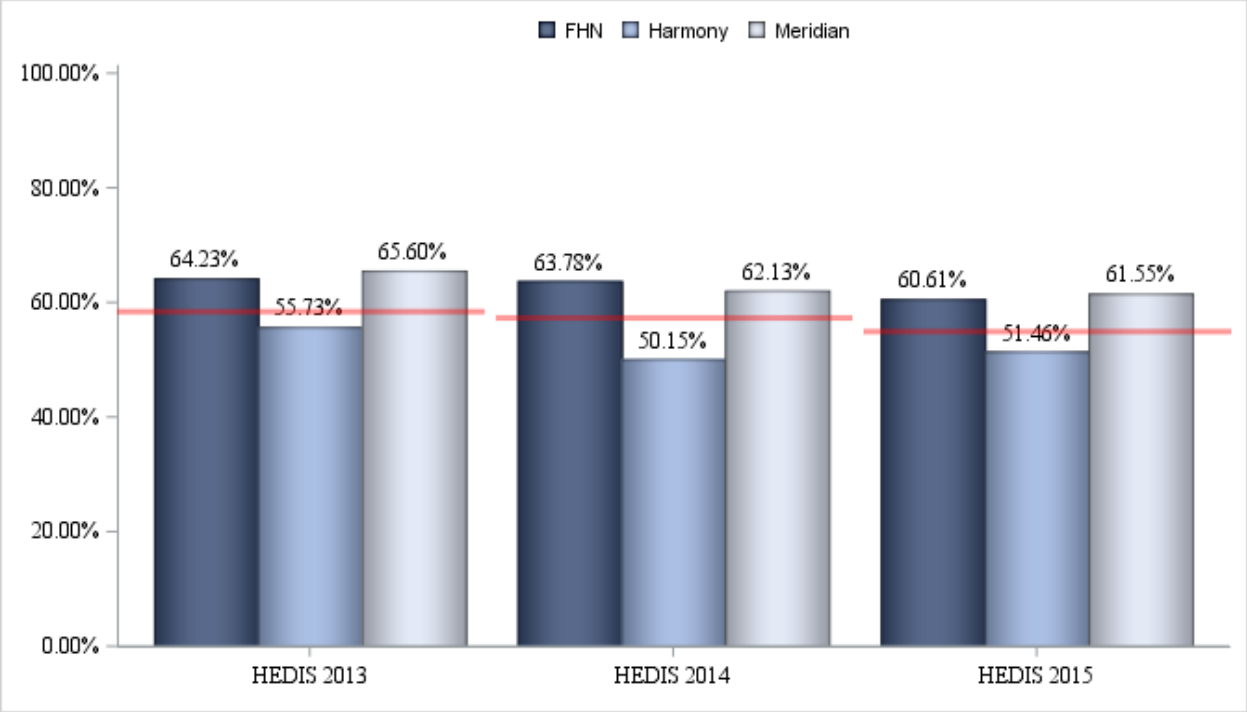


FHN's and **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles each year. **Harmony**'s HEDIS 2014 rate declined from HEDIS 2013, and remained similar in HEDIS 2015, with the rates from each year falling below the Quality Compass 50th percentiles.

Chlamydia Screening in Women—Total

Figure 4-31 presents comparative rates for *Chlamydia Screening in Women—Total.*

Figure 4-31—Comparison of HFS MCO Performance for *Chlamydia Screening in Women—Total*



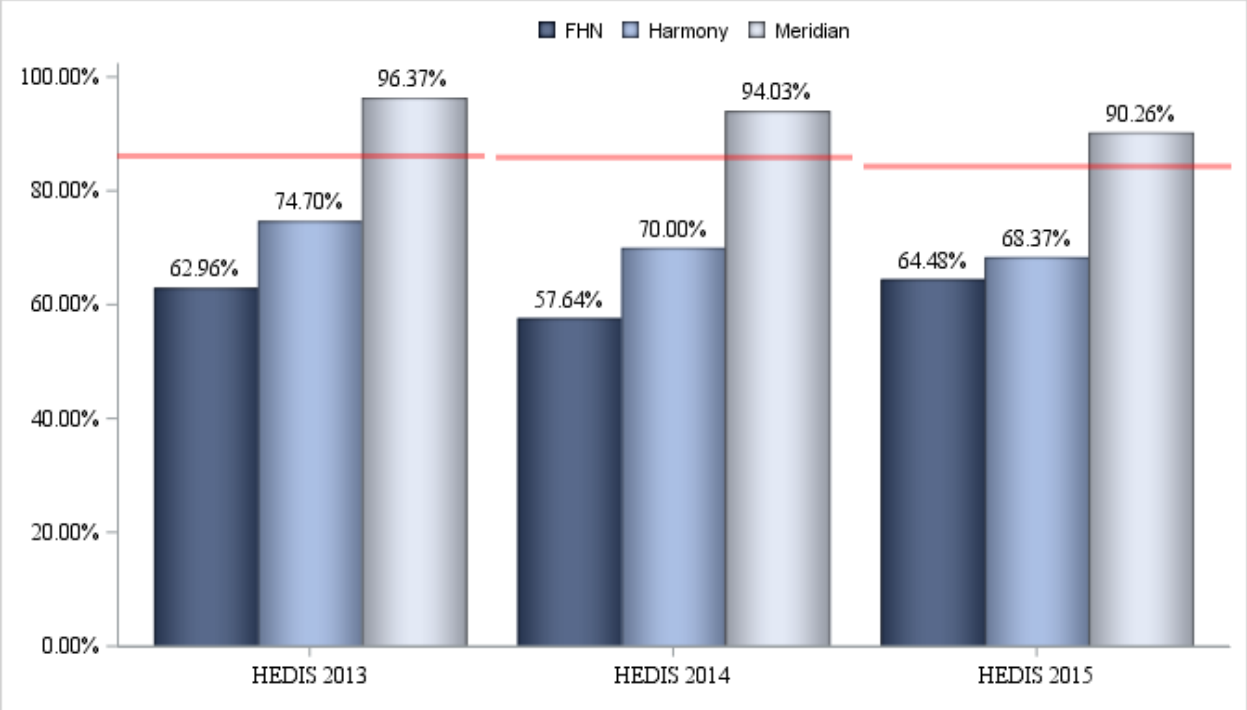
FHN and **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles each year. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and the rates fell below the Quality Compass 50th percentiles each year.

Prenatal and Postpartum Care

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Figure 4-32 presents comparative rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

Figure 4-32—Comparison of HFS MCO Performance for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

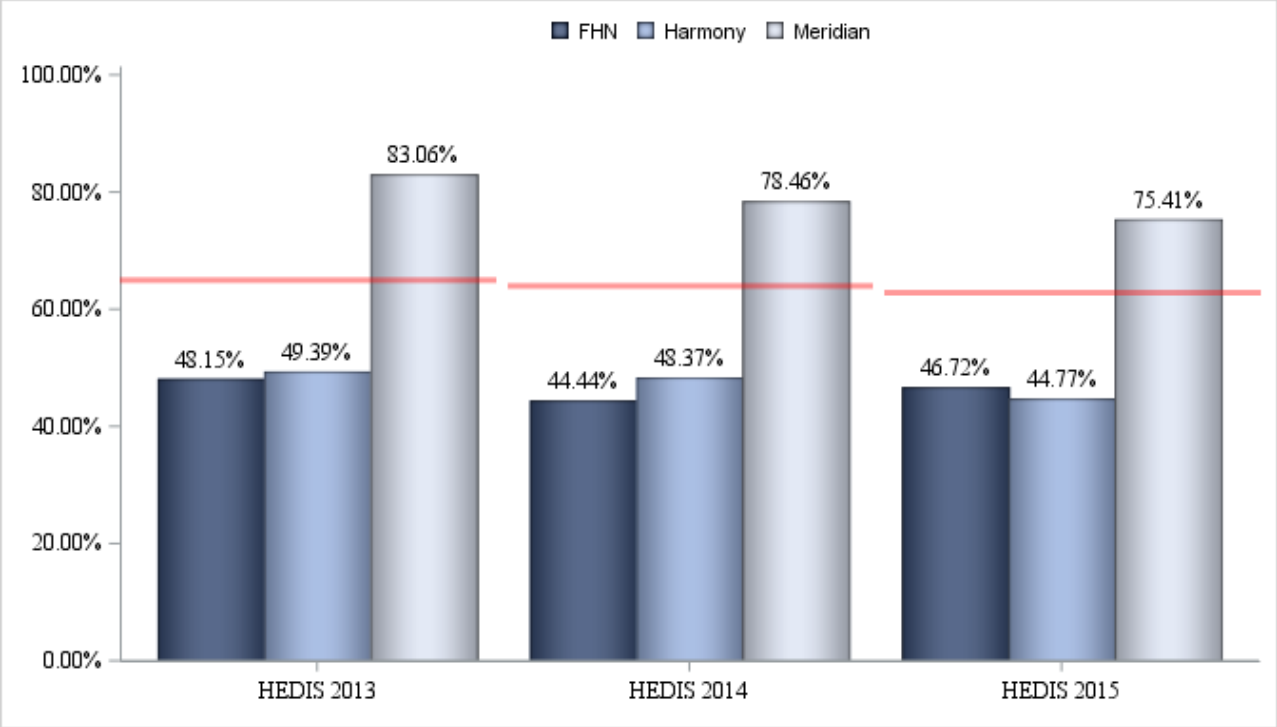


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates were at or above the respective Quality Compass 50th percentiles each year. **Harmony**'s rates steadily declined from HEDIS 2013 to HEDIS 2015 rates, with the rates below the Quality Compass 50th percentiles each year. **FHN**'s rates decreased from HEDIS 2013 to HEDIS 2014, increased by nearly 7 percentage points in HEDIS 2015, but the rates remained below the Quality Compass 50th percentiles.

Prenatal and Postpartum Care—Postpartum Care

Figure 4-33 presents comparative rates for *Prenatal and Postpartum Care—Postpartum Care*.

Figure 4-33—Comparison of HFS MCO Performance for *Prenatal and Postpartum Care—Postpartum Care*



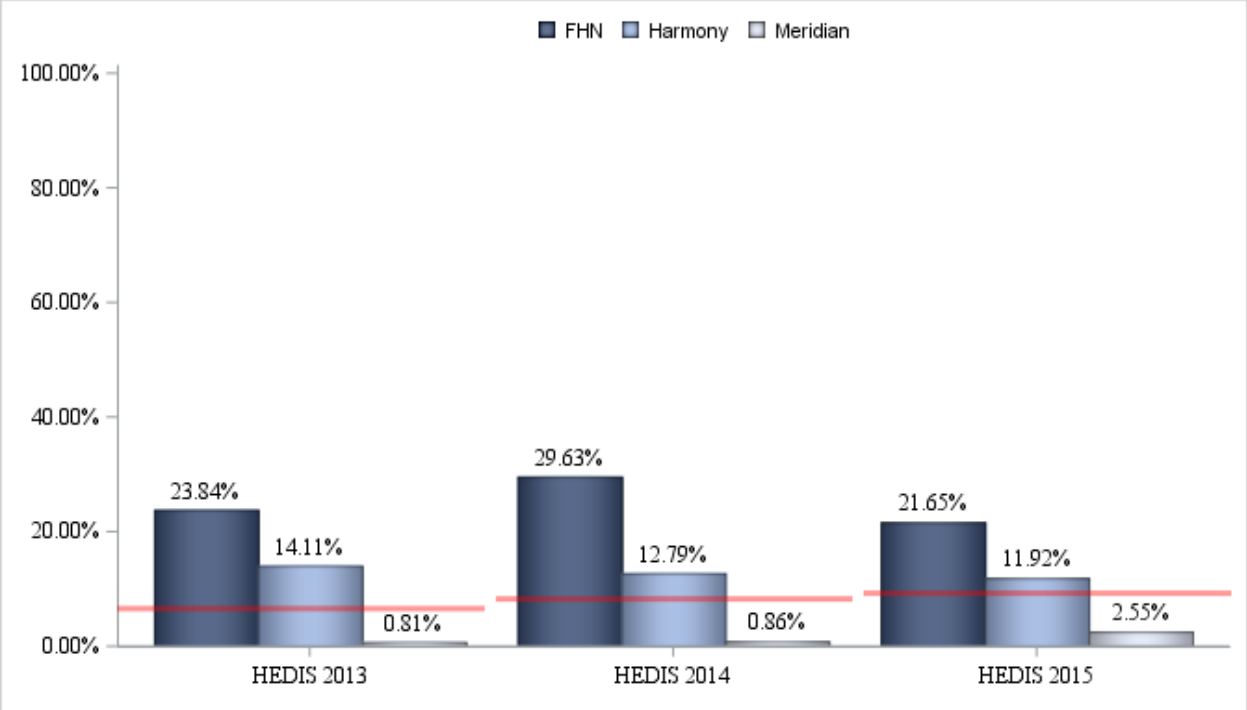
As with the previous measure, **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates were at or above the respective Quality Compass 50th percentiles each year. **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates remained similar, and were below the Quality Compass 50th percentiles. **FHN**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates also remained similar, and fell below the Quality Compass 50th percentiles as well.

Frequency of Ongoing Prenatal Care

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

Figure 4-34 presents comparative rates for *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*. **For this measure, a lower rate indicates better performance**.

Figure 4-34—Comparison of HFS MCO Performance for *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*

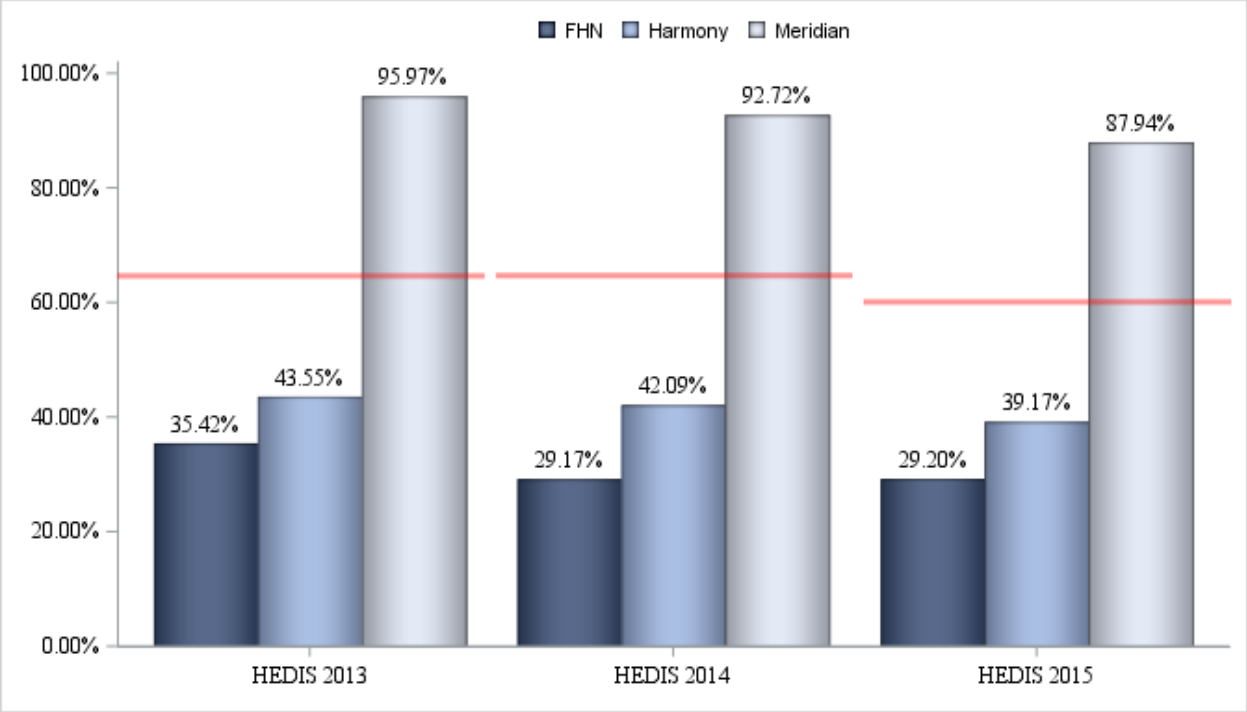


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored more favorably than the rates reported by **FHN** and **Harmony**, and **Meridian**'s rates were below the respective Quality Compass 50th percentiles each year, indicating high performance. Although the performance for **FHN** worsened by nearly 6 percentage points from HEDIS 2013 to HEDIS 2014, the performance improved in HEDIS 2015 by nearly 8 percentage points. However, **FHN**'s rates all fell short of the Quality Compass 50th percentiles. **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates remained similar and fell short of the Quality Compass 50th percentiles each year.

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

Figure 4-35 presents comparative rates for *Frequency of Ongoing Prenatal Care—≥81Percent of Expected Visits.* **In contrast to the previous measure, higher rates are better for this measure.** However, this measure uses the same eligible population as *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits.*

Figure 4-35—Comparison of HFS MCO Performance for *Frequency of Ongoing Prenatal Care—≥81Percent of Expected Visits*



Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates consistently scored above the rates reported by **FHN** and **Harmony**, more than doubling **FHN**'s and **Harmony**'s rates each year. Most notably, **Meridian**'s HEDIS 2013 rate exceeded the 2012 Quality Compass 50th percentile by approximately 31 percentage points. **FHN**'s rate declined by more than 6 percentage points from HEDIS 2013 to HEDIS 2014, and remained similar in HEDIS 2015. Each year, **FHN**'s rates fell below the Quality Compass 50th percentiles. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, and also fell below the Quality Compass 50th percentiles each year.

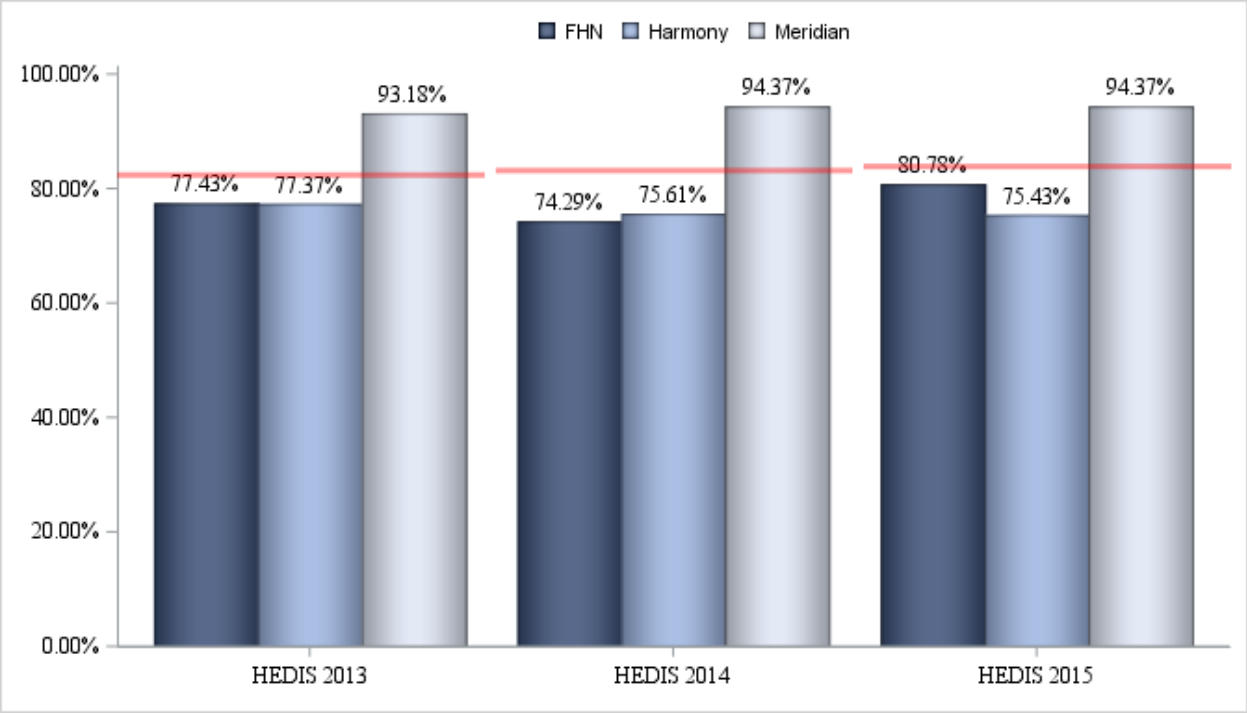
Care for Chronic Conditions

Comprehensive Diabetes Care

Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing

Figure 4-36 presents comparative rates for *Comprehensive Diabetes Care—HbA1c Testing*.

Figure 4-36—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Testing*

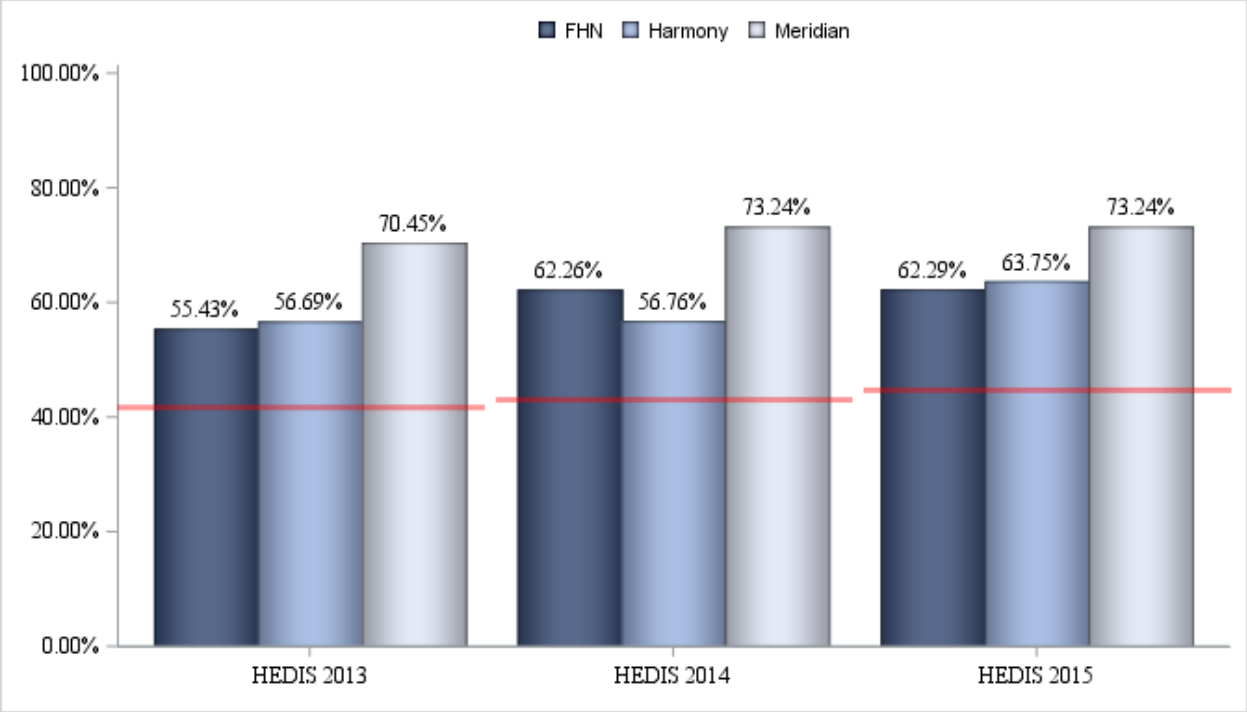


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates scored above the rates reported by **FHN** and **Harmony** each year and consistently scored at or above the respective Quality Compass 50th percentile each year. While **FHN**'s rate decreased in HEDIS 2014, the HEDIS 2015 rate increased by more than 6 percentage points. **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 remained similar. Both **FHN**'s and **Harmony**'s rates from HEDIS 2013 to HEDIS 2015 fell below the respective Quality Compass 50th percentiles.

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

Figure 4-37 presents comparative rates for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*. **For this measure, a lower rate indicates better performance**.

Figure 4-37—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*

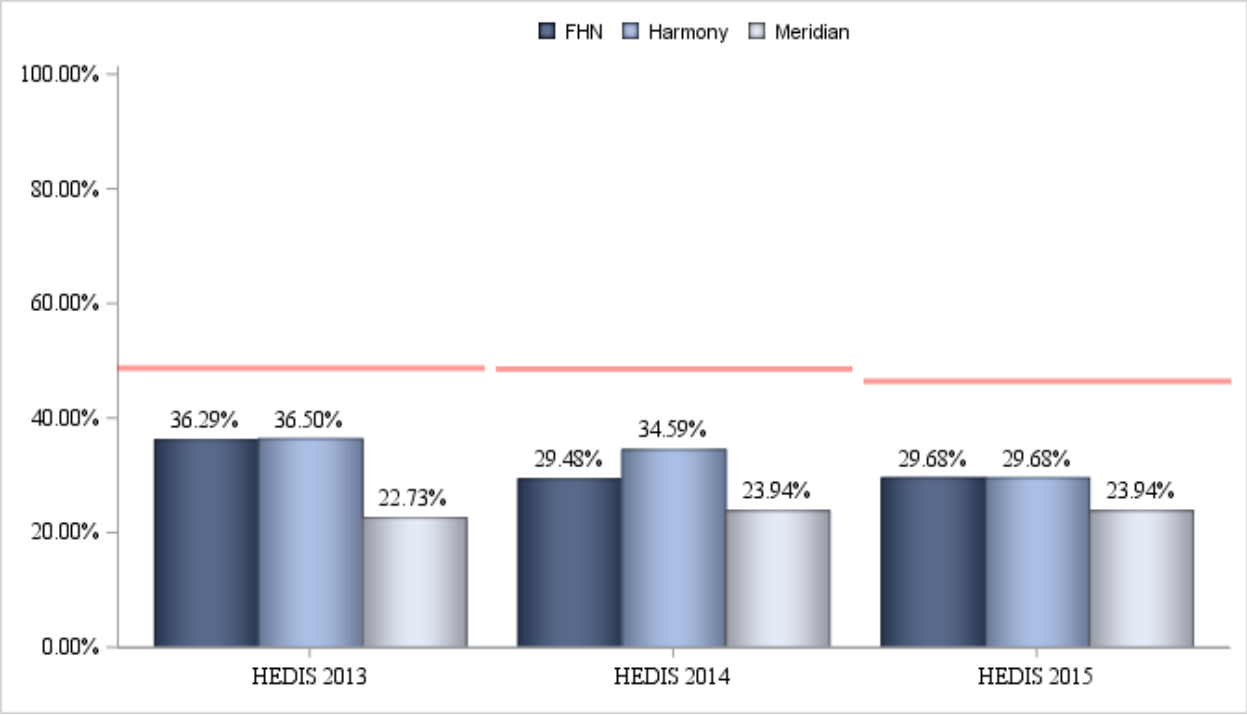


HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates for all three MCOs failed to meet the 2012, 2013, and 2014 Quality Compass 50th percentiles, respectively. In HEDIS 2015, **FHN**, **Harmony**, and **Meridian**'s rates were 18, 19, and 29 percentage points, respectively, above the 2014 Quality Compass 50th percentile, indicating poor performance for all three MCOs. **FHN** and **Harmony** performed better than **Meridian** in all three years.

Comprehensive Diabetes Care—HbA1c Control (<8.0%)

Figure 4-38 presents comparative rates for *Comprehensive Diabetes Care—HbA1c Control (<8.0%).*

Figure 4-38—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*

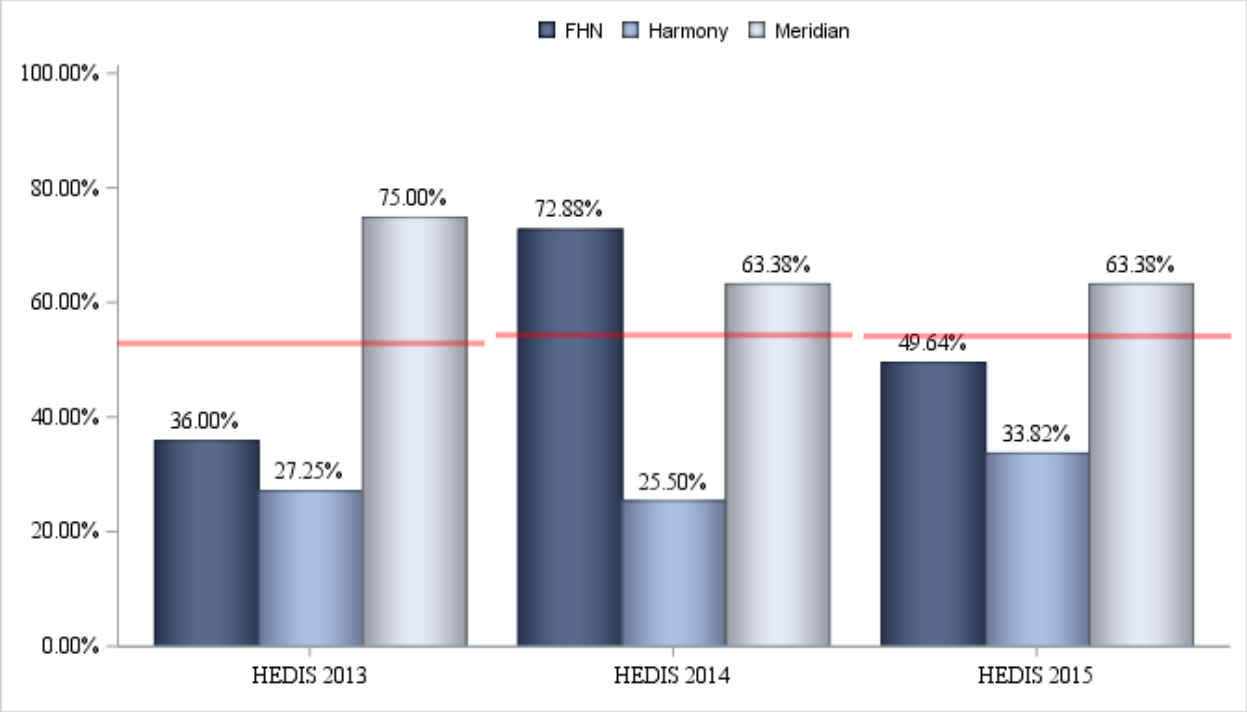


As with the previous measure, HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates for all three MCOs failed to meet the 2012, 2013, and 2014 Quality Compass 50th percentiles, respectively. **FHN**'s rates declined from HEDIS 2013 to HEDIS 2014 by 7 percentage points and remained similar from HEDIS 2014 to HEDIS 2015. **Harmony**'s HEDIS 2013 rate remained similar for HEDIS 2014, but declined in HEDIS 2015. **Meridian**'s rates from HEDIS 2013 to HEDIS 2015 remained similar, and they were below the rates reported by **FHN** and **Harmony** in all three years.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Figure 4-39 presents comparative rates for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*.

Figure 4-39—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

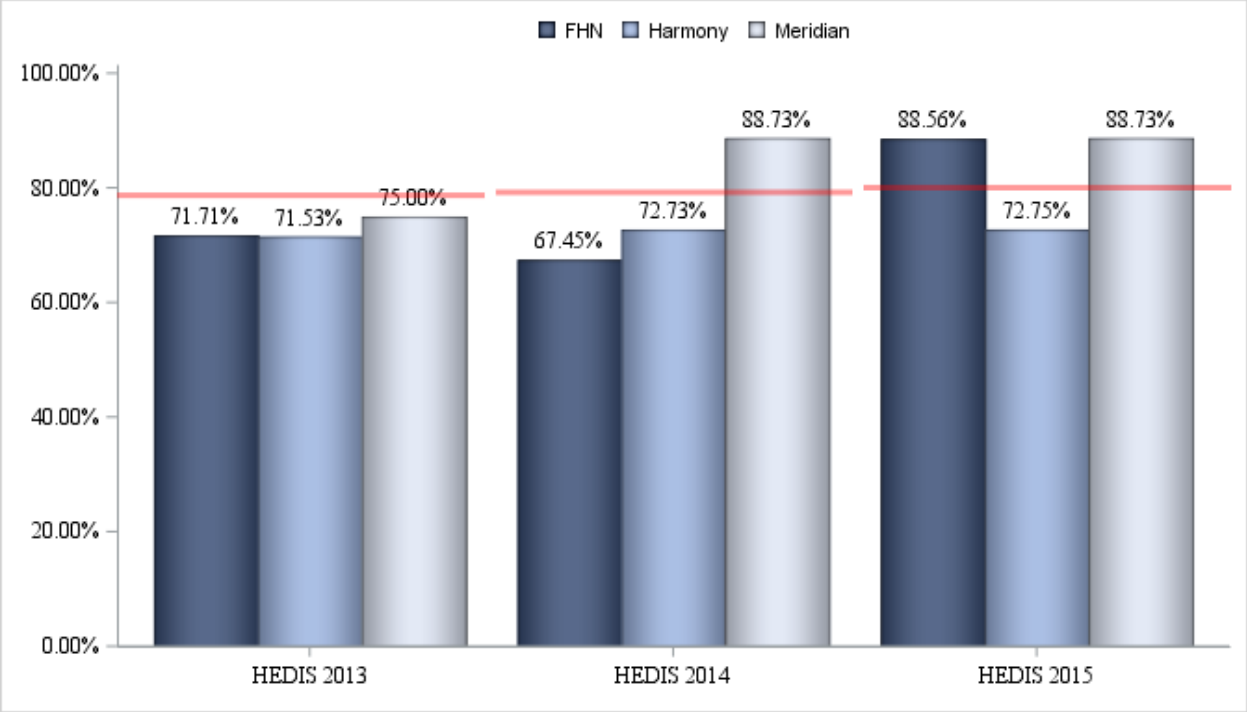


Meridian's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were at or above the Quality Compass 50th percentiles each year. **FHN**'s rate improved by nearly 37 percentage points in HEDIS 2014, scoring at or above the 2013 Quality Compass 50th percentile. However, in HEDIS 2015, the rate declined by approximately 23 percentage points, falling below the 2014 Quality Compass 50th percentile. Although **Harmony**'s rate decreased in HEDIS 2014, the HEDIS 2015 rate increased by more than 8 percentage points. However, all of **Harmony**'s rates fell below the Quality Compass 50th percentiles.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

Figure 4-40 presents comparative rates for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*.

Figure 4-40—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

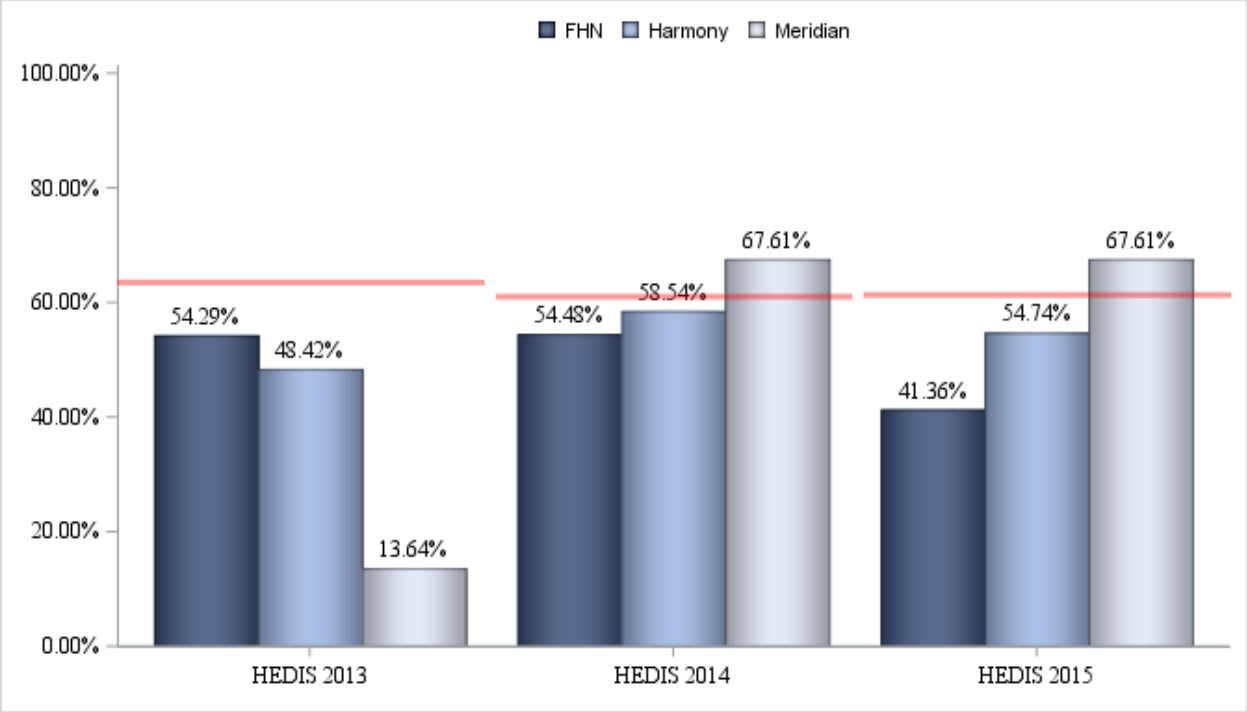


In HEDIS 2013, all three MCO rates fell below the Quality Compass 50th percentiles. **FHN**'s HEDIS 2014 rate also fell below the 2013 Quality Compass 50th percentile, then increased by 21 percentage points in HEDIS 2015, scoring at or above the 2014 Quality Compass 50th percentile. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, falling below the Quality Compass 50th percentiles each year. **Meridian**'s HEDIS 2014 and HEDIS 2015 rates remained similar, and scored at or above the Quality Compass 50th percentiles.

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

Figure 4-41 presents comparative rates for *Comprehensive Diabetes Care—BP Control (<140/90 mm Hg)*.

Figure 4-41—Comparison of HFS MCO Performance for *Comprehensive Diabetes Care—BP Control (<140/90 mm Hg)*

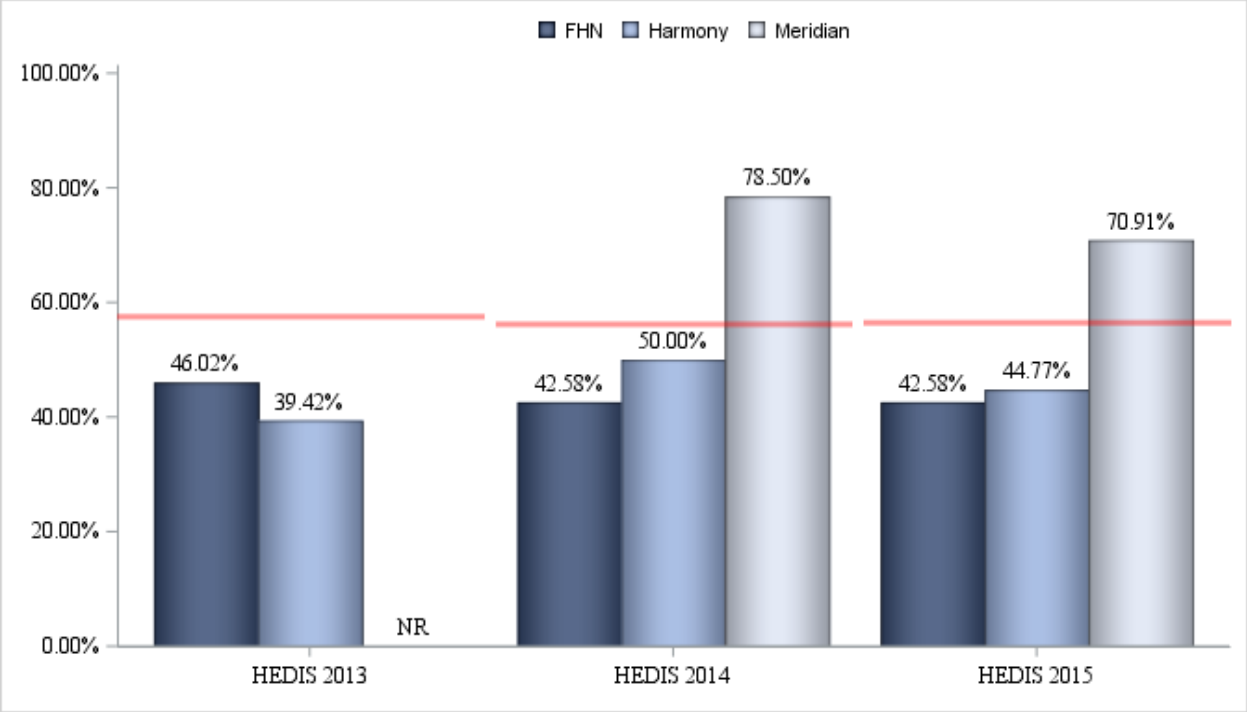


While **FHN**'s HEDIS 2013 and HEDIS 2014 rates remained similar, the HEDIS 2015 rate decreased by more than 13 percentage points. **Harmony**'s rate increased approximately 10 percentage points in HEDIS 2014 and remained similar in HEDIS 2015. From HEDIS 2013 to HEDIS 2015, **FHN** and **Harmony**'s rates fell below the Quality Compass 50th percentiles. **Meridian**'s rate increased in HEDIS 2014 by approximately 54 percentage points, scoring at or above the 2013 Quality Compass 50th percentile. However, the increase in **Meridian**'s rate is mostly due to a change in reporting rather than a change in performance, as HEDIS 2014 was the first year that **Meridian** reported this measure using the hybrid methodology. **Meridian**'s rate remained similar in HEDIS 2015, scoring at or above the 2014 Quality Compass 50th percentile.

Controlling High Blood Pressure

Figure 4-42 presents comparative rates for *Controlling High Blood Pressure*.

Figure 4-42—Comparison of HFS MCO Performance for *Controlling High Blood Pressure*



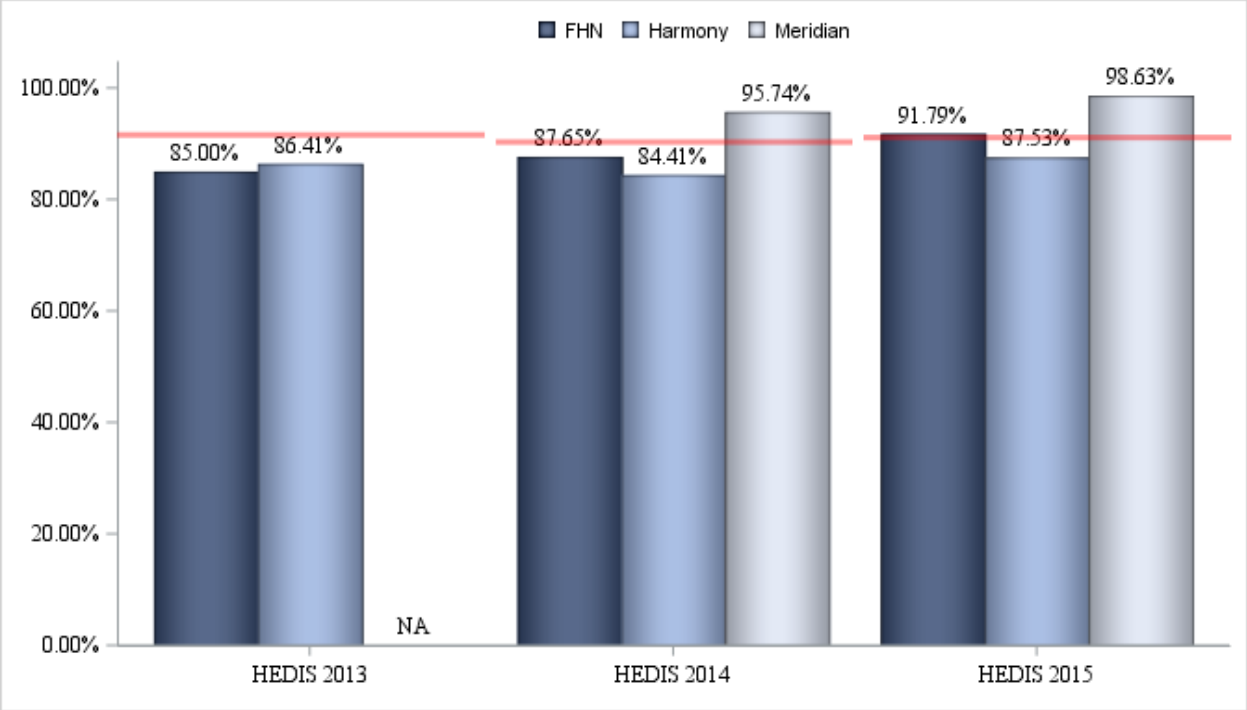
FHN's HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates remained similar, and fell below the Quality Compass 50th percentiles each year. **Harmony**'s rate increased by nearly 11 percentage points from HEDIS 2013 to HEDIS 2014, then declined in HEDIS 2015. Each year, **Harmony**'s rates fell below the Quality Compass 50th percentiles. **Meridian**'s HEDIS 2013 rate was deemed NR, but **Meridian**'s HEDIS 2014 and HEDIS 2015 rates both scored at or above the Quality Compass 50th percentiles.

Use of Appropriate Medications for People With Asthma

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

Figure 4-43 presents comparative rates for *Use of Appropriate Medications for People With Asthma—5–11 Years*.

Figure 4-43—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—5–11 Years*

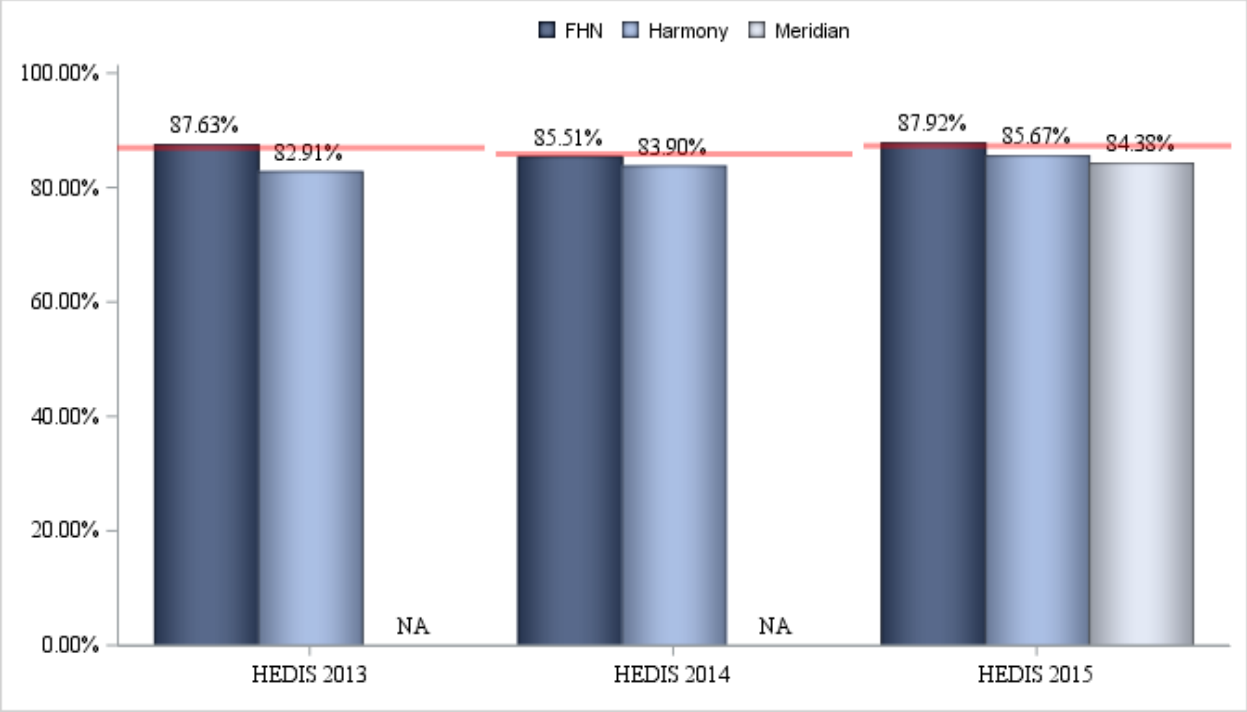


Harmony's rates remained similar from HEDIS 2013 to HEDIS 2015 and fell below the Quality Compass 50th percentiles each year. Performance steadily increased for **FHN**, starting from below the 2012 Quality Compass 50th percentile in HEDIS 2013, to scoring at or above the 2014 Quality Compass 50th percentile in HEDIS 2015. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30. **Meridian**'s HEDIS 2014 performance scored at or above the 2013 Quality Compass 50th percentile by more than 5 percentage points, and **Meridian**'s HEDIS 2015 rate scored at or above the 2014 Quality Compass 50th percentile by nearly 8 percentage points.

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

Figure 4-44 presents comparative rates for *Use of Appropriate Medications for People With Asthma—12–18 Years*.

Figure 4-44—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—12–18 Years*

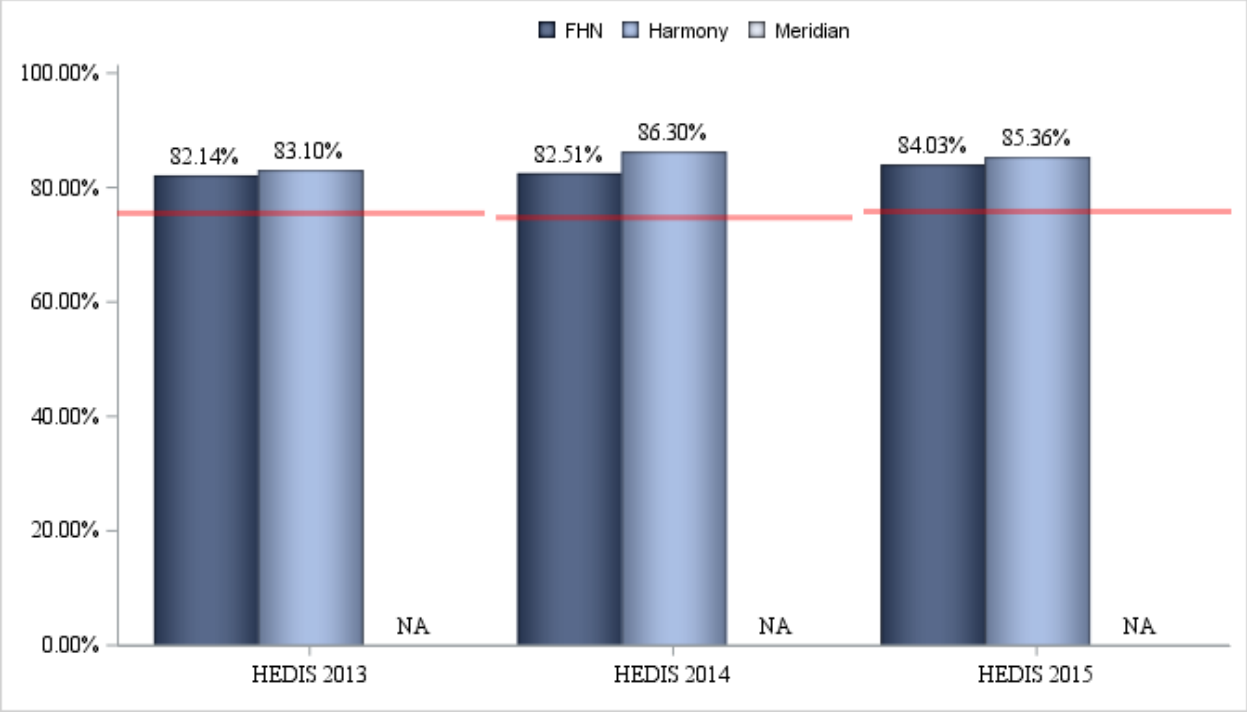


In HEDIS 2013 and 2015, **FHN** was the only MCO to score at or above the 2012 and 2014 Quality Compass 50th percentiles, respectively. **Harmony**'s rates improved steadily from HEDIS 2013 to HEDIS 2015, but they fell below the Quality Compass 50th percentiles each year. **Meridian**'s HEDIS 2013 and HEDIS 2014 rates were reported as NA because they were based on denominators of less than 30. In HEDIS 2015, **Meridian**'s rate fell below the 2014 Quality Compass 50th percentile.

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

Figure 4-45 presents comparative rates for *Use of Appropriate Medications for People With Asthma—19–50 Years*.

Figure 4-45—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—19–50 Years*



Although rates remained similar from HEDIS 2013 to HEDIS 2015 for **FHN** and **Harmony**, the rates for each year were at or above the Quality Compass 50th percentiles. Most notably, **Harmony**'s HEDIS 2014 rate was nearly 12 percentage points above the 2013 Quality Compass 50th percentile. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30.

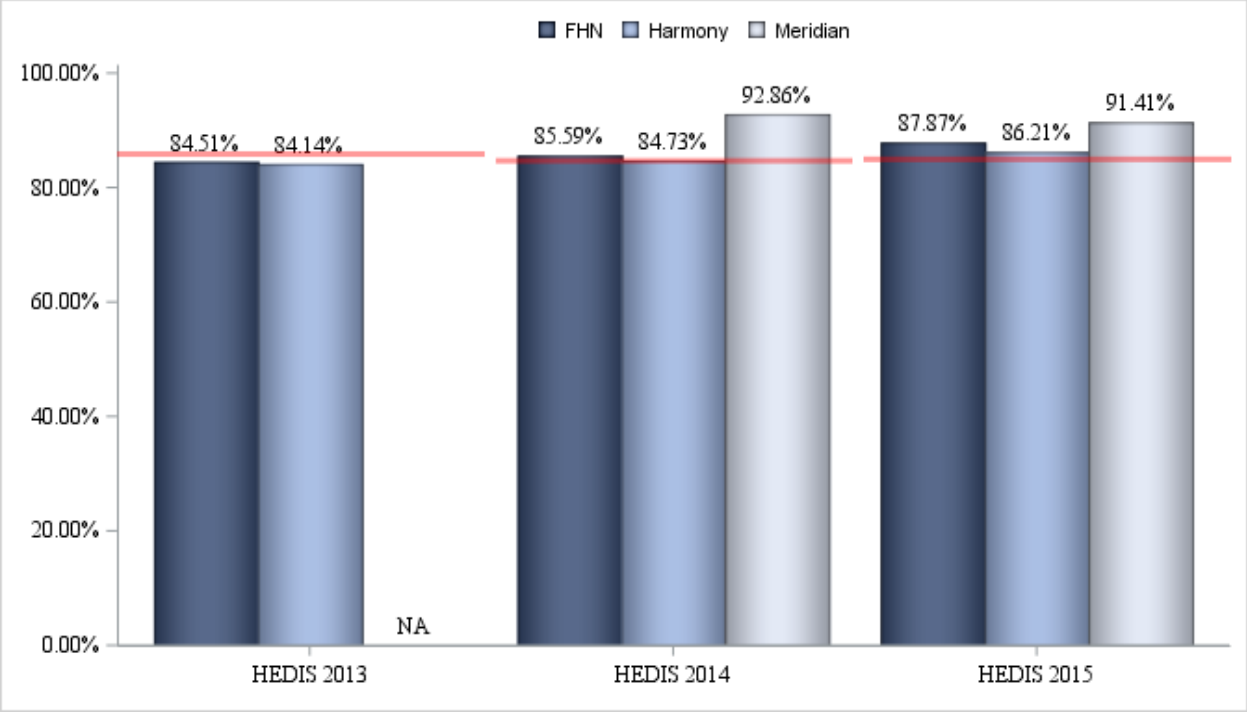
Use of Appropriate Medications for People With Asthma—51–64 Years

For *Use of Appropriate Medications for People With Asthma—51–64 Years*, all three MCOs' HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were NA because they were based on denominators less than 30.

Use of Appropriate Medications for People With Asthma—Total

Figure 4-46 presents comparative rates for *Use of Appropriate Medications for People With Asthma—Total*.

Figure 4-46—Comparison of HFS MCO Performance for *Use of Appropriate Medications for People With Asthma—Total*



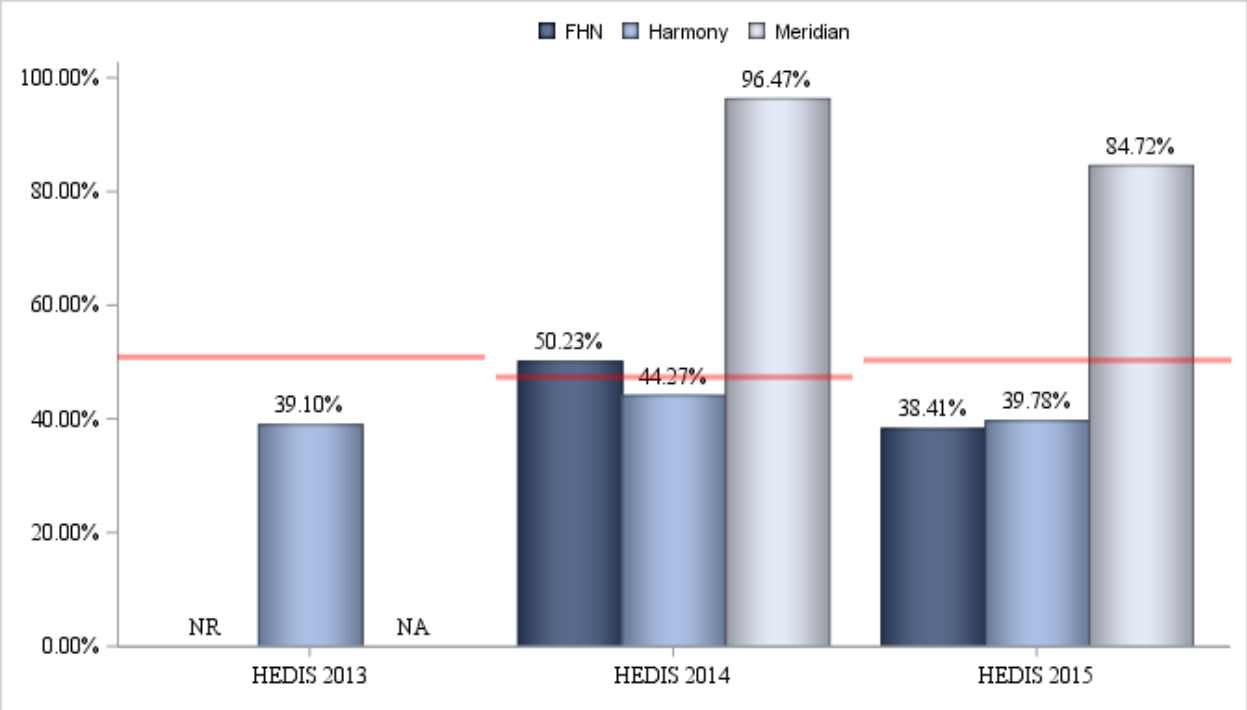
In HEDIS 2014 and HEDIS 2015, rates for all three MCOs scored at or above the 2013 and 2014 Quality Compass 50th percentiles, respectively. Most notably, **Meridian**'s HEDIS 2014 rate was more than 8 percentage points above the 2013 Quality Compass 50th percentile. **FHN** and **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30.

Medication Management for People With Asthma

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

Figure 4-47 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—5–11 Years*. Quality Compass does not release benchmarks for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators. Therefore, comparisons were made to the HEDIS Audit Means and Percentiles.

Figure 4-47—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—5–11 Years*

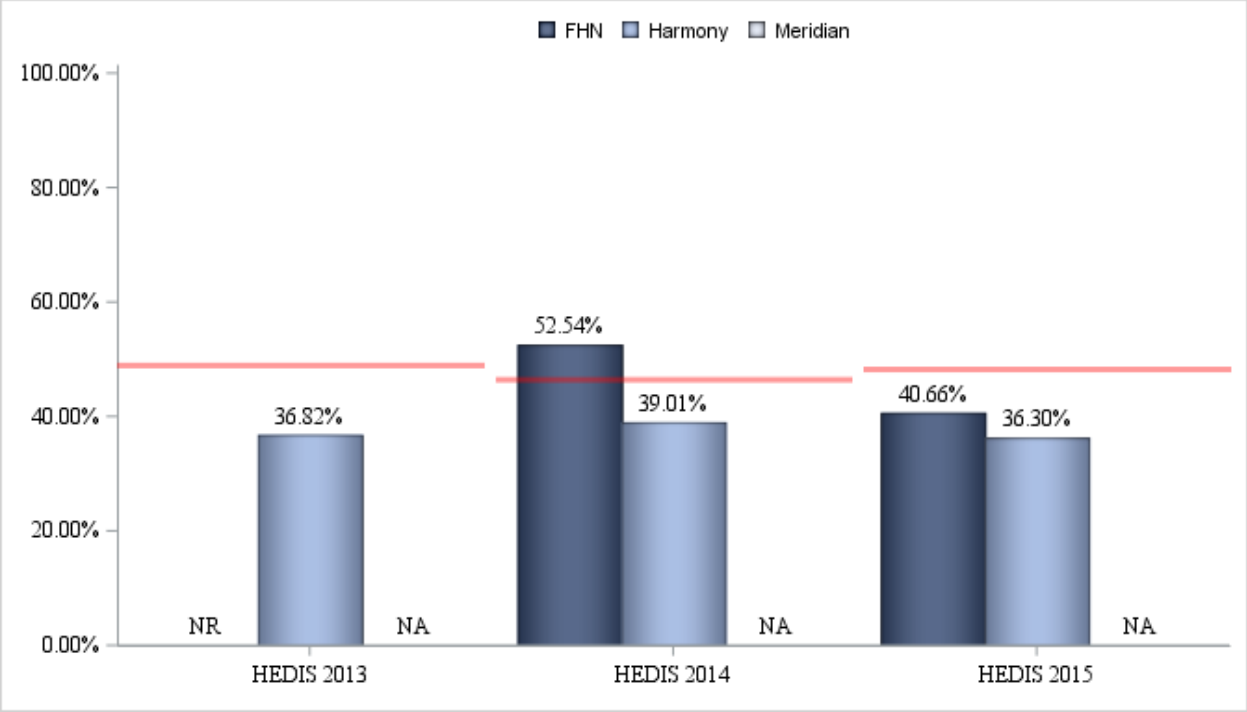


For HEDIS 2014 and HEDIS 2015, **Meridian** performed better than **Harmony** and **FHN**, and exceeded the 2013 and 2014 HEDIS Audit Means and Percentiles 50th percentiles by approximately 49 and 34 percentage points, respectively. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, but consistently fell below the HEDIS Audit Means and Percentiles 50th percentiles. **FHN**'s HEDIS 2013 rate was deemed NR, while **FHN**'s HEDIS 2014 rate scored at or above the 2013 HEDIS Audit Means and Percentiles percentile. In HEDIS 2015, however, **FHN**'s rate declined by nearly 12 percentage points, falling below the 2014 HEDIS Audit Means and Percentiles 50th percentile.

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

Figure 4-48 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—12–18 Years*. Quality Compass does not release benchmarks for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators. Therefore, comparisons were made to the HEDIS Audit Means and Percentiles.

Figure 4-48—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—12–18 Years*

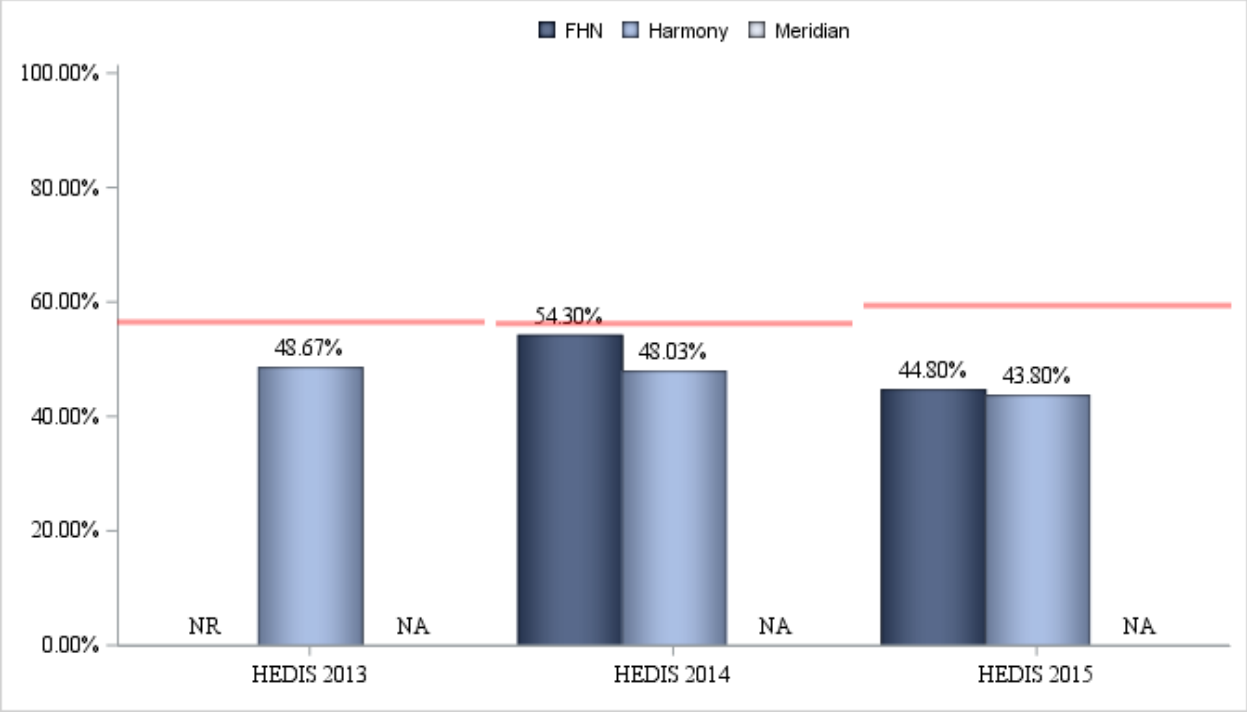


For HEDIS 2014 and HEDIS 2015, **FHN**'s rates scored above the rates reported by **Harmony**; however, neither MCO's rates met the 2014 HEDIS Audit Means and Percentiles 50th percentiles. **FHN**'s HEDIS 2014 rate exceeded the 2013 HEDIS Audit Means and Percentiles 50th percentile by approximately 6 percentage points, and **FHN**'s HEDIS 2013 rate was deemed NR. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, but each year the rates fell below the HEDIS Audit Means and Percentiles 50th percentiles. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30.

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

Figure 4-49 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—19–50 Years*. Quality Compass does not release benchmarks for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators. Therefore, comparisons were made to the HEDIS Audit Means and Percentiles.

Figure 4-49—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—19–50 Years*



Harmony's rates remained similar from HEDIS 2013 to HEDIS 2015. Additionally, **Harmony**'s rates fell below the HEDIS Audit Means and Percentiles 50th percentiles each year. **FHN**'s HEDIS 2015 rate fell by almost 10 percentage points and was below the 2014 HEDIS Audit Means and Percentiles 50th percentile by approximately 15 percentage points. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30.

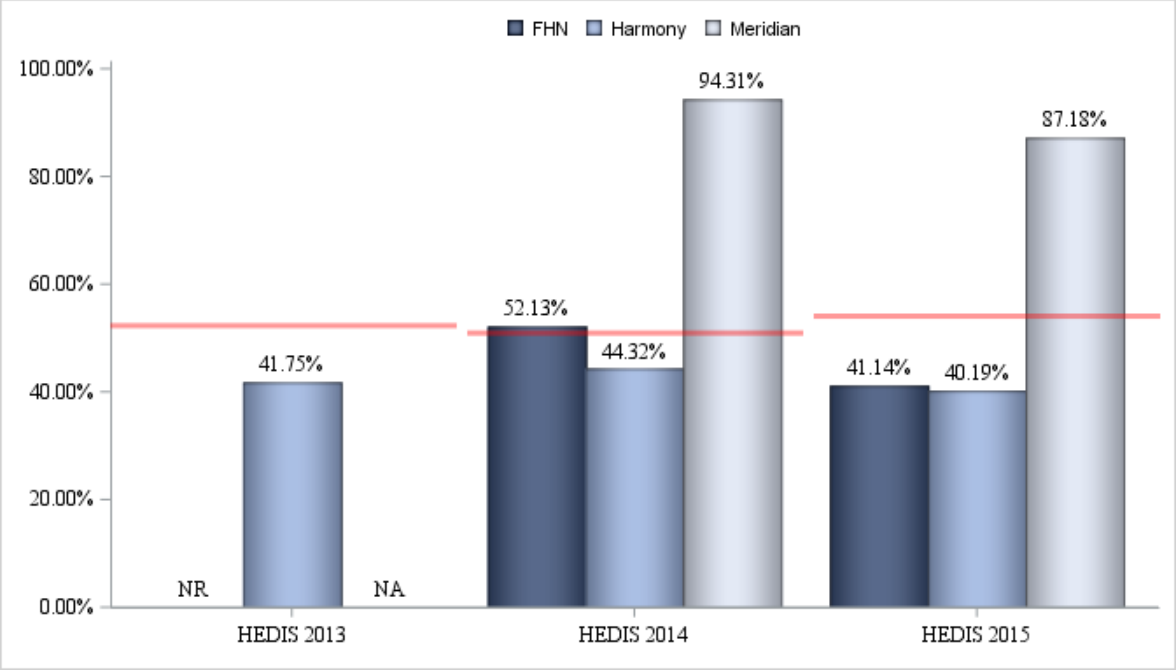
Medication Management for People With Asthma—Medication Compliance 50%—51–64 Years

For *Medication Management for People With Asthma—Medication Compliance 50%—51–64 Years*, **FHN**'s HEDIS 2014 and HEDIS 2015 rates; **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates; and **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were NA because they were based on denominators of less than 30. **FHN**'s HEDIS 2013 rate was deemed NR.

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

Figure 4-50 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 50%—Total*. Quality Compass does not release benchmarks for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators. Therefore, comparisons were made to the HEDIS Audit Means and Percentiles.

Figure 4-50—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 50%—Total*

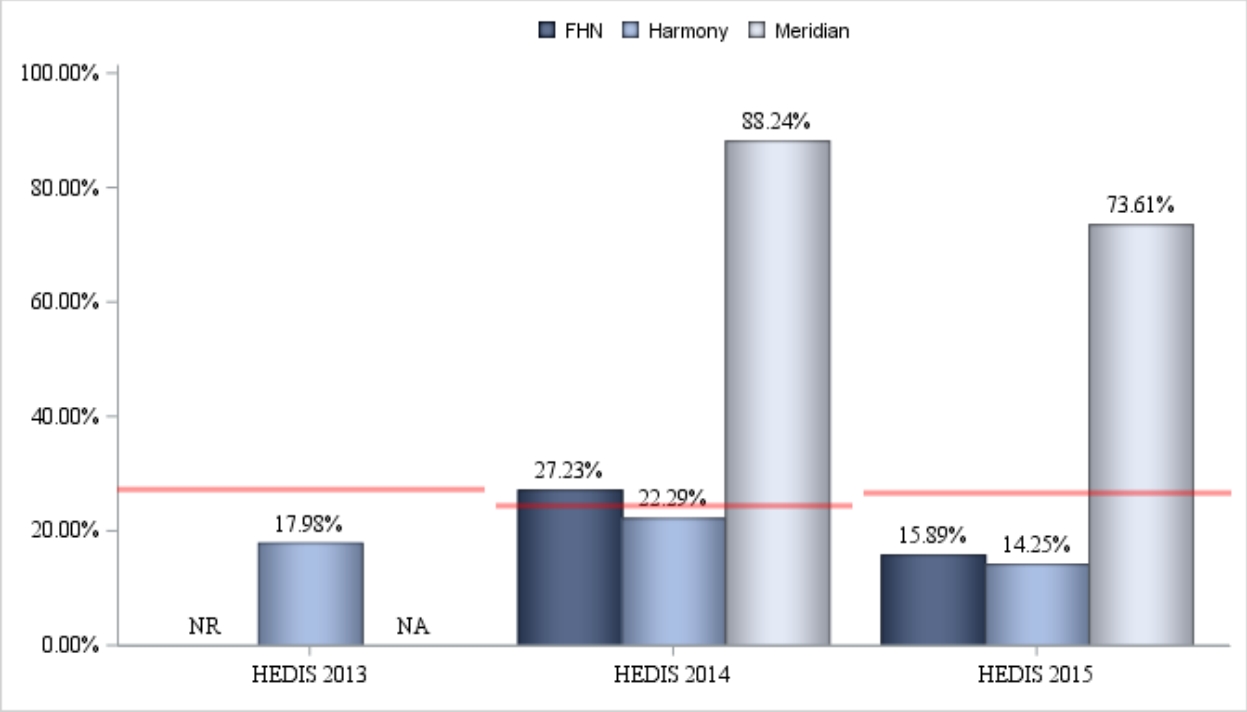


Meridian's HEDIS 2015 rate was approximately 33 percentage points above the 2014 HEDIS Audit Means and Percentiles 50th percentile, exceeding both rates reported by **FHN** and **Harmony**, which fell below the 2014 HEDIS Audit Means and Percentiles 50th percentile. Similarly, **Meridian**'s HEDIS 2014 rate was nearly 44 percentage points above the 2013 HEDIS Audit Means and Percentiles 50th percentile. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30. **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates remained similar, but they fell below the HEDIS Audit Means and Percentiles 50th percentiles each year. **FHN**'s HEDIS 2014 rate scored at or above the 2013 HEDIS Audit Means and Percentiles 50th percentile, but it declined by nearly 11 percentage points in HEDIS 2015, falling below the 2014 HEDIS Audit Means and Percentiles 50th percentile. **FHN**'s HEDIS 2013 rate was deemed NR.

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

Figure 4-51 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—5–11 Years*.

Figure 4-51—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—5–11 Years*

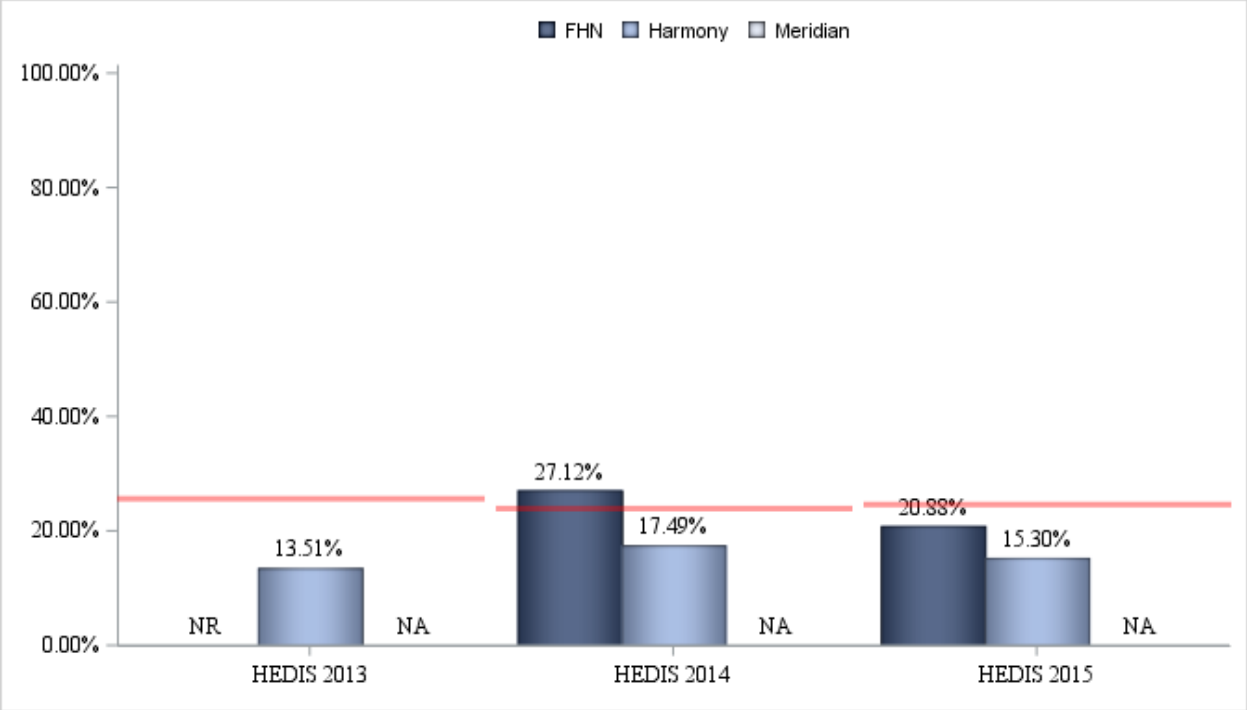


For HEDIS 2015, **Meridian**'s rate exceeded the 2014 Quality Compass 50th percentile by approximately 47 percentage points. **Meridian**'s HEDIS 2014 rate was notably above the 2013 Quality Compass 50th percentile by nearly 64 percentage points, while the HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30. The **FHN** rate for HEDIS 2014 scored at or above the 2013 Quality Compass 50th percentile, but declined in HEDIS 2015 by approximately 11 percentage points, falling below the 2014 Quality Compass 50th percentile. **FHN**'s HEDIS 2013 rate was deemed NR. **Harmony**'s rates increased by approximately 4 percentage points from HEDIS 2013 to HEDIS 2014, and declined by 8 percentage points in HEDIS 2015. All of **Harmony**'s rates fell below the Quality Compass 50th percentiles.

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

Figure 4-52 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—12–18 Years*.

Figure 4-52—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—12–18 Years*

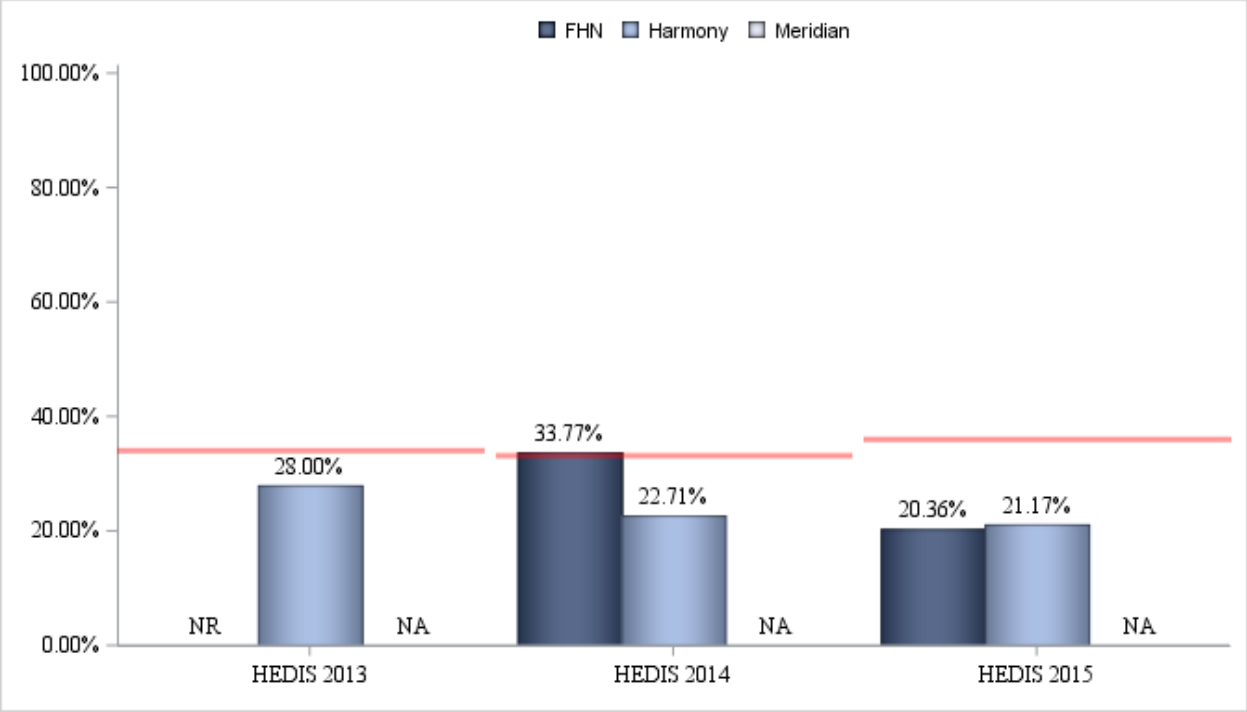


Harmony and **FHN**'s HEDIS 2015 rates fell below the 2014 Quality Compass 50th percentile. **FHN**'s HEDIS 2013 rate was deemed NR. **FHN**'s HEDIS 2014 rate exceeded the 2013 Quality Compass 50th percentile, by approximately 3 percentage points, before declining in HEDIS 2015 by approximately 6 percentage points. **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates remained similar, but they fell below the Quality Compass 50th percentiles each year. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30.

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

Figure 4-53 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—19–50 Years*.

Figure 4-53—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—19–50 Years*



FHN's HEDIS 2014 rate was at or above the 2013 Quality Compass 50th percentile, but declined by more than 13 percentage points in HEDIS 2015, falling below the 2014 Quality Compass 50th percentile. **FHN**'s HEDIS 2013 rate was deemed NR. **Harmony**'s rates steadily declined from HEDIS 2013 to HEDIS 2015, with the rates from each year falling below the respective Quality Compass 50th percentile. **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30.

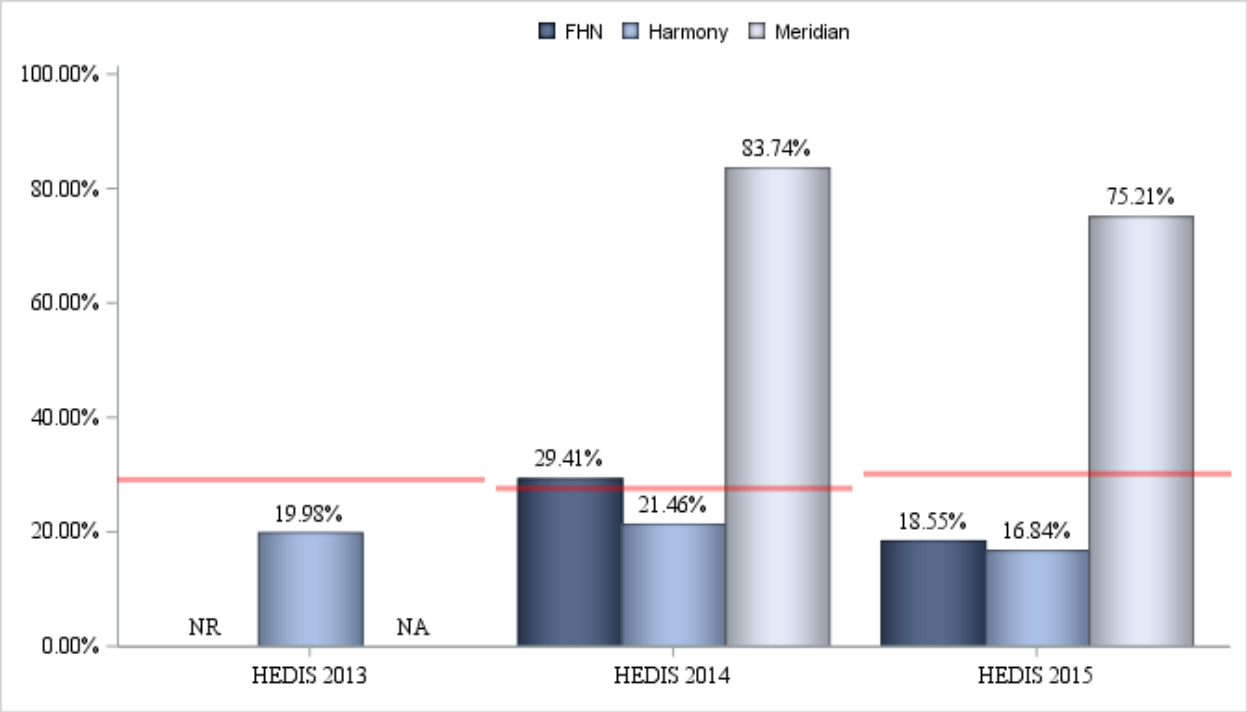
Medication Management for People With Asthma—Medication Compliance 75%—51–64 Years

For *Medication Management for People With Asthma—Medication Compliance 75%—51–64 Years*, **FHN**'s HEDIS 2014 and HEDIS 2015; **Harmony**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015; and **Meridian**'s HEDIS 2013, HEDIS 2014, and HEDIS 2015 rates were reported as NA because they were based on denominators of less than 30. **FHN**'s HEDIS 2013 rate was deemed NR.

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

Figure 4-54 presents comparative rates for *Medication Management for People With Asthma—Medication Compliance 75%—Total*.

Figure 4-54—Comparison of HFS MCO Performance for *Medication Management for People With Asthma—Medication Compliance 75%—Total*



For HEDIS 2015, **Meridian**'s rate exceeded the 2014 Quality Compass 50th percentile by approximately 45 percentage points and also exceeded the rates reported by **FHN** and **Harmony**. **Meridian** also exceeded the 2013 Quality Compass 50th percentile by approximately 56 percentage points in HEDIS 2014. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30. **FHN**'s HEDIS 2014 rate scored at or above the 2013 Quality Compass 50th percentile but declined by nearly 11 percentage points in HEDIS 2015. **FHN**'s HEDIS 2013 rate was deemed NR. **Harmony**'s rates remained similar from HEDIS 2013 to HEDIS 2015, but the rates for each year fell below the Quality Compass 50th percentiles.

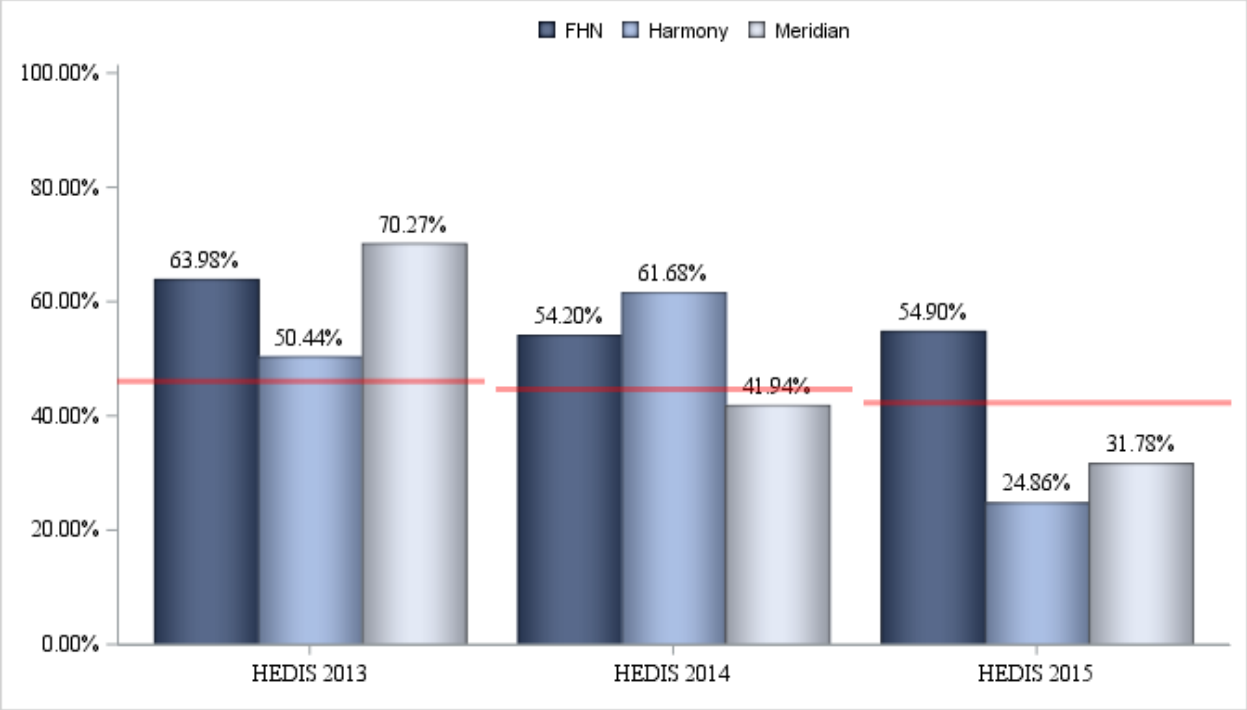
Behavioral Health

Follow-Up After Hospitalization for Mental Illness

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

Figure 4-55 presents comparative rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*.

Figure 4-55—Comparison of HFS MCO Performance for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

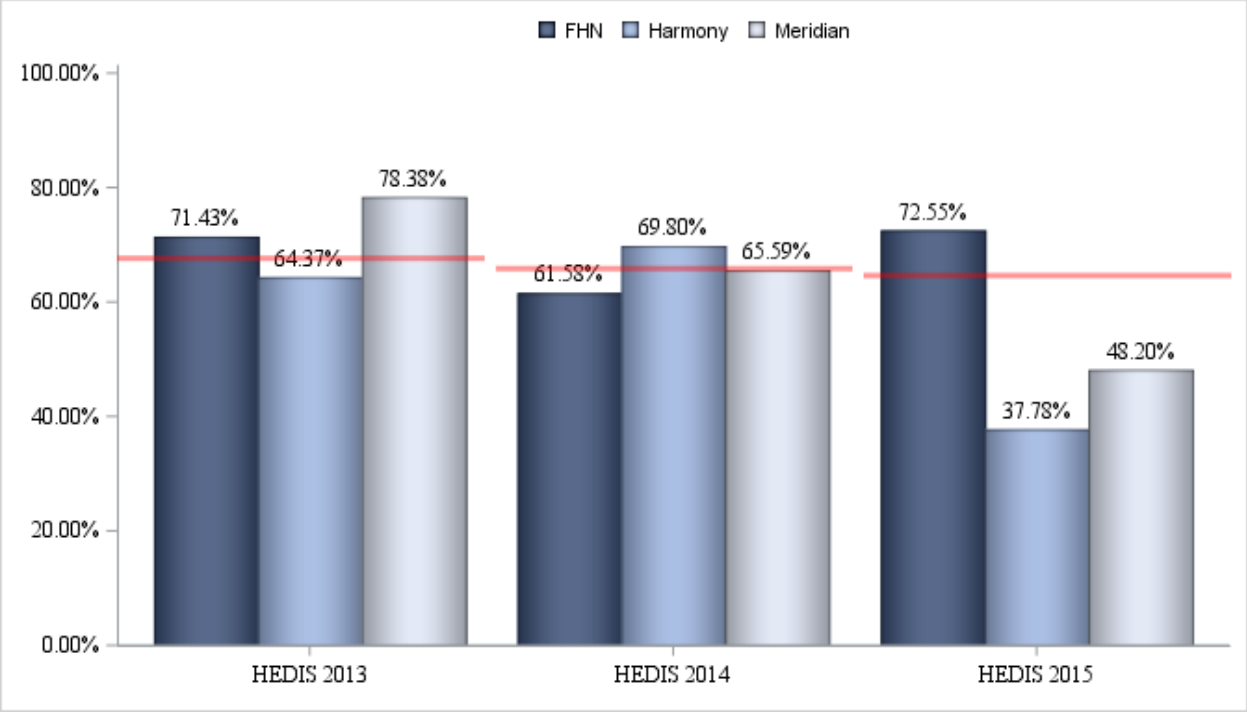


For HEDIS 2015, **FHN**'s rate exceeded the rates reported for **Harmony** and **Meridian** and was nearly 13 percentage points above the 2014 Quality Compass 50th percentile. **Meridian**'s rate declined by nearly 39 percentage points from HEDIS 2013, when it had scored at or above the 2012 Quality Compass 50th percentile, to HEDIS 2015. **FHN**'s rate declined by nearly 10 percentage points from HEDIS 2013 to HEDIS 2014, and remained similar in HEDIS 2015. Each year, however, **FHN**'s rates scored at or above the Quality Compass 50th percentiles. **Harmony**'s rates improved by approximately 11 percentage points from HEDIS 2013 to HEDIS 2014, when the rates scored at or above the respective Quality Compass 50th percentile, but its rate declined by nearly 37 percentage points from HEDIS 2014 to HEDIS 2015, when it fell below the 2014 Quality Compass 50th percentile.

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

Figure 4-56 presents comparative rates for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*.

Figure 4-56—Comparison of HFS MCO Performance for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*



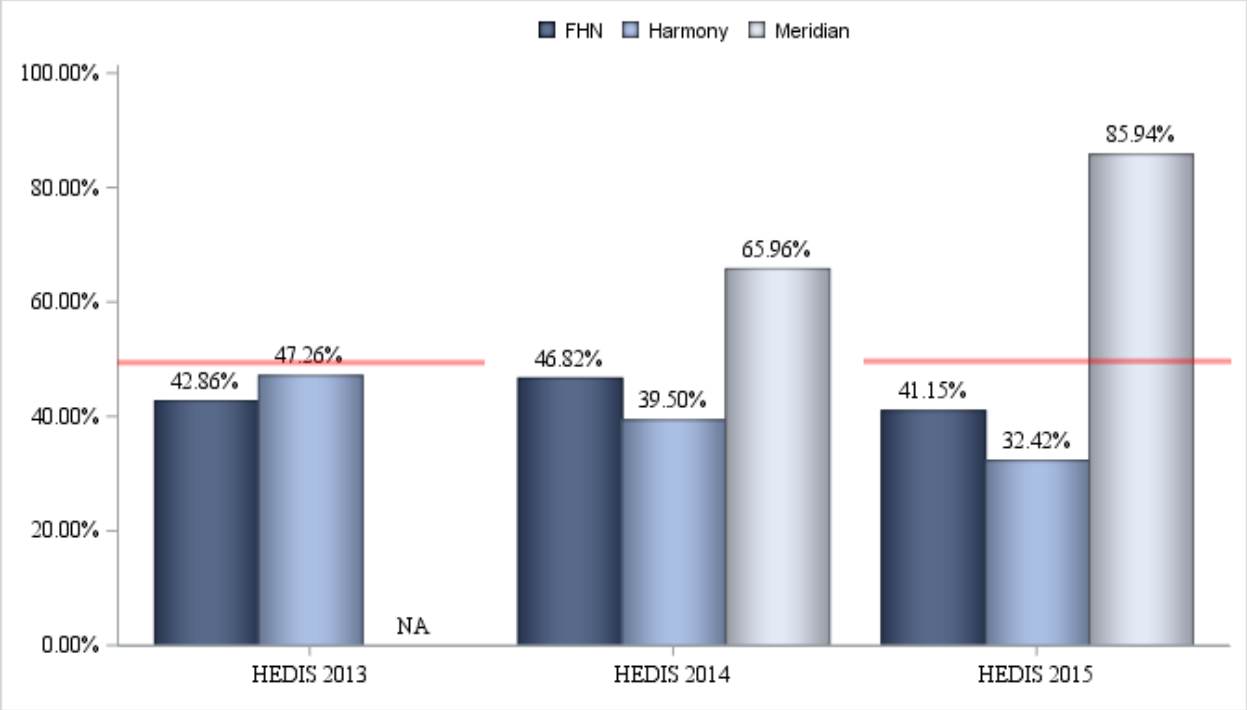
FHN's rate declined by nearly 10 percentage points from HEDIS 2013 to HEDIS 2014, but the HEDIS 2015 rate reported by **FHN** exceeded the 2014 Quality Compass 50th percentile by nearly 8 percentage points. **Harmony**'s rate improved by more than 5 percentage points from HEDIS 2013 to HEDIS 2014 and scored at or above the 2013 Quality Compass 50th percentile; however, **Harmony**'s performance declined by 32 percentage points from HEDIS 2014 to HEDIS 2015, when the rate fell below the 2014 Quality Compass 50th percentile. **Meridian**'s rates declined from HEDIS 2013 to HEDIS 2014 by nearly 13 percentage points, and from HEDIS 2014 to HEDIS 2015 by more than 17 percentage points. Only **Meridian**'s HEDIS 2013 rate scored at or above the Quality Compass 50th percentile.

Antidepressant Medication Management

Antidepressant Medication Management—Effective Acute Phase Treatment

Figure 4-57 presents comparative rates for *Antidepressant Medication Management—Effective Acute Phase Treatment.* Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 4-57—Comparison of HFS MCO Performance for *Antidepressant Medication Management—Effective Acute Phase Treatment*

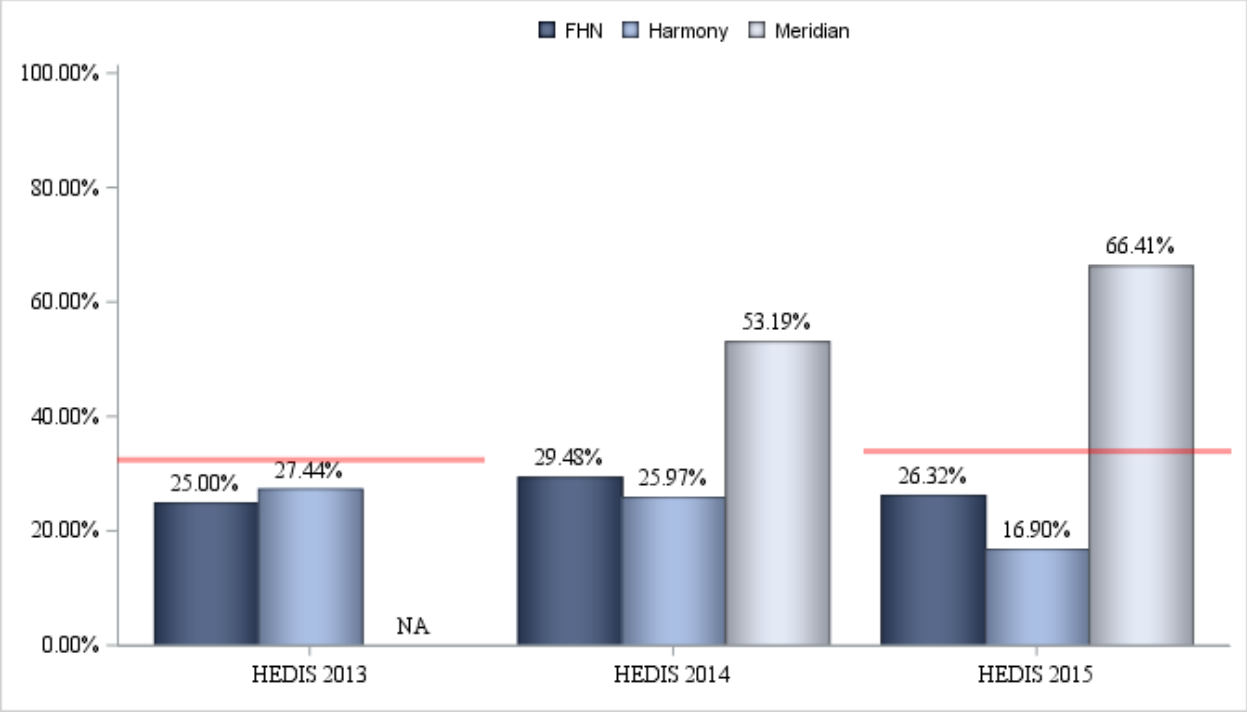


Meridian's HEDIS 2015 rate exceeded the 2014 Quality Compass 50th percentile by more than 36 percentage points. **Harmony** and **FHN**'s rates, however, were the lowest-reported HEDIS 2015 rates, falling below the 2014 Quality Compass 50th percentile by more than 17 and nearly 9 percentage points, respectively. **Harmony**'s rate decreased by nearly 8 percentage points in HEDIS 2014, while **FHN**'s rate increased in HEDIS 2014 by nearly 4 percentage points. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30.

Antidepressant Medication Management—Effective Continuation Phase Treatment

Figure 4-58 presents comparative rates for *Antidepressant Medication Management—Effective Continuation Phase Treatment.* Comparisons to the 2013 Quality Compass National Percentiles were not performed for this measure due to changes in the technical specifications that materially altered the rate compared to prior years.

Figure 4-58—Comparison of HFS MCO Performance for *Antidepressant Medication Management—Effective Continuation Phase Treatment*



For HEDIS 2015, **Meridian**'s rate exceeded **FHN** and **Harmony**'s rates by approximately 40 and 50 percentage points, respectively. **Meridian**'s HEDIS 2015 rate also exceed the 2014 Quality Compass 50th percentile. **FHN** and **Harmony**'s HEDIS 2013 and HEDIS 2015 rates fell below the Quality Compass 50th percentiles. **Meridian**'s HEDIS 2013 rate was reported as NA because it was based on a denominator of less than 30.

CHIPRA Results

This section presents the following CHIPRA measures reported by **FHN**, **Harmony**, and **Meridian**: *Annual Number of Asthma Patients Ages 2–20 with One or More Asthma-related ED Visits*, *Annual Pediatric A1c Testing*, and *Developmental Screening in First Three Years of Life*. This was the third year the three MCOs reported these measures. The measures are not HEDIS measures and have no benchmarks for comparison.

Table 4-11—CHIPRA Measure Results

CHIPRA Measure	FHN Rate	Harmony Rate	Meridian Rate
*Annual Number of Asthma Patients Ages 2–20 with One or More Asthma-related ED Visits**	NR	16.76%	22.15%
Annual Pediatric A1c Testing	NR	68.57%	64.71%
Developmental Screening in First Three Years of Life—Year 1	45.26%	53.28%	67.36%
Developmental Screening in First Three Years of Life—Year 2	40.88%	38.69%	60.42%
Developmental Screening in First Three Years of Life—Year 3	36.50%	29.20%	40.97%
Developmental Screening in First Three Years of Life—Total	40.88%	40.39%	56.25%

***** Lower rates represent better performance for this measure.
NR indicates the MCO did not report this measure.

Harmony and **Meridian** reported rates below 25 percent for the *Annual Number of Asthma Patients Ages 2–20 with One or More Asthma-related ED Visits*. Of the two plans that reported this measure, **Harmony** reported the best rate, at 16.76 percent. **FHN** did not report this measure; therefore, the result is reported as NR.

For *Annual Pediatric A1c Testing*, **Harmony**'s rate of 68.57 percent was almost 4 percentage points higher than **Meridian**'s rate of 64.71 percent. **FHN** did not report this measure; therefore, the result is reported as NR.

The overall rate for *Developmental Screening in First Three Years of Life–Total* ranged from 40.39 percent for **Harmony** to 56.25 percent for **Meridian**. Except for the Year 1 indicator, all of **FHN**'s rates were higher than **Harmony**'s rates, but they were lower than all of **Meridian**'s rates.

Although this was the third year for reporting these measures, none of the rates appeared to be representative of superior performance. HSAG recommends that the MCOs continue monitoring these measures and implement quality improvement initiatives, as needed.

Encounter Data Completeness

Table 4-12 provides an estimate of the data completeness for the hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in Table 4-12 represent the percentage of the final HEDIS rates that were determined solely through the use of administrative encounter data. Note that **Meridian** used only administrative data in 2013 and 2014, except for the HEDIS 2014 *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Comprehensive Diabetes Care* measures, where it used administrative data and medical record data. 2015 marks the first year more than the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Comprehensive Diabetes Care* measures were reported using a hybrid methodology.

Table 4-12—Estimated Encounter Data Completeness for Hybrid Measures

HEDIS Measure	Percentage of Numerator Positive Cases Determined by Administrative Data								
	FHN			Meridian			Harmony		
	2015	2014	2013	2015	2014	2013	2015	2014	2013
Child and Adolescent Care									
Childhood Immunization Status									
Combination 2	50.19%	59.28%	59.41%	95.47%			78.06%	82.30%	72.03%
Combination 3	36.29%	46.67%	49.52%	94.65%			74.23%	79.79%	67.92%
Lead Screening in Children									
Lead Screening in Children	93.08%	69.82%	80.06%				82.65%	82.68%	92.31%
Immunizations for Adolescents									
Combination 1 (Meningococcal, Tdap/Td)	81.75%	81.39%	72.35%	96.86%			82.46%	79.76%	84.75%
Human Papillomavirus Vaccine for Female Adolescents									
Human Papillomavirus Vaccine for Female Adolescents	68.24%	54.79%		74.47%			77.63%	60.94%	
Well-Child Visits in the First 15 Months of Life									
No Well-Child Visits	88.89%	100.00%	100.00%	100.00%			100.00%	100.00%	100.00%
Six or More Well-Child Visits	68.23%	54.50%	41.94%	98.86%			81.12%	78.84%	85.28%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life									
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	94.98%	78.50%	68.56%	98.89%			92.22%	95.10%	96.65%
Adolescent Well-Care Visits									
Adolescent Well-Care Visits	84.65%	79.05%	64.97%	94.27%			89.56%	89.77%	93.72%

HEDIS Measure	Percentage of Numerator Positive Cases Determined by Administrative Data								
	FHN			Meridian			Harmony		
	2015	2014	2013	2015	2014	2013	2015	2014	2013
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents									
BMI Percentile Documentation—Total	8.47%	3.05%	0.41%	14.72%	67.86%		9.65%	10.30%	6.75%
Counseling for Nutrition—Total	9.38%	1.55%	0.41%	67.27%	67.27%		12.08%	3.50%	1.02%
Counseling for Physical Activity—Total	9.32%	0.00%	0.00%	6.07%	54.60%		12.33%	3.38%	0.59%
Women's Health									
Cervical Cancer Screening									
Cervical Cancer Screening	85.11%	76.62%	73.89%	97.61%			84.98%	88.67%	95.58%
Prenatal and Postpartum Care									
Timeliness of Prenatal Care	81.89%	58.23%	55.88%	97.43%			92.53%	92.36%	90.23%
Postpartum Care	79.69%	72.92%	67.31%	92.62%			88.04%	81.73%	88.67%
Frequency of Ongoing Prenatal Care									
<21 Percent of Expected Visits	95.51%	95.31%	93.20%	100.00%			93.88%	94.55%	89.66%
≥81 Percent of Expected Visits	74.17%	19.84%	35.29%	97.89%			78.88%	80.66%	81.56%
Care for Chronic Conditions									
Comprehensive Diabetes Care									
Hemoglobin A1c (HbA1c) Testing	71.39%	49.84%	42.80%	100.00%+	100.00%		82.90%	81.82%	93.71%
HbA1c Poor Control (>9.0%)	77.73%	72.73%	62.89%	100.00%+	100.00%		66.03%	69.92%	72.96%
HbA1c Control (<8.0%)	35.25%	0.00%	0.00%	52.94%+	52.94%		13.93%	7.05%	15.33%
Eye Exam (Retinal) Performed	87.25%	98.38%	83.33%	100.00%+	100.00%		73.38%	80.00%	70.54%
Medical Attention for Nephropathy	98.08%	93.71%	88.84%	100.00%+	100.00%		92.64%	94.21%	97.96%
BP Control (<140/90 mm Hg)	0.00%	0.00%	0.53%	10.42%+	10.42%		4.89%	1.89%	0.00%

Note: Rates with more than 75 percent data completeness are highlighted in green; rates with less than 50 percent data completeness are highlighted in red.

+ Meridian elected to rotate this measure for HEDIS 2015. Therefore, rates for 2015 are representative of performance for 2014.

For **FHN**, four HEDIS 2015 measure indicators had encounter data that were more than 90 percent complete, six measure indicators had encounter data completeness rates between 80 percent and 89 percent, four measure indicators had encounter data completeness rates between 70 percent and 79 percent, and three measure indicators had data completeness rates between 50 percent and 69 percent. The remaining six measure indicators for **FHN** in HEDIS 2015 had data completeness rates below 50

percent. Although some encounter data completeness has improved, these results indicate that **FHN** continues to have difficulty obtaining complete encounter data for all measures. **FHN** is strongly encouraged to continue its efforts to improve encounter data submission.

Harmony's HEDIS 2015 had five measure indicators with encounter data completeness levels of 90 percent or greater, seven measure indicators had encounter data completeness rates between 80 percent and 89 percent, five measure indicators had encounter data completeness rates between 70 percent and 79 percent, and one measure indicators had data completeness rates between 50 percent and 69 percent. The remaining five measure indicators for **Harmony** in HEDIS 2015 had data completeness rates below 50 percent. Although some encounter data completeness has improved, these results indicate that **Harmony** continues to have difficulty obtaining complete encounter data for all measures.

Meridian had encounter data for 16 measure indicators in HEDIS 2015, not including rotated measures, with two measure indicators achieving encounter data completeness levels of 100 percent. Of the remaining measures, 10 indicators were more than 90 percent complete. One measure indicator had encounter data completeness rates between 70 percent and 79 percent, and one measure indicator had data completeness rates between 50 percent and 69 percent. The remaining two measure indicators had encounter data completeness rates below 50 percent for HEDIS 2015. **Meridian** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission for the select measures that are not solely determined through administrative data.

Validation of Performance Measures—Integrated Care Plan Findings—SFY 2014–2015

Background

HFS implemented the Integrated Care Program (ICP) on May 1, 2011, for seniors and persons with disabilities (SPD) who are eligible for Medicaid but not eligible for Medicare. The ICP program expanded to align with the State's mission to comply with Public Act 96-1501, which required 50 percent of Medicaid clients to be enrolled in a form of care coordination by January 2015.

Aetna Better Health (**Aetna**) and **IlliniCare Health Plan, Inc.** (**IlliniCare**) have participated in the ICP since 2011. HFS worked collaboratively with HSAG and the ICPs to identify and develop performance measures specific to ICP members. Through this collaboration, ICP performance measures were developed by HFS and the ICPs that are a mix of HEDIS, HEDIS-like, and State-defined measures.

SFY 2015 is the third year of reporting the performance measures for **Aetna** and **IlliniCare**. Both plans were required to report on a set of 39 performance measures. An additional set of 18 bonus incentive measures (or pay-for-performance) were required for reporting. In addition, SFY 2015 represents the first year of reporting the performance measures for **Community Care Alliance of Illinois** (**CCAI**), **Health Alliance Connect, Inc.** (**Health Alliance**), **Meridian**, and **Molina Healthcare of Illinois, Inc.**

(**Molina**). These ICPs were also required to report on the same set of 39 performance measures and 18 bonus incentive measures.

ICP Findings and Comparisons

Aetna and IlliniCare

SFY 2015 was the third year of reporting the ICP measures for **Aetna** and **IlliniCare**. HFS calculated the baselines for the ICP measures using FFS claims data. The utilization measures, with the exception of emergency department (ED) visits, are presented for informational purposes but are not included when comparing the 2015 reported rates to the 2012 baseline rates.

The ICP 2015 rates for the 39 non-incentive measures for **Aetna** and **IlliniCare** are presented in Table 4-13 below. Rates in red font indicate that performance declined from the baseline rate.

Table 4-13—Aetna and IlliniCare ICP Rates for Non-Incentive Measures

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2015 Rate	Change From Baseline	IlliniCare 2015 Rate	Change From Baseline
Access to Care Measures (Percentages)					
*Inpatient Hospital 30-Day Readmission Rate**	8.31%	6.73%	1.58%	10.85%	-2.54%
*Inpatient Mental Hospital 30-Day Readmission Rate**	24.20%	4.85%	19.35%	13.65%	10.55%
*Adults' Access to Preventive/Ambulatory Health Services***	NA	81.73%	NA	80.59%	NA
Preventive Care Measures (Percentages)					
*Colorectal Cancer Screening***	NA	37.96%	NA	28.13%	NA
*Breast Cancer Screening***	NA	48.43%	NA	51.08%	NA
Cervical Cancer Screening	40.81%	48.42%	7.61%	38.21%	-2.60%
*Adult BMI Assessment***	NA	68.37%	NA	67.14%	NA
Appropriate Care Measures (Percentages)					
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.00%	89.89%	3.89%	90.63%	4.63%
Annual Monitoring for Patients on Persistent Medications—Digoxin	81.46%	57.89%	-23.57%	62.35%	-19.11%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.60%	89.67%	3.07%	91.12%	4.52%
Annual Monitoring for Patients on Persistent Medications—Total	84.12%	89.11%	4.99%	90.28%	6.16%

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2015 Rate	Change From Baseline	IlliniCare 2015 Rate	Change From Baseline
Comprehensive Diabetes Care—HbA1c Testing (DD Population Only)	79.05%	86.86%	7.81%	87.96%	8.91%
*Use of High-Risk Medications in the Elderly—60–65 Years–1 Prescription***	NA	36.30%	NA	34.87%	NA
*Use of High-Risk Medications in the Elderly—60–65 Years–2+ Prescriptions***	NA	9.35%	NA	9.48%	NA
*Use of High-Risk Medications in the Elderly—65+ Years–1 Prescription***	NA	14.68%	NA	13.06%	NA
*Use of High-Risk Medications in the Elderly—65+ Years–2+ Prescriptions***	NA	2.56%	NA	2.68%	NA
Behavioral Health Measures (Percentages)					
*Adherence to Antipsychotic Medications for Individuals With Schizophrenia***	NA	79.82%	NA	75.93%	NA
*Behavioral Health Risk Assessment (BHRA) Completed within 60 Days of Enrollment***	NA	14.40%	NA	42.85%	NA
*Follow-Up Completed within 30 Days of Positive BHRA***	NA	39.47%	NA	13.33%	NA
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Initiation of AOD Treatment	45.71%	44.26%	-1.45%	50.07%	4.36%
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Engagement of AOD Treatment	8.97%	10.31%	1.34%	7.79%	-1.18%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	34.67%	28.22%	-6.45%	44.91%	10.24%
Utilization Measures (Per 1,000 Member Months)^					
*Dental ED Visits Per 1,000 Member Months**	11.37	12.44	1.07	13.20	1.83
Inpatient Utilization (Per 1,000 Member Months)^					
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient Discharges (Per 1,000 Member Months)	40.35	20.38	-19.97	24.97	-15.38
Inpatient Utilization—General Hospital/Acute Care: Total Medicine Discharges (Per 1,000 Member Months)	28.95	14.00	-14.95	17.25	-11.70

Measure	Baseline Rate (2012)	Aetna		IlliniCare	
		Aetna 2015 Rate	Change From Baseline	IlliniCare 2015 Rate	Change From Baseline
Inpatient Utilization—General Hospital/Acute Care: Total Surgery Discharges (Per 1,000 Member Months)	10.78	5.96	-4.82	7.40	-3.38
Inpatient Utilization—General Hospital/Acute Care: Total Maternity Discharges (Per 1,000 Member Months)	0.62	0.53	-0.09	0.43	-0.19
Mental Health Utilization Inpatient and Outpatient (Percentages)^					
Mental Health Utilization—Any Services Total	25.04%	27.50%	2.46%	19.01%	-6.03%
Mental Health Utilization—Inpatient Total	6.11%	8.43%	2.32%	5.54%	-0.57%
Mental Health Utilization—Intensive outpatient/partial Hospitalization Total	2.74%	0.37%	-2.37%	0.17%	-2.57%
Mental Health Utilization—Outpatient Total	23.32%	23.48%	0.16%	16.52%	-6.80%
Long Term Care (Per 1,000 Member Months)					
*Long Term Care Urinary Tract Infection Admission Rate**	2.17	1.09	-1.08	0.82	-1.35
*Long Term Care Bacterial Pneumonia Admission Rate**	2.42	0.75	-1.67	1.30	-1.12
*Long Term Care Prevalence of Hospital Acquired Pressure Ulcers**	NA	NR	NA	NR	NA
Member Movement (Percentages)					
*Movement of Members—Started and Ended in Community***	NA	77.82%	NA	72.50%	NA
*Movement of Members—Started and Ended in HCBS (Long Term Services and Supports [LTSS])***	NA	73.56%	NA	74.10%	NA
*Movement of Members—Started and Ended in LTC***	NA	80.73%	NA	73.32%	NA
*Movement of Members—Total Medicaid Members with No Movement***	NA	77.68%	NA	72.70%	NA
*Movement of Members—No Longer Enrolled***	NA	19.24%	NA	22.57%	NA

* Lower rates represent better performance for these measures.

** There were no baseline rates established for these measures.

^ Indicates measure is utilization based, not performance based; therefore, changes in rates are not necessarily indicative of changes in performance.

NR indicates the measure was not reported.

Aetna's rates for three measures represented a decline from the baseline rates (excluding all utilization measures), although the rate for *Initiation and Engagement of AOD Dependence Treatment 18+ Years—*

Initiation of AOD Treatment Rate was only 1.45 percentage points lower than the baseline rate. Overall, 10 measure rates improved from the baseline rates. The rates for **IlliniCare** showed that four measures represented a decline from the baseline rates. Overall, **IlliniCare** showed that nine measure rates improved from the baseline rates.

Either **Aetna** or **IlliniCare** scored more than 5.0 percentage points above the other ICP on the following 10 measures (including all utilization measures): *Inpatient Mental Hospital 30-Day Readmission Rate, Colorectal Cancer Screening, Cervical Cancer Screening, Behavioral Health Risk Assessment (BHRA) Completed within 60 Days of Enrollment, Follow-up Completed within 30 Days of Positive BHRA, Initiation and Engagement of AOD Dependence Treatment 18+ Years—Initiation of AOD Treatment, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up, Mental Health Utilization (Any Services Total), Mental Health Utilization (Outpatient Total),* and *Movement of Members—Started and Ended in LTC [Long-term Care]*.

CCAI, Health Alliance, Meridian, and Molina

SFY 2015 was the first year reporting the ICP measures for **CCAI**, **Health Alliance**, **Meridian**, and **Molina**. HFS did not recalculate baselines for these ICP measures; therefore, no baselines for these ICPs are presented. The utilization measures are presented for informational purposes only.

The ICP 2015 rates for the 39 non-incentive measures for **CCAI**, **Health Alliance**, **Meridian**, and **Molina** are presented in Table 4-14 below.

Table 4-14—CCAI, Health Alliance, Meridian, and Molina ICP Rates for Non-Incentive Measures

Measure	CCAI	Health Alliance	Meridian	Molina
Access to Care Measures (Percentages)				
*Inpatient Hospital 30-Day Readmission Rate**	8.68%	14.73%	6.87%	13.63%
*Inpatient Mental Hospital 30-Day Readmission Rate**	NA	32.24%	13.80%	7.69%
Adults' Access to Preventive/Ambulatory Health Services	87.92%	90.31%	86.77%	77.43%
Preventive Care Measures (Percentages)				
Colorectal Cancer Screening	NA	NA	NA	NA
Breast Cancer Screening	NA	NA	NA	NA
Cervical Cancer Screening	51.34%	30.81%	45.84%	36.94%
Adult BMI Assessment	NA	NA	NA	NA
Appropriate Care Measures (Percentages)				
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	92.41%	92.49%	87.90%	86.36%
Annual Monitoring for Patients on Persistent Medications—Digoxin	NA	NA	50.00%	NA

Measure	CCAI	Health Alliance	Meridian	Molina
Annual Monitoring for Patients on Persistent Medications—Diuretics	91.10%	92.50%	88.43%	87.81%
Annual Monitoring for Patients on Persistent Medications—Total	91.45%	92.26%	87.65%	86.73%
Comprehensive Diabetes Care—HbA1c Testing (DD Population Only)	90.35%	87.57%	94.37%	82.63%
Use of High-Risk Medications in the Elderly—60–65 Years–1 Prescription	51.76%	36.38%	NA	37.18%
Use of High-Risk Medications in the Elderly—60–65 Years–2+ Prescriptions	11.76%	8.16%	NA	8.97%
Use of High-Risk Medications in the Elderly—65+ Years–1 Prescription	15.52%	26.32%	NA	10.34%
Use of High-Risk Medications in the Elderly—65+ Years–2+ Prescriptions	1.72%	5.26%	NA	2.76%
Behavioral Health Measures (Percentages)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	60.38%	72.52%	59.55%	71.33%
Behavioral Health Risk Assessment (BHRA) Completed within 60 Days of Enrollment	7.43%	0.57%	7.55%	0.26%
Follow-Up Completed within 30 Days of Positive BHRA	11.76%	NA	13.26%	NA
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Initiation of AOD Treatment	38.28%	38.23%	44.48%	38.58%
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Engagement of AOD Treatment	4.17%	9.09%	13.71%	5.17%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	42.64%	33.12%	28.18%	30.27%
Utilization Measures (Per 1,000 Member Months)^				
*Dental ED Visits Per 1,000 Member Months**	18.12	51.79	1.70	27.94
Inpatient Utilization (Per 1,000 Member Months)^				
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient Discharges (Per 1,000 Member Months)	19.96	27.80	19.32	21.76
Inpatient Utilization—General Hospital/Acute Care: Total Medicine Discharges (Per 1,000 Member Months)	14.32	21.27	18.64	16.04

Measure	CCAI	Health Alliance	Meridian	Molina
Inpatient Utilization—General Hospital/Acute Care: Total Surgery Discharges (Per 1,000 Member Months)	5.05	5.82	1.65	4.91
Inpatient Utilization—General Hospital/Acute Care: Total Maternity Discharges (Per 1,000 Member Months)	0.67	0.75	0.72	0.86
Mental Health Utilization Inpatient and Outpatient (Percentages)^				
Mental Health Utilization—Any Services Total	20.29%	25.98%	17.14%	25.35%
Mental Health Utilization—Inpatient Total	3.82%	4.55%	3.94%	7.09%
Mental Health Utilization—Intensive outpatient/partial Hospitalization Total	0.19%	0.16%	0.53%	0.25%
Mental Health Utilization—Outpatient Total	18.97%	23.39%	15.33%	23.18%
Long Term Care (Per 1,000 Member Months)				
*Long Term Care Urinary Tract Infection Admission Rate**	6.87	1.28	1.39	0.47
*Long Term Care Bacterial Pneumonia Admission Rate**	0.98	4.68	1.85	0.68
*Long Term Care Prevalence of Hospital Acquired Pressure Ulcers**	0.27	0.43	0.00	0.81
Member Movement (Percentages)				
Movement of Members—Started and Ended in Community	74.82%	78.88%	80.07%	73.85%
Movement of Members—Started and Ended in HCBS (LTSS)	67.72%	79.64%	68.80%	66.03%
Movement of Members—Started and Ended in LTC	73.17%	69.14%	50.00%	NA
Movement of Members—Total Medicaid Members with No Movement	74.01%	78.61%	78.81%	72.99%
Movement of Members—No Longer Enrolled	22.57%	19.20%	17.40%	22.97%

* Lower rates represent better performance for these measures.

^ Indicates measure is utilization based, not performance based; therefore, changes in rates are not necessarily indicative of changes in performance.

NA indicates the measure required more than one year of continuous enrollment for members, or it allowed a lookback period to identify events when the ICP was not providing services.

Either **CCAI**, **Health Alliance**, **Meridian**, or **Molina** scored more than 10.0 percentage points above the lowest-scoring ICP on the following 11 measures (including all utilization measures): *Inpatient Mental Hospital 30-Day Readmission Rate, Adults' Access to Preventive/Ambulatory Health Services, Cervical Cancer Screening, Comprehensive Diabetes Care—HbA1c Testing (DD Population Only), Use*

of High-Risk Medications in the Elderly—60–65 Years–1 Prescription, Use of High-Risk Medications in the Elderly—65+ Years–1 Prescription, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up, Dental ED Visits Per 1,000 Member Months, Movement of Members—Started and Ended in HBCS (LTSS), and *Movement of Members—Started and Ended in LTC.*

ICP Pay-for-Performance Results

Aetna and IlliniCare

Table 4-15 and Table 4-16 display the results for the 18 pay-for-performance measures for **Aetna** and **IlliniCare**, respectively. The target goals were established using the baseline rate, along with minimum expected improvement. **Aetna**'s and **IlliniCare**'s performance results for the pay-for-performance measures in previous years were also used to established target goals for 2015. Therefore, the target goals may differ between **Aetna** and **IlliniCare**. In addition, to achieve an overall *Met* status, several of the performance measures were grouped together, with each group having specific requirements. For example, the Coronary Artery Disease group consisted of four measures, with a minimum requirement that two of the four rates achieve the target goal in order to achieve an overall result of *Met*. Some performance measures were reported as NA due to the enrollment criteria for the measure. Rates in red font indicate that performance declined from the baseline rate.

Table 4-15—ICP Pay-for-Performance Results for 2015 Contracted Goals and Results

Measure	Aetna			
	2014 Rate	Target Goal	2015 Rate	Overall Result
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness—30 Day Follow-Up	49.59%	59.88%	47.01%	NOT MET
Antidepressant Medication Management—Effective Acute Phase Treatment	76.99%	59.90%	73.89%	**MET**
Antidepressant Medication Management—Effective Continuation Phase Treatment	64.52%	52.90%	63.94%	**MET**
Access/Utilization of Care				
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	42.24%	46.83%	41.60%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	52.87%	58.69%	52.04%	NOT MET

Measure	Aetna			
	2014 Rate	Target Goal	2015 Rate	Overall Result
*Ambulatory Care—ED Visits per 1,000 Member Months**	75.69	69.24	84.56	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met Target Goal for 2 of #1–3 and 1 of #4–5***			
1. HbA1c Testing	85.62%	85.05%	86.86%	NOT MET
2. Medical Attention for Nephropathy	80.53%	82.42%	82.24%	
*3. LDL-C Screening***	83.63%	82.76%	—	
4. Statin Therapy (80% of Eligible Days)	48.86%	47.09%	44.03%	
5. ACEI/ARB Therapy (80% of Eligible Days)	51.88%	46.36%	54.51%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met Target Goal for 2 of #1–4***			
1. Cholesterol Testing	78.70%	79.77%	79.26%	**MET**
2. Statin Therapy 80% of the Time	53.90%	51.18%	44.16%	
3. ACEI/ARB Therapy 80% of the Time	50.96%	46.79%	54.07%	
4. Persistence of Beta-Blocker Treatment After a Heart Attack	93.33%	87.40%	92.59%	
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met Target Goal for 2 of #1–3***			
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	69.21%	72.97%	70.56%	NOT MET
2. Bronchodilator Dispensed within 30 Days of the Event	89.40%	90.52%	87.70%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)****	NA	36.70%	18.68%	

* Lower rates represent better performance for this measure.

** The *CDC—LDL-C Screening* indicator was retired from HEDIS 2015; therefore, it was not applicable for 2015.

*** The *SPR* measure required two years of continuous enrollment for members; therefore, it was not applicable for 2014.

Overall, **Aetna** achieved a *Met* status for three measures, which included meeting the target goals for six of the individual rates. Twelve individual rates did not meet the target goals. **Aetna** achieved a *Met* status for *CAD* for a second consecutive year but showed a decline in performance for *CDC*, which did

not meet the overall goal. **Aetna** continued to show good performance in effectively monitoring antidepressant medication management.

Table 4-16—ICP Pay-for-Performance Results for 2015 Contracted Goals and Results

Measure	IlliniCare			
	2014 Rate	Target Goal	2015 Rate	Overall Result
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	55.11%	59.88%	59.88%	**MET**
Antidepressant Medication Management—Effective Acute Phase Treatment	50.82%	56.85%	50.34%	NOT MET
Antidepressant Medication Management—Effective Continuation Phase Treatment	36.07%	47.37%	37.46%	NOT MET
Access/Utilization of Care				
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.28%	46.23%	42.63%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	54.50%	55.86%	55.40%	NOT MET
*Ambulatory Care—ED Visits per 1,000 Member Months**	74.93	72.50	79.12	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met Target Goal for 2 of #1–3 and 1 of #4–5***			
1. HbA1c Testing	85.42%	81.72%	87.96%	**MET**
2. Medical Attention for Nephropathy	85.65%	84.50%	87.96%	
*3. LDL-C Screening***	80.56%	78.07%	83.56%	
4. Statin Therapy (80% of Eligible Days)	42.11%	46.77%	56.44%	
5. ACEI/ARB Therapy (80% of Eligible Days)	41.67%	44.54%	58.03%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met Target Goal for 2 of #1–4***			
1. Cholesterol Testing	79.79%	78.41%	82.24%	**MET**
2. Statin Therapy 80% of the Time	47.48%	49.04%	59.48%	

Measure	IlliniCare			
	2014 Rate	Target Goal	2015 Rate	Overall Result
3. ACEI/ARB Therapy 80% of the Time	39.37%	43.92%	54.59%	
4. Persistence of Beta-Blocker Treatment After a Heart Attack	96.43%	89.02%	85.00%	
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met Target Goal for 2 of #1–3***			
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	77.11%	75.13%	80.00%	NOT MET
2. Bronchodilator Dispensed within 30 Days of the Event	89.88%	91.71%	88.54%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)****	NA	36.70%	15.93%	

* Lower rates represent better performance for this measure.

** Although the CDC—LDL-C Screening indicator was retired from HEDIS 2015, IlliniCare reported this measure indicator. Therefore, it was included in the results for 2015.

*** The SPR measure required two years of continuous enrollment for members; therefore, it was not applicable for 2014.

IlliniCare achieved a *Met* status for three measures, including 10 individual rates; the other eight individual rates did not meet the target goals. **IlliniCare** achieved a *Met* status for *CAD* for a second consecutive year and improved performance for *CDC* to meet the overall measure goal, after previously failing to meet the overall goal. **IlliniCare** also improved performance for *Follow Up After Hospitalization for Mental Illness* (*FUH)* after previously failing to meet the overall goal.

Aetna and **IlliniCare** failed to meet the target goals for the *PCE* measure category. In addition, neither ICP met the target goals for *Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit*, *Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge*, and *Ambulatory Care—ED Visits per 1,000 Member Months.*

CCAI, Health Alliance, Meridian, and Molina

Table 4-17 through Table 4-20 display the results for the 18 pay-for-performance measures for **CCAI**, **Health Alliance**, **Meridian** and **Molina**, respectively. SFY 2015 represents the first year reporting the ICP measures. For purposes of evaluating performance, the target goals were established using the baseline rates originally intended for evaluating **Aetna** and **IlliniCare**, which were calculated using FFS claims data. To achieve an overall *Met* status, several of the performance measures were grouped together, with each group having specific requirements. For example, the Coronary Artery Disease group consisted of four measures, with a minimum requirement that two of the four rates achieve the target goal in order to achieve an overall result of *Met*. Some performance measures were reported as NA due to the enrollment criteria for the measure.

Table 4-17—ICP Pay-for-Performance Results for 2015 Contracted Goals and Results

Measure	CCAI		
	Target Goal	2015 Rate	Overall Result
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	55.42%	51.94%	NOT MET
Antidepressant Medication Management—Effective Acute Phase Treatment	52.05%	60.00%	**MET**
Antidepressant Medication Management—Effective Continuation Phase Treatment	41.52%	40.00%	NOT MET
Access/Utilization of Care			
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.25%	33.75%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	46.85%	60.65%	**MET**
*Ambulatory Care—ED Visits per 1,000 Member Months**	78.70	100.22	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met Target Goal for 2 of #1–3 and 1 of #4–5***		
1. HbA1c Testing	77.13%	90.35%	NOT MET
2. Medical Attention for Nephropathy	75.42%	84.65%	
*3. LDL-C Screening***	75.63%	NA	
4. Statin Therapy (80% of Eligible Days)	40.85%	38.51%	
5. ACEI/ARB Therapy (80% of Eligible Days)	38.38%	33.31%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met Target Goal for 2 of #1–4***		
1. Cholesterol Testing	76.01%	72.90%	**MET**
2. Statin Therapy 80% of the Time	42.74%	47.98%	
3. ACEI/ARB Therapy 80% of the Time	36.59%	59.11%	
*4. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)****	35.00%	NA	

Measure	CCAI		
	Target Goal	2015 Rate	Overall Result
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met Target Goal for 2 of #1–3***		
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	62.08%	69.39%	**MET**
2. Bronchodilator Dispensed within 30 Days of the Event	78.13%	89.80%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*****	29.67%	NA	

* Lower rates represent better performance for this measure.

** The *CDC—LDL-C Screening* indicator was retired from HEDIS 2015; therefore, it was not applicable for 2015.

*** The *PBH* measure required an event/diagnosis to occur from July 1 of the year prior to the measurement year through June 30 of the measurement year; therefore, it was not applicable for 2015.

**** The *SPR* measure required two years of continuous enrollment for members; therefore, it was not applicable for 2015.

CCAI achieved a *Met* status for four measures, including eight individual rates; the other seven individual rates did not meet the target goals. Additionally, three individual rates were reported as NA. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* indicator was reported as NA because the continuous enrollment criteria for the measure were not met, the rate for *Persistence of Beta-Blocker Treatment After a Heart Attack* indicator was reported as "NA" because the measure required an event/diagnosis to occur prior to program implementation, and the rate for the *Comprehensive Diabetes Care—LCL-C Screening* indicator was reported as NA because it was retired from HEDIS 2015; therefore, it was not applicable for reporting year (RY) 2016.

Table 4-18—ICP Pay-for-Performance Results for 2015 Contracted Goals and Results

Measure	Health Alliance		
	Target Goal	2015 Rate	Overall Result
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	55.42%	56.49%	**MET**
Antidepressant Medication Management—Effective Acute Phase Treatment	52.05%	60.53%	**MET**
Antidepressant Medication Management—Effective Continuation Phase Treatment	41.52%	50.00%	**MET**
Access/Utilization of Care			
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.25%	47.57%	**MET**

Measure	Health Alliance		
	Target Goal	2015 Rate	Overall Result
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	46.85%	54.51%	**MET**
*Ambulatory Care—ED Visits per 1,000 Member Months**	78.70	128.13	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met Target Goal for 2 of #1–3 and 1 of #4–5***		
1. HbA1c Testing	77.13%	87.57%	**MET**
2. Medical Attention for Nephropathy	75.42%	83.16%	
*3. LDL-C Screening***	75.63%	NA	
4. Statin Therapy (80% of Eligible Days)	40.85%	80.44%	
5. ACEI/ARB Therapy (80% of Eligible Days)	38.38%	80.16%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met Target Goal for 2 of #1–4***		
1. Cholesterol Testing	76.01%	64.58%	**MET**
2. Statin Therapy 80% of the Time	42.74%	48.74%	
3. ACEI/ARB Therapy 80% of the Time	36.59%	41.78%	
*4. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)****	35.00%	NA	
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met Target Goal for 2 of #1–3***		
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	62.08%	77.03%	**MET**
2. Bronchodilator Dispensed within 30 Days of the Event	78.13%	85.65%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*****	29.67%	NA	

* Lower rates represent better performance for this measure.

** The *CDC—LDL-C Screening* indicator was retired from HEDIS 2015; therefore, it was not applicable for 2015.

*** The *PBH* measure required an event/diagnosis to occur from July 1 of the year prior to the measurement year through June 30 of the measurement year; therefore, it was not applicable for 2015.

**** The *SPR* measure required two years of continuous enrollment for members; therefore, it was not applicable for 2015.

Health Alliance achieved a *Met* status for eight measures, including 13 individual rates; the other two individual rates did not meet the target goals. Additionally, three individual rates were reported as NA. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* indicator was reported as NA because the continuous enrollment criteria for the measure were not met, the rate for *Persistence of Beta-Blocker Treatment After a Heart Attack* indicator was reported as "NA" because the measure required an event/diagnosis to occur prior to program implementation, and the rate for the *Comprehensive Diabetes Care—LCL-C Screening* was reported as NA because the indicator was retired from HEDIS 2015; therefore, it was not applicable for RY 2016.

Table 4-19—ICP Pay-for-Performance Results for 2015 Contracted Goals and Results

Measure	Meridian		
	Target Goal	2015 Rate	Overall Result
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	55.42%	42.96%	NOT MET
Antidepressant Medication Management—Effective Acute Phase Treatment	52.05%	85.71%	**MET**
Antidepressant Medication Management—Effective Continuation Phase Treatment	41.52%	75.71%	**MET**
Access/Utilization of Care			
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.25%	28.37%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	46.85%	42.42%	NOT MET
*Ambulatory Care—ED Visits per 1,000 Member Months**	78.70	291.49	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met Target Goal for 2 of #1–3 and 1 of #4–5***		
1. HbA1c Testing	77.13%	94.37%	NOT MET
2. Medical Attention for Nephropathy	75.42%	88.73%	
*3. LDL-C Screening***	75.63%	NA	
4. Statin Therapy (80% of Eligible Days)	40.85%	9.46%	

Measure	Meridian		
	Target Goal	2015 Rate	Overall Result
5. ACEI/ARB Therapy (80% of Eligible Days)	38.38%	32.43%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met Target Goal for 2 of #1–4***		
1. Cholesterol Testing	76.01%	76.79%	**MET**
2. Statin Therapy 80% of the Time	42.74%	10.95%	
3. ACEI/ARB Therapy 80% of the Time	36.59%	42.08%	
*4. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)****	35.00%	NA	
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met Target Goal for 2 of #1–3***		
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	62.08%	67.20%	**MET**
2. Bronchodilator Dispensed within 30 Days of the Event	78.13%	87.63%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*****	29.67%	NA	

* Lower rates represent better performance for this measure.

** The *CDC—LDL-C Screening* indicator was retired from HEDIS 2015; therefore, it was not applicable for 2015.

*** The *PBH* measure required an event/diagnosis to occur from July 1 of the year prior to the measurement year through June 30 of the measurement year; therefore, it was not applicable for 2015.

**** The *SPR* measure required two years of continuous enrollment for members; therefore, it was not applicable for 2015.

Meridian achieved a *Met* status for four measures, including eight individual rates; the other seven individual rates did not meet the target goals. Additionally, three individual rates were reported as NA. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* indicator was reported as NA because the continuous enrollment criteria for the measure were not met, the rate for *Persistence of Beta-Blocker Treatment After a Heart Attack* indicator was reported as "NA" because the measure required an event/diagnosis to occur prior to program implementation, and the rate for the *Comprehensive Diabetes Care—LCL-C Screening* indicator was reported as NA because the indicator was retired from HEDIS 2015; therefore, it was not applicable for RY 2016.

Table 4-20—ICP Pay-for-Performance Results for 2015 Contracted Goals and Results

Measure	Molina		
	Target Goal	2015 Rate	Overall Result
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	55.42%	51.89%	NOT MET
Antidepressant Medication Management—Effective Acute Phase Treatment	52.05%	92.31%	**MET**
Antidepressant Medication Management—Effective Continuation Phase Treatment	41.52%	88.81%	**MET**
Access/Utilization of Care			
Ambulatory Care Follow-Up with a Provider within 14 Days of Emergency Department Visit	40.25%	34.39%	NOT MET
Ambulatory Care Follow-Up with a Provider within 14 Days of Inpatient Discharge	46.85%	46.11%	NOT MET
*Ambulatory Care—ED Visits per 1,000 Member Months**	78.70	138.71	NOT MET
Comprehensive Diabetes Care (CDC)	***The CDC measure requires a Met Target Goal for 2 of #1–3 and 1 of #4–5***		
1. HbA1c Testing	77.13%	82.63%	**MET**
2. Medical Attention for Nephropathy	75.42%	79.73%	
*3. LDL-C Screening***	75.63%	NA	
4. Statin Therapy (80% of Eligible Days)	40.85%	40.47%	
5. ACEI/ARB Therapy (80% of Eligible Days)	38.38%	50.09%	
Coronary Artery Disease (CAD)	***The CAD measure requires a Met Target Goal for 2 of #1–4***		
1. Cholesterol Testing	76.01%	66.80%	NOT MET
2. Statin Therapy 80% of the Time	42.74%	38.46%	
3. ACEI/ARB Therapy 80% of the Time	36.59%	52.02%	

Measure	Molina		
	Target Goal	2015 Rate	Overall Result
*4. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)****	35.00%	NA	
Pharmacotherapy Management of COPD Exacerbation (PCE)	***The PCE measure requires a Met Target Goal for 2 of #1–3***		
1. Systemic Corticosteroid Dispensed within of 14 Days of the Event	62.08%	71.24%	**MET**
2. Bronchodilator Dispensed within 30 Days of the Event	78.13%	88.89%	
*3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*****	29.67%	NA	

* Lower rates represent better performance for this measure.

** The *CDC—LDL-C Screening* indicator was retired from HEDIS 2015; therefore, it was not applicable for 2015.

*** The *PBH* measure required an event/diagnosis to occur from July 1 of the year prior to the measurement year through June 30 of the measurement year; therefore, it was not applicable for 2015.

**** The *SPR* measure required two years of continuous enrollment for members; therefore, it was not applicable for 2015.

Molina achieved a *Met* status for four measures, including eight individual rates; the other seven individual rates did not meet the target goals. Additionally, three individual rates were reported as NA. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* indicator was reported as NA because the continuous enrollment criteria for the measure were not met, the rate for *Persistence of Beta-Blocker Treatment After a Heart Attack* indicator was reported as "NA" because the measure required an event/diagnosis to occur prior to program implementation, and the rate for the *Comprehensive Diabetes Care—LCL-C Screening* indicator was reported as NA as the indicator was retired from HEDIS 2015; therefore, it was not applicable for RY 2016.

5. Administrative Compliance

Introduction

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

During state fiscal year (SFY) 2015, HFS' external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), focused on working with HFS to develop and conduct the readiness review process for the Family Health Plan/Accountable Care Act (FHP/ACA), Care Coordination Entities (CCEs), and Accountable Care Entities (ACEs) as part of the expansion of managed care. HSAG conducted a delegation readiness review, performed care coordination staffing reviews, and completed a staffing evaluation for the ACEs and CCEs. Oversight activities for Home and Community-based Services (HCBS) Waiver programs included on-site record reviews for the Integrated Care Program (ICP) and the Medicare-Medicaid Alignment Initiative (MMAI) to monitor performance on the HCBS Waiver performance measures, an annual training and qualifications review of staff serving HCBS enrollees, and monitoring of HCBS provider networks.

HSAG also performed a provider network validation of the health plans' provider networks as a key component of the readiness reviews as well as ongoing, quarterly monitoring of compliance with provider network requirements. Finally, to monitor compliance with updated national guidelines, HSAG conducted a family planning focused review.

Readiness Review Process

Overview

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

Procedure

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

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

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

To complete the readiness review, HSAG assembled a team to:

- Collaborate with HFS to determine the scope of the review and scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Report its findings.

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

Each health plan received a pre-assessment form and document checklist and a customized set of readiness review tools which facilitated the preparation for the review. The pre-assessment form and document checklist contained detailed instructions for preparing for each area of review (e.g., documents to collect, staff to interview). The readiness review tool included requirements that addressed operational areas necessary to service the targeted population and ensure that health plans had the system capacity needed to enroll recipients in their designated service areas. The health plan was expected to describe in detail and provide supporting policies and procedures for the operational areas identified in the tool.

Data Collection and Analysis

Throughout preparation for readiness reviews and performance of on-site reviews, HSAG worked closely with HFS and the health plans to ensure a coordinated and informed approach to completing the required activities. Pre-on-site review activities consisted of scheduling and developing timelines for the site reviews and report development; developing data collection tools, report templates, and on-site agendas; and reviewing documents prior to the on-site portion of the review. The desk review assisted in determining areas that required additional focus during the on-site review.

On-site review activities included a review of additional documents, policies, and committee minutes to determine compliance with federal healthcare regulations and implementation of the organizations' policies. HSAG conducted an opening conference to review the agenda and objectives of the site review and to allow the health plans to present any important information to assist the reviewers in understanding the unique attributes of each organization. On-site interviews included interviews with health plan leadership and staff that managed key operational areas. The on-site interviews were conducted to provide clarity and perspective to the documents reviewed both prior to the site review and on-site, to obtain further information to determine the health plan's compliance with contract requirements, and to review systems demonstrations. HSAG then conducted a closing conference to summarize preliminary findings.

Upon completion of the on-site review, HSAG aggregated all information obtained. HSAG analyzed the findings from the document and record reviews and from the interviews. HSAG analyzed the review information to determine the organization's performance and used the designations *Met*, *Partially Met*, and *Not Met* to document the degree to which the health plan complied with the requirements. Certain elements were designated by HFS and HSAG as critical and had to be in compliance prior to a health plan receiving enrollment.

HSAG noted any elements that were identified as *Partially Met* and *Not Met* and the corrective action the health plan needed to take to bring the requirement into compliance. HSAG used the standardized monitoring tools to document follow-up on any elements that required corrective action. Corrective actions were monitored by HSAG and HFS until successfully remediated.

Using information obtained during the on-site readiness review and desk review, HSAG and HFS determined, prior to client enrollment, whether each health plan's internal organizational structure, health information systems, staffing, and oversight were sufficient to ensure compliance with contract requirements, quality oversight, and monitoring. Once the health plan began enrollment, monthly reports on care coordination, enrollment, network development, and staffing were submitted to both HFS and HSAG. The reports were reviewed and analyzed by HSAG and HFS. Ongoing feedback was provided by HSAG and HFS to the health plans following review of the required reports.

Provider Network Analysis for Readiness Reviews

HSAG is contracted to conduct an analysis of the health plans' provider networks as a key component of pre-implementation readiness reviews. The purpose of the provider network review prior to

implementation is to evaluate the progress of each health plan in contracting and credentialing providers to ensure sufficient network capacity to serve enrollees. The network analysis allows HFS to evaluate the provider network across the health plans using a standardized approach. This process ensures that the health plans are analyzed with a consistent methodology that allowed for fair comparisons, and that each health plan has a broad range of specialties and services to provide access to care and services to its enrollees.

Each health plan was required to submit a provider file that included all contracted and credentialed providers within its network. HSAG analyzed the provider network for the following provider types:

- Primary care providers
- Specialty providers
- Facilities
- Hospitals
- Behavioral health providers
- Skilled nursing facilities

HSAG also conducted a review of the Home and Community Based Services (HCBS) provider network for the contractually required service types.

The provider network analysis included a review of the number and types of providers by county and region for the contracted service areas. The data collected for each provider type included:

- Demographics
- Provider specialty type (e.g., cardiothoracic surgery)
- County served
- Contract status
- Credentialing status, to include approval by the Credentialing Committee
- Appropriate inclusion in the provider directory
- Providers located in counties contiguous to the service area, if applicable

Analysis and Data Integrity

HSAG assessed the provider network data submitted by the health plans for the following to ensure consistency and accuracy:

- **Duplicate entries**—A provider may be counted more than once if it offers the same service at two or more sites, or two or more services at the same site.
- **Lack of standardization of provider types and specialties**—Health plans were required to report a prescribed list of provider types, facilities, hospitals, and HCBS services.

- **Providers contracted, credentialed, and loaded in the network database**—Health plans were required to complete the contracting and credentialing processes before loading providers and facilities in the database.
- **Comparison to external resources**—Provider, facility, HCBS, and/or HCBS services were compared to external resources to compare the providers and services reported by the health plans to those potentially available for possible contracting.

Reporting and Resubmission

Following analysis of the data, HSAG reviewed the results with HFS and each health plan to include the following: data integrity issues; provider, facility, hospital, and HCBS service distribution per county; identification of network deficiencies; identification of items requiring action by the health plan; and determination of subsequent resubmission of the health plan provider network data based on the network analysis findings.

FHP/ACA Readiness Reviews

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

Table 5-1 details the FHP/ACA review activities conducted in SFY 2015, as well as the "go live" date for each health plan which indicates when the health plan began accepting enrollment for the FHP/ACA program.

Table 5-1—FHP/ACA Pre-Implementation Readiness Reviews

Operational Readiness Reviews		
Program	**Health Plan**	**Date of Review**
FHP/ACA	**Aetna Better Health (Aetna)**	July 21–22, 2014
	Blue Cross Blue Shield of Illinois (BCBSIL)	August 7–8, 2014
	Health Alliance Connect, Inc. (Health Alliance)	July 10–11, 2014
	IlliniCare Health Plan, Inc. (IlliniCare)	July 23–24, 2014

Scope of FHP/ACA Pre-Implementation Readiness Review

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

Access Standards:

- Availability of Services
- Assurance of Adequate Capacity and Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Credentialing and Re-credentialing
- Confidentiality
- Enrollment and Disenrollment

Structure and Operations Standards:

- Subcontractual Relationships and Delegation
- Enrollee Information/Enrollee Rights
- Grievance Process
- Critical Incidents

Measurement and Improvement Standards:

- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information System

Program Integrity Standards:

- Fraud and Abuse

In addition, HFS was responsible for reviewing financial management including financial reporting and financial solvency.

Readiness Review Follow-up

Following the pre-implementation readiness review, each health plan worked with HSAG to complete follow-up on all items identified in the Pre-Implementation Status grid. During the pre-implementation readiness review process, each health plan also worked with HSAG to begin submitting provider network data to HSAG. Following receipt of the data, HSAG completed an analysis and validation of the updated provider network capacity and monitored ongoing development of the FHP/ACA provider networks.

Each plan had to remediate critical components identified on the pre-implementation status grid before receiving approval from HFS to accept enrollment. HSAG provided readiness status to HFS who approved health plans to proceed with FHP/ACA enrollment in the designated service areas based on the pre-implementation activities, reporting, and responses to the findings of the pre-implementation readiness reviews.

FHP/ACA Pre-Implementation Readiness Review Findings

The information below is a summary of the readiness review activities for the FHP/ACA program implementation. The items that each health plan was required to follow up on after their pre-implementation readiness review are listed in the summary grids. The background information for each health plan was submitted to HSAG by the health plans in their pre-on-site review documents.

Aetna Better Health

Aetna is a wholly owned subsidiary of Aetna. This experienced managed care company was established in 1853 and is headquartered in Hartford, Connecticut. Aetna offers a range of healthcare services including medical, dental, behavioral health, pharmacy, and long-term coverage. This Fortune 100 Company offers healthcare coverage to over 22 million members nationwide. **Aetna** has built a performance-driven culture focused on its members and the integration of their healthcare across various clinical disciplines and healthcare settings. All training and support activities have been designed to reinforce this culture. **Aetna**'s primary objective is to see that all members receive the right care, in the right place, at the right time through a comprehensive network of providers. These providers also have a support infrastructure which enables them to provide quality care to its members.

Table 5-2—Aetna Access Requirement Findings

Access Requirements	
Requirements	**Description of Findings**
Availability of Services	• No follow-up required.
Assurance of Adequate Capacity and Services	• Submit the network capacity reports to provide additional information on pediatric specialties, behavioral health, and facilities. • Provide a list of the community mental health centers (CMHCs), federally qualified health centers (FQHCs), and provider practices that have medical home accreditation, including the level of accreditation. • Submit policies and procedures that meet the requirements of family planning in the FHP/ACA contract—Attachment XXI—Required Minimum Standards of Care. • Revise the provider Microsoft PowerPoint training to include FHP/ACA benefits, including family planning requirements. • Submit the contraceptives formulary. • Submit training materials for member service staff for the expansion population.

Access Requirements	
Requirements	**Description of Findings**
Coordination and Continuity of Care	• Submit a copy of the Case Management/Care Coordination Productivity report. • Submit an organizational chart that identifies the management and staffing for the long term services and supports (LTSS), and FHP/ACA populations. • Develop and submit the Children with Special Health Care Needs Plan.
Coverage and Authorization of Services	• Revise the clinical practice guidelines for the FHP/ACA populations.
Credentialing and Recredentialing	• No follow-up required.
Confidentiality	• No follow-up required.
Enrollment and Disenrollment	• No follow-up required.

Table 5-3—Aetna Structure and Operations Requirement Findings

Structure and Operations Requirements	
Requirement	**Description of Findings**
Subcontractual Relationships and Delegation	• Submit a copy of the last quarter delegation oversight committee meeting.
Enrollee Information/ Enrollee Rights	• Submit an organizational chart for member services showing reporting structure and staffing positions added for the FHP/ACA population. • Documentation of additional training for member and provider services management and staff for the expansion population. • Develop and submit policies and procedures for the Colbert and Williams Consent Decrees. • Submit the American Recovery and Reinvestment Act Policy.
Grievance Process	• No follow-up required.
Critical Incidents	• No follow-up required.

Table 5-4—Aetna Measurement and Improvement Requirement Findings

Measurement and Improvement Requirements	
Requirement	**Description of Findings**
Practice Guidelines	• Provide evidence of review and adoption of clinical practice guidelines specific to the FHP/ACA population.
Quality Assessment and Performance Improvement Program	• Revise the Quality Assessment and Performance Improvement (QAPI) plan to incorporate the requirements of the FHP/ACA population. • Submit a copy of the organizational chart for the quality program to identify all QAPI resources and the chief medical officer. • Submit a copy of the QAPI work plan. • Ensure all policies and procedures have been revised to include the needs of the FHP/ACA population.
Health Information System	• Submit enrollment file testing results prior to "Go Live."

Table 5-5—Aetna Program Integrity Requirement Findings

Program Integrity Requirements	
Requirement	**Description of Findings**
Fraud and Abuse	• No follow-up required.

Blue Cross Blue Shield of Illinois

BCBSIL (a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association) is the largest and the most experienced health insurance company in Illinois, providing more than 7 million members with comprehensive and affordable health plans. **BCBSIL** provides its members with a high level of confidence and security. **BCBSIL** health plans include flexible benefit designs and access to the largest network of hospitals and physicians in the State. **BCBSIL** is committed to the highest standards of business ethics and integrity, as well as to fulfilling its corporate citizenship responsibilities to the communities it serves.

Table 5-6—BCBSIL Access Requirement Findings

Access Requirements	
Requirements	**Description of Findings**
Availability of Services	• No follow-up required.
Assurance of Adequate Capacity and Services	• Provide data for analysis of the network capacity reports. Provide additional information for the pediatric specialties, facilities, behavioral health, and hospitals. • Submit policies and procedures that support the requirements of the medical home. • Provide a list of the CMHC, FQHCs and provider practices that have medical home accreditation, including the level of accreditation. • Submit policies and procedures that meet the requirements of family planning in Attachment XXI—Required Minimum Standards of Care. • Submit Family Planning—contraceptive formulary. • Update the provider manual to include FHP/ACA benefits and provide a link to the manual when finalized. • Revise the Appointment and Availability survey tool to include the additional FHP/ACA appointment standard. • Revise the Network Adequacy policy and procedure to include the network capacity standards for the FHP/ACA contract.
Coordination and Continuity of Care	• Submit a copy of the case management/care coordination productivity reports, caseloads, risk levels, and contacts. • Submit the Children with Special Health Care Needs Plan. • Submit an implementation plan for timely processing of the Integrated Predictive Modeling scores.
Coverage and Authorization of Services	• No follow-up required.
Credentialing and Recredentialing	• No follow-up required.
Confidentiality	• No follow-up required.
Enrollment and Disenrollment	• No follow-up required.

Table 5-7—BCBSIL Structure and Operations Requirement Findings

Structure and Operations Requirements	
Requirement	**Description of Findings**
Subcontractual Relationships and Delegation	• No follow-up required.
Enrollee Information/ Enrollee Rights	• Member handbook, identification card, and welcome packet. Submit evidence of HFS approval. • Submit training materials for the Crisis Line training module.
Grievance Process	• No follow-up required.
Critical Incidents	• Develop and submit a policy and procedure for handling abuse and neglect for children.

Table 5-8—BCBSIL Measurement and Improvement Requirement Findings

Measurement and Improvement Requirements	
Requirement	**Description of Findings**
Practice Guidelines	• Provide evidence, minutes of review, and adoption of clinical practice guidelines specific to the FHP/ACA population.
Quality Assessment and Performance Improvement Program	• Ensure all requirements as outlined in Section XXI of the HFS contract are included in the QAPI.
Health Information System	• Submit enrollment file testing results prior to "Go Live." • Submit an overview of the process for identifying the FHP/ACA population within the Health Information Technology (HIT) system.
Critical Incidents	• Develop and submit a policy and procedure for handling abuse and neglect for children.

Table 5-9—BCBSIL Program Integrity Requirement Findings

Program Integrity Requirements	
Requirement	**Description of Findings**
Fraud and Abuse	• No follow-up required.

Health Alliance Connect, Inc.

With focus on quality, local customer service, and wellness, plus tens of thousands of doctors in the network, hundreds of network hospitals, and more than 600 employees and growing, **Health Alliance** delivers top-notch health insurance to its members. **Health Alliance** maintains a comprehensive network of medical providers and home and long-term support services to meet the needs of its membership. **Health Alliance** Family Health Plan (FHP) has a diverse network to ensure that all service needs of the membership can be met. FHP helps improve the management and coordination of medical and support services for families, men, women, and children not eligible for Medicare. These support services include family planning services and supplies, well-child visits, coordination of community resources, and more. **Health Alliance** serves FHP members in the Central Illinois service area.

Table 5-10—Health Alliance Access Requirement Findings

Access Requirements	
Requirements	**Description of Findings**
Availability of Services	• No follow-up required.
Assurance of Adequate Capacity and Services	• Submit minutes from the Needs Assessment committee, if available, and any documentation of the network needs for the FHP/ACA population. • Submit dental provider information when available—in contract negotiations with Denta Quest. • Submit policies and procedures that meet the requirements of family planning in Attachment XXI—Required Minimum Standards of Care.
Coordination and Continuity of Care	• Submit a screen shot of the Claims Risk versus User Risk tab. Evaluate the use of the claims versus user risk stratification. • Submit an example of a care management (CM) case load report and any other CM management reports.
Coverage and Authorization of Services	• Family Planning and Reproductive Health Care—Submit updated prior authorization policies and procedures to align with Attachment XXI of the FHP-ACA contract. Include pharmacy policies. • Family Planning and Reproductive Health Care—Submit formulary including contraceptives.
Credentialing and Recredentialing	• No follow-up required.
Confidentiality	• No follow-up required.
Enrollment and Disenrollment	• No follow-up required.

Table 5-11—Health Alliance Structure and Operations Requirement Findings

Structure and Operations Requirements	
Requirement	**Description of Findings**
Subcontractual Relationships and Delegation	• No follow-up required.
Enrollee Information/ Enrollee Rights	• Member handbook–Health Alliance is in the process of updating the member handbook. Obtain HFS approval, submit approval notice from HFS. • Submit the welcome script for the expansion population. • Submit training materials for member service staff for the expansion population. • Submit the call center welcome scripts for HFS review. • Update the member services organizational chart to clearly identify the staff allocated for the expansion population. Identify customer service staff versus the health risk screening staff.
Grievance Process	• No follow-up required.
Critical Incidents	• No follow-up required.

Table 5-12—Health Alliance Measurement and Improvement Requirement Findings

Measurement and Improvement Requirements	
Requirement	**Description of Findings**
Practice Guidelines	• Submit any additional practice guidelines for the FHP/ACA populations.
Quality Assessment and Performance Improvement Program	• Revise and submit the program description as necessary to incorporate the requirements of the FHP/ACA contract.
Health Information System	• Submit enrollment file testing results prior to "Go Live." • Work with HFS on the eligibility status code for identification of the ACA population.

Table 5-13—Health Alliance Program Integrity Requirement Findings

Program Integrity Requirements	
Requirement	**Description of Findings**
Fraud and Abuse	• Submit the fraud, waste, and abuse plan if any changes have occurred.

IlliniCare Health Plan, Inc.

IlliniCare is a managed care organization (MCO) contracted with HFS to provide health services for Medicaid recipients under the FHP. **IlliniCare** staff members include doctors, nurses, and behavioral health case workers, and **IlliniCare** is a wholly owned subsidiary of Centene Corporation. Centene Corporation, a Fortune 500 company, is a diversified, multinational healthcare enterprise that provides a portfolio of services to government-sponsored healthcare programs, focusing on under-insured and uninsured individuals. The company operates local health plans and offers a range of health insurance solutions. It also contracts with other healthcare and commercial organizations to provide specialty services including behavioral health management, care management software, correctional healthcare services, dental benefits management, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy, and telehealth services.

Table 5-14—IlliniCare Access Requirement Findings

Access Requirements	
Requirements	**Description of Findings**
Availability of Services	• No follow-up required.
Assurance of Adequate Capacity and Services	• Revise network capacity standards to meet the requirements of the FHP/ACA population. • Submit policies and procedures that support the requirements of the medical home. • Revise provider training to include FHP/ACA benefits, including family planning requirements. • Submit an organizational chart that identifies the management and staffing for the LTSS and FHP/ACA populations. • Submit an organizational chart that identifies the Medical Management staffing for the LTSS and FHP/ACA populations including names and FTEs. • Submit policies and procedures that meet the requirements of family planning in Attachment XXI—Required Minimum Standards of Care. • Family Planning and Reproductive Health Care—Submit formulary including contraceptives.
Coordination and Continuity of Care	• Submit an organizational chart that identifies the Medical Management staffing for the LTSS and FHP/ACA populations including names and FTEs. • Develop and submit the Children with Special Health Care Needs Plan.
Coverage and Authorization of Services	• No follow-up required.
Credentialing and Recredentialing	• No follow-up required.
Confidentiality	• No follow-up required.
Enrollment and Disenrollment	• No follow-up required.

Table 5-15—IlliniCare Structure and Operations Requirement Findings

Structure and Operations Requirements	
Requirement	**Description of Findings**
Subcontractual Relationships and Delegation	• Submit a copy of the last quarterly delegation oversight committee meeting minutes.
Enrollee Information/Enrollee Rights	• Member handbook, identification card, and welcome packet. Submit evidence of HFS approval. • Submit an organizational chart for member services showing reporting structure and staffing positions added for the FHP/ACA population. • Develop and submit policies and procedures for the Colbert and Williams Consent Decrees. • Submit the American Recovery and Reinvestment Act Policy.
Grievance Process	• No follow-up required.
Critical Incidents	• Submit Critical Incident Report Templates.

Table 5-16—IlliniCare Measurement and Improvement Requirement Findings

Measurement and Improvement Requirements	
Requirement	**Description of Findings**
Practice Guidelines	• Submit approval and adoption of revised clinical practice guidelines specific to the FHP/ACA population.
Quality Assessment and Performance Improvement Program	• Submit a copy of the Cultural Competency Plan.
Health Information System	• Provide an overview of the process for identifying the FHP/ACA population within the HIT system.

Table 5-17—IlliniCare Access Requirement Findings

Program Integrity Requirements	
Requirement	**Description of Findings**
Fraud and Abuse	• Submit a copy of the Compliance Committee meeting minutes from last quarter.

CCE Pre- and Post-Implementation Administrative Reviews

HFS launched the Coordinated Care Innovations Project in 2011. A goal of this project was to allow providers to design and offer care coordination models other than traditional MCOs, while supporting recipients as they transitioned from a fee-for-service program into managed care. Provider groups were chosen to form CCEs to coordinate and deliver services to seniors and adults as well as children with complex conditions using holistic, cost-efficient approaches.

HSAG conducted pre-implementation readiness reviews for the CCEs to determine, prior to client enrollment, whether each CCE's internal organizational structure, health information systems, staffing, and oversight were sufficient to ensure ongoing compliance with contract requirements, quality oversight, and monitoring. In SFY 2015, HSAG also conducted post-implementation administrative reviews of the CCEs that had previously implemented their programs. These reviews focused on the requirements in the executed contract with the State to evaluate each CCE's progress following one year of operation as a CCE. Table 5-18 details the CCE pre- and post-implementation review activities conducted in SFY 2015.

Table 5-18—CCE Operational Reviews

Operational Reviews			
Program	**Pre-Implementation Reviews**	**Post-Implementation Reviews**	**Date of Review**
CCE		**Be Well Partners in Health (Be Well)**	February 2–3, 2015
	Choices Medicaid Care Coordination (CMCC)		September 30–October 1, 2014
		EntireCare Coordination (EntireCare)	January 29–30, 2015
		My Healthcare Coordination (MHCC)	September 16–17, 2014
		Precedence Care Coordination Entity, LLC (Precedence)	September 7–8, 2014
	EntireCare/Southland Care Coordination Partners (SCCP)		August 6, 2014
		Together4Health (T4H)	February 26–27, 2015

Scope of CCE Pre-Implementation Readiness Reviews

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

- Governance Structure, Scope of Collaboration, and Leadership
- Populations and Providers

- Care Coordination Model
- HIT
- Critical Incidents and Grievances

HFS was responsible for reviewing financial management including financial reporting and financial solvency. Pursuant to P.A. 98-104, the CCEs were required to take steps to become a licensed HMO or MCCN within 18 months of being approved and accepting enrollment as an CCE. In their first 18 months of operation, CCEs were reimbursed care coordination fees. CCEs were not required to perform many of the administrative functions of a capitated health plan such as processing claims, submitting encounter data, and implementing utilization control. Therefore, systems management (including claims and encounter data) was not included in the readiness review.

Due to State budget changes, the timeline was accelerated for CCEs to become a capitated health plan or partner with an existing health plan to continue care coordination services to beneficiaries. Due to the expedited implementation time frame of this program, the pre-implementation review was conducted prior to the execution of the CCE contracts with HFS.

The readiness review tools included the global CCE model requirements but also focused on each CCE's proposed care coordination model as described in the RFP response. The CCEs were required to submit thorough documentation in the operational areas listed above. HSAG reviewed these areas to determine those that required additional focus during the on-site review. During the on-site readiness review, HSAG conducted CCE staff interviews to obtain further information to determine the CCE's compliance with contract requirements, and HSAG reviewed systems demonstrations when systems were in place for review.

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

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

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

CCE Pre-Implementation Operational Readiness Review Findings

The information below is a summary of the readiness review activities for the CCE program implementation. The background information for CCE was submitted to HSAG by the CCEs in their pre-on-site review documents.

Choices Medicaid Care Coordination

CMCC is a new CCE providing behavioral healthcare management and physical healthcare coordination. **CMCC**'s parent company, Choices, Inc. has provided care coordination services for severely emotionally disturbed youth for 17 years. Choices, Inc. entered into a contract with HFS July 1, 2014, to coordinate the delivery of necessary services for youth with a prior history of mental health crisis service utilization and inpatient psychiatric admissions. Youth targeted for initial enrollment with the **CMCC** were previously served through the State's Screening Assessment and Support Services (SASS) program.

Findings

HSAG conducted an on-site pre-implementation readiness review for **CMCC** on September 30–October 1, 2014. Following the pre-implementation readiness reviews, **CMCC** continued to work with HSAG to complete follow-up on all items identified in the Pre-Implementation Status grid. All elements identified on this grid as critical components of the readiness review were remediated and approved by HFS prior to accepting CCE enrollment in July 1, 2014.

Governance Structure, Scope of Collaboration, and Leadership

CMCC had an operating agreement and organizational structure in place. For governance requirements, **CMCC** was required to follow up on the below items after the pre-implementation review.

- Submit composition of the board of directors.
- Submit executed bylaws and articles of incorporation.
- Submit executed business associate agreements (BAAs).
- Submit an organizational chart with governance structure.
- Submit an independent contractor agreement with the medical director upon execution.
- Submit charters for various committees (i.e., Medical Advisory Committee).

Populations and Geography

CMCC serves youth with a prior history of mental health crisis service utilization and inpatient psychiatric admissions.

CMCC was in the process of developing the provider network and submitted network provider data to HSAG both before, during, and post implementation of the CCE program to ensure network adequacy.

For the populations and geography requirements, **CMCC** was required to receive final HFS approval on the enrollee handbook and welcome packet. The CCE also had to submit the client rights and responsibilities policy and procedure and work with HFS to identify inclusion of a toll-free 24/7 line for enrollees to access care coordination and a PCP for medical care.

Care Coordination Model

Youth enrolled in **CMCC** will receive care coordination services, the frequency of which will be determined by the tier to which the youth is assigned. There are four tiers: crisis, intervention, early intervention, and prevention. Tier assignments are based on the score of the most recent Child and Adolescent Needs and Strengths assessment completed for each youth and the youth's prior service utilization, particularly crisis services, and psychiatric admissions. Care coordination will be delivered using a Child and Family Team approach and the four phases of wraparound.

After the pre-implementation review, **CMCC** was required to follow up on the below items for the Care Coordination Model:

- Submit the Care Coordination Model Program Description and associated policies and procedures.
- Submit a copy of the assessment tools used to identify needs assessment and transitions of care.
- Develop and submit a policy to monitor the 90-business-day timeline required for completion of the health risk assessment.
- Develop a process and training for Choices staff to verify the identity of the authorized representative.
- Include frequency of administration of medications on the Enrollee Care Plan and the Crisis Plan.
- Within six months after the execution date of the contract, develop and maintain a resource manual for care coordinators, enrollees, and enrollees' families detailing local resources.

Health Information Technology

After the pre-implementation review, **CMCC** was required to follow up on the below items for the HIT requirements:

- Continue to work with HFS on processing of the patient roster (enrollment file), provider file, and care coordination claims data (CCCD) file.

EntireCare/Southland Care Coordination Partners

EntireCare expanded its care coordination contract with HFS to provide care coordination services to eligible Medicaid populations residing within additional ZIP codes located in South Suburban Cook and Will County. The expanded service area was referred to as "Entire Care Southland." **SCCP** serves as **EntireCare**'s subcontracting partner to provide the essential care coordination services for Entire Care Southland. **SCCP** represents health organizations, community and faith-based organizations, businesses,

residents, and civic agencies that believe in the value of a healthy community and support community development activities.

Findings

HSAG conducted an on-site pre-implementation readiness review for **SCCP** on August 6, 2014.

Governance Structure, Scope of Collaboration, and Leadership

For governance requirements, **SCCP** needed to finalize and execute the administrative services agreements between **EntireCare** and **SCCP** as well as **SCCP**'s bylaws. Organizational charts showing the authority between the organizations were required as well as interim staffing agreements. **SCCP** was required to revise its Quality Program Description to include several required elements. In addition, **SCCP** submitted staffing, qualifications, and training data to HSAG to allow for monitoring prior to accepting enrollment.

Populations and Geography

With the expanded service areas, **SCCP** also expanded the priority population served to include adults (19–64) with severe mental illnesses, seniors (over 65), as well as non-priority adults 19–64 years old.

SCCP was required to develop a policy and procedure that describes how **SCCP**/**EntireCare** will monitor the provider network as described in Section 5.2.3 of the HFS contract. It was also required that **SCCP** complete development of the member handbook and welcome packet, marketing materials, and the provider manual and obtain HFS approval before accepting enrollment.

Care Coordination Model

The goal for **SCCP**'s care coordination model is addressing the inter-relational aspects of physical, psychological, and social determinants of health status through providing a comprehensive array of coordinated and integrated, timely, accessible services to the targeted population that are culturally competent and promote health literacy.

After the pre-implementation review, **SCCP** was required to follow up on the below items for the Care Coordination Model:

- Revise the **SCCP** Care Coordination Model to include required elements.
- Develop and submit a policy that clearly describes the oversight and monitoring of the timelines for completion of the HRS, HRA, and enrollee care plans.
- Submit a copy of the training curriculum for the care model team.
- Submit a copy of care model training for the provider office sites, if applicable.
- Submit a training outline for the ICT on MicroMD software.

Health Information Technology

SCCP used a standardized, integrated HIT system with functionalities essential to care coordination among members, PCPs, and other providers. After the pre-implementation review, **SCCP** was required to follow up on the below items for the HIT requirements:

- Develop and submit an implementation plan for Mpact Partners care coordination software.

Scope of CCE Post-Implementation Reviews

HSAG conducted a desk review, site visit, and supporting care coordination systems review to evaluate the CCE's operations in the following key areas:

- Governance Structure, Scope of Collaboration, and Leadership
- Populations and Providers
- Care Coordination Model
- HIT
- Critical Incidents and Grievances

The primary objective of HSAG's on-site post implementation administrative reviews was to evaluate CCEs' implementation of their care coordination programs, identify key accomplishments and challenges experienced during the first year of operation, and assess the impact of the CCEs' care coordination models of care.

The post-implementation administrative review included a review of the same areas as the pre-implementation review with a focus on:

- The care coordination model.
- Implementation of HIT to support the care coordination activities.

The pre-implementation readiness review tool was revised to incorporate all requirements in the executed CCE contract in preparation for the post-implementation review. In addition, HSAG developed a care coordination record review tool to review the care coordination documentation to evaluate compliance with the care coordination requirements of the program. The post-implementation tools were shared with the CCEs in preparation for the post-implementation administrative review.

For the care coordination record review, each CCE was required to provide a list of all high-risk enrollees in active care management to HSAG, and a random sample of 20 high-risk enrollees were chosen for the on-site record review. The record review tool consisted of elements to ensure: (1) timeline requirements for the initial health risk screen, comprehensive assessment, and enrollee care plans were met, (2) the care plan is individualized to the enrollee, (3) follow-up of the care plan within the required time frame was met, and (4) a crisis plan had been developed, if necessary.

Post-Implementation Operational Review Summary

The information below is a summary of the review activities for the CCE program implementation. The background information for each CCE was submitted to HSAG by the CCEs in their pre-on-site review documents.

Be Well Partners in Health

Be Well is a Limited Liability Company (LLC) founded in 2010 by four equal partners: MADO Healthcare, Bethany Homes/Methodist Hospital, Norwegian American Hospital, and Neumann Family Services. **Be Well**'s vision is to become the "choice" coordinated care network providing access and care to adults with serious mental illness (SMI). **Be Well**'s value proposition provides meaningful assistance to adults with SMI who need support to manage their health, communicate with providers/families, and self-manage their health conditions and related psychosocial problems. Coordination of care among multiple health and community providers, bridging gaps in care, ensuring that members receive the appropriate level of care, and achieving a higher quality of life are highly important.

Be Well met or partially met 42 of the 53 elements assessed for the care coordination model standard, nine of the 19 requirements for reporting critical incidents and grievances, and five of seven requirements for HIT standards. A review of 10 **Be Well** care coordination records showed overall compliance with all elements of the record review tool; therefore, no further records were reviewed. **Be Well** had 100 percent compliance in all of the target review areas.

EntireCare Coordination

Healthcare Consortium of Illinois (HCI) is a not-for-profit community-based agency that was established in 1991 under the name Southside Heath Consortium. Four hospitals collaborated to view the duplication and insufficient healthcare system serving the impoverished community areas of the southern region of Chicago and to establish a network of physicians and community-based organizations.

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

EntireCare is an operating subunit of HCI. **EntireCare**'s coordination model is based on a person-centered, assessment-based, interdisciplinary approach that identifies a member's required clinical care and nonclinical services and facilitates linkages between other care services.

As a result of the post-implementation review, HFS and HSAG identified deficiencies in **EntireCare**'s Care Coordination Program; as a result, **EntireCare** failed the review.

HCI d/b/a **EntireCare** was notified that HFS identified substantial and serious deficiencies in implementation of the *Contract for Coordination of Services under the Innovations Project for Seniors and Persons with Disabilities, Contract #2013-24-002 EntireCare*.

Pursuant to **EntireCare** CCE Contract Section 4.1.6 and Section 4.2.1, HFS had the authority to determine that any further enrollments would exceed **EntireCare**'s capacity, and the authority to limit the number of enrollees enrolled with **EntireCare** to a level that will not exceed **EntireCare**'s physical and professional capacity as determined by HFS. Given the results of the post-implementation review, HFS believed that **EntireCare** was capable of taking voluntary enrollment only. HFS discontinued auto-assignment for **EntireCare**'s CCE Program on February 11, 2015.

EntireCare was notified that auto-assignment would not be resumed until **EntireCare** demonstrated to HFS, and received written confirmation from HFS, that all deficiencies were addressed and that **EntireCare** was in full compliance with all care coordination requirements of the CCE contract.

EntireCare was placed on a corrective action plan (CAP), and HFS and HSAG continued to work with **EntireCare** to address the following deficiencies:

Care Coordination Program Oversight:

- The medical director does not provide clinical guidance to CCE care coordination staff in operating an effective care coordination program to promote quality of care and prevent potential lapses in the quality of care. (Section 5.6.2.3.1.3 of the contract.)
- The medical director does not participate in staffing, committees, and project teams in the CCE mission to coordinate care. (Section 5.6.2.3.1.5 of the contract.)
- The director of care management does not participate in staffing and determining client population needs.
- The director of care management does not evaluate programming and plan service delivery and staffing. (Section 5.6.2.4.7 of the contract.)
- There was no evidence of monitoring and coordinating staff to ensure quality of services reflective of enrollees' needs. (Section 5.6.2.4.9 of the contract.)

Staffing and Care Coordination Documentation:

- Review of enrollee care coordination records identified that the tier assignment from the performance tracker risk report did not align with the risk level identified in the enrollee record.
- Review of staff assigned to the Care Coordination program identified a lack of qualified staff allocated to licensed staff to oversee the care coordination activities.
- Tier I enrollees were assigned to staff that were not registered nurses (RNs). RNs shall be care managers for Tier 1 enrollees according to Section 5.6.7.3.5.8 of the contract.
- The majority of care coordination records reviewed did not contain evidence that the care managers were completing the comprehensive assessments and care plans. In the majority of cases, the patient navigators were completing the comprehensive assessments and care plans for Tier 1 and Tier 2 enrollees. (Section 5.6.7.3.4 of the contract.)

Health Information Technology Infrastructure:

- **EntireCare** did not have an electronic system to maintain health records as required in Section 5.6.4.4 of the contract.

During remediation, **EntireCare** merged with **NextLevel Health**. **NextLevel** took over the CAP on April 4, 2015, and worked with HFS and HSAG to meet CCE requirements.

My Healthcare Coordination

MHCC has developed and implemented an evidence-based program built on over 20 years of care coordination demonstrations and research. It began its contract with HFS in September 2013, which provided **MHCC** an opportunity to develop and implement a care coordination health plan. **MHCC** developed an extensive provider network that covered Macon and the surrounding counties. **MHCC** worked toward sustainability of the care coordination program and model.

MHCC met or partially met 60 of 68 elements assessed for the care coordination model standard, 10 of the 19 requirements for the reporting of critical incidents and grievances, and seven of the eight requirements for HIT standards. A review of 10 **MHCC** care coordination records showed overall compliance with all elements of the record review tool; therefore, no further records were reviewed.

MHCC had 100 percent compliance in 13 of the 16 target review areas. It was 80 percent compliant in the following areas, indicating room for improvement:

- Completing the initial health risk screening within 30 days after receiving initial notification from the Department.
- Completing a comprehensive assessment within 60 days after receiving initial notification from the Department.
- Developing an individualized care plan within 90 days after the enrollee is enrolled with the CCE.

Precedence Care Coordination Entity, LLC

Precedence CCE is a collaboration of providers and community organizations located in a nine-county region in northwest and central Illinois. This care coordination entity created a governance structure to enable a range of accountable care strategies, including innovative care coordination activities envisioned by the HFS Innovations Project 2013-24-002 and Section 2703 of the ACA. **Precedence** provides a comprehensive collaborative process of systematic care management to all program enrollees. Care navigators assist enrollees to achieve optimal levels of care and to provide real-time communication related to enrollees' healthcare utilization.

Precedence met or partially met all 31 elements assessed for the care coordination model standard, 18 of the 19 requirements for the reporting of critical incidents and grievances, and all seven requirements for HIT standards. A review of 10 **Precedence** care coordination records showed overall compliance with all elements of the record review tool; therefore, no further records were reviewed.

Precedence had 100 percent compliance in 11 of the 15 target review areas. However, the review noted several opportunities for improvement in the following areas:

- Completing the initial health risk screening within 10 days of receiving initial notification from HFS.
- Completing the comprehensive health risk assessment, individual care plan, and crisis plan within 30 days after notification by HFS.

Together4Health

T4H is a limited liability company composed of member providers, member organizations, and member businesses, and governed by a board of managers composed of no more than 19 members, and an additional two-to-four consumers. The mission of **T4H** is to be a regional community health home safety network that supports vulnerable people, including those living with chronic and multiple medical, mental health, and substance use conditions; those living in poverty; those experiencing homelessness; those who are unemployed and underemployed; and those with limited access to services due to cultural or language barriers. **T4H** is committed to going outside its own walls to find and link the people it serves to a full range of services that improve and support the health of the overall community.

T4H met or partially met 38 of 56 elements assessed for the care coordination model standard, 14 of the 17 requirements for the reporting of critical incidents and grievances, and five of six requirements for HIT standards. A review of 10 **T4H** care coordination records showed overall compliance with all elements of the record review tool; therefore, no further records were reviewed.

T4H had 100 percent compliance in seven of the 13 target review areas. The record review also identified 90 percent compliance with the components of crisis plans. However, the review noted several opportunities for improvement in the following areas:

- Completing the initial health risk screening within 30 days of notification from HFS.
- Reviewing an individual care plan with each enrollee every six months or within three business days after a request by the enrollee.

ACE Readiness Reviews

An ACE was a new model of care coordination passed by the General Assembly in May 2013, and signed into law on July 22, 2013 (Public Act 98-104). This model coordinates a network of Medicaid services for children and their family members (initially), as well as ACA Medicaid adults. The State sought a redesigned healthcare delivery system that would provide integrated and accountable care, improve health outcomes, and enhance patient access. HSAG's readiness review was designed to evaluate implementation by the ACEs of their care coordination programs and readiness to provide services.

Table 5-19 details the ACE readiness review activities conducted in SFY 2015, as well as the "go live" date for each ACE which indicates when the ACE began accepting enrollment for the ACE program.

Table 5-19—ACE Operational Readiness Reviews

Operational Readiness Reviews			
Program	**ACEs**	**Date of Review**	**Date of Go Live**
ACE	**Community Care Partners (CCP)**	July 2–3, 2014	September 8, 2014
	UI Health Plus (UIH+)	July 16–17, 2014	September 8, 2014

Scope of the ACE Readiness Reviews

HSAG conducted a desk review, site visit, and network review to evaluate if the ACEs demonstrated appropriate knowledge of ACE contract requirements and systems preparedness in the following key operational areas.

- Organization and Governance
- Care Coordination Model
- Provider Network
- Subcontracts and Delegation
- Enrollee Information
- Complaints and Grievances
- HIT

HFS was responsible for reviewing financial management including financial reporting and financial solvency. Pursuant to P.A. 98-104, the ACEs were required to take steps to become a licensed HMO or MCCN within 18 months of being approved and accepting enrollment as an ACE. In their first 18 months of operation, ACEs were reimbursed care coordination fees. ACEs were not required to perform many of the administrative functions of a capitated health plan such as processing claims, submitting encounter data, and implementing utilization control. Therefore, systems management (including claims and encounter data) was not included in the readiness review.

Due to State budget changes, the timeline was accelerated for ACEs to become a capitated health plan or partner with an existing health plan to continue care coordination services to beneficiaries.

The ACE readiness review tools included the global ACE model requirements but also focused on each ACE's proposed care coordination model as described in the RFP response. The ACEs were required to submit thorough documentation in the operational areas listed above. HSAG reviewed these areas to determine those that required additional focus during the on-site review. During the on-site readiness review, HSAG conducted ACE staff interviews to obtain further information to determine the ACE's compliance with contract requirements and reviewed systems demonstrations when systems were in place for review.

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

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

Following the on-site pre-implementation readiness reviews, HFS and HSAG worked with the ACEs to meet the pre-implementation requirements. HFS worked with each ACE to oversee the organization's ability to accept and process the enrollment file. In an email from HFS prior to enrollment, the ACEs were notified that member enrollment had been approved in response to the initial readiness review process; however, continued approval of enrollment was subject to ongoing monitoring of the following areas: (1) care model staffing capacity and training, (2) monitoring of care coordination activities through record reviews, (3) member call center capacity and metric reporting, (4) provider network capacity, and (5) IT capabilities as enrollment increases and/or expansion into additional counties/service areas occurs.

ACE Care Model Descriptions

This section provides a brief description of each ACE's organizational structure and care coordination model. This background information for ACEs was submitted to HSAG by the CCEs in their pre-on-site review documents.

Community Care Partners

CCP comprises four dedicated partners: NorthShore Physician Associates, Erie Family Health, Lake County Health Department and Community Center, and Vista Heath System with NorthShore being the

ACE lead entity. NorthShore strategically aligned with partners who have had success in managing Medicaid patients, complemented NorthShore capabilities, and have a strong community presence, including behavioral health integration and providing culturally and linguistically appropriate care.

CCP's ACE model leverages key learnings from partners across the entire network to create a system that supports best practices and continuous learning. The vision is to provide end-to-end care and support through a well-coordinated and patient-centric system and develop a model of care that assures access to all necessary care, improves access to specialty care, and clarifies how providers work together to coordinate care. **CCP**'s case management program identifies members with healthcare needs and evaluates those members through a defined assessment process. Members are stratified into levels of care and evaluated using evidence-based assessment tools to develop and implement a coordinated, member-focused, multidisciplinary plan of care. The plan of care is designed to meet the specific health needs of the member with the ultimate goal of helping members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. **CCP**'s social work and case management teams routinely conduct assessments. The assessment process offers insight into barriers to compliance and care, allowing identification of interventions to reduce or eliminate these barriers.

HSAG conducted an on-site pre-implementation readiness review for **CCP** on July 2–3, 2014. Following the pre-implementation readiness reviews, **CCP** continued to work with HSAG to complete follow-up on all items identified in the Pre-Implementation Status grid. The majority of items identified on the pre-implementation status grid were completed and approved prior to accepting ACE enrollment in September 2014.

UI Health Plus

The Patient-Centered Medical Home (PCMH) model of care will serve as the foundation for the **UIH+** care model. To be cost effective, care management needs to be directed at the right patients. For a subset of high-risk individuals, early intervention can reduce the potential for catastrophic medical events—saving money and improving quality of life. **UIH+** employs a dual strategy to identify the subset of high-risk members by: (i) conducting a retrospective review of relevant electronic medical records (EMRs) to identify patients who would benefit from care management, and (ii) hiring dedicated care connection coordinators ("C3s") to ensure that patients receive appropriate treatments. The embedded C3s will be a key component to **UIH+**'s care model. The C3 care managers are the key enabling resources to successfully execute the PCMH model.

Using its integrated and holistic approach to care management, **UIH+** focuses on early identification of high-risk members and then helps them with behavior change, thereby improving patient medical outcomes. The total care approach engages all members with interventions at an appropriate level. Not all enrollees require active care management, but through patient education, support, rewards, and follow-up, **UIH+** works to improve patient health, thus reducing medical spending.

UIH+ is led by a single entity, the University of Illinois Hospital and Health Sciences System, which includes the clinical operations of a 495-bed hospital, over 23 outpatient care clinics, 12 FQHC sites,

and seven health sciences colleges (medicine, nursing, dentistry, pharmacy, public health, social work, and applied health sciences), and employs over 8,000 people.

HSAG conducted an on-site pre-implementation readiness review for **UIH+** on July 16–17, 2014. Following the pre-implementation readiness reviews, **UIH+** continued to work with HSAG to complete follow-up on all items identified in the Pre-Implementation Status grid. The majority of items identified on the grid were completed and approved prior to accepting ACE enrollment in September 2014.

Findings and Conclusions

Based on the readiness review activities, reporting, and responses to the findings, HSAG provided a readiness review status to HFS who provided approval of the ACEs to proceed with enrollment in the designated service areas, with continued monitoring in designated improvement areas as determined for each ACE. HSAG and HFS continued to monitor the ACEs to ensure progress toward the improvement areas and to ensure they had sufficient resources and operational capacity to serve current and future enrollment.

Upon completion of the on-site activities, all deficiencies from the desk review and site visits were identified, and the ACEs were required to remediate each deficiency prior to program implementation. HSAG and HFS used a standardized monitoring tool to document follow-up on any elements that required remediation.

Delegation Readiness Review

HFS has requirements that the health plans must follow when delegating functions or services to vendors to ensure oversight of the delegated organizations because the health plan remains accountable for the delegated functions. Health plans are responsible for monitoring and evaluating delegated services. HFS contracted with HSAG to conduct a review of the contract requirements for delegation oversight and monitoring to validate that **CountyCare Health Plan** (**CountyCare**) had the operational aspects of delegation oversight in place for the delegation of care coordination activities to **Medical Home Network** (**MHN**).

CountyCare delegated care coordination activities for members enrolled in a medical home to **MHN**. HSAG conducted a readiness review to evaluate **MHN**'s care coordination program and key functional areas of operation related to care coordination and delegation to ensure readiness to provide services to **CountyCare**'s medical home enrollees.

Scope of the Delegation Readiness Review

The readiness review included review of:

- The written executed agreement that includes provisions for a predelegation audit; quarterly delegation oversight review by the delegation oversight committee; monthly joint operations

meetings; an annual audit of the delegated activities; regular monitoring of enrollee complaints, grievances, provider complaints, and quality of care concerns regarding the delegated activities; potential development of a corrective action plan to improve performance; the subcontractor's accountability and the frequency of reporting; **CountyCare**'s responsibility for the performance of any of its delegated services; **CountyCare**'s right to terminate any subcontract or impose other sanctions if the subcontractor's performance is inadequate.

- Written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
- Evidence of a delegated oversight committee which provides oversight of subcontractors to ensure compliance.
- The **MHN** care coordination model of care.

The delegation readiness review tool included 61 elements focused on **MHN**'s care coordination model, medical home competencies and provider network, case management systems and functions, care coordinators, caseload requirements and standards, and quality assurance, as well as key care coordination activities such as outreach, screening, assessment, and care planning.

Care Model Descriptions

This section provides a brief description of the organizational structure and care coordination model of **CountyCare** and **MHN**. These organizations submitted this background information to HSAG in their pre-on-site review documents.

CountyCare Health Plan

CountyCare was established in October 2012 under CMS' 1115 Waiver, which provided for the early enrollment of ACA-eligible adults. **CountyCare** obtained health plan status on July, 1 2014, allowing the provider-owned/operated health plan to serve all Medicaid beneficiaries living in Cook County. **CountyCare** has a broad network of providers geographically dispersed throughout Cook County including nearly 150 primary care access points (which include FQHCs and American Indian Health Services), more than 35 community hospitals, six academic medical centers, and hundreds of ancillary providers.

Medical Home Network

MHN is a 5-year-old formal provider collaborative working to transform healthcare delivery for Medicaid recipients in Chicago by enhancing care coordination and quality, improving access, and reducing fragmentation and cost, all while reinforcing the medical home. In 2009, the Comer Science and Education Foundation (CSEF) established **MHN** as a pilot dedicated to improving the health of Medicaid recipients residing on Chicago's South Side. **MHN**'s network comprises six hospital systems and their primary care practices and six FQHCs, one of which included Cook County Health and Hospitals System (CCHHS). In May 2014, MHN ACO, LLC was formed, owned by nine FQHCs and three non-profit hospitals systems—all of which are critical safety net providers who serve a diverse

group of patients. The owners of the LLC are the anchor providers that serve the **CountyCare** membership.

Findings and Conclusions

Following the readiness review, **CountyCare** and **MHN** worked with HSAG to complete follow-up on any deficient items. **CountyCare**/**MHN** had to remediate critical elements identified in the review as noncompliant before receiving approval from HFS. **MHN** was approved to begin delegated care coordination activities for **CountyCare**'s high- and medium-risk enrollees on December 1, 2015.

Annual Care Coordination Staffing Reviews

HSAG is contracted to conduct an annual review of health plan compliance with requirements for care coordination/care management (CC/CM) staff qualifications, related experience, full-time equivalent (FTE) allocation, caseload assignments, and training. HSAG reviewed the contract requirements for care coordinators serving nonwaiver populations as well as those serving the HCBS waiver populations. HSAG developed review criteria and an evaluation tool to standardize the review process as well as a project timeline for conducting the annual staffing and training reviews. The standardized data collection tool (i.e., Staffing, Qualifications, and Training Workbook [workbook]) collects the names and credentials of staff members, as well as their positions, hire dates, education, related experience, licensures, and FTE allocations.

To determine the total FTE allocation serving the waiver population for a health plan, HSAG requested that the health plans provide an FTE equivalent of each staff member assigned to waiver enrollees. When a staff member served both waiver and nonwaiver enrollees, then health plans provided the portion of that staff member's FTE that was allocated to serving the waiver population. The workbook auto-calculates the cumulative weighted caseload for each staff member across programs and indicates when the weighted caseload total exceeds contract requirements to ensure each care coordinator responsible for enrollees with varying risk levels had an overall caseload that met case limit and case mix requirements.

HSAG reviewed the qualifications and training requirements for the care coordinators as applicable to each of the programs. The data and documentation were reviewed and compared to program requirements for mandated training. Caseload, training, and qualifications categories were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

Staffing Evaluation for Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs)

HSAG conducted a staffing, qualifications, and training evaluation of the ACEs and CCEs to assess and monitor staffing efforts during program implementation. HSAG developed a standardized data collection tool to gather data for the staffing, qualifications, training, and FTE allocations of the care coordination, decision support, quality committee, and call center staff. The tool collected the names and credentials of staff members, as well as information such as their positions, hire dates, education, related experience, training completion, licensures and certifications, languages spoken, and FTE allocations.

HSAG calculated the data to produce a dashboard which displayed the staffing trends for each ACE and CCE so that staffing ratios could be easily monitored as the ACEs and CCEs completed hiring to implement their programs. HFS and HSAG used these reports to ensure the ACEs and CCEs were complying with contract requirements for staff qualifications, training, and FTE ratios.

Care Coordination Reporting

HFS also wanted to monitor the ACEs/CCEs care coordination activities throughout program implementation. HSAG designed care coordination report that ACEs/CCEs were required to submit on a monthly basis. The report captured enrollment, number of completed health risk screenings, and categorized the percentages of risk stratifications that were completed. The report also documented how many comprehensive assessments and enrollee care plans were completed each month.

These reports allowed HFS and HSAG to monitor the outreach efforts employed by the ACEs/CCEs to locate and engage enrollees and their success in completing care coordination activities with those enrollees.

Oversight Activities for HCBS Waiver Programs

CMS HCBS Waiver Performance Measures Record Reviews

Overview

HFS works in partnership with its operating agencies, contractors, and CMS to oversee the design and implementation of each waiver's quality improvement system. To monitor the quality of services and supports provided to the HCBS waiver program enrollees, HSAG began on-site record reviews for ICP and MMAI health plans in SFY 2014 to monitor performance on the HCBS Waiver performance measures. HSAG developed a sampling methodology based on the waiver requirements approved by HFS. In SFY 2015, HSAG continued quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the measures. Ongoing performance was monitored through quarterly record reviews, plan-specific feedback, and remediation of record review findings. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, resulting in better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS Waiver enrollees.

Sampling Methodology

A two-step protocol for selecting a statistically valid, representative sample of waiver enrollees was developed to account for small waiver population sizes in some of the plans. Based on enrollment data received from HFS, HSAG first determined the appropriate sample size by plan and by waiver. Next, the appropriate sample size by waiver program based on the plan distribution was determined. Once the required sample sizes were determined, the larger of the two sample sizes from each plan-waiver combination was used to generate the final sample size, which ensures that the minimum required confidence level (95 percent) and margin of error (five percent) were maintained when the samples were combined. Additionally, a ten percent oversample based on the proportional distribution of enrollees across plans was selected.

Development of a Web-Based Abstraction Tool and Reporting Database

An electronic web-based abstraction tool and reporting database were developed by HSAG to collect and store the data gathered during on-site record reviews. The automated tool included all waiver performance measures gathered from the review of records, as well as contract requirements, and was modeled after the current tool used by the State to monitor the fee-for-service population to ensure all waiver enrollees are monitored in a similar manner.

Interrater Reliability—(IRR)

HSAG conducts ongoing validation during reviewer training and record abstraction to ensure accurate collection and recording of data. Each reviewer is required to maintain a 95 percent accuracy rate. If a reviewer fails to maintain a 95 percent accuracy rate, retraining is completed. The reviewer is allowed to resume abstraction, and the over-read rate is increased to 100 percent until the reviewer reaches the

established accuracy rate of 95 percent. If the reviewer does not return to the established accuracy rate, the reviewer will not be allowed to continue reviewing cases and will be removed from the project.

Remediation Tracking

HSAG's report of findings was submitted to the State within 30 days of each review. Findings were reported for each plan reviewed and as a summary by waiver. Once approved by the State, the report of findings was forwarded to each plan for remediation. HSAG developed a remediation tracking database which details findings related to waiver performance measures, as well as contract requirements. The remediation tracking database tracks the date the plan was notified of findings, the date the remediation action was completed (as reported by the plan), and the number of days from notification of the finding until the remediation action was completed. HFS and each plan have access to their respective reports and the remediation tracking database via the HSAG Web portal.

Remediation Validation

HSAG will conduct validation reviews while on-site for subsequent monitoring reviews. A portion of sample enrollees from each waiver will be selected and their records examined to ensure remediation occurred and was reported accurately by the plan. HSAG will complete the validation reviews during SFY 2016.

Waiver Programs Included in SFY 2015 Reviews

The following HCBS Waiver Programs were included in the CMS Performance Measures record reviews:

- Persons with Physical Disabilities (PD)
- Persons with HIV/AIDS (HIV)
- Persons with Brain Injury (BI)
- Persons who are Elderly (ELD)
- Persons in a Supportive Living Facility (SLF)

CMS Performance Measures Description

Table 5-20 provides a description of the 12 CMS performance measures, including the identification of waiver-specific measures.

Table 5-20—CMS Waiver Performance Measure Descriptions

Measure #	Measure Description
26C	Number and percentage of enrolled non-licensed/non-certified Waiver service providers by provider type, who meet initial Waiver provider qualifications. Measured by the following: The personal assistant evaluation is completed and in the record at the time of the most recent assessment/reassessment (BI, HIV, and PD Waivers).
31D	The most recent care plan includes all enrollee goals as identified in the comprehensive assessment.
32D	The most recent care plan includes all enrollee needs as identified in the comprehensive assessment.
33D	The most recent care plan includes all enrollee risks as identified in the comprehensive assessment.
35D	The most recent care/service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.
36D	PD Waiver—The case manager made annual contact with the enrollee or there is valid justification in record.
	HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record. (prior to March 2014) The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record. (after March 2014)
	BI Waiver—The case manager made valid contact with the enrollee at least 1 time a month, or valid justification is documented in the enrollee's record.
37D	PD, HIV, SLF, and ELD Waivers—The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
	BI Waiver—The most recent care/service plan is in the record and completed in a timely manner. (Completed within 6 months from review date)
38D	The care/service plan was updated when the enrollee needs changed.
39D	The most recent care/service plan includes the type, amount, and frequency of services (including the number of hours each task is to be provided per month).
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
49G	BI, HIV, PD Waivers—The most recent care plan includes the name of the backup personal assistant (PA) service (if receiving PA).

ICP Record Reviews

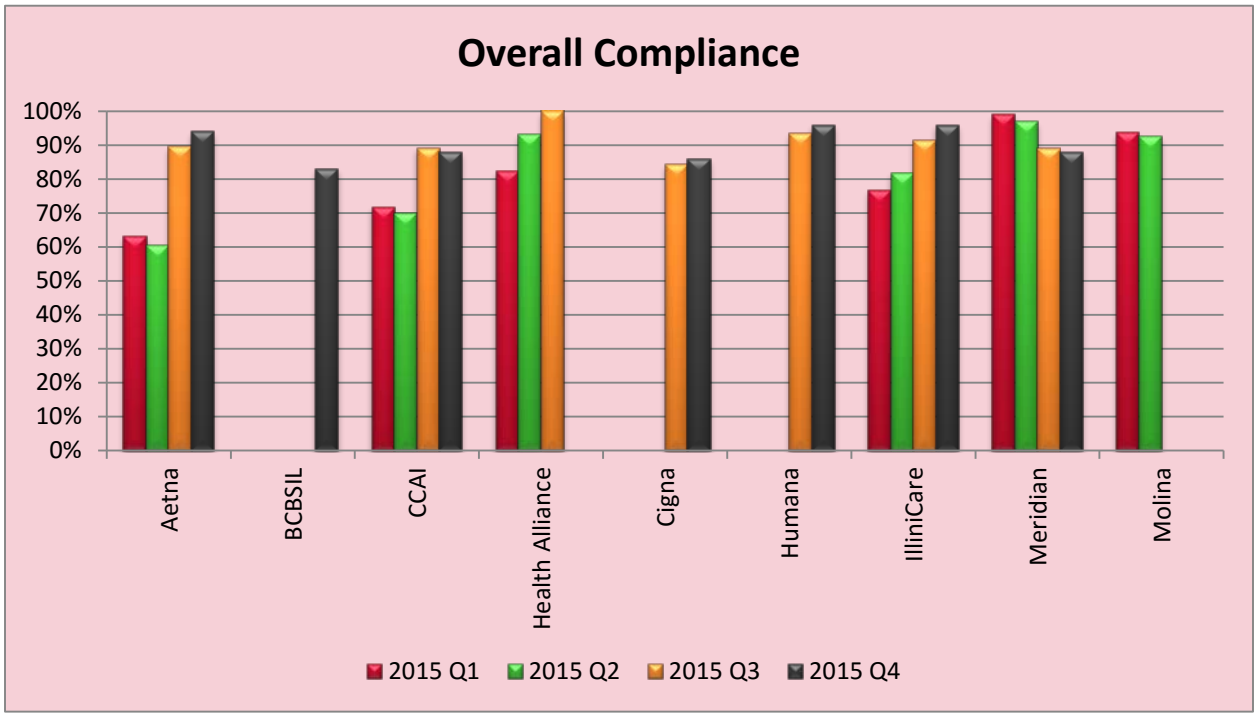
Due to the phased-in implementation of the ICP and to ensure health plans were allowed sufficient time to establish their membership, not all plans were reviewed across all quarters during SFY 2015. Table 5-21 displays the ICP health plans reviewed by quarter.

Table 5-21—MCO Reviewed by Quarter SFY 15

ICP Health Plan	Q1	Q2	Q3	Q4
Aetna	X	X	X	X
IlliniCare	X	X	X	X
Meridian Health Plan, Inc. (Meridian)	X	X	X	X
Molina Healthcare of Illinois, Inc. (Molina)	X	X	-	-
Health Alliance	X	X	X	-
Community Care Alliance of Illinois (CCAI)	X	X	X	X
BCBSIL	-	-	-	X
Cigna-HealthSpring of Illinois (Cigna)	-	-	X	X
Humana Health Plan, Inc. (Humana)	-	-	X	X

Nine plans were reviewed during quarters 1 and 4 of SFY 2015. Figure 5-1 displays a computed average of the percentages achieved by each ICP health plan on all 12 CMS waiver performance measures reviewed by the EQRO in Q1–Q4 SFY 2015. Each plan's overall average on the 12 CMS HCBS waiver performance measures is used as a comparison of overall compliance for each plan and as a compliance comparison across plans.

Figure 5-1—Overall ICP Compliance



As evidenced by Figure 5-1, **Health Alliance**, **Cigna**, **Humana,** and **IlliniCare** realized improvements in every quarter they were reviewed. **Cigna** and **Humana**'s performance differences were 2 percentage points each and represent normal variation.

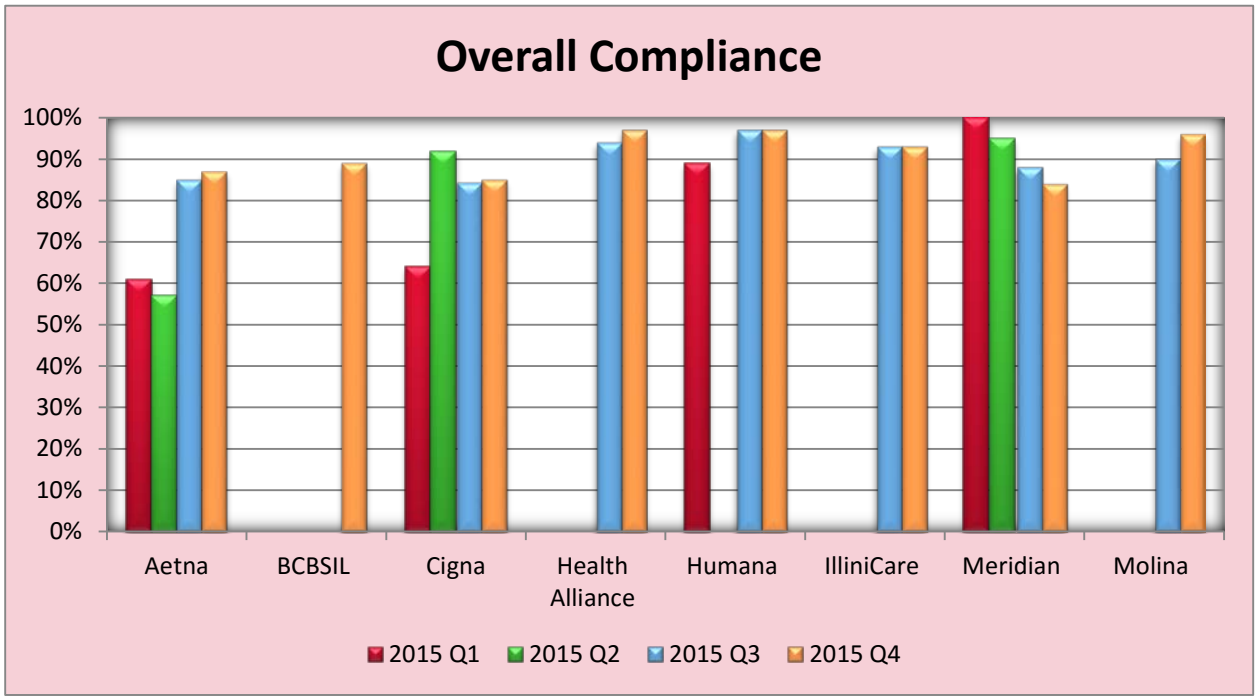
- **Aetna** realized a statistically significant increase in overall performance (p=<0.0001) from Q1 (63 percent) to Q4 (94 percent).
- **CCAI** realized a statistically significant increase in overall performance (p=<0.0001) from Q1 (72 percent) to Q4 (88 percent).
- **IlliniCare** realized a statistically significant increase in overall performance (p=<0.0001) from Q1 (77 percent) to Q4 (96 percent).

Meridian and **Molina** realized a decrease in performance in every quarter they were reviewed. **Molina**'s performance difference was 1 percentage point only and represents normal variation. **Meridian**'s decrease was statistically significant (p=<0.0001) from Q1 (99 percent) to Q4 (88 percent).

MMAI Record Reviews

A total of eight plans were reviewed during quarters 1 and 4 of SFY 2015. Figure 5-2 displays a computed average of the percentages achieved by each plan on all 12 CMS waiver performance measures reviewed by the EQRO in Q1–Q4 SFY 2015. Each plan's overall average on the 12 CMS HCBS waiver performance measures is used as a comparison of overall compliance for each plan and as a compliance comparison across plans.

Figure 5-2—Overall MMAI Compliance



As evidenced by Figure 5-2, **Health Alliance** and **Molina** realized improvements in every quarter they were reviewed, and four plans had statistically significant changes from Q1 to Q4 performance:

- **Aetna** realized a statistically significant increase in overall performance (p=<0.0001) from Q1 (61 percent) to Q4 (87 percent).
- **Cigna** realized a statistically significant increase in overall performance (p=<0.0001) from Q1 (64 percent) to Q4 (85 percent).
- **Humana** realized a statistically significant increase in overall performance (p=0.0043) from Q1 (89 percent) to Q4 (97 percent).
- **Meridian** demonstrated a statistically significant decrease in overall performance (p=0.0008) from Q1 (100 percent) to Q4 (84 percent).

HCBS Waiver Program Post-Implementation Monitoring Overview

HSAG identified the following systemic remediation recommendations to address the record review findings.

- Case Manager Training—Training or retraining of case managers/care coordinators within 60 days, and on an ongoing basis, to ensure staff understand CMS Waiver Performance Measure documentation requirements**.** Training should focus on the deficiencies identified in the record reviews, include education on person-centered care planning, and be documented in the remediation tracking database.

- Oversight and Monitoring of Case Manager/Care Coordinator Resources and Activities—Conduct ongoing evaluation of staffing resources to ensure the case management/care coordination activities of HCBS Waiver enrollees can be managed. An oversight process should be developed and implemented to ensure case manager records are reviewed to facilitate compliance with CMS performance measure requirements. The process should evaluate case manager performance in areas such as enrollee satisfaction, percentage of enrollee goals met, compliance with enrollee contact standards, service plan updates, etc. Oversight processes should also monitor remediation actions to ensure timely remediation of record review findings.
- Case Management Systems and Processes—Develop and implement a systematic process to ensure incorporation of the waiver service plan into the care plan, documentation of both enrollee and case manager signatures on the care plan and service plan, and timely completion of the personal assistant evaluation and Participant Outcomes and Status Measures Survey (as applicable). A checklist or process should also be developed to ensure that case managers have the necessary information to complete the required documentation for the initial assessment/reassessment with enrollees. Annual evaluation of the case management program should include input and feedback from staff about case management software and processes, as well as record review findings, in order to implement systematic quality improvement initiatives.

HCBS Waiver Program Post-Implementation Monitoring Overview

The following areas were reviewed and monitored for compliance throughout SFY 2015. Additionally, the health plans were asked to complete a survey to present a thoughtful analysis of their challenges and successes throughout SFY 2015.

- Care Management System—The contract requires that the health plan care coordinators will use the care management system to review assessments, interventions, and management of chronic health conditions to gather information to support enrollee care plans and identification of enrollees' needs.
- Other Management Systems and Documentation—The health plans were asked to provide feedback on other systems that represented challenges, specifically external data systems.
- Unable to Reach Members—A key ingredient of effective care coordination is the ability to communicate with members. Health plans actively attempt to engage members; however, there are continued challenges with members who are unable to be reached.
- Staff Qualifications and Training—The contract outlines the qualifications and training requirements for care coordinators assigned to the HCBS Waiver program enrollees. As part of the oversight process, HSAG conducts an annual review of all health plan staff qualifications and training. Health plans were required to submit staffing, qualifications, and training reports to HFS/HSAG to ensure care coordinators assigned to the HCBS Waiver enrollees had the necessary qualifications, experience, and training required by the contract. During the post-implementation phase, HSAG has continued to work with HFS and the health plans to monitor the staffing resources and ongoing training of the HCBS Waiver care coordinators.
- Determination of Need and Service Planning—The Determination of Need (DON) is an assessment instrument completed by the State operating agencies to determine an individual's nonfinancial

eligibility for HCBS services based on the individual's impairment in the completion of the activities of daily living (ADLs) and the individual's need for care that is not met by existing family and other resources. Health plan access to the DON information is imperative to ensure the unmet needs identified are addressed in the enrollee's care and service plan. HSAG continued to work with HFS and the HCBS Waiver agencies throughout the post-implementation phase to address concerns raised by the health plans regarding communication and access barriers between the plans and the State operating agencies.

- Provider and Community Partnerships—A number of the health plans developed partnerships with community-based providers and organizations to optimize their care coordination activities and use the expertise of organizations that have been involved in providing services to HCBS Waiver enrollees. HFS and HSAG will continue to obtain feedback and monitor the results of these partnerships to determine their impact and effectiveness in improving care coordination for waiver enrollees.
- Health, Safety, and Welfare Monitoring—The contract requires the health plans to comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, including critical incident reporting regarding abuse, neglect, and exploitation (ANE); critical incident reporting regarding any incident that has the potential to place an enrollee, or an enrollee's services, at risk, but which does not rise to the level of ANE; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.
- HCBS Network Review and Validation—The contract describes the required providers for each of the HCBS covered services. The health plans are required to maintain a sufficient provider network to meet the needs of enrollees across all geographical and service type areas. HSAG continues to assist HFS with monitoring the HCBS provider network.
- Monthly and Quarterly Quality Meetings—HFS conducts monthly conference calls and quarterly face-to-face meetings with the health plans. The meetings provide a forum for HFS and the health plans to discuss challenges and barriers, and for sharing best practices.
- Ongoing Waiver Training—HSAG/HFS and the HCBS Waiver agencies have conducted ongoing waiver-specific training sessions for the health plans prior to and following implementation of the HCBS Waiver program. Training topics may be identified through the results of record reviews and through input from the health plans based on individual challenges and needs of their individual programs.

HCBS Annual Training and Qualifications Review

As described above, HSAG's annual care coordination staffing review includes care coordinators that serve HCBS enrollees. The workbook for the HCBS review also contains formulas that calculate the staffing ratios for specific waiver types and staff ratios by program type. In addition, HSAG developed an HCBS Training Requirements Review Tool to capture the training requirements specific to each waiver type.

To evaluate whether health plans met the HCBS training requirements, HSAG reviewed the number of annual training hours completed by HCBS waiver staff, the HCBS Waiver Training Curriculum, and the employee training sign-in sheets. The data and documentation were reviewed and compared to program requirements for mandated training. Training categories were scored as either "Pass" or "Fail." If gaps were identified for health plans, HSAG requested that a corrective action plan be completed within a specified time period.

HCBS Provider Network Monitoring

As described in more detail below, HSAG validates and monitors the network of HCBS providers for each health plan serving HCBS Waiver enrollees.

Validation and Monitoring of Provider Network Capacity

At the request of HFS, HSAG established a process for health plans to submit provider network data for each of their service areas. HSAG evaluates and monitors progress of contracting and credentialing providers to ensure sufficient network capacity. HSAG also uses the provider network submissions to identify potential network gaps and to monitor progress toward establishing an adequate provider network for members. The network analysis allows HFS to evaluate the provider network capacity across the health plans using a multifaceted, iterative, standardized approach. These data are used to support ongoing monitoring, assessment, and reporting activities to evaluate provider network adequacy.

Submission Process

HSAG worked extensively with HFS and the health plans to standardize the format that the health plans use to report the providers in their networks. The standardized format includes standardized provider categories, a protocol to detect and minimize duplication of providers, and expanded provider network reporting including provider counts by county for each health plan.

Health plans are required to submit their provider network data each quarter by completing a standardized Provider File Layout (PFL), which is a Microsoft Excel workbook. MCOs are required to adhere to specific submission instructions for provider network data. The data provided also included all HCBS providers by county and region.

Submission Guidance

HSAG developed a Provider Network Data Submission Instruction Manual (manual) to provide detailed guidance to MCOs to ensure they submitted accurate network capacity data using a consistent file format. The manual accompanied the PFL, and MCOs were required to adhere to this guidance when submitting provider network data.

Reporting and Resubmission

Following analysis of the data, HSAG reviews the results with HFS and each health plan to include the following: data integrity issues; provider, facility, hospital, and HCBS service distribution per county; identification of network deficiencies; identification of items requiring action by the health plan; and determination of subsequent resubmission of the health plan provider network data based on the network analysis findings.

Family Planning Focused Review

Overview

To ensure health plans were complying with the many updated national guidelines regarding the provision of contraceptives, HFS contracted with HSAG to review health plan family planning/reproductive health services policies and procedures.

Procedure

HSAG, in collaboration with HFS, determined the scope of the review, data collection methods, and schedules. A desk review process was used for the focused review. Each health plan was required to submit any documents concerning usual and customary medical management of FDA-approved contraceptives, including emergency contraception. If the health plan did not provide direct services for contraceptives due to Right of Conscience objections, it was required to submit policies and procedures regarding the referral process including an updated list of referral sites.

To accomplish its objective, and based on the results of collaborative planning with HFS, HSAG developed standardized data collection tools and processes to assess and document each health plan's compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements. HSAG developed tools specific to the health plans serving the FHP/ACA population as well as the CCEs and ACEs.

Customized review tools facilitated the preparation for the review. The document submission list itemized the type of documentation required for submission.

Data Collection and Analysis

HSAG aggregated all information obtained to determine the organization's performance and used the designations *Met*, *Partially Met*, *Not Met*, or *N/A* to document the degree to which the health plan, ACE, or CCE complied with the requirements.

HSAG noted any elements that were identified as *Partially Met* and *Not Met* and the corrective action needed to bring the requirement into compliance. HSAG used the standardized monitoring tools to

document follow-up on any elements that required corrective action. Corrective actions were monitored by HSAG and HFS until successfully completed.

HFS and HSAG also developed a Family Planning Review Status Grid to indicate the status of each portion of the review including document submission, document review, number of elements out of compliance, communication to health plan, health plan response due date, and date of review completion.

Scope of Review

FHP/ACA

HSAG conducted a desk review to determine FHP/ACA health plan compliance with the following contract requirements regarding family planning:

General:

- Family Planning and Reproductive Health Care
- Barriers or Restrictions to Access to Care

Family Planning and Reproductive Health Services:

- Reproductive Life Plan
- Education and Counseling
- Permanent Methods of Birth Control
- Basic Infertility Counseling
- Reproductive Health Exam
- Sexually Active Females
- All Enrollees
- HIV Testing
- Testing and Treatment
- Lab Testing
- Cervical Cancer Screening
- Vaccines
- Breast Cancer Genetic Counseling

Maternity Care:

- Prenatal Evaluation
- Systems and Protocols
- Risk Counseling

Prenatal Care:

- Screening
- Health Maintenance
- Laboratory Screening and Physical Exam
- Genetic Screening and Counseling
- Protocols for Visits
- Identify High-Risk Pregnancies

Postpartum Care:

- Immediate and Subsequent Postpartum Visits
- Depression Screening
- Seamless Referrals
- Well Woman Care
- 24 Months Following Delivery

Well Woman Exam:

- Documentation
- Age Appropriate Discussions
- Appropriate Referrals
- Routine Pelvic Exam
- Cervical Cytology

Coordination With Other Service Providers:

- Family Case Management Program

ACE

HSAG conducted a desk review to determine ACE compliance with all of the contract requirements regarding family planning listed above for FHP/ACA.

CCE

HSAG conducted a desk review to determine CCE compliance with the following contract requirements regarding family planning:

- Policies and procedures regarding Right of Conscience objections.
- Policies and procedures regarding family planning.
- Policy regarding allowing enrollees to see any Medicaid provider of their choice when seeking family planning and reproductive healthcare services.

- The use of nationally recognized standards of care and guidelines for sexual and reproductive health and access to nationally recognized standards of care and guidelines.
- The use of and access to the reproductive life plan and preconception care risk assessment.
- Member educational materials regarding all contraceptive methods with emphasis on the most effective methods first, specifically long-acting reversible contraceptives (LARC) such as intrauterine devices (IUDs) and the implantable rod, and including over-the-counter and prescription emergency contraception, including the copper IUD as emergency contraception.
- Member education includes permanent methods of birth control: tubal ligation, transcervical sterilization, and vasectomy.
- Providers are informed that basic infertility counseling is permissible but infertility medications and procedures are not covered.
- Providers are informed about sexually transmitted disease (STD) testing for males and females younger than 26 years of age; syphilis screening and hepatitis C screening for enrollees born between 1945 and 1965; universal HIV testing, counseling, and screening; and testing and treatment for genital and related infections.
- Providers are informed about lab testing or screening necessary for family planning and reproductive health services; and cervical cancer screening, management, and early treatment.
- Providers are informed about vaccines for preventable reproductive health-related.
- Providers are informed about mammography referral and breast cancer genetic counseling and testing.

Results

Using information obtained during the focused review, HSAG and HFS determined whether the family planning policies and procedures were sufficient to ensure compliance with State and federal requirements. If any corrective actions were identified during the review, health plans, ACEs, and CCEs were required to complete them and submit updated documentation to demonstrate compliance. HFS and HSAG monitored the corrective action process to ensure compliance with family planning requirements.

6. Consumer Quality of Care Surveys

Consumer Satisfaction Surveys

Objectives

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **Aetna Better Health** (**Aetna**), **Community Care Alliance of Illinois** (**CCAI**), **CountyCare Health Plan** (**CountyCare**), **Family Health Network** (**FHN**), **Harmony Health Plan of Illinois** (**Harmony**), **IlliniCare Health Plan, Inc.** (**IlliniCare**), and **Meridian Health Plan, Inc.** (**Meridian**) were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. Results for all seven plans were forwarded to Health Services Advisory Group, Inc. (HSAG), for analysis. For the statewide **Illinois Medicaid** (Title XIX) and **All Kids** (Title XXI) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS. The CAHPS results are presented by program type, with **FHN**, **Harmony**, and **Meridian** under Family Health Plans/Affordable Care Act (FHP/ACA); **Aetna**, **CCAI**, **CountyCare**, and **IlliniCare** under the Integrated Care Program (ICP); and **All Kids** and **Illinois Medicaid** under Statewide Child Medicaid Survey.

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their healthcare experiences.

Technical Methods of Data Collection and Analysis

FHP/ACA Health Plans

In July 2014, Illinois transitioned from voluntary managed care (VMC) in select counties to FHP/ACA with mandatory managed care regions that cover most of the State. Under this transition, VMC continues to be an option for clients to choose for their care coordination services within many nonmandatory counties. The health plans of **FHN**, **Harmony**, and **Meridian** conducted the CAHPS activities presented in this section with the VMC population in the years prior to the FHP/ACA transition. In this reporting year, those health plans continued to conduct CAHPS activities with both the VMC population (in select, nonmandatory counties) and the FHP/ACA population. FHP/ACA health plans that began accepting enrollment in this reporting year will initiate CAHPS activities in subsequent reporting years.

For **FHN**, **Harmony**, and **Meridian**, the adult Medicaid and child Medicaid populations were surveyed. SPH Analytics (formerly named The Myers Group) administered the CAHPS surveys on behalf of **FHN** and **Harmony**. Morpace administered the CAHPS surveys on behalf of **Meridian**.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Survey to the adult population and the CAHPS 5.0H Child Medicaid Survey to the child population. **FHN**, **Harmony**, and **Meridian** used a mixed methodology for data collection, which included both mail and telephone surveys for data collection, and offered the surveys in English or Spanish.[6-1,6-2]

ICP Health Plans

Aetna and **IlliniCare** served the ICP population in prior reporting years; therefore, comparisons to 2014 CAHPS survey measure results for these ICP health plans are presented in this section. Only baseline results are reported for **CCAI** and **CountyCare** since they began serving the ICP population this reporting year. ICP health plans that began accepting enrollment during this reporting year will initiate CAHPS activities in subsequent reporting years.

For **Aetna**, **CCAI**, **CountyCare**, and **IlliniCare**, the adult Medicaid populations were surveyed. SPH Analytics administered the CAHPS surveys on behalf of **CCAI**, **CountyCare**, and **IlliniCare**. The Center for the Study of Services (CSS) administered the CAHPS survey on behalf of **Aetna**.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Survey to the adult population. **Aetna**, **CCAI**, **CountyCare**, and **IlliniCare** used a standard Internet mixed methodology for data collection, which included both mail and telephone surveys for data collection with the option to complete the survey via Internet, and offered the surveys in English.[6-3]

All Kids and Illinois Medicaid Statewide Survey

For the **All Kids** and **Illinois Medicaid** populations, statewide samples of the **All Kids** (i.e., children covered under Title XXI/Children's Health Insurance Program [CHIP]) and **Illinois Medicaid** (i.e., children covered under Title XIX) populations were surveyed. HSAG administered the CAHPS surveys on behalf of HFS.

The technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Survey with the Children with Chronic Conditions (CCC) measurement set to a statewide sample of the child population enrolled in each program. For **All Kids** and **Illinois Medicaid**, a sample, representing the general child population, and a sample of child members who were identified as more likely to have a chronic condition (i.e., CCC supplemental sample) were selected from each program. **All Kids** and

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6-1 **FHN**'s CAHPS 5.0H Adult Medicaid Survey administration protocol (i.e., method of data collection for the adult population) was a standard Internet mixed-methodology protocol, which allowed sampled members the option to complete the survey via Internet. Information on the protocol **FHN** used to administer the CAHPS 5.0H Child Medicaid Survey was not provided to HSAG.

6-2 **Harmony** used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.0H Adult Medicaid Survey to its adult population, which allowed sampled members the option to complete the survey via Internet. For administration of the CAHPS 5.0H Child Medicaid Survey, **Harmony** used a standard HEDIS mixed-mode methodology which included mail and telephone surveys only (i.e., surveys could not be completed via Internet).

6-3 Information regarding whether **Aetna**, **CCAI**, **CountyCare**, and **IlliniCare** offered the surveys in Spanish was not provided to HSAG.

Illinois Medicaid used a standard mixed methodology for data collection, which included both mail and telephone surveys for data collection with the option to complete the survey in English or Spanish.

Survey Measures for CAHPS

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

The National Committee for Quality Assurance (NCQA) requires a minimum of 100 responses on each item to report the measure as a valid CAHPS Survey result; however, for purposes of this report, if available, plans'/populations' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box response). In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (i.e., 1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2) "No" and "Yes." A positive or top-box response for four of the composites (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*) was defined as a response of "Usually" or "Always." For 2015, for one composite (*Shared Decision Making*), a positive or top-box response was defined as a response of "Yes." The percentage of top-box responses was referred to as a global proportion for the composite scores.

In addition to the global proportions, a three-point mean was calculated for four of the composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*). Scoring was based on a three-point scale. Responses of "Usually/Always" were given a score of 3, responses of "Sometimes" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.

For each of the CAHPS global ratings and four of the composite measures, the resulting three-point mean scores were compared to NCQA's 2015 HEDIS Benchmarks and Thresholds for Accreditation.[6-4] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for the four global ratings and four composite measures, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

★★★★★ = indicates a score at or above the 90th percentile

★★★★ = indicates a score at or between the 75th and 89th percentiles

★★★ = indicates a score at or between the 50th and 74th percentiles

★★ = indicates a score at or between the 25th and 49th percentiles

★ = indicates a score below the 25th percentile

NCQA does not publish benchmarks and thresholds for the *Shared Decision Making* composite measure; therefore, three-point mean scores are not presented and star ratings could not be derived for this measure. These are denoted with a dash (—) in the plan-specific findings below.

For **FHN**'s, **Harmony**'s, **Meridian**'s, **Aetna**'s, and **IlliniCare**'s plan-specific findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points from 2014 to 2015. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points from 2014 to 2015.[6-5] Due to changes to the *Shared Decision Making* composite measure, comparisons to the previous year's results could not be performed for this measure for 2015.

For **All Kids** and **Illinois Medicaid**, in addition to the four global ratings and five composite measures, the CAHPS survey also included the CCC measurement set of survey questions, which are categorized into five measures of satisfaction. These measures included three CCC composite measures and two CCC individual item measures. The CCC composites and items are sets of questions and individual questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population. Additional information on calculation of CAHPS results for the general child and CCC populations is included in the statewide survey findings below.

For **All Kids**' and **Illinois Medicaid**'s program-specific findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points from 2013 to 2015. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points from 2013 to 2015.[6-6] Due to

[6-4] National Committee for Quality Assurance. *HEDIS/CAHPS 5.0H Benchmarks and Thresholds for Accreditation 2015*. Washington, DC: NCQA. August 4, 2015.

[6-5] 2015 represents the first year **CCAI** and **CountyCare** administered the standard CAHPS 5.0H Adult Medicaid Health Plan Survey to its adult populations. Therefore, the 2015 Adult CAHPS results presented in this report for **CCAI** and **CountyCare** represent baseline results, and 2014 CAHPS results are not available for comparison.

[6-6] The **All Kids** and **Illinois Medicaid** programs' child Medicaid populations were not surveyed in 2014. Therefore, 2015 CAHPS results were compared to 2013 CAHPS results, where appropriate.

changes to the *Shared Decision Making* composite measure, comparison of 2013 to 2015 results could not be performed for this measure. The **All Kids**' and **Illinois Medicaid**'s statewide survey results are presented in the statewide survey findings section below, following the plan-specific findings for the VMCOs and ICPs.

Plan-Specific Findings and Comparisons

FHP/ACA Health Plans

Family Health Network

Adult Medicaid

SPH Analytics collected 353 valid surveys from the eligible **FHN** adult Medicaid population of 2,228 sampled members from January through May 2015, yielding a response rate of 16.4 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2014 and 2015 adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-1.

Table 6-1—FHN Adult Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	69.0%	69.2%	2.10 ★
Getting Care Quickly	73.2%	70.6%	2.20 ★
How Well Doctors Communicate	87.9%	90.0%	2.64 ★★★★★
Customer Service	84.1%	83.3%	2.50 ★★
Shared Decision Making	55.7%+	75.9%+	—

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Global Ratings			
Rating of All Health Care	47.0%	44.9%	2.22 ★
Rating of Personal Doctor	62.7%	62.7%	2.49 ★★
Rating of Specialist Seen Most Often	69.4%+	48.3%+	2.33+ ★
Rating of Health Plan	56.9%	51.8%	2.38 ★★

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **FHN**'s 2014 results to its 2015 results revealed that **FHN**'s rates increased for three measures: *Getting Needed Care*, *How Well Doctors Communicate*, and *Shared Decision Making*. The rate increase was substantial for *Shared Decision Making*. However, a comparison of **FHN**'s 2014 results to its 2015 results revealed that **FHN**'s rates decreased for five measures: *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. The rate decrease was substantial for *Rating of Health Plan* and *Rating of Specialist Seen Most Often*. There was no change in the *Rating of Personal Doctor* measure's rate.

FHN's 2015 overall member satisfaction ratings revealed that **FHN** scored:

- At or above the 90th percentile on one measure, *How Well Doctors Communicate*.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on no measures.
- At or between the 25th and 49th percentiles on three measures: *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan.*
- Below the 25th percentile on four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

Child Medicaid

SPH Analytics collected 376 valid surveys from the eligible **FHN** child Medicaid population of 2,723 sampled members from January through May 2015, yielding a response rate of 14.1 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2014 and 2015 child Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-2.

Table 6-2—FHN Child Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	75.7%	77.2%	2.30 ★
Getting Care Quickly	76.6%	81.0%	2.44 ★
How Well Doctors Communicate	91.3%	93.1%	2.74 ★★★★
Customer Service	84.1%	89.8%	2.54 ★★★
Shared Decision Making	48.1%+	76.6%	—
Global Ratings			
Rating of All Health Care	58.9%	65.3%	2.58 ★★★★
Rating of Personal Doctor	73.9%	71.3%	2.64 ★★★
Rating of Specialist Seen Most Often	64.3%+	57.6%+	2.45+ ★
Rating of Health Plan	65.8%	62.5%	2.51 ★★

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **FHN**'s 2014 results to its 2015 results revealed that **FHN**'s rates increased for six measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate, Customer Service*, *Shared Decision Making*, and *Rating of All Health Care.* The rate increases were substantial for three measures*: Customer Service*, *Shared Decision Making*, and *Rating of All Health Care.* However, rates for three measures decreased from 2014: *Rating of Personal Doctor*, *Rating of Specialist Seen Most*

Often, and *Rating of Health Plan*. The rate for only one of these measures, *Rating of Specialist Seen Most Often*, demonstrated a substantial decrease.

FHN's 2015 overall member satisfaction ratings revealed that **FHN** scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *How Well Doctors Communicate* and *Rating of All Health Care*.
- At or between the 50th and 74th percentiles on two measures: *Customer Service* and *Rating of Personal Doctor*.
- At or between the 25th and 49th percentiles on one measure, *Rating of Health Plan*.
- Below the 25th percentile on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Specialist Seen Most Often*.

Harmony Health Plan

Adult Medicaid

SPH Analytics collected 262 valid surveys from the eligible **Harmony** adult Medicaid population of 1,350 sampled members from January through May 2015, yielding a response rate of 20.3 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2014 and 2015 adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-3.

Table 6-3—Harmony Adult Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	69.8%	73.5%	2.23 ★
Getting Care Quickly	74.3%	70.9%	2.26 ★
How Well Doctors Communicate	88.7%	86.8%	2.58 ★★★
Customer Service	86.9%	86.6%+	2.53+ ★★
Shared Decision Making	48.1%	85.2%	—
Global Ratings			
Rating of All Health Care	36.6%	41.3%	2.18 ★
Rating of Personal Doctor	55.3%	56.1%	2.35 ★
Rating of Specialist Seen Most Often	57.5%+	58.3%+	2.50+ ★★
Rating of Health Plan	38.8%	51.8%	2.32 ★

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Star Rating Percentiles:

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **Harmony**'s 2014 results to its 2015 results showed an increase in rates for six measures: *Getting Needed Care*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. A substantial

increase was displayed in two of these measures: *Shared Decision Making* and *Rating of Health Plan.* Three measures showed a decrease in rates from 2014 to 2015: *Getting Care Quickly*, *How Well Doctors Communicate,* and *Customer Service;* none of these decreases were substantial.

Harmony's 2015 overall member satisfaction ratings revealed that **Harmony** scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on one measure, *How Well Doctors Communicate.*
- At or between the 25th and 49th percentiles on two measures: *Customer Service* and *Rating of Specialist Seen Most Often.*
- Below the 25th percentile on five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan.*

Child Medicaid

SPH Analytics collected 351 valid surveys from the eligible **Harmony** child Medicaid population of 2,063 sampled members from January through May 2015, yielding a response rate of 17.8 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2014 and 2015 child Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-4.

Table 6-4—Harmony Child Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	72.6%	74.8%	2.29 ★
Getting Care Quickly	74.8%	78.3%	2.41 ★
How Well Doctors Communicate	89.3%	93.8%	2.71 ★★★
Customer Service	85.7%	84.4%	2.55 ★★★
Shared Decision Making	52.7%+	78.6%+	—
Global Ratings			
Rating of All Health Care	55.4%	59.7%	2.48 ★
Rating of Personal Doctor	70.6%	70.3%	2.66 ★★★★
Rating of Specialist Seen Most Often	70.0%+	82.1%+	2.75+ ★★★★★
Rating of Health Plan	55.9%	58.7%	2.48 ★

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **Harmony**'s 2014 results to its 2015 results showed an increase in rates for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Two of these measures showed a substantial increase: *Shared Decision Making* and *Rating of Specialist Seen Most Often*. **Harmony**'s rate decreased from 2014 to 2015 for two measures: *Customer*

Service and *Rating of Personal Doctor*. Neither of the rates for these measures showed a substantial decrease.

Harmony's 2015 overall member satisfaction ratings revealed that **Harmony** scored:

- At or above the 90th percentile on one measure, *Rating of Specialist Seen Most Often.*
- At or between the 75th and 89th percentiles on one measure, *Rating of Personal Doctor.*
- At or between the 50th and 74th percentiles on two measures: *How Well Doctors Communicate* and *Customer Service.*
- At or between the 25th and 49th percentiles on no measures.
- Below the 25th percentile on four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan.*

Meridian Health Plan

Adult Medicaid

Morpace collected 559 valid surveys from the eligible **Meridian** adult Medicaid population of 1,755 sampled members from January through May 2015, yielding a response rate of 33.4 percent. The overall NCQA target number of valid surveys is 411. **Meridian**'s 2014 and 2015 adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented, on the following page, in Table 6-5.

Table 6-5—Meridian Adult Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	85.0%	77.9%	2.30 ★
Getting Care Quickly	84.1%	79.7%	2.39 ★★
How Well Doctors Communicate	89.8%	88.5%	2.61 ★★★★
Customer Service	92.3%	89.4%	2.62 ★★★★★
Shared Decision Making	54.4%	75.9%	—
Global Ratings			
Rating of All Health Care	56.7%	54.6%	2.36 ★★★
Rating of Personal Doctor	66.4%	62.8%	2.46 ★★
Rating of Specialist Seen Most Often	73.4%	71.0%	2.59 ★★★★★
Rating of Health Plan	62.0%	57.4%	2.40 ★★

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **Meridian**'s 2014 results to its 2015 results revealed that **Meridian**'s rate substantially increased for one measure, *Shared Decision Making*. However, a comparison of **Meridian**'s 2014 results to its 2015 results revealed that **Meridian**'s rates decreased for eight measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health*

Care, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* The rate decrease was substantial for *Getting Needed Care*.

Meridian's 2015 overall member satisfaction ratings revealed that **Meridian** scored:

- At or above the 90th percentile on two measures: *Customer Service* and *Rating of Specialist Seen Most Often*.
- At or between the 75th and 89th percentiles on one measure, *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on one measure, *Rating of All Health Care*.
- At or between the 25th and 49th percentiles on three measures: *Getting Care Quickly*, *Rating of Personal Doctor*, and *Rating of Health Plan*.
- Below the 25th percentile on one measure, *Getting Needed Care*.

Child Medicaid

Morpace collected 723 valid surveys from the eligible **Meridian** child Medicaid population of 2,310 sampled members from January through May 2015, yielding a response rate of 33.3 percent. The overall NCQA target number of valid surveys is 411. **Meridian**'s 2014 and 2015 child Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-6.

Table 6-6—Meridian Child Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	82.6%	85.8%	2.47 ★★★
Getting Care Quickly	89.8%	89.7%	2.62 ★★★
How Well Doctors Communicate	93.1%	92.6%	2.66 ★★
Customer Service	93.0%	91.7%	2.61 ★★★★
Shared Decision Making	52.5%	74.4%	—
Global Ratings			
Rating of All Health Care	65.6%	66.3%	2.58 ★★★★
Rating of Personal Doctor	74.1%	74.8%	2.68 ★★★★
Rating of Specialist Seen Most Often	NA*	78.2%	2.75 ★★★★★
Rating of Health Plan	75.7%	71.9%	2.65 ★★★★

* NCQA requires a minimum of 100 responses in order for an item to be reported as a CAHPS/HEDIS result. NA indicates that a measure had less than 100 responses and therefore could not be reported.

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **Meridian**'s 2014 results to its 2015 results revealed that **Meridian**'s rates increased for four measures: *Getting Needed Care*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Personal Doctor*. However, **Meridian**'s rates decreased for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Health Plan*. There were no substantial decreases, but the rate for one measure increased substantially, *Shared Decision Making*.

Meridian's 2015 overall member satisfaction ratings revealed that **Meridian** scored:

- At or above the 90th percentile on one measure, *Rating of Specialist Seen Most Often*.
- At or between the 75th and 89th percentiles on four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.
- At or between the 50th and 74th percentiles on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- At or between the 25th and 49th percentiles on one measure, *How Well Doctors Communicate*.
- Below the 25th percentile on no measures.

FHP/ACA Health Plan Comparisons

Adult Medicaid

Table 6-7 presents the 2015 adult Medicaid CAHPS results for **FHN**, **Harmony**, and **Meridian**.

Table 6-7—2015 Adult Medicaid CAHPS Results

	FHN	Harmony	Meridian
Composite Measures			
Getting Needed Care	69.2%	73.5%	77.9%
Getting Care Quickly	70.6%	70.9%	79.7%
How Well Doctors Communicate	90.0%	86.8%	88.5%
Customer Service	83.3%	86.6%+	89.4%
Shared Decision Making	75.9%+	85.2%+	75.9%
Global Ratings			
Rating of All Health Care	44.9%	41.3%	54.6%
Rating of Personal Doctor	62.7%	56.1%	62.8%
Rating of Specialist Seen Most Often	48.3%+	58.3%+	71.0%
Rating of Health Plan	51.8%	51.8%	57.4%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

A comparison of the health plans' results showed that **Meridian** outperformed **FHN** and **Harmony** on seven of the nine CAHPS measures. For four measures, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often,* and *Rating of Health Plan*, **Meridian** scored substantially higher than both **FHN** and **Harmony**. For *Customer Service*, **Meridian** scored substantially higher than **FHN**. For 2015, **FHN** had the lowest rates among the three health plans for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Specialist Seen Most Often*. Conversely, **FHN** had the highest rate among the three plans on one measure, *How Well Doctors Communicate.*

Child Medicaid

Table 6-8 presents the 2015 child Medicaid CAHPS results for **FHN**, **Harmony**, and **Meridian**.

Table 6-8—2015 Child Medicaid CAHPS Results

	FHN	Harmony	Meridian
Composite Measures			
Getting Needed Care	77.2%	74.8%	85.8%
Getting Care Quickly	81.0%	78.3%	89.7%
How Well Doctors Communicate	93.1%	93.8%	92.6%
Customer Service	89.8%	84.4%	91.7%
Shared Decision Making	76.6%	78.6%+	74.4%
Global Ratings			
Rating of All Health Care	65.3%	59.7%	66.3%
Rating of Personal Doctor	71.3%	70.3%	74.8%
Rating of Specialist Seen Most Often	57.6%	82.1%+	78.2%
Rating of Health Plan	62.5%	58.7%	71.9%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

A comparison of **FHN**'s, **Harmony**'s, and **Meridian**'s results show that **Meridian** outperformed **FHN** and **Harmony** on six of the CAHPS measures: *Getting Needed Care*, *Getting Care Quickly, Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan.* Furthermore, **Meridian** scored substantially higher than both **FHN** and **Harmony** on three of these measures: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Health Plan*. **Harmony** scored lowest among the health plans on six measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan.*

ICP Health Plans

Aetna Better Health

Adult Medicaid

CSS collected 479 valid surveys from the eligible **Aetna** adult Medicaid population of 1,350 sampled members from February through May 2015, yielding a response rate of 36.4 percent. The overall NCQA target number of valid surveys is 411. **Aetna**'s 2014 and 2015 Adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-9.

Table 6-9—Aetna Adult Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	78.6%	78.9%	2.32 ★★
Getting Care Quickly	76.6%	82.0%	2.41 ★★
How Well Doctors Communicate	87.8%	88.9%	2.58 ★★★★
Customer Service	82.9%	84.5%	2.44 ★
Shared Decision Making	55.0%	76.9%	—
Global Ratings			
Rating of All Health Care	44.0%	50.3%	2.32 ★★
Rating of Personal Doctor	59.1%	61.3%	2.47 ★★
Rating of Specialist Seen Most Often	59.7%	67.1%	2.59 ★★★★★
Rating of Health Plan	47.9%	51.7%	2.30 ★

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

From 2014 to 2015, **Aetna** showed rate increases for all nine measures. Four of these measures displayed a substantial increase: *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often.*

Aetna's 2015 overall member satisfaction ratings revealed that **Aetna** scored:

- At or above the 90th percentile on one measure, *Rating of Specialist Seen Most Often*.
- At or between the 75th and 89th percentiles on one measure, *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on no measures.
- At or between the 25th and 49th percentiles on four measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor.*
- Below the 25th percentile on two measures: *Customer Service* and *Rating of Health Plan*.

Community Care Alliance of Illinois

Adult Medicaid

SPH Analytics collected 422 valid surveys from the eligible **CCAI** adult Medicaid population of 1,350 sampled members from January through May 2015, yielding a response rate of 32 percent. The overall NCQA target number of valid surveys is 411. **CCAI**'s 2015 Adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-10.

Table 6-10—CCAI Adult Medicaid CAHPS Results

	2015 Top-Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures		
Getting Needed Care	71.6%	2.19 ★
Getting Care Quickly	73.3%	2.26 ★
How Well Doctors Communicate	90.3%	2.63 ★★★★
Customer Service	82.6%	2.47 ★
Shared Decision Making	78.0%	—
Global Ratings		
Rating of All Health Care	48.8%	2.27 ★
Rating of Personal Doctor	66.7%	2.55 ★★★★
Rating of Specialist Seen Most Often	65.0%	2.52 ★★★
Rating of Health Plan	51.8%	2.31 ★

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

In 2015, **CCAI** conducted CAHPS 5.0H Adult Medicaid Surveys of its adult population for the first time; therefore, the 2015 CAHPS results presented for **CCAI** represent baseline results and 2014 CAHPS survey measure results are not available for comparison.

CCAI's 2015 overall member satisfaction ratings revealed that **CCAI** scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *How Well Doctors Communicate* and *Rating of Personal Doctor*.
- At or between the 50th and 74th percentiles on one measure, *Rating of Specialist Seen Most Often.*
- At or between the 25th and 49th percentiles on no measures.
- Below the 25th percentile on five measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, and *Rating of Health Plan.*

CountyCare Health Plan

Adult Medicaid

SPH Analytics collected 689 valid surveys from the eligible **CountyCare** adult Medicaid population of 1,755 sampled members from January through May 2015, yielding a response rate of 40 percent. The overall NCQA target number of valid surveys is 411. **CountyCare**'s 2015 Adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-11.

Table 6-11—CountyCare Adult Medicaid CAHPS Results

	2015 Top-Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures		
Getting Needed Care	75.2%	2.26 ★
Getting Care Quickly	79.1%	2.36 ★
How Well Doctors Communicate	89.7%	2.65 ★★★★★
Customer Service	89.1%	2.57 ★★★
Shared Decision Making	76.6%	—
Global Ratings		
Rating of All Health Care	49.5%	2.32 ★★
Rating of Personal Doctor	67.7%	2.57 ★★★★★
Rating of Specialist Seen Most Often	60.6%	2.51 ★★★
Rating of Health Plan	56.2%	2.41 ★★

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

In 2015, **CountyCare** conducted CAHPS 5.0H Adult Medicaid Surveys of its adult population for the first time; therefore, the 2015 CAHPS results presented for **CountyCare** represent baseline results and 2014 CAHPS survey measure results are not available for comparison.

CountyCare's 2015 overall member satisfaction ratings revealed that **CountyCare** scored:

- At or above the 90th percentile on two measures: *How Well Doctors Communicate* and *Rating of Personal Doctor*.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on two measures: *Customer Service* and *Rating of Specialist Seen Most Often.*
- At or between the 25th and 49th percentiles on two measures: *Rating of All Health Care* and *Rating of Health Plan*.
- Below the 25th percentile on two measures: *Getting Needed Care* and *Getting Care Quickly*.

IlliniCare Health Plan

Adult Medicaid

SPH Analytics collected 547 valid surveys from the eligible **IlliniCare** adult Medicaid population of 1,755 sampled members from January through May 2015, yielding a response rate of 33 percent. The overall NCQA target number of valid surveys is 411. **IlliniCare**'s 2014 and 2015 Adult Medicaid CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-12.

Table 6-12—IlliniCare Adult Medicaid CAHPS Results

	2014 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	78.6%	78.6%	2.31 ★★
Getting Care Quickly	78.8%	80.7%	2.40 ★★
How Well Doctors Communicate	91.1%	91.1%	2.64 ★★★★★
Customer Service	87.7%	88.8%	2.56 ★★★
Shared Decision Making	46.9%	77.0%	—
Global Ratings			
Rating of All Health Care	46.8%	54.8%	2.34 ★★★
Rating of Personal Doctor	61.7%	68.7%	2.55 ★★★★
Rating of Specialist Seen Most Often	67.1%	76.8%	2.72 ★★★★★
Rating of Health Plan	52.6%	58.3%	2.40 ★★

Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Seven out of nine measures for **IlliniCare** showed an increase in rates from 2014 to 2015: *Getting Care Quickly*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* Five measures showed a substantial increase: *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* None of the measures showed rate

declines, and rates for two measures showed no change: *Getting Needed Care* and *How Well Doctors Communicate*.

IlliniCare's 2015 overall member satisfaction ratings revealed that **IlliniCare** scored:

- At or above the 90th percentile on two measures: *How Well Doctors Communicate* and *Rating of Specialist Seen Most Often*.
- At or between the 75th and 89th percentiles on one measure, *Rating of Personal Doctor*.
- At or between the 50th and 74th percentiles on two measures: *Customer Service* and *Rating of All Health Care*.
- At or between the 25th and 49th percentiles on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Health Plan.*
- Below the 25th percentile on no measures.

ICP Comparisons

Adult Medicaid

Table 6-13 presents the 2015 adult Medicaid CAHPS results for **Aetna**, **CCAI**, **CountyCare**, and **IlliniCare**.

Table 6-13—2015 Adult Medicaid CAHPS Results

Measure Name	Aetna	CCAI	CountyCare	IlliniCare
Composite Measures				
Getting Needed Care	78.9%	71.6%	75.2%	78.6%
Getting Care Quickly	82.0%	73.3%	79.1%	80.7%
How Well Doctors Communicate	88.9%	90.3%	89.7%	91.1%
Customer Service	84.5%	82.6%	89.1%	88.8%
Shared Decision Making	76.9%	78.0%	76.6%	77.0%
Global Ratings				
Rating of All Health Care	50.3%	48.8%	49.5%	54.8%
Rating of Personal Doctor	61.3%	66.7%	67.7%	68.7%
Rating of Specialist Seen Most Often	67.1%	65.0%	60.6%	76.8%
Rating of Health Plan	51.7%	51.8%	56.2%	58.3%

Aetna, **CCAI**, and **CountyCare** scored substantially lower than **IlliniCare** on one measure, *Rating of Specialist Seen Most Often.* **IlliniCare** scored higher than **Aetna** on seven measures, higher than **CCAI** on eight measures, and higher than **CountyCare** on eight measures. For *Rating of Personal Doctor, Rating of Specialist Seen Most Often*, and *Rating of Health Plan,* **IlliniCare** scored substantially higher than **Aetna**. **CountyCare** scored substantially higher than **CCAI** on two measures: *Getting Care Quickly* and *Customer Service.*

Conclusions and Recommendations—VMCOs

The following provides a summary of the CAHPS survey findings for **FHN**, **Harmony**, and **Meridian**. Recommendations have been provided for all health plans based on survey findings. Areas of improvement have been identified based on a comparison of the health plans' 2015 CAHPS survey top-box results to the prior year's top-box results, as well as comparisons of three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation (i.e., overall member satisfaction ratings or "star ratings").

Conclusions

Family Health Network

Based on **FHN**'s 2015 adult and child Medicaid CAHPS results, **FHN** has several areas that can be improved. **FHN** should focus on those areas for which the CAHPS measure's top-box rates decreased from 2014 to 2015 and/or the overall member satisfaction ratings were below the NCQA Benchmarks and Thresholds 25th percentile (i.e., measures with a rating of one star).

For the adult Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.*

For the child Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Needed Care*, *Getting Care Quickly*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.*

Harmony Health Plan

Based on **Harmony**'s 2015 adult and child Medicaid CAHPS results, **Harmony** has several areas that can be improved. **Harmony** should focus on those areas for which the CAHPS measure's top-box rates decreased from 2014 to 2015 and/or the overall member satisfaction ratings were below the NCQA Benchmarks and Thresholds 25th percentile.

For the adult Medicaid population, **Harmony** should focus on improving performance in the areas for which the CAHPS measure's top-box rates decreased from 2014 to 2015 or the overall member satisfaction ratings were below the NCQA Benchmarks and Thresholds 25th percentile: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan.*

For the child Medicaid population, **Harmony** should focus on improving performance in the areas for which the 2015 CAHPS measure scores were below NCQA's benchmarks and thresholds 25 percentile: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan.*

Meridian Health Plan

Based on **Meridian**'s 2015 adult and child Medicaid CAHPS results, **Meridian** has several areas that can be improved. **Meridian** should focus on those areas for which the CAHPS measure's top-box rates decreased from 2014 to 2015 and/or the overall member satisfaction ratings were below the NCQA Benchmarks and Thresholds 49th percentile.

For the adult Medicaid population, **Meridian** should focus on those areas for which the CAHPS measure's top-box rates were below the NCQA Benchmarks and Thresholds 49th percentile: *Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, and Rating of Health Plan.*

For the child Medicaid population, **Meridian** should focus on those areas for which the CAHPS measure's top-box rates decreased from 2014 to 2015: *Getting Care Quickly, How Well Doctors Communicate, Customer Service,* and *Rating of Health Plan.*

Recommendations for FHP/ACA Health Plans

Based on **FHN**'s, **Harmony**'s, and **Meridian**'s CAHPS surveys results, the following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was low and opportunities for improvement exist for the health plans. Each health plan should evaluate these general recommendations in the context of its own operational and quality improvement (QI) activities

Getting Needed Care

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

Getting Care Quickly

- An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.
- A patient flow analysis can be conducted to determine if dissatisfaction with timely care may be partly due to bottlenecks and redundancies in administrative and clinical patient flow processes (e.g.,

diagnostic tests). A patient flow analysis involves tracking a patient's experience throughout a visit or clinical process (i.e., the time it takes to complete various parts of the visit/service).

- Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Furthermore, an online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.

How Well Doctors Communicate

- Health plans can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Further, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.
- Often, health information is presented to patients in a way that is too complex and technical, which can result in patient nonadherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Providing training for healthcare workers on how to use these materials with their patients and ask questions to gauge patient understanding can also help improve patients' level of satisfaction with provider communication. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.
- Health plans could consider hiring interpreters who serve as full-time staff members at provider offices with a high volume of non-English-speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationships between the patient and family members with their physician.

Customer Service

- An evaluation of health plans' current call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- Health plans could consider implementing a training program to meet the needs of their unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. Training topics could also include conflict resolution and service recovery to ensure staff members feel

competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they return to the job.

- Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

Rating of All Health Care

- Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.
- To improve patients' healthcare experience, health plans should identify and eliminate patient challenges when receiving healthcare. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.
- Since both patients and families have the direct experience of an illness or healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; marketing of healthcare services; and design of new materials or tools that support the provider-patient relationship.

Rating of Personal Doctor

- Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans also can create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.
- Health plans should request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

Rating of Specialist Seen Most Often

- Health plans could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system

could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

- Health plans could create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
- Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Further, the local provider is more involved in the consultation process and more informed about care the patient is receiving.

Rating of Health Plan

- Health plans could engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability.
- Creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures to providers and staff, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members. Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards.
- Health plans could develop a structured approach to coordinating care for members with complex needs. This includes developing strategies for meeting the behavioral health, learning, and/or attention needs of their members. Research has identified a planning approach that can be used to provide a coordinated care system that addresses the medical, behavioral, and social needs of children with chronic conditions. Health plans could explore the option of developing a similar planning approach to meet the needs of adult members with chronic conditions. The planning approach focuses on the developing aspect of providing care management services to children and their families. Some of the key elements involved in the planning process include a patient- and family-centered system of care that focuses on community-based services that are built on a system of care values (e.g., team-based, individualized, outcomes-based).

Conclusions and Recommendations—ICP Health Plans

The following provides a summary of the CAHPS survey findings for **Aetna**, **CCAI**, **CountyCare**, and **IlliniCare**. Recommendations have been provided for all health plans based on survey findings. For **Aetna** and **IlliniCare**, areas of improvement have been identified based on a comparison of the health plans' 2015 CAHPS survey top-box results to the prior year's top-box results, as well as comparisons of three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation (i.e., overall member satisfaction ratings or "star ratings"). For **CCAI** and **CountyCare**, areas of improvement have been identified based on a comparison of the health plans' 2015 CAHPS survey three-point mean scores to NCQA benchmarks and thresholds percentile distributions (i.e., overall member satisfaction or "star" ratings).

Conclusions

Aetna Better Health

For the adult Medicaid population, **Aetna**'s top-box rates increased from 2014 to 2015 for all CAHPS measures; therefore, **Aetna** should focus on the measures which scored below the NCQA 25th percentile distribution: *Customer Service* and *Rating of Health Plan.*

CCAI

CCAI conducted CAHPS 5.0H Adult Medicaid Surveys of its adult population for the first time in 2015; therefore, the 2014 CAHPS survey measure results are not available for comparison. **CCAI** should focus on the measures which scored below the NCQA 25th percentile distribution: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, and *Rating of Health Plan.*

CountyCare

CountyCare conducted CAHPS 5.0H Adult Medicaid Surveys of its adult population for the first time in 2015; therefore, the 2014 CAHPS survey measure results are not available for comparison. **CountyCare** should focus on the measures which scored below the NCQA 49th percentile distribution: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan.*

IlliniCare

For the adult Medicaid population, **IlliniCare**'s top-box rates either increased from 2014 to 2015 for all CAHPS measures, or remained the same; therefore, **IlliniCare** should focus on the measures which scored below the NCQA 49th percentile distribution: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Health Plan.*

Recommendations

Based on **Aetna**'s, **CCAI**'s, **CountyCare**'s, and **IlliniCare**'s, CAHPS surveys results, the following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was low and opportunities for improvement exist for the health plans. Each health plan should evaluate these general recommendations in the context of its own operational and QI activities.

Getting Needed Care

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

Getting Care Quickly

- An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.
- A patient flow analysis can be conducted to determine if dissatisfaction with timely care may be partly due to bottlenecks and redundancies in administrative and clinical patient flow processes (e.g., diagnostic tests). A patient flow analysis involves tracking a patient's experience throughout a visit or clinical process (i.e., the time it takes to complete various parts of the visit/service).
- Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Furthermore, an online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.

Customer Service

- An evaluation of health plans' current call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

- Health plans could consider implementing a training program to meet the needs of their unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they return to the job.
- Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

Rating of Health Plan

- Health plans could engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability.
- Creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures to providers and staff, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members. Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards.
- Health plans could develop a structured approach to coordinating care for members with complex needs. This includes developing strategies for meeting the behavioral health, learning, and/or attention needs of their members. Research has identified a planning approach that can be used to provide a coordinated care system that addresses the medical, behavioral, and social needs of children with chronic conditions. Health plans could explore the option of developing a similar planning approach to meet the needs of adult members with chronic conditions. The planning approach focuses on the developing aspect of providing care management services to children and their families. Some of the key elements involved in the planning process include a patient- and family-centered system of care that focuses on community-based services that are built on a system of care values (e.g., team-based, individualized, outcomes-based).

Rating of All Health Care

- Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary,

obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.

- To improve patients' healthcare experience, health plans should identify and eliminate patient challenges when receiving healthcare. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.
- Since both patients and families have the direct experience of an illness or healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; marketing of healthcare services; and design of new materials or tools that support the provider-patient relationship.

Statewide Survey Findings and Comparisons

The following section presents the 2013 and 2015 CAHPS results for the general child and CCC populations for **All Kids** and **Illinois Medicaid** based on the results of the statewide survey administered to child members enrolled in each program.

General Child Population

All Kids

HSAG collected 1,631 valid surveys from the eligible **All Kids** general child Medicaid and CCC supplemental sample population of 3,655 child members selected for survey from March through June 2015, yielding a response rate of 45.5 percent. Of these completed surveys, **All Kids** had 785 completed general child CAHPS Surveys for 2015. **All Kids**' 2013 and 2015 General Child CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-14.

Table 6-14—All Kids General Child CAHPS Results

	2013 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	77.9%	76.7%	2.30 ★
Getting Care Quickly	89.8%	81.7%	2.45 ★
How Well Doctors Communicate	94.4%	92.5%	2.67 ★★
Customer Service	86.6%	84.3%	2.39 ★
Shared Decision Making	NC	77.1%	—
Global Ratings			
Rating of All Health Care	65.8%	64.7%	2.56 ★★★
Rating of Personal Doctor	78.3%	72.9%	2.67 ★★★★
Rating of Specialist Seen Most Often	74.2%+	71.7%+	2.64+ ★★★★
Rating of Health Plan	64.0%	57.9%	2.45 ★

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

NC: 2013 score is not comparable to 2015 score.

Star Rating Percentiles:

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **All Kids**' 2013 results to its 2015 results revealed that **All Kids**' rates did not increase for any measures. However, a comparison of **All Kids**' 2013 results to its 2015 results revealed that **All Kids**' rates decreased for eight measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan.* The rate decrease was substantial for *Getting Care Quickly*, *Rating of Personal Doctor*, and *Rating of Health Plan***.**

All Kids' 2015 overall member satisfaction ratings revealed that **All Kids** scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*.
- At or between the 50th and 74th percentiles on one measure, *Rating of All Health Care.*
- At or between the 25th and 49th percentiles on one measure, *How Well Doctors Communicate.*
- Below the 25th percentile on four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Health Plan*.

Table 6-15—Illinois Medicaid General Child CAHPS Results

	2013 Top Box Percentages	2015 Top Box Percentages	2015 Three-Point Means and Star Ratings
Composite Measures			
Getting Needed Care	71.8%	81.5%	2.35 ★
Getting Care Quickly	93.0%	85.7%	2.56 ★★
How Well Doctors Communicate	93.5%	92.0%	2.65 ★★
Customer Service	85.9%	86.6%	2.48 ★
Shared Decision Making	NC	76.9%+	—
Global Ratings			
Rating of All Health Care	59.9%	62.2%	2.51 ★★
Rating of Personal Doctor	75.2%	73.0%	2.68 ★★★★
Rating of Specialist Seen Most Often	65.2%+	70.8%+	2.65+ ★★★★
Rating of Health Plan	56.5%	55.0%	2.38 ★

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC: 2013 score is not comparable to 2015 score.
Star Rating Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

A comparison of **Illinois Medicaid**'s 2013 results to its 2015 results revealed that **Illinois Medicaid**'s rates increased for four measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. The rate increase was substantial for *Getting Needed Care* and *Rating of Specialist Seen Most Often*. However, a comparison of **Illinois Medicaid**'s 2013 results to its 2015 results revealed that **Illinois Medicaid**'s rates decreased for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan.* The rate decrease was substantial for *Getting Care Quickly*.

Illinois Medicaid's 2015 overall member satisfaction ratings revealed that **Illinois Medicaid** scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*.
- At or between the 50th and 74th percentiles on no measures.
- At or between the 25th and 49th percentiles on three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care.*
- Below the 25th percentile on three measures: *Getting Needed Care*, *Customer Service*, and *Rating of Health Plan*.

CCC Population

All Kids

All Kids' 2013 and 2015 CCC CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-16.

Table 6-16—All Kids CCC CAHPS Results

	2013 Top-Box Percentages	2015 Top-Box Percentages
Composite Measures		
Getting Needed Care	81.1%	82.6%
Getting Care Quickly	90.0%	91.4%
How Well Doctors Communicate	93.0%	94.2%
Customer Service	78.2%	86.8%
Shared Decision Making	NC	82.9%
Global Ratings		
Rating of All Health Care	59.8%	64.5%
Rating of Personal Doctor	76.2%	78.8%
Rating of Specialist Seen Most Often	75.4%	71.2%
Rating of Health Plan	57.9%	54.6%
CCC Composites and Items		
Access to Specialized Services	68.1%	70.4%+
Family-Centered Care (FCC): Personal Doctor Who Knows Child	89.6%	86.5%
Coordination of Care for Children with Chronic Conditions	68.6%	79.9%+
Access to Prescription Medicines	79.5%	90.7%
FCC: Getting Needed Information	90.8%	90.0%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC: 2013 score is not comparable to 2015 score.

A comparison of **All Kids**' 2013 CCC results to its 2015 CCC results revealed that **All Kids**' rates increased for nine measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Access to Specialized Services*, *Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines*. The rate increase was substantial for *Customer Service*, *Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines*. However, a comparison of

All Kids' 2013 CCC results to its 2015 CCC results revealed that **All Kids**' rates decreased for four measures: *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *FCC: Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information.*

Illinois Medicaid

Illinois Medicaid's 2013 and 2015 CCC CAHPS top-box percentages, and 2015 three-point mean scores and overall member satisfaction rating (i.e., star ratings) are presented in Table 6-17.

Table 6-17—Illinois Medicaid CCC CAHPS Results

	2013 Top-Box Percentages	2015 Top-Box Percentages
Composite Measures		
Getting Needed Care	77.8%	83.6%
Getting Care Quickly	92.2%	86.8%
How Well Doctors Communicate	95.1%	91.3%
Customer Service	81.1%	84.3%+
Shared Decision Making	NC	78.0%+
Global Ratings		
Rating of All Health Care	54.3%	51.9%
Rating of Personal Doctor	69.6%	68.0%
Rating of Specialist Seen Most Often	65.9%	66.3%+
Rating of Health Plan	45.6%	46.5%
CCC Composites and Items		
Access to Specialized Services	70.5%	65.2%+
Family-Centered Care (FCC): Personal Doctor Who Knows Child	88.8%	87.6%
Coordination of Care for Children with Chronic Conditions	72.9%	80.4%+
Access to Prescription Medicines	78.1%	86.4%
FCC: Getting Needed Information	91.4%	86.7%

+ Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
NC: 2013 score is not comparable to 2015 score.

A comparison of **Illinois Medicaid**'s 2013 CCC results to its 2015 CCC results revealed that **Illinois Medicaid**'s rates increased for six measures: *Getting Needed Care*, *Customer Service*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines*. The rate increase was substantial for three measures:

Getting Needed Care, *Coordination of Care for Children with Chronic Conditions*, and *Access to Prescription Medicines*. However, a comparison of **Illinois Medicaid**'s 2013 results to its 2015 results revealed that **Illinois Medicaid**'s rates decreased for seven measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information.* The rate decrease was substantial for *Getting Care Quickly* and *Access to Specialized Services*.

7. Optional EQR Activities

Ad Hoc Network Capacity Reporting

Health Services Advisory Group, Inc. (HSAG), produces ad hoc network capacity reports at the request of the Illinois Department of Healthcare and Family Services (HFS). The reports included a range of topics, from samples of home and community-based services (HCBS) and specialty providers for particular enrollee populations, to specific ZIP code analysis, to county-specific analyses for individual provider types. With its flexible ability to provide ad hoc network capacity reports, HSAG provides analyses which focus on areas of concern.

HSAG produced a multitude of ad hoc network capacity reports for HFS during state fiscal year (SFY) 2015. The reports were requested by HFS throughout the expansion process, and during the readiness and implementation processes. The reports included a range of topics, providing analyses which focused on areas such as:

- Comparative analysis of State Medicaid agency network standards.
- Analysis of Illinois network standards and network reporting and development of recommendations for strengthening Illinois network reporting.
- Comparative analysis of health plan community-based partners.

To assist HFS in monitoring and evaluating the capacity of the Medicaid managed care provider network, HSAG also provided program-specific, provider type-specific reports by county and region for individual health plans. HSAG continued to work with HFS to create multiple reports during the reporting year to monitor the continued development of provider networks in each of the Medicaid managed care regions.

Ad hoc reports that HSAG produced for HFS included analysis of the following network providers:

- Number of federally qualified health centers (FQHCs) contracted with Accountable Care Entities (ACEs).
- Plan-specific contracted hospitals in specific counties/regions.
- Contracted hospitals in the Metro East Region by plan/county.
- Contracted FQHCs and community mental health center (CMHC) providers by plan/county.
- Contracted PCPs, specialists, and hospitals by plan/county and region.
- Comparative analysis of ICP network providers by plan/county and region.
- Unique national provider identification (NPI) analysis for PCPs and specialists in the Greater Chicago Region.

Validation of State Performance Measures for Primary Care Case Management (PCCM)/Children's Health Insurance Program Reauthorization Act (CHIPRA)

Introduction

HFS contracts with HSAG to conduct annual validation of performance measures for the PCCM Program, the ICP, and CHIPA.

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 2.0, September 2002 (the CMS Performance Measure Validation Protocol).* HSAG also uses the *National Committee for Quality Assurance (NCQA) manual, HEDIS 2013 Compliance Audit: Standards, Policies and Procedures, Volume 5*.

Conducting the Review

The primary objectives of the performance measure validation (PMV) process are to:

- Evaluate the processes used to collect the performance measure data by HFS.
- Determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.

HFS identifies the performance measurement period for validation for each program for the reporting year. HFS opts to use selected NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as non-HEDIS performance measures designed specifically for the PCCM, ICP, and CHIPRA programs. The set of performance measures selected by HFS differs by program, but many of the measures that are classified as non-HEDIS measures are very similar to existing or retired HEDIS measures.

Pre-Audit Activities

HSAG requests that HFS submit an Information Systems Capabilities Assessment Tool (ISCAT); source code for each performance measure and any additional supporting documentation necessary to complete the audit; and a list of the measures under the scope of the audit. A conference call is conducted to answer questions and prepare for the audit.

Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of these data:

- **ISCAT**: HFS was responsible for completing and submitting the ISCAT document to HSAG. Upon receipt, HSAG conducted a cursory review of the ISCAT to ensure that HFS completed all sections and included all needed attachments. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used the information in the ISCAT to complete the review tools, as applicable.
- **Source code (programming language) for performance measures:** HSAG requested source code (computer programming language) from HFS for all performance measures. HSAG source code reviewers completed a line-by-line code review and evaluation of program logic flow to ensure compliance with State measure definitions. The source code reviewers identified areas of deviation and shared them with HFS for adjustment. The source code reviewers also informed the audit team of any deviations from the measure specifications so the team could evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- **Supporting documentation**: HSAG requested documentation and data queries that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for follow-up.

Reporting

To validate the performance measures, data from various sources, including provider data, claims/encounter systems, and enrollment data, must be audited. The auditor scrutinizes these processes and makes a determination as to the validity of the data collected. HSAG uses a variety of audit methods, including analysis of computer programs, primary source verification, and staff member interviews to determine a result for each measure.

Monthly and Quarterly Managed Care Meetings

HSAG meets regularly with HFS throughout the term of its EQRO contract in order to partner effectively and efficiently with the State. Currently, HSAG assists and attends HFS' on-site quarterly meetings with the health plans as well as the monthly teleconference meetings. The purpose of these meetings is to review all current and upcoming EQR activities, discuss any barriers or progress, design solutions or a course of action, and review the goals of the quality strategy. The meetings include discussion of compliance with the State's quality strategy, ongoing monitoring of performance of Medicaid programs, program changes or additions, readiness reviews, and future initiatives. In addition, the on-site quarterly meetings serve as a forum for review of the health plans' progress in managing

their quality assessment and performance improvement programs, as well as provide time for technical assistance and training sessions provided by HSAG.

For both monthly and quarterly meetings, HSAG is responsible for consulting with HFS in selecting meeting content, preparing the agenda and any necessary meeting materials, forwarding materials to participants in advance of the meeting, and facilitating the meeting. Meeting materials may include worksheets, PowerPoint presentations, slide handouts, or technical demonstrations. Subject matter experts, including clinical and analytical staff as required, are involved in the development of meeting content; and appropriate staff provide the instruction and/or facilitation, as appropriate. Following each meeting, HSAG forwards all meeting materials to HFS and the health plans and prepares an action item list and then follows up with the health plans and HFS to ensure timely completion of those items. HSAG provides status updates to HFS so it can track health plan progress on completing follow-up items.

Quality Strategy Guidance

HSAG understands that HFS must update its Quality Strategy as necessary based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Medicaid program.

To assist with Quality Strategy development, HSAG facilitated stakeholder meetings, monitored project progress according to the proposed time frames to ensure the Quality Strategy was completed on time for CMS submission, and provided feedback and guidance on the initial draft. This technical assistance helps HFS design a Quality Strategy that provides an effective framework to accomplish HFS' goals and objectives.

HSAG stays abreast of CMS requirements for a state Quality Strategy and advised HFS on the development of its Quality Strategy in accordance with CMS' *Quality Strategy Toolkit for States*.[7-1] In addition, HSAG prepared presentations and briefs to update states on new regulations affecting the Quality Strategy, such as the *Medicaid and CHIP Managed Care Final Rule*.[7-2] As described in further detail below, HSAG's assistance in developing performance measures helps HFS design an effective Quality Strategy.

[7-1] Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Mar 2, 2017.

[7-2] Centers for Medicare & Medicaid Services. Medicaid and CHIP Managed Care Final Rule. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Mar 2, 2017.

Technical Assistance to HFS and Health Plans

Technical Assistance to HFS

Technical assistance is one of the activities identified by CMS that EQROs can provide to state Medicaid agencies as well as health plans.

HSAG has provided a variety of technical assistance to HFS that has led to quality outcomes. This includes technical assistance in the following areas: performance improvement projects (PIPs), grievance and appeals process, care management/care coordination programs, Consumer Assessment of Healthcare Providers and Systems (CAHPS) sampling and development of CAHPS supplemental questions, pay-for-performance (P4P) program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS Waiver program requirements, and much more.

Specific examples of technical assistance topics conducted to assist HFS in SFY 2015 are described below.

HEDIS and PIP Training

HSAG developed comprehensive trainings to assist HFS staff in understanding HEDIS performance measures and PIPs. This "HEDIS 101" training provided an overview of HEDIS and why it is important, as well as how to read HEDIS results and rates. The training also described uses for HEDIS and the HEDIS audit process. The "PIP 101" training discussed PIP stages and documentation requirements for all 10 PIP activities and provided PIP tips.

Evidence-Based Measures Development

To achieve optimal outcomes and measure performance across programs, HFS set out to select a uniform set of evidenced-based measures (EBMs) for the Family Health Plans/Affordable Care Act (FHP/ACA), Integrated Care Program (ICP) and Medicare-Medicaid Alignment Initiative (MMAI) that support the Quality Strategy goals. The goal was to select EBMs for each program to measure performance in service areas unique to each program population and establish benchmarks for each priority measure to ensure health plans are accountable for performance.

To assist HFS in developing a set of EBMs, HSAG conducted an analysis of performance measures collected by other state Medicaid agencies throughout the country. The analysis highlighted measures collected in California, Hawaii, Illinois, Michigan, and Ohio and identified measures required for NCQA accreditation. This provided a comparative analysis for HFS to use while considering the selection of measures.

Development of Performance Measures

Throughout SFY 2015, HSAG continued to assist HFS in developing performance measures that would meet the unique demands of the FHP/ACA health plans, Care Coordination Entities (CCEs), ACEs, and MMAI health plans. HSAG worked collaboratively with HFS to identify and develop performance measures specific to each of the programs and the populations they currently serve as part of the care coordination expansion.

HSAG has provided technical assistance in the development and selection of performance measures in the following areas:

- HEDIS, HEDIS-like, and State-defined measure recommendations.
- Developing a rate reporting workbook for collection and reporting of the HEDIS, HEDIS-like, and State-defined rates for the health plans.
- Developing and updating performance measure specifications for HEDIS-like and State-defined performance measures.
- Assisting HFS with methodologies for establishing performance improvement benchmarks for the HEDIS and non-HEDIS performance measures.
- Developed calendar year (CY) 2014 HEDIS (reporting year 2015) FHP/ACA and ICP performance measures comparison rate tables. The tables also included the pay-for-performance (P4P) measure results and HSAG calculated if the health plans met the performance goals for the P4P measures.

Research

To remain informed about national policies and current standards, HFS occasionally requested that HSAG conduct research and analysis on various topics of interest in SFY 2015 such as the following:

- Comparative analysis of accreditation requirements and states that require NCQA accreditation.
- Informative analysis of an "opt out" option for the MMAI.
- CMS Waiver Contract Measure Report.
- Health Home Concept Paper.
- Mobile crisis services crosswalk and draft tool.
- Comparative analysis of provider contracts from other states.

CAHPS Reviews

HFS requested that HSAG assist with the review of study questions and sampling on **Community Care Alliance of Illinois**' Enrollee Satisfaction Survey.

Care Coordination Expansion Map

Given the significant care coordination expansion occurring in Illinois, HFS requested HSAG to design a graphical depiction of the State's expansion efforts that could be shared with stakeholders. As a result, HFS and HSAG created the Care Coordination Expansion Map, which demonstrates which health plans are operating in regions across the State of Illinois, and in which programs those plans participate. HFS used the map to inform stakeholders and legislators of expansion progress, and the map was displayed publicly on the HFS website. Throughout SFY 2015, HSAG provided ongoing technical assistance to periodically update the map to reflect up-to-date expansion. The most recent version of the expansion map can be found at: http://www.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf.

Consumer Dashboards

HFS began to develop consumer report cards to measure and compare plan performance. The aim was to create a user-friendly, easy-to-read report that addressed areas of interest for consumers. HEDIS and CAHPS data would be used to create "star ratings" to compare health plan performance in providing care and services to members relative to specific measures in key performance areas.

To assist HFS, HSAG provided examples of Consumer Dashboard reports developed for other state Medicaid agencies. In addition, HSAG provided technical assistance in creating the star rating methodology.

Alignment of CMS Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs) to Illinois PIPs

In 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative to more effectively integrate the Medicare and Medicaid programs to improve the overall beneficiary experience, as well as both quality and costs of care. Under this initiative, CMS is seeking to advance an integrated quality and performance improvement program in which Medicare-Medicaid Plans (MMPs) submit a single set of quality and performance improvement projects that meet the requirements and needs of both CMS and the states, avoid unnecessary duplication, and reduce burden for the plans.

At HFS' request, HSAG conducted research on current requirements of the Medicare QIPs and CCIPs. HSAG presented HFS with background information and a crosswalk between the QIP, CCIP, and Illinois PIP programs to provide guidance regarding the new requirement for MMPs to submit quality and performance improvement projects for a joint review and approval by CMS and the states.

University of Illinois at Chicago (UIC)—Independent Evaluation of the Integrated Care Program

HFS contracted with UIC to conduct an independent evaluation of the ICP. UIC released a report in August, 2015 which presented results through the third year of the ICP's implementation. This report was the final report of the four-year evaluation of ICP. HSAG worked extensively with UIC and HFS to assist with the evaluation process. HSAG conducted meetings with HFS to discuss the information requests from UIC and worked cooperatively with UIC to deliver reports and data to support the evaluation. One of HSAG's key roles was to provide information to UIC for provider network data

validation and performance measures. The UIC team used HSAG's network capacity reports in the study's analysis of provider networks and used HEDIS performance measure results calculated by HSAG for program evaluation.

Technical Assistance to Health Plans

HSAG has worked with HFS and the health plans to develop models of stakeholder collaboration for quality improvement projects which are essential for identifying and implementing sustainable activities that lead to improved preventive and developmental services. The Illinois collaborative PIPs have improved. Topics include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services for children; perinatal care, postpartum care, and depression screening for women; and care coordination following hospitalizations by linking enrollees to community resources.

HSAG understands the importance of providing ongoing and specific technical assistance to each health plan, as needed, and provides consultation, expertise, suggestions, and advice to assist with decision-making and strategic planning. HSAG works in partnership and collaboration with the State and health plans to ensure that it delivers effective technical support that facilitates the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG has continued to provide technical guidance to the health plans to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective corrective action plans (CAPs).

Specific examples of technical assistance topics conducted to assist the health plans in SFY 2015 are described below.

Conducting PIPs

HSAG conducts ongoing technical assistance with the health plans to provide training in the PIP activities identified below to ensure that the health plans' PIPs are designed, conducted, and reported in a methodologically sound manner.

- Selecting PIP Topics
- Development of Study Question(s)
- Selection of Study Indicator(s)
- Selection of Study Population
- Sampling Methods
- Data Collection/Analyses
- Assessment of Quality Improvement Strategies
- Sustained Improvement

Technical Assistance to ACEs and CCEs

HSAG worked with HFS to provide technical assistance to the ACEs and CCEs on a variety of topics as described below.

- At the request of HFS, HSAG developed and presented training for the health plans regarding health risk screening (HRS) and health risk assessment (HRA). The training defined case management and care coordination; outlined the contract requirements for HRS, HRA, and enrollee care plans; and described the purpose of HRS and HRA. Training participants learned the required reassessment frequency and components of HRS and HRA. Finally, the training also covered requirements for the qualifications of care coordination staff.
- Culturally and Linguistically Appropriate Services (CLAS) Standards—These national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the healthcare system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The 14 standards are organized by themes: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8–14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations. The collective set of CLAS mandates, guidelines, and recommendations is intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.
- Children with Special Health Care Needs Screening Tools—HSAG provided training on the use of the Children with Special Health Care Needs (CSHCN) Screener developed through the Child and Adolescent Health Measurement Initiative, a national collaboration coordinated by FACCT—the Foundation for Accountability. The CSHCN Screener is a five-item, parent survey-based tool that responds to the need for an efficient, flexible, standardized method for identifying CSHCN. The CSHCN Screener uses noncondition-specific, consequence-based criteria to identify children with special health care needs for purposes of quality assessment or other population-based applications. Children are identified on the basis of experiencing one or more current functional limitations or service use needs that are the direct result of an ongoing physical, emotional, behavioral, developmental, or other health condition. The noncondition-specific approach used by the CSHCN Screener identifies children across the range and diversity of childhood chronic conditions and special needs, allowing a more comprehensive assessment of healthcare system performance than is attainable by focusing on a single diagnosis or type of special need.
- Call Center Reporting—HFS requires that health plans' administrative quality assurance (QA) and improvement policies and procedures contain standards and a monitoring plan for all telephone access and call center performance, and that health plans take immediate corrective action when standards are not met. Health plans must analyze data collected from their phone systems as necessary to perform QA and improvement tasks, monitor compliance with performance standards, and ensure adequate call center staffing. Health plans are also assessed on HEDIS performance measures for call center performance. HSAG provided assistance to the ACEs and CCEs regarding

call center standards and monitoring procedures, including the provision of a sample call center report.

- Sample Care Management Program Description—HSAG designed and drafted a sample care management (CM) program description to guide the ACEs and CCEs in developing CM program descriptions that include all applicable requirements. The sample outlined sections and topics to include in the program description and provided a template for organizing the document. The sample provided examples of statements that could be used to describe program elements and listed the specific descriptions the ACEs and CCEs would need to include to meet requirements.
- Sample Health Risk Screening Tool—HSAG designed and drafted a sample health risk screening tool specific to the ACE and CCE population for the organizations to use in developing appropriate screening tools.
- Sample Delegated Services Agreement—HSAG designed and drafted a sample Delegated Services Agreement for ACEs and CCEs to use in contracting with delegated entities to provide services to enrollees. This allowed ACEs and CCEs to develop and finalize their service agreements with efficiency while ensuring they would include all contractual requirements.

Contract Language

- HSAG advises HFS and the health plans on specific questions regarding contract language. For example, during SFY 2015, HSAG created a contract guidance review document for the ACEs and CCEs, assisted with drafting amendments for health plan contracts, and reviewed contract language for individual health plans.

Appendix A. HEDIS 2015 Medicaid Rates and MCO Trended Rates

Access to Care Measures

HEDIS Measures	MER	FHN	HAR	All MCOs
Children's Access to PCPs				
Children's Access to PCPs (12–24 Months)	98.12%	89.28%	90.59%	91.45%
Children's Access to PCPs (25 months–6 Years)	90.53%	78.85%	78.33%	80.01%
Children's Access to PCPs (7–11 Years)	96.81%	79.10%	79.12%	79.88%
Adolescent's Access to PCPs (12–19 Years)	96.80%	78.55%	81.29%	80.95%
Adults' Access to Preventive/Ambulatory Care				
20–44 Years of Age	83.54%	69.20%	69.93%	71.76%
45–64 Years of Age	90.05%	69.09%	72.49%	79.03%

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Prevention and Screening for Children and Adolescents

HEDIS Measures	MER	FHN	HAR	All MCOs
Prevention and Screening for Children and Adolescents				
Childhood Immunizations—Combo 2	76.62%	65.45%	67.64%	70.02%
Childhood Immunizations—Combo 3	73.61%	60.34%	63.26%	65.87%
Lead Screening in Children	84.60%	77.37%	77.13%	80.97%
Appropriate Testing for Children with Pharyngitis	64.12%	31.19%	41.69%	44.74%
*Well-Child Visits in the First 15 Months (0 Visits)**	0.46%	2.19%	3.46%	2.00%
Well-Child Visits in the First 15 Months (6+ Visits)	81.25%	46.72%	57.53%	62.18%
Well-Child Visits (3–6 Years)	83.29%	77.62%	71.39%	77.79%
Adolescent Well-Care Visits	60.65%	52.31%	44.28%	52.55%
Immunizations for Adolescents	73.61%	61.31%	66.83%	67.36%
Human Papillomavirus Vaccine for Female Adolescents	41.41%	20.68%	18.49%	24.31%
Weight Assessment and Counseling—BMI (Total)	69.21%	71.78%	63.02%	68.02%
Weight Assessment and Counseling—Nutrition (Total)	64.35%	62.29%	58.39%	61.72%
Weight Assessment and Counseling—Physical Activity (Total)	49.54%	57.42%	55.23%	53.99%
*** Lower rates indicate better performance for this measure. The percentiles have been reversed to be consistent with the color coding.**				

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Preventive Screening for Women and Maternity-Related Measures

HEDIS Measures	MER	FHN	HAR	All MCOs
Preventive Screening for Women				
Breast Cancer Screening	NA	45.79%	43.62%	47.59%
Cervical Cancer Screening	68.30%	63.75%	69.55%	67.06%
Chlamydia Screening (16–20 Years of Age)	54.73%	56.29%	45.21%	50.12%
Chlamydia Screening (21–24 Years of Age)	65.11%	63.99%	56.80%	60.53%
Chlamydia Screening (Combined Rate)	61.55%	60.61%	51.46%	55.95%
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	2.55%	21.65%	11.92%	11.89%
Frequency of Ongoing Prenatal Care (81–100% of Visits)	87.94%	29.20%	39.17%	52.67%
Timeliness of Prenatal Care	90.26%	64.48%	68.37%	74.62%
Postpartum Care	75.41%	46.72%	44.77%	55.95%

*** Lower rates indicate better performance for this measure. The percentiles have been reversed to be consistent with the color coding.**

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Chronic Conditions / Disease Management Measures

HEDIS Measures	MER	FHN	HAR	All MCOs
Adult BMI Assessment	87.18%	NR	73.98%	81.32%
Chronic Conditions/Disease Management				
Medication Management for Asthma—Total, 50%	87.18%	41.14%	40.19%	43.68%
Medication Management for Asthma—Total, 75%	75.12%	18.55%	16.84%	21.39%
Use of Appropriate Medications for Asthma—Total	91.41%	87.87%	86.21%	87.20%
Controlling High Blood Pressure	70.91%	42.58%	44.77%	53.17%
Diabetes Care (HbA1C Testing)	94.37%	80.78%	75.43%	79.40%
*Diabetes Care (Poor HbA1c Control)**	73.24%	62.29%	63.75%	63.83%
Diabetes Care (Good HbA1c Control <8%)	23.94%	29.68%	29.68%	29.23%
Diabetes Care (Eye Exam)	63.38%	49.64%	33.82%	43.45%
Diabetes Care (Nephropathy Monitoring)	88.73%	88.56%	72.75%	81.30%
Diabetes Care (BP < 140/90)	67.61%	41.36%	54.74%	49.61%
*** Lower rates indicate better performance for this measure. The percentiles have been reversed to be consistent with the color coding.**				

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Mental / Behavioral Health Measures

HEDIS Measures	MER	FHN	HAR	All MCOs
Mental / Behavioral Health				
Follow-up After Hospitalization for Mental Illness—7 Days	31.78%	54.90%	24.86%	31.62%
Follow-up After Hospitalization for Mental Illness—30 Days	48.20%	72.55%	37.78%	46.68%
Antidepressant Medication Management—Effective	85.94%	41.15%	32.42%	48.36%
Antidepressant Medication Management—Continuation	66.41%	26.32%	16.90%	31.93%

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Family Health Network Rate Trending for HEDIS 2013–HEDIS 2015

HEDIS Measures	HEDIS Rates for FHN Health Plan			
	2013	2014	2015	Trend
Child and Adolescent Care				
Childhood Immunizations—Combo 2	78.70	71.06	65.45	**-13.25**
Childhood Immunizations—Combo 3	72.92	65.97	60.34	**-12.58**
Lead Screening in Children	82.41	78.24	77.37	**-5.04**
*Well-Child Visits in the First 15 Months (0 Visits)**	3.24	1.62	2.19	-1.05
Well-Child Visits in the First 15 Months (6+ Visits)	50.23	51.39	46.72	-3.51
Well-Child Visits (3–6 Years)	69.21	71.06	77.62	8.41
Adolescent Well-Care Visits	45.60	48.61	52.31	6.71
Immunizations for Adolescents	50.23	53.47	61.31	11.08
Human Papillomavirus Vaccine for Female Adolescents	NA	16.90	20.68	3.78
Weight Assessment and Counseling—BMI (Total)	NA	60.65	71.78	11.13
Weight Assessment and Counseling—Nutrition (Total)	NA	59.72	62.29	2.57
Weight Assessment and Counseling—Physical Activity (Total)	NA	52.31	57.42	5.11
Appropriate Testing for Children with Pharyngitis	NA	20.20	31.19	10.99
Access to Care				
Children's Access to PCPs (12–24 Months)	75.42	85.91	89.28	13.86
Children's Access to PCPs (25 months–6 Years)	61.74	71.52	78.85	17.11
Children's Access to PCPs (7–11 Years)	60.84	74.34	79.10	18.26

HEDIS Measures	HEDIS Rates for FHN Health Plan			
	2013	2014	2015	Trend
Adolescent's Access to PCPs (12–19 Years)	61.20	74.25	78.55	17.35
Adults' Access to Preventive/Ambulatory Care (20–44 Years)	64.90	63.85	69.20	4.30
Adults' Access to Preventive/Ambulatory Care (45–64 Years)	67.54	65.66	69.09	1.55
Preventive Screening for Women				
Breast Cancer Screening	49.04	52.67	45.79	-3.25
Cervical Cancer Screening	72.85	64.50	63.75	**-9.10**
Chlamydia Screening (16–20 Years of Age)	58.02	59.35	56.29	-1.73
Chlamydia Screening (21–24 Years of Age)	70.39	67.71	63.99	**-6.40**
Chlamydia Screening (Combined Rate)	64.23	63.78	60.61	-3.62
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21 of Visits)**	23.84	29.63	21.65	-2.19
Frequency of Ongoing Prenatal Care (81–100 of Visits)	35.42	29.17	29.20	**-6.22**
Timeliness of Prenatal Care	62.96	57.64	64.48	1.52
Postpartum Care	48.15	44.44	46.72	-1.43
Chronic Conditions/Disease Management				
Adult BMI Assessment	NA	NA	NR	**NR**
Controlling High Blood Pressure	46.02	42.58	42.58	-3.44
Diabetes Care (HbA1C Testing)	77.43	74.29	80.78	3.35
*Diabetes Care (Poor HbA1c Control)**	55.43	62.26	62.29	**6.86**
Diabetes Care (Good HbA1c Control)	36.29	29.48	29.68	**-6.61**

HEDIS Measures	HEDIS Rates for FHN Health Plan			
	2013	2014	2015	Trend
Diabetes Care (Eye Exam)	36.00	72.88	49.64	13.64
Diabetes Care (Nephropathy Monitoring)	71.71	67.45	88.56	16.85
Diabetes Care (BP < 140/90)	54.29	54.48	41.36	**-12.93**
Appropriate Medications for Asthma (Combined)	84.51	85.59	87.87	3.36
Medication Management for Asthma—Total, 50	NA	52.13	41.14	**-10.99**
Medication Management for Asthma—Total, 75	NA	29.41	18.55	**-10.86**
Follow-up After Hospitalization for Mental Illness—7 Days	63.98	54.20	54.90	**-9.08**
Follow-up After Hospitalization for Mental Illness—30 Days	71.43	61.58	72.55	1.12
Antidepressant Medication Management—Effective	NA	46.82	41.15	**-5.67**
Antidepressant Medication Management—Continuation	NA	29.48	26.32	-3.16
*** Lower rates indicate better performance for these measures.** **NA = Denominator less than 30**				

Harmony Health Plan of Illinois, Inc. Rate Trending for HEDIS 2013–HEDIS 2015

HEDIS Measures	HEDIS Rates for Harmony Health Plan			
	2013	2014	2015	Trend
Child and Adolescent Care				
Childhood Immunizations—Combo 2	69.59	70.60	67.64	-1.95
Childhood Immunizations—Combo 3	64.48	66.44	63.26	-1.22
Lead Screening in Children	79.21	78.84	77.13	-2.08
*Well-Child Visits in the First 15 Months (0 Visits)**	4.38	3.76	3.46	-0.92
Well-Child Visits in the First 15 Months (6+ Visits)	56.20	56.57	57.53	1.33
Well-Child Visits (3–6 Years)	71.54	68.06	71.39	-0.15
Adolescent Well-Care Visits	46.47	49.77	44.28	-2.19
Immunizations for Adolescents	43.07	58.33	66.83	23.76
Human Papillomavirus Vaccine for Female Adolescents	NA	14.81	18.49	3.68
Weight Assessment and Counseling—BMI (Total)	NA	38.19	63.02	24.83
Weight Assessment and Counseling—Nutrition (Total)	NA	59.49	58.39	-1.1
Weight Assessment and Counseling—Physical Activity (Total)	NA	54.86	55.23	0.37
Appropriate Testing for Children with Pharyngitis	NA	34.15	41.69	7.54
Access to Care				
Children's Access to PCPs (12–24 Months)	88.89	89.98	90.59	1.7
Children's Access to PCPs (25 months–6 Years)	76.47	76.47	78.33	1.86
Children's Access to PCPs (7–11 Years)	72.95	75.63	79.12	6.17

HEDIS Measures	HEDIS Rates for Harmony Health Plan			
	2013	2014	2015	Trend
Adolescent's Access to PCPs (12–19 Years)	73.44	77.70	81.29	7.85
Adults' Access to Preventive/Ambulatory Care (20–44 Years)	71.09	70.38	69.93	-1.16
Adults' Access to Preventive/Ambulatory Care (45–64 Years)	72.82	71.23	72.49	-0.33
Preventive Screening for Women				
Breast Cancer Screening	36.86	42.99	43.62	6.76
Cervical Cancer Screening	72.81	72.73	69.55	-3.26
Chlamydia Screening (16–20 Years of Age)	50.60	44.13	45.21	**-5.39**
Chlamydia Screening (21–24 Years of Age)	62.68	56.60	56.80	**-5.88**
Chlamydia Screening (Combined Rate)	55.73	50.15	51.46	**-4.27**
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21 of Visits)**	14.11	12.79	11.92	-2.19
Frequency of Ongoing Prenatal Care (81–100 of Visits)	43.55	42.09	39.17	**-4.38**
Timeliness of Prenatal Care	74.70	70.00	68.37	**-6.33**
Postpartum Care	49.39	48.37	44.77	**-4.62**
Chronic Conditions/Disease Management				
Adult BMI Assessment	NA	71.69	73.98	2.29
Controlling High Blood Pressure	39.42	50.00	44.77	5.35
Diabetes Care (HbA1C Testing)	77.37	75.61	75.43	-1.94
*Diabetes Care (Poor HbA1c Control)**	56.69	56.76	63.75	**7.06**
Diabetes Care (Good HbA1c Control)	36.50	34.59	29.68	**-6.82**

HEDIS Measures	HEDIS Rates for Harmony Health Plan			
	2013	2014	2015	Trend
Diabetes Care (Eye Exam)	27.25	25.50	33.82	6.57
Diabetes Care (Nephropathy Monitoring)	71.53	72.73	72.75	1.22
Diabetes Care (BP < 140/90)	48.42	58.54	54.74	6.32
Appropriate Medications for Asthma (Combined)	84.14	84.73	86.21	2.07
Medication Management for Asthma—Total, 50	NA	44.32	40.19	**-4.13**
Medication Management for Asthma—Total, 75	NA	21.46	16.84	**-4.62**
Follow-up After Hospitalization for Mental Illness—7 Days	50.44	61.68	24.86	**-25.58**
Follow-up After Hospitalization for Mental Illness—30 Days	64.37	69.80	37.78	**-26.59**
Antidepressant Medication Management—Effective	NA	39.50	32.42	**-7.08**
Antidepressant Medication Management—Continuation	NA	25.97	16.90	**-9.07**
***Lower rates indicate better performance for these measures.** **NA = Denominator less than 30**				

Meridian Health Plan, Inc. Rate Trending for HEDIS 2013–HEDIS 2015

HEDIS Measures	HEDIS Rates for Meridian Health Plan			
	2013	2014	2015	Trend
Child and Adolescent Care				
Childhood Immunizations—Combo 2	84.89	85.68	76.62	**-8.27**
Childhood Immunizations—Combo 3	82.73	83.37	73.61	**-9.12**
Lead Screening in Children	85.97	88.45	84.60	-1.37
*Well-Child Visits in the First 15 Months (0 Visits)**	0.58	0.00	0.46	-0.12
Well-Child Visits in the First 15 Months (6+ Visits)	92.40	90.46	81.25	**-11.15**
Well-Child Visits (3–6 Years)	88.90	88.44	83.29	**-5.61**
Adolescent Well-Care Visits	79.65	74.58	60.65	**-19.00**
Immunizations for Adolescents	68.57	70.26	73.61	5.04
Human Papillomavirus Vaccine for Female Adolescents	NA	48.60	41.41	**-7.19**
Weight Assessment and Counseling—BMI (Total)	NA	58.33	69.21	10.88
Weight Assessment and Counseling—Nutrition (Total)	NA	64.35	64.35	0.00
Weight Assessment and Counseling—Physical Activity (Total)	NA	37.73	49.54	11.81
Appropriate Testing for Children with Pharyngitis	NA	52.23	64.12	11.89
Access to Care				
Children's Access to PCPs (12–24 Months)	96.74	98.50	98.12	1.38
Children's Access to PCPs (25 months–6 Years)	95.52	95.36	90.53	**-4.99**
Children's Access to PCPs (7–11 Years)	95.28	97.00	96.81	1.53

HEDIS Measures	HEDIS Rates for Meridian Health Plan			
	2013	2014	2015	Trend
Adolescent's Access to PCPs (12–19 Years)	94.93	97.24	96.80	1.87
Adults' Access to Preventive/Ambulatory Care (20–44 Years)	88.21	87.08	83.54	**-4.67**
Adults' Access to Preventive/Ambulatory Care (45–64 Years)	90.55	87.98	90.05	-0.5
Preventive Screening for Women				
Breast Cancer Screening	NA	88.89	NA	NA
Cervical Cancer Screening	80.56	80.65	68.30	**-12.26**
Chlamydia Screening (16–20 Years of Age)	58.95	46.90	54.73	**-4.22**
Chlamydia Screening (21–24 Years of Age)	70.73	71.28	65.11	**-5.62**
Chlamydia Screening (Combined Rate)	65.60	62.13	61.55	**-4.05**
Maternity-Related Measures				
*Frequency of Ongoing Prenatal Care (<21 of Visits)**	0.81	0.86	2.55	1.74
Frequency of Ongoing Prenatal Care (81–100 of Visits)	95.97	92.72	87.94	**-8.03**
Timeliness of Prenatal Care	96.37	94.03	90.26	**-6.11**
Postpartum Care	83.06	78.46	75.41	**-7.65**
Chronic Conditions/Disease Management				
Adult BMI Assessment	NA	84.69	87.18	2.49
Controlling High Blood Pressure	NA	78.50	70.91	**-7.59**
Diabetes Care (HbA1C Testing)	93.18	94.37	94.37	1.19
*Diabetes Care (Poor HbA1c Control)**	70.45	73.24	73.24	2.79
Diabetes Care (Good HbA1c Control)	22.73	23.94	23.94	1.21

HEDIS Measures	HEDIS Rates for Meridian Health Plan			
	2013	2014	2015	Trend
Diabetes Care (Eye Exam)	75.00	63.38	63.38	**-11.62**
Diabetes Care (Nephropathy Monitoring)	75.00	88.73	88.73	13.73
Diabetes Care (BP < 140/90)	13.64	67.61	67.61	53.97
Appropriate Medications for Asthma (Combined)	NA	92.86	91.41	-1.45
Medication Management for Asthma—Total, 50	NA	94.31	87.18	**-7.13**
Medication Management for Asthma—Total, 75	NA	83.74	75.12	**-8.62**
Follow-up After Hospitalization for Mental Illness—7 Days	NA	41.94	31.78	**-10.16**
Follow-up After Hospitalization for Mental Illness—30 Days	NA	65.59	48.20	**-17.39**
Antidepressant Medication Management—Effective	NA	65.96	85.94	19.98
Antidepressant Medication Management—Continuation	NA	53.19	66.41	13.22
***Lower rates indicate better performance for these measures. NA = Denominator less than 30**				

Appendix B. Illinois Performance Measure 2015 Medicaid Rates for the ICP

Table B-1—2015 ICP Rates for Non-Incentive Measures

Measure	Aetna	IlliniCare	CCAI	Health Alliance	Meridian	Molina
Access to Care Measures (Percentages)						
*Inpatient Hospital 30-Day Readmission Rate**	6.73%	10.85%	8.68%	14.73%	6.87%	13.63%
*Inpatient Mental Hospital 30-Day Readmission Rate**	4.85%	13.65%	NA	32.24%	13.80%	7.69%
Adults' Access to Preventive/Ambulatory Health Services	81.73%	80.59%	87.92%	90.31%	86.77%	77.43%
Preventive Care Measures (Percentages)						
Colorectal Cancer Screening	37.96%	28.13%	NA	NA	NA	NA
Breast Cancer Screening	48.43%	51.08%	NA	NA	NA	NA
Cervical Cancer Screening	48.42%	38.21%	51.34%	30.81%	45.84%	36.94%
Adult BMI Assessment	68.37%	67.14%	NA	NA	NA	NA
Appropriate Care Measures (Percentages)						
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.89%	90.63%	92.41%	92.49%	87.90%	86.36%
Annual Monitoring for Patients on Persistent Medications—Digoxin	57.89%	62.35%	NA	NA	50.00%	NA
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.67%	91.12%	91.10%	92.50%	88.43%	87.81%
Annual Monitoring for Patients on Persistent Medications—Total	89.11%	90.28%	91.45%	92.26%	87.65%	86.73%
Comprehensive Diabetes Care—HbA1c Testing (DD Population Only)	86.86%	87.96%	90.35%	87.57%	94.37%	82.63%
Use of High-Risk Medications in the Elderly—60-65 Years–1 Prescription	36.30%	34.87%	51.76%	36.38%	NA	37.18%
Use of High-Risk Medications in the Elderly—60-65 Years–2+ Prescriptions	9.35%	9.48%	11.76%	8.16%	NA	8.97%
Use of High-Risk Medications in the Elderly—65+ Years–1 Prescription	14.68%	13.06%	15.52%	26.32%	NA	10.34%
Use of High-Risk Medications in the Elderly—65+ Years–2+ Prescriptions	2.56%	2.68%	1.72%	5.26%	NA	2.76%

Measure	Aetna	IlliniCare	CCAI	Health Alliance	Meridian	Molina
Behavioral Health Measures (Percentages)						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	79.82%	75.93%	60.38%	72.52%	59.55%	71.33%
Behavioral Health Risk Assessment (BHRA) Completed within 60 Days of Enrollment	14.40%	42.85%	7.43%	0.57%	7.55%	0.26%
Follow-Up Completed within 30 Days of Positive BHRA	39.47%	13.33%	11.76%	NA	13.26%	NA
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Initiation of AOD Treatment	44.26%	50.07%	38.28%	38.23%	44.48%	38.58%
Initiation and Engagement of AOD Dependence Treatment 18+ Years—Engagement of AOD Treatment	10.31%	7.79%	4.17%	9.09%	13.71%	5.17%
Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up	28.22%	44.91%	42.64%	33.12%	28.18%	30.27%
Utilization Measures (Per 1,000 Member Months)^						
*Dental ED Visits Per 1,000 Member Months**	12.44	13.20	18.12	51.79	1.70	27.94
Inpatient Utilization (Per 1,000 Member Months)^						
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient Discharges (Per 1,000 Member Months)	20.38	24.97	19.96	27.80	19.32	21.76
Inpatient Utilization—General Hospital/Acute Care: Total Medicine Discharges (Per 1,000 Member Months)	14.00	17.25	14.32	21.27	18.64	16.04
Inpatient Utilization—General Hospital/Acute Care: Total Surgery Discharges (Per 1,000 Member Months)	5.96	7.40	5.05	5.82	1.65	4.91
Inpatient Utilization—General Hospital/Acute Care: Total Maternity Discharges (Per 1,000 Member Months)	0.53	0.43	0.67	0.75	0.72	0.86
Mental Health Utilization Inpatient and Outpatient (Percentages)^						
Mental Health Utilization—Any Services Total	27.50%	19.01%	20.29%	25.98%	17.14%	25.35%
Mental Health Utilization—Inpatient Total	8.43%	5.54%	3.82%	4.55%	3.94%	7.09%

Measure	Aetna	IlliniCare	CCAI	Health Alliance	Meridian	Molina
Mental Health Utilization—Intensive Outpatient/Partial Hospitalization Total	0.37%	0.17%	0.19%	0.16%	0.53%	0.25%
Mental Health Utilization—Outpatient Total	23.48%	16.52%	18.97%	23.39%	15.33%	23.18%
Long Term Care (Per 1,000 Member Months)						
*Long Term Care Urinary Tract Infection Admission Rate**	1.09	0.82	6.87	1.28	1.39	0.47
*Long Term Care Bacterial Pneumonia Admission Rate**	0.75	1.30	0.98	4.68	1.85	0.68
*Long Term Care Prevalence of Hospital Acquired Pressure Ulcers**	NR	NR	0.27	0.43	0.00	0.81
Member Movement (Percentages)						
Movement of Members—Started and Ended in Community	77.82%	72.50%	74.82%	78.88%	80.07%	73.85%
Movement of Members—Started and Ended in HCBS (LTSS)	73.56%	74.10%	67.72%	79.64%	68.80%	66.03%
Movement of Members—Started and Ended in LTC	80.73%	73.32%	73.17%	69.14%	50.00%	NA
Movement of Members—Total Medicaid Members with No Movement	77.68%	72.70%	74.01%	78.61%	78.81%	72.99%
Movement of Members—No Longer Enrolled	19.24%	22.57%	22.57%	19.20%	17.40%	22.97%

* Lower rates represent better performance for these measures.

^ Indicates measure is utilization based, not performance based; therefore, changes in rates are not necessarily indicative of changes in performance.

NA indicates the measure required more than one year of continuous enrollment for members, or allowed a lookback period to identify events/diagnoses prior to the ICPs implementation in the program.

NR indicates the measure was not reported.

Appendix C. Acronyms

AABD ..... Aid to Aged Blind and Disabled
ACA ..... Affordable Care Act
ACE ..... Accountable Care Entity
ADA ..... Americans with Disabilities Act
AOD ..... Alcohol and Other Drug
AQRA ..... Agency for Healthcare Research and Quality
BBA ..... Balanced Budget Act of 1997
BHRA ..... Behavioral Health Risk Assessment
BMI ..... Body Mass Index
BP ..... Blood Pressure
CAD ..... Coronary Artery Disease
CAHPS ..... Consumer Assessment of Healthcare Providers and Systems
CAP ..... Corrective Action Plan
CC ..... Care Coordination
CCC ..... Children with Chronic Conditions
CCCD ..... Care Coordination Claims Data
CCE ..... Care Coordination Entity
CCIP ..... Chronic Care Improvement Program
CDC ..... Comprehensive Diabetes Care
CFR ..... Code of Federal Regulations
CHIP ..... Children's Health Insurance Program
CHIPRA ..... Children's Health Insurance Program Reauthorization Act
CIS ..... Client Information System
CLAS ..... Culturally and Linguistically Appropriate Services
CM ..... Care Management
CMHC ..... Community Mental Health Center
CMS ..... Centers for Medicare & Medicaid Services
COPD ..... Chronic Obstructive Pulmonary Disease
CORE ..... Consolidated Outreach and Risk Evaluation
CPG ..... Clinical Practice Guidelines
CPT ..... Current Procedural Technology
CRG ..... Clinical Risk Grouping
CSHCN ..... Children with Special Health Care Needs

CSS ..... Center for the Study of Services
CY ..... Calendar Year
DCFS ..... Department of Children and Family Services
DD ..... Developmental Disability
DHS ..... Department of Human Services
DIS ..... Division of Information Systems
DoA ..... Department on Aging
DPH ..... Department of Public Health
EDM ..... Evidenced Based Measures
ED ..... Emergency Department
EDW ..... Enterprise Data Warehouse
EHR ..... Electronic Health Record
EIS ..... Executive Information System
EPSDT ..... Early and Periodic Screening, Diagnosis, and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ESP ..... Education and Screening Program
FCC ..... Family Centered Care
FFS ..... Fee-for-Service
FHP ..... Family Health Plan
FQHC ..... Federally Qualified Health Center
FTE ..... Full-Time Equivalent
FTP ..... File Transfer Protocol
FUH ..... Follow Up After Hospitalization for Mental Illness
HCBS ..... Home and Community Based Services
HEDIS ..... Healthcare Effectiveness Data and Information Set
HFS ..... Illinois Department of Healthcare and Family Services
HHS ..... U.S. Department of Health and Human Services
HIPAA ..... Health Insurance Portability and Accountability Act
HMO ..... Health Maintenance Organization
HRA ..... Health Risk Assessment
HRS ..... Health Risk Screening
HSAG ..... Health Services Advisory Group, Inc.
IBNR ..... Incurred but Not Received
ICD ..... International Classification of Diseases
ICP ..... Integrated Care Program

ICT ..... Integrated Care Team
IDSS ..... Interactive Data Submission System
IHC ..... Illinois Health Connect
ILCS ..... Illinois Compiled Statutes
IRR ..... Interrater Reliability
IS ..... Information Systems
ISCAT ..... Information Systems Capabilities Assessment Tool
IT ..... Information Technology
IUD ..... Intrauterine Device
LLC ..... Limited Liability Company
LTC ..... Long-Term Care
LTSS ..... Long-Term Services and Supports
MAC ..... Medical Advisory Committee
MCCN ..... Managed Care Community Network
MCO ..... Managed Care Organization
MCS ..... Managed Care System
MMAI ..... Medicare-Medicaid Alignment Initiative
MMIS ..... Medicaid Management Information System
MRR ..... Medical Record Review
MRRV ..... Medical Record Review Validation
MY ..... Measurement Year
NCQA ..... National Committee for Quality Assurance
NPI ..... National Provider Identifier
OMH ..... Office of Minority Health
P4P ..... Pay-for-Performance
PBH ..... Persistence of Beta-Blocker Treatment After a Heart Attack
PCCM ..... Primary Care Case Management
PCE ..... Pharmacotherapy Management of COPD Exacerbation
PCMH ..... Patient-Centered Medical Home
PCP ..... Primary Care Physician
PDSA ..... Plan-Do-Study-Act
PFL ..... Provider File Layout
PHI ..... Protected Health Information
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
POSM ..... Participant Outcomes and Status Measures

QA ..... Quality Assurance
QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
QIP ..... Quality Improvement Project
QISMC ..... Quality Improvement System for Managed Care
RFP ..... Request for Proposal
RY ..... Reporting Year
SFY ..... State Fiscal Year
SCHIP ..... State Children's Health Insurance Program
SHCN ..... Special Health Care Needs
SLF ..... Supportive Living Facility
SNF ..... Skilled Nursing Facility
SPR ..... Use of Spirometry Testing in the Assessment and Diagnosis of COPD
STD ..... Sexually Transmitted Disease
TA ..... Technical Assistance
VMC ..... Voluntary Managed Care