

State of Illinois  
Department of Healthcare and Family Services

**2007–2008  
External Quality Review  
Technical Report**

July 2009



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### 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 or the Department), formerly known as the Illinois Department of Public Aid (IDPA). The 2007–2008 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, and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to participants of the Illinois Medical Assistance Program. These beneficiaries were enrolled in one of Illinois' two contracted managed care organizations (referred to as HFS managed care organizations or MCOs): **Family Health Network, Inc. (FHN)**, and **Harmony Health Plan of Illinois, Inc. (Harmony)**.

This EQR technical report provides an evaluation of the data sources reviewed by HSAG. As the EQRO, HSAG assessed the progress that the two Illinois managed care plans made in fulfilling the Department's goals for the quality and timeliness of, and access to, care for all individuals enrolled in the Illinois managed care program for the 2007–2008 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the Balanced Budget Act of 1997 (BBA) and State requirements.

### Scope of EQR Activities Conducted

This EQR technical report focuses on the following three federally mandated EQR activities set forth in 42 CFR 438.352:

- ◆ **Compliance monitoring evaluation.** This evaluation was designed to determine an MCO's compliance with its contract with the State, federal regulations, and various compliance monitoring standards. Compliance was also determined through review of individual files to evaluate implementation of standards.
- ◆ **Validation of performance measures.** HSAG validated each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, an MCO. HSAG conducted the validation to determine the extent to which Medicaid-specific performance measures calculated by an MCO followed specifications established by the State.
- ◆ **Validation of performance improvement projects (PIPs).** For each MCO, HSAG reviewed three PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner that would allow real improvements in care to be achieved, and for interested parties to have confidence in the reported improvements.

## Mandatory EQR Activities—2007–2008

### **Comprehensive Compliance Monitoring Evaluation—Quality Assurance Plan (QAP) Structure and Operations**

HSAG conducted on-site, comprehensive compliance reviews of each MCO. This is the fourth year HSAG has performed on-site evaluations for HFS. The purpose of this year's review was to evaluate the plans' compliance with elements of 11 standards. The 2008 on-site compliance review also included a review of individual files and records for the areas of delegation, credentialing/recredentialing, continuity of care and case management, grievances, appeals, and denials. For each MCO, HSAG calculated compliance scores for the review of standards, the review of records, and the overall compliance score. Further, HSAG compared compliance standards scores for 2006 and 2008 for each MCO.

### **Conclusions**

**FHN** showed improvement on 8 out of 11 standards and its score improved from 64 percent in 2006 to 79 percent in 2008. **FHN** demonstrated considerable improvement on the following standards: Credentialing and Recredentialing; Coordination of QAP Activity with Other Management Activities; Enrollee Information, Rights, and Protections; and Utilization Management. Three standards showed a decline compared to 2006. The lowest-performing area of compliance was Continuity of Care and Case Management. Monitoring of Delegated Activities also had a large decline in performance.

**Harmony** demonstrated improvement on 2 out of the 11 standards and remained the same on 4 other standards. Harmony demonstrated a stronger level of compliance with Medical Records Standards and Access and Availability—Service Delivery. In addition, QAP Structure was an area of strong performance, achieving 100 percent compliance in both 2006 and 2008. The lowest-performing area of compliance was Continuity of Care and Case Management. Monitoring of Delegated Activities also had a large decline in performance. Five standards showed a decline compared to 2006, and the overall compliance score dropped from 86 percent to 83 percent between 2006 and 2008. However, five of the standards received scores of 90 percent or more.

Both MCOs had ongoing opportunities to enhance compliance with the quality standards.

### **Recommendations**

**FHN** and **Harmony** are required to implement corrective actions as identified in each plan's compliance monitoring report.

## Validation of Performance Measures—NCQA HEDIS Compliance Audit

HSAG performed an independent audit of **FHN**'s and **Harmony**'s 2007 Healthcare Effectiveness Data and Information Set (HEDIS<sup>1-1</sup>) data. Three HEDIS measures were selected for validation:

- ◆ *Childhood Immunization Status*
- ◆ *Prenatal and Postpartum Care*
- ◆ *Well-Child Visits in the First 15 Months of Life (0 Visits and 6 or More Visits)*

**FHN** and **Harmony** reported on 11 other HEDIS measures that were not validated during the audit, although the processes for collecting and calculating each measure were validated. The rates for these HEDIS measures are included in this report and consist of the following performance measures:

- ◆ *Breast Cancer Screening*
- ◆ *Cervical Cancer Screening*
- ◆ *Comprehensive Diabetes Care*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ *Adolescent Well-Care Visits*
- ◆ *Adults' Access to Preventative/Ambulatory Care*
- ◆ *Controlling High Blood Pressure*
- ◆ *Chlamydia Screening in Women*
- ◆ *Frequency of Ongoing Prenatal Care*
- ◆ *Follow-up After Hospitalization for Mental Illness*

## Conclusions

HSAG determined that both MCOs were in compliance with the *HEDIS 2008 Technical Specifications*, and all selected HEDIS measures received a *Report (R)* audit designation status.

Half of the rates for the performance measures have improved since 2005. However, most of the improvements have been small, averaging less than 3 percentage points per year. Despite improvements over time, results for the majority of the rates for both MCOs were still well below the national Medicaid 2007 HEDIS 50th percentiles.

## Recommendations

HSAG recommends the following for both MCOs:

- ◆ Conduct barrier analysis for maternity-related measures to determine the causes for noncompliance by both providers and members, and develop and implement targeted interventions for achieving improvement on these measures.

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<sup>1-1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ Continue to educate providers on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and members on the importance of obtaining these services. EPSDT services impact multiple HEDIS measures, including well-child visits and immunizations.
- ◆ Establish a monitoring program that routinely collects and analyzes data on the performance measures, providing interpretation of these data to practitioners. Consider a pay-for-performance bonus program based on performance by provider. Develop a detailed work plan to improve reporting of encounter data. Consider, for example, contracting with individual providers on a fee-for-service basis for those who do not submit a sufficient amount of encounter data. The lack of encounter data may have a ripple effect as it is difficult to implement effective interventions and target specific areas if the MCO is unaware of the issues. HSAG strongly recommends that **FHN** and **Harmony** focus on the submission and capture of encounter data. Ensuring accurate and complete encounter data should improve rates and allow the MCOs to follow the above recommendations more effectively.

**Validation of Performance Improvement Projects (PIPs)**

As part of its quality assessment and performance improvement program, each health plan is required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of PIPs is to achieve through ongoing measurements and intervention significant improvements in clinical and nonclinical care areas that are sustained over time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted MCOs and prepaid inpatient health plans (PIHPs). The Department contracted with HSAG to meet this validation requirement.

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

- ◆ Measurement of 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.

Table 1-1 displays the PIPs conducted by each MCO that were validated by HSAG in 2007–2008.

Table 1-1—Illinois 2007–2008 Performance Improvement Projects			
MCO	Perinatal/Depression Screening	Asthma	EPSDT Screening
Family Health Network	√	√	√
Harmony Health Plan	√	√	√

The validation of the PIPs does not include a discussion of the rates for the study indicators. This section only considers the validity and reliability of the PIP. The study indicators are typically addressed in a separate section under performance measures. However, for this technical report, the rates for the perinatal and depression screening and EPSDT study indicators were not yet

completed; therefore, an addendum to this report will be forthcoming with the actual study indicator rates and a discussion regarding these results.

## Conclusions

**FHN** received a *Met* score for 89 percent of the total possible evaluation elements and 100 percent of the critical elements for its 2007–2008 asthma PIP, achieving a *Met* validation status. **Harmony** received a *Met* score for 79 percent of the total possible evaluation elements and 92 percent of the critical elements for its 2007–2008 asthma PIP, achieving a *Partially Met* validation status.

Both **FHN** and **Harmony** achieved a *Met* validation status for the 2007–2008 EPSDT screening PIPs. **FHN** received a *Met* score for 95 percent of the total possible evaluation elements and 100 percent of the critical elements. **Harmony** received a *Met* score for 92 percent of the total possible evaluation elements and 100 percent of the critical elements.

Following the baseline EPSDT study, the MCOs were required to implement interventions to improve EPSDT rates. The intervention period was to be conducted during State fiscal year (SFY) 2005–2006, with a remeasurement phase scheduled for SFY 2006–2007. Based on the findings from the baseline EPSDT study, however, the Department and the HFS MCOs decided to continue their intervention efforts throughout SFY 2006–2007. Furthermore, the Department and the MCOs agreed that an EPSDT provider survey should be conducted in SFY 2006–2007 to help identify potential barriers providers may encounter in providing EPSDT services and, therefore, pinpoint areas the HFS MCOs could target for intervention. The results of the survey and recommendations are included in the 2006–2007 EQR Technical Report. A remeasurement of the baseline EPSDT PIP study indicators occurred during SFY 2007–2008. The results of this remeasurement will be included as an addendum to this EQR Report.

**FHN** received a *Met* score for 94 percent of the total possible evaluation elements and 100 percent of the critical elements for its 2007–2008 perinatal care and depression screening PIP, achieving a *Met* validation status. **Harmony** received a *Met* score for 84 percent of the total possible evaluation elements and 92 percent of the critical elements for its 2007–2008 perinatal care and depression screening PIP, achieving a *Partially Met* validation status. A remeasurement of the baseline perinatal care and depression screening PIP study indicators occurred during SFY 2007–2008. The results of this remeasurement will be included as an addendum to this EQR report.

HSAG reported confidence in validity and reliability of the PIPs that achieved *Met* status, and low confidence in the two **Harmony** PIPs that received *Partially Met* status.

## Recommendations

Both MCOs should continue to use technical assistance to enhance compliance with PIP standards and ensure scientifically sound data to help improve the health outcomes of beneficiaries. Both MCOs also have opportunities for improvement in the documentation of reported PIP results, including providing an interpretation of the extent of which the study was successful and data to indicate whether actual improvement in outcomes of care had occurred. In addition, both MCOs should strengthen their focus on improving clinical outcomes and the quality of care and services to HFS beneficiaries.

## Optional EQR Activities—2007-2008

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<sup>1-2</sup> Surveys**

Since 2001, **FHN** and **Harmony** have contracted with The Meyers Group (TMG), a HEDIS survey vendor certified by the National Committee for Quality Assurance (NCQA), to conduct annual consumer satisfaction surveys and to submit a report to each MCO summarizing the survey findings. In the past, TMG used a modified version of the CAHPS instrument when assessing consumer satisfaction for the Illinois MCOs. In 2007, for the first time, TMG used the standard CAHPS instruments, the CAHPS 4.0H Adult Medicaid Health Plan Survey and the CAHPS 3.0H Child Medicaid Health Plan Survey to conduct surveys for **FHN** and **Harmony**.

### **Conclusions**

For the adult Medicaid CAHPS, **FHN** and **Harmony** both scored above the 2007 NCQA national averages for five of the comparable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rates for *Getting Care Quickly* and *How Well Doctors Communicate* were higher than the national averages by more than 10 percentage points, representing areas of strength for both plans.

For the child Medicaid CAHPS, **FHN** and **Harmony** both scored above the 2007 NCQA national averages for six of the comparable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rates for *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* were higher than the national averages by more than 10 percentage points, representing areas of strength for both plans. However, both **FHN** and **Harmony** scored below the national average on the child Medicaid CAHPS composite of *Getting Needed Care*.

### **Recommendations**

Both plans should focus on implementing examples in the CAHPS literature for improving *Getting Needed Care* results, which include enhancing provider directories so they contain the most up-to-date information, streamlining the referral process to expedite patients' access to care, and ensuring receipt of care by the appropriate physician.

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<sup>1-2</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

## Technical Assistance—2007–2008

As requested by the Department, HSAG has continued to provide technical guidance to the MCOs to assist them in conducting the mandatory EQR activities, particularly to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). In addition, HFS requested that HSAG work with the Department and the MCOs to provide technical assistance that may be required by the MCOs prior to the Department exercising sanctions for failure to show a continued commitment to, or achieve progress toward, ongoing quality improvement.

HSAG, at the request of the Department, provided technical assistance training to the MCOs in conducting root cause analyses and implementing meaningful interventions to address the findings outlined in the MCO Annual Program Evaluations, results of PIPs, and performance measures.

### *Illinois Quality Strategy for Managed Care*

HSAG provided technical assistance to the Department in an assessment of the level of compliance of the Illinois Quality Strategy for Managed Care (Quality Strategy) with the requirements of 42 CFR 438.202. HSAG reviewed quality strategies developed by other states and conducted a literature review to identify approaches and tactics that might assist HFS in making any needed revisions to help improve the health outcomes of HFS beneficiaries.

### **Conclusions**

The evaluation identified that the Quality Strategy developed by HFS closely follows information in the Centers for Medicare & Medicaid Services (CMS) State Quality Strategy Tool Kit for State Medicaid Agencies (October 2006). The quality strategy satisfied the requirements set forth in 42 CFR 438.202. The strategy has evolved over time based on community concerns and feedback, participant health needs, federal and State law, industry standards, lessons learned, and best practices, and in collaboration with the MCOs to establish objectives, priorities, and achievable timelines.

CMS provided a review to HFS on May 28, 2008, inviting HFS to provide any corrections or new information and to share any interesting new quality strategies in Illinois that might be useful to other states. On August 13, 2008, HFS provided a response to each question or request.

### **Validation of PCCM Performance Measures**

HFS contracted with HSAG to conduct a validation of 16 performance measures for the Primary Care Case Management Program (PCCM) for SFY 2007–2008. Following the validation findings and recommendations, HFS should update and/or revise the source code and technical specifications, then resubmit them to HSAG for validation. Feedback was provided to HFS to ensure source code and technical specifications were accurately corrected.

### **Conclusions**

The development of PCCM program performance measures demonstrates a commitment by HFS to improve services provided to all HFS beneficiaries. This major project will allow HFS to compare administrative MCO rates to the PCCM rates, allowing for specific drill-down of the data by HFS (e.g., rates can be calculated overall and by county and race/ethnicity). HSAG has completed validation of the PCCM performance measures for 11 of the 16 measures.

### **Recommendations**

With the validation of the PCCM performance measures not yet completed, the following are next steps in the process rather than recommendations:

- ◆ HFS should complete the updates and/or revisions to the source code and technical specifications, then resubmit them to HSAG for final approval.
- ◆ The rates for the PCCM performance measures should be generated and provided as an addendum to this report.

### **Performance Tracking Tool (PTT)**

One of HFS' new quality initiatives is the creation of minimum standards for performance measures. In 2008, HFS and HSAG created a PTT for each MCO. The PTT was initially designed as a mechanism for the State and the MCOs to monitor and trend the results of each performance measure identified in the tool. The PTT was used to record baseline and remeasurement results for each performance measure, and to identify how the plan is performing in comparison to national benchmarks and the calculated goals for the subsequent reporting period.

## Overall Conclusions

The scores of both **FHN** and **Harmony** on the 2005–2006 compliance reviews resulted in a large number of required corrective actions. While both MCOs showed improvements in the 2007–2008 reviews, HSAG identified areas that require continued quality improvement efforts.

The *R* audit designation for both MCOs for all selected HEDIS measures demonstrated a continuation of the strong performance achieved in the HEDIS 2007 validation, when all selected measures also received an *R* audit designation.

Despite the improvements achieved by both MCOs in performance measures over time, the majority of rates remained well below the national Medicaid HEDIS 50th percentiles.

The two HFS MCOs differed in the reliability of their PIP results. **FHN** achieved *Met* validation status for all three 2007–2008 PIPs: asthma, EPSDT screening, and perinatal care and depression screening. **Harmony** achieved *Met* validation status for EPSDT screening, but only *Partially Met* status for asthma and perinatal care and depression screening.

HFS beneficiaries for both MCOs appeared to be generally satisfied with the two health plans. Both **FHN** and **Harmony** scored above the 2007 NCQA national averages on 11 of the comparable adult and child CAHPS measures. Both **FHN** and **Harmony** scored below average for the child *Getting Needed Care* measure.

## Overall Recommendations

Both MCOs should implement the recommendations for improvement discussed in detail in their respective 2008 compliance monitoring reports and summarized in Section 3 of this EQR technical report. In particular, both MCOs must focus on the continued development and implementation of a basic system that promotes continuity of care and case management.

Achieving improvements in the MCOs' performance on HEDIS measures should be a top priority. The MCOs should focus efforts on maternity-related services, EPSDT services, provider incentives, and improvements to the encounter data reporting process.

HFS encourages the MCOs to continue to use technical assistance when conducting PIPs. Validation of the asthma PIPs indicated that both MCOs should improve the statistical analysis of data and achieve measurable improvements in outcomes of care for beneficiaries with asthma. **FHN**'s perinatal care and depression screening PIP results indicated progress in achieving improved outcomes of care. The validation results of **Harmony**'s perinatal care and depression screening PIP showed the need to improve the reliability of reported study results. Both MCOs should improve several noncritical evaluation elements to reach a level of high confidence in the reported EPSDT screening PIP results.

**FHN**'s and **Harmony**'s 2008 child Medicaid CAHPS results indicated that quality improvement initiatives should focus on improving *Getting Needed Care*.

### Overview

Since June 2002, HSAG has served as the EQRO for the Department and performed EQR activities for Illinois' contracted MCOs. At this time, the contracted MCOs are **FHN** and **Harmony**. Participation in a Medicaid MCO is voluntary in Illinois and HFS beneficiaries may switch plans at any time, with no lock-in period.

For each EQR activity, the technical methods of data collection and analysis were standardized and systematically applied across the MCOs. Common elements included the use of standardized data collection monitoring tools, surveyor training and oversight to ensure interrater reliability (IRR), extensive document review and analysis, and the scoring of findings to indicate whether standards were *Met*. HSAG conducted on-site reviews as part of compliance monitoring evaluations. As a result of these EQR activities, HSAG prepared individual MCO reports summarizing findings and recommendations. Based on these report findings, the Department required the MCOs to develop CAPs for standards or measures with scores of *Partially Met* or *Not Met*.

### Purpose of the EQR Technical Report

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

Pursuant to the BBA, 42 CFR 438.364 calls for the production by each state of a detailed technical report on EQR results. In accordance with 42 CFR 438.358, the EQR technical report describes the manner in which the data from EQR activities were aggregated and analyzed, and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients by Department-contracted MCOs. Information released in this technical report does not disclose the identity of any recipient, in accordance with 438.350(f) and 438.364(a)(b). This report specifically addresses the following for each EQR activity conducted:

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

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

furnished by each MCO. Comparisons of the MCOs' performance for quality, timeliness, access, and performance improvement are also included.

## History of State Medicaid

Managed care is a voluntary program in Illinois and has been a health care option for medical assistance participants since 1976. MCOs include health maintenance organizations (HMOs) and managed care community networks (MCCNs). The Department contracts with the MCOs to manage the provision of health care for HFS beneficiaries. The contracts require the MCOs to offer the same comprehensive set of services to their HFS beneficiaries that are available to the fee-for-service population. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements. The Department of Insurance licenses HMOs, which contract on an at-risk basis to provide medical services to their HFS beneficiaries. MCCNs are provider-sponsored organizations within Illinois certified by the Department as meeting requirements established by the Department for such organizations.

All Kids (formerly known as KidCare) offers health insurance coverage to income-eligible children and pregnant women. FamilyCare broadens coverage to eligible parents or caretaker relatives, as well as children. Children with family incomes of up to 200 percent of the federal poverty level (FPL) can qualify, regardless of available insurance. Children in families above 200 percent of the FPL must be uninsured to qualify. Parents can qualify with a family income of up to 185 percent of the FPL. The Department increased the income standard for parents to 185 percent of the FPL in January 2006. Children and pregnant women can be enrolled in a State-administered All Kids health plan. All children enrolled in All Kids get 12 months of continuous financial eligibility, both upon initial determination of eligibility and upon renewal of eligibility.

All Kids and FamilyCare provide health insurance coverage to children, parents, and pregnant women who are eligible based on their income and meet other nonfinancial eligibility requirements. At the end of fiscal year (FY) 2006, 1.7 million children and their parents were covered by one of six All Kids and FamilyCare plans.

## Primary Care Case Management Program

In FY 2007 Illinois began implementing Illinois Health Connect, a statewide PCCM program for most persons covered by an HFS medical program. Automated Health Systems (AHS) administers the PCCM program, which is a managed care model in which each HFS beneficiary has a medical home with a primary care provider (PCP). HFS beneficiaries may pick their own family doctor or clinic as their PCP if that provider is enrolled as an HFS provider and enrolled as a PCP with Illinois Health Connect. HFS beneficiaries who do not choose a PCP are assigned to one. The intent of the medical home is to ensure that each PCP knows about the health care its HFS beneficiaries receive, and help ensure that HFS beneficiaries get immunizations and other preventive health care, prevents duplication of services, ensures that HFS beneficiaries receive the most appropriate level of care, and improves the quality of care that an HFS beneficiary receives. In counties with MCOs, participants can choose between enrolling in the PCCM program or voluntary managed care.

The goals of Illinois Health Connect are to:

- ◆ Improve access to high-quality medical care for HFS clients.
- ◆ Make sure HFS clients have a medical home with a PCP.
- ◆ Ensure that all clients receive all necessary preventive and primary care, including immunizations and health screenings.
- ◆ Increase the provider network.
- ◆ Reduce inappropriate emergency department (ED) visits and hospitalizations.

The PCCM program has an ongoing monitoring and oversight process, and stakeholders have been involved in the development and implementation of the quality assurance component of the program since its inception.

The Illinois Health Connect population totals 1.6 million, including:

- ◆ Children in the current All Kids program (1,100,000)
- ◆ Parents in the FamilyCare program (400,000)
- ◆ Adults with disabilities and the elderly (100,000)<sup>1-1</sup>

Until the referral system is implemented, claims will continue to be processed without a referral. Providers will be notified by AHS three months prior to full implementation of the referral process.

### **Description of HFS MCOs**

The Illinois Medical Assistance Program's managed care initiative in Illinois operates in selected counties throughout the State. Enrollment in the program is voluntary. The Department's overall goal for its managed care system is to appropriately respond to the health care needs of Illinois Medical Assistance Program enrollees. Specifically, the goal is to respond to HFS beneficiaries in a timely manner, ensure adequate access to covered services, provide quality health care, improve health outcomes, and conduct ongoing internal monitoring and oversight. The focus is on quality improvement and providing a delivery system alternative that is available to certain population groups on a voluntary basis. During the report period, the Department contracted with two MCOs, **FHN** and **Harmony**, to provide health care services to Medicaid managed care recipients.

**FHN** operates as an MCCN and is a not-for-profit, provider-sponsored organization. **FHN** and **Harmony** operate in Cook County. **Harmony** also operated in the southern counties of Madison, Perry, Randolph, St. Clair, Washington, Jackson, and Williamson counties in FY 2007–2008. **Harmony** serves commercial, Medicare, and Medicare Part D enrollees.

Through its contracts with the MCOs, the Department strives to ensure the accessibility and availability of appropriate health care, provide for continuity of care, and provide quality care to HFS beneficiaries. The major focus is on timely preventive and primary care, health promotion, disease prevention, and improving health outcomes.

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<sup>1-1</sup> Illinois Health Connect Fact Sheet, 2/20/08, [http://www.hfs.illinois.gov/assets/pccm\\_fs.pdf](http://www.hfs.illinois.gov/assets/pccm_fs.pdf).

Table 2-1 shows enrollment in the Illinois voluntary Medicaid and SCHIP managed care program by MCO.<sup>2-2</sup> As of October 2008, total enrollment was 180,637.

Table 2-1—2007–2008 MCO Enrollment in Illinois		
HFS MCOs	October 2008	October 2007
FHN	46,249	44,503
Harmony	134,388	121,100
<b>Total</b>	<b>180,637</b>	<b>165,603</b>

## Scope of the Report

### Description of EQR Activities

#### Mandatory EQR Activities

The 2007–2008 EQR Technical Report focuses on the three federally mandated EQR activities that HSAG performed for each MCO over a 12-month period (July 1, 2006, to June 30, 2007). As set forth in 42 CFR 438.352, these mandatory activities were:

- ◆ Compliance with QAP standards. During 2007–2008, HSAG conducted a comprehensive review of each MCO’s compliance with the QAP standards and follow-up on the implementation of the CAPs from the last comprehensive review conducted in 2005–2006.
- ◆ Validation of performance measures. The State contracted with HSAG to conduct a HEDIS compliance audit of 2007 data for each MCO. Note that the process of validating performance measures includes two elements: (1) validation of the MCO’s data collection process and (2) a review of performance measure results compared with other MCOs and national benchmarks.
- ◆ Validation of PIPs. As part of the 2007–2008 review, HSAG validated PIPs conducted by the MCOs regarding compliance with requirements set forth in 42 CFR 438.240(b)(1). In 2007–2008, the MCOs conducted PIPs on the topics of asthma, EPSDT screening, and perinatal care and depression screening.

#### Optional EQR Activities

Other EQR activities conducted by HSAG included:

- ◆ Assessment of consumer satisfaction surveys. Each year, the MCOs are required to independently administer a consumer satisfaction survey. As part of its 2007–2008 review, HSAG evaluated the results of adult and child CAHPS surveys conducted in 2008 by TMG to identify trends, strengths, and opportunities for improvement.
- ◆ Provision of technical assistance. HSAG has provided ongoing technical assistance to the MCOs at the request of the Department, with particular emphasis on establishing scientifically sound PIPs. The MCOs use these PIPs to improve services to their HFS beneficiaries. The MCOs also evaluate the PIPS in their own annual program evaluation report. HSAG has provided technical

<sup>2-2</sup> Enrollment figures are from the Department: [http://www.hfs.illinois.gov/managedcare/managedcare\\_enrollment.html](http://www.hfs.illinois.gov/managedcare/managedcare_enrollment.html)

assistance to the MCOs in the development of their annual program evaluations, discussing how to provide meaningful statistics and appropriate barrier analysis for quality interventions. HSAG provided technical assistance to the Department for the evaluation of the HFS Quality Strategy for Managed Care, conducted a validation of 16 performance measures for the PCCM program, and assisted HFS in creating a PTT for each MCO.

## Summary of State Quality Strategy Objectives and Incentives

### Quality Strategy

HFS developed a Quality Strategy for the quality assurance component of the managed care program that: (1) supported its mission to improve the health of Illinois families by providing access to quality health care, (2) considered the health needs of the participants served, and (3) complied with federal and State regulations. The Quality Strategy satisfied the requirements set forth in 42 CFR 438.202.

The process HFS used to refine the Quality Strategy included stakeholder involvement, collaboration between the MCOs and HFS through ongoing monthly telephonic and quarterly face-to-face meetings, HFS' monitoring of compliance with the contract, and adoption and monitoring of the MCOs' results using industry standards such as HEDIS measures and benchmarks and PIPs. After drafting the strategy with the MCOs' involvement, HFS had the strategy reviewed by a diverse set of stakeholders, including providers and advocates. Their input was incorporated into the strategy. The strategy, to be achieved through consistent application, focuses on ensuring that quality health care services are delivered with timely access to appropriate covered services; coordination and continuity of care; prevention and early intervention, including risk assessment and health education; improved health outcomes; and ongoing quality improvement. The systematic approach to assess and monitor performance and patient results will be reviewed and updated annually, as needed. The State will make revisions to this Quality Strategy and seek additional stakeholder input upon "significant changes," which are defined as changes in State or federal law affecting managed care, changes in demographics, or changes in the State's contract with the MCOs. HFS will periodically review the Quality Strategy to determine the need for revision and to ensure that the MCOs are in contract compliance and commit adequate resources to perform internal monitoring and ongoing quality improvement.

The strategy has evolved over time based on community concerns and feedback, participant health needs, federal and State law, industry standards, lessons learned and best practices, and in collaboration with the MCOs to establish objectives, priorities, and achievable timelines.

The Quality Strategy is a work in progress as the state of health care quality (e.g., clinical practice and improved methods for quality measurement and monitoring accountability) continually evolves. The strategy will be reviewed annually for its effectiveness based on the MCOs' ongoing written submissions reporting access to care and network adequacy; organizational structure and operations; quality assurance processes, including peer review and utilization review; grievances and complaints; financial status; nonclinical and clinical quality measures (e.g., HEDIS or State-defined); and PIP findings. The State's evaluation includes trending of clinical care and services and success in improving health outcomes and provider performance.

CMS has charged the Division of Quality, Evaluations, and Health Outcomes (DQEHO) with providing feedback to states on the state quality strategies and EQR reports that are required of states with Medicaid managed care delivery systems (42 CFR, Part 438, Parts D and E). CMS provided a review to HFS on May 28, 2008, and invited HFS to provide any corrections or new information and to share any interesting new quality strategies in Illinois that might be useful to other states.

CMS reviewed the Quality Strategy regarding the following:

- ◆ Comprehensiveness of strategy
- ◆ Objectives
- ◆ Terms and conditions for compliance requirements
- ◆ Code of Federal Regulations
- ◆ Specific comments on the Quality Strategy
- ◆ Center for Medicaid and State Operations (CMSO) Quality Initiative

CMS made observations about Illinois' compliance with Quality Strategy expectations, asked questions, and suggested enhancements. On August 13, 2008, HFS responded to each question or request.

### **Quality Performance Withhold**

HFS offered quality performance payments to encourage the improvement of certain quality-of-care indicators. The HEDIS measures used to determine the quality performance payments were:

- ◆ *Childhood Immunization Status—Combo 2*
- ◆ *Well-Child Visits in the First 15 Months of Life—6 or more Visits*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ *Breast Cancer Screening*
- ◆ *Cervical Cancer Screening*
- ◆ *Timeliness of Prenatal Care*
- ◆ *Use of Appropriate Medications for People With Asthma—Ages Combined*
- ◆ *Comprehensive Diabetes Care—HbA1C Testing*

The previous year's score served as the baseline for each year. The Department withheld one-half of 1 percent of each capitation payment during the first year of the contract, and 1 percent during the second and third years. One-eighth of the withheld money was allotted to each of the eight measures. The Department paid the withheld money if the contractor improved its HEDIS scores as follows:

- ◆ If the baseline measurement was less than 30 percent, the measurement-year score must have exceeded the baseline score by 15 percentage points.
- ◆ If the baseline measurement was between 30 and 50 percent, the measurement-year score must have exceeded the baseline score by 10 percentage points.

- ◆ If the baseline measurement was more than 50 percent, the measurement-year score must have exceeded the baseline score by 5 percentage points.
- ◆ If the baseline measurement exceeded the 50th percentile for the baseline year's HEDIS Medicaid benchmarks, the measurement-year score must have exceeded the baseline score by 2.5 percentage points, regardless of the percentage score.
- ◆ If the baseline measurement exceeded the 75th percentile for the baseline year's HEDIS Medicaid benchmarks, the contractor only needed to maintain a score that exceeded the 75th percentile benchmark of the baseline year, regardless of the percentage score.

## Organization of the Report

The EQR technical report is organized as follows:

- ◆ Section 1 (Executive Summary) of this report outlines the purpose of the EQR technical report, describes at a high level the approach taken by HSAG in conducting EQR activities and drawing conclusions, summarizes the conclusions and recommendations for each EQR activity, and provides overall conclusions and recommendations.
- ◆ Section 2 (Background) provides contextual information about the purpose of the report and the scope of mandatory and optional EQR activities. A brief description of the Illinois managed care program and its MCOs is provided, including current enrollment data. Further, the objectives and incentives of the State's Quality Strategy are summarized.
- ◆ Section 3 (Description of EQR Activities) describes for each EQR activity the objectives, data collection and analysis methodology, and type of data obtained. The section also presents plan-specific EQR activity results and conclusions.
- ◆ Section 4 (Plan Comparisons and Recommendations) compares the results and findings from the three mandatory EQR activities and the optional customer satisfaction surveys for the two MCOs. The section provides overall conclusions and recommendations based on the MCO comparisons.
- ◆ Appendix A displays trended line graphs for the performance measures with at least two years of HEDIS reporting, and compares them to the national Medicaid HEDIS 75th percentile for each reporting year.
- ◆ Appendix B displays the Illinois HEDIS 2008 Medicaid rates.
- ◆ Appendix C displays the HEDIS 2007 means and percentiles.
- ◆ Addendum A includes the aggregate results of the EPSDT and perinatal and depression screening PIPs.

### Introduction

This section describes the EQR activities conducted in accordance with 42 CFR 438.358 for each of the two Department-contracted Medicaid MCOs. For each of the activities, the report presents the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. EQR activities conducted over a 12-month period by HSAG included:

- ◆ Compliance with QAP standards
- ◆ Validation of PCCM program performance measures
- ◆ Validation of MCO's PIPs
- ◆ Review of consumer satisfaction survey results
- ◆ Provision of technical assistance

Additional details about the results of the EQR activities are included in the individual and aggregate MCO reports prepared by HSAG (i.e., 2008 Plan Specific Compliance Monitoring Report; 2007–2008 Asthma, Perinatal, and EPSDT PIP Validation Tools; 2007–2008 Perinatal Care and Depression Screening Aggregate Report; and the EPSDT Aggregate Report).

### Compliance Monitoring—QAP Structure and Operations—2007–2008

Compliance monitoring is designed to determine an MCO's compliance with its contract, State and federal regulations, and various compliance monitoring standards. Compliance is also determined through review of individual files to evaluate implementation of standards.

In this fourth year of performing on-site evaluations for HFS, HSAG conducted comprehensive, on-site compliance reviews of each MCO. The purpose of this year's review was to evaluate the plans' compliance with elements of 11 standards and follow-up on compliance with the CAPs from the 2005–2006 compliance review. The 2008 on-site compliance review also included a review of individual files and records in the areas of delegation, credentialing/recredentialing, continuity of care and case management, grievances, appeals, and denials.

### Objectives

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine health plan compliance with QAP standards. HSAG assessed compliance in 2007–2008 through monitoring tools it developed that incorporated questions from the protocol and items from the

current contract. A primary objective of the reviews was to determine the MCOs' compliance with QAP-related contractual standards specified in the April 1, 2006, Illinois Department of Public Aid Contract for Furnishing Health Services by a Health Maintenance Organization. The Illinois Department of Public Aid has since been renamed the Illinois Department of Healthcare and Family Services. A particular focus was on how policies were being implemented through written procedures and daily practices, and how outcomes were addressed.

The State and the individual MCOs are using the information and findings from the compliance reviews to:

- ◆ Evaluate the quality and timeliness of, and access to, health care furnished by the MCOs to Medicaid members.
- ◆ Identify, implement, and monitor system interventions to improve quality.
- ◆ Evaluate current performance processes.
- ◆ Plan and initiate activities to sustain and enhance current performance processes.

### **Technical Methods of Data Collection and Analysis**

HSAG determined findings for the 2007–2008 comprehensive site review from an on-site review of the documents prepared by the MCOs, interviews with key MCO staff members, a review of information systems (IS), and a review of records conducted during the site review. For the review of the 11 standards, HSAG scored the individual elements (i.e., contract requirements) reviewed for each standard *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*. HSAG then determined a summary score by calculating the percentage of applicable elements found compliant. For the review of records, HSAG scored elements in each record reviewed *Yes* (compliant), *No* (not compliant), or *Not Applicable (N/A)*. For each area evaluated through the review of records, HSAG determined a summary score by calculating the percentage of applicable elements found compliant.

In developing the monitoring tools, HSAG used the requirements as set forth in the State of Illinois Department of Healthcare and Family Services Contract for Furnishing Health Services by a Managed Care Organization, dated August 1, 2006, and the regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. The administrative compliance review adhered to the CMS protocols. During the on-site visit, surveyors used standard-specific tools and worksheets to conduct the evaluation to ensure that all required information was collected completely and consistently across the MCOs.

Prior to the site visits, each MCO received a list of documents, including confirmation of the dates of its evaluation, a detailed site visit agenda, and notification of the survey team members. In addition, HSAG received the quality program description, work plan, and annual program evaluation report documentation for each MCO.

To ensure IRR, HSAG surveyors were trained on the review methodology and the standardized data collection survey tool to ensure that they made determinations regarding each element of the review in the same manner. Members of the survey team were assigned specific sections, and ongoing communication and coordination among the team members ensured uniformity of review. The team

leader reviewed all standard designations and reports to ensure consistency across the surveyors. The surveyors also reviewed each other's completed section reviews to ensure consistency in terminology and designation assignments.

HSAG validated all surveyor-completed tools against the final report to ensure accuracy of information. Discrepancies were brought to the attention of the team leader, discussed among the survey team members, addressed, and rectified.

Throughout the process of preparing for the site review and performing the activities during the site review, HSAG worked closely with HFS and the MCOs to ensure a coordinated and supportive approach to completing the required activities.

As part of the site review process, HSAG:

1. Established the review schedule.
2. Prepared the data collection tools and submitted them to HFS for approval.
3. Developed a site review agenda and submitted it to the MCOs.
4. Participated in pre-site review conference calls with the MCOs.
5. Received record review listings and posted samples to HSAG's FTP site prepared for each MCO.
6. Conducted the on-site portion of the review.
7. Prepared a report of findings and required actions.

### **Description of the Data Obtained**

To assess compliance with standards, HSAG evaluated elements for the 11 standards reviewed, as follows:

- I. Quality Assurance Program (QAP)
- II. Systematic Process of Quality Assessment and Improvement
- III. QAP Structure
- IV. Monitoring of Delegated Activities
- V. Credentialing/Recredentialing
- VI. Continuity of Care and Case Management
- VII. Coordination of QAP Activity With Other Management Activities
- VIII. Medical Records Standards
- IX. Enrollee Information, Rights, and Protections
- X. Utilization Management
- XI. Access and Availability—Service Delivery

HSAG reviewed records associated with the following standards for the file review:

- ◆ Delegation (Standard IV)
- ◆ Credentialing (Standard V)
- ◆ Recredentialing (Standard V)
- ◆ Continuity of Care and Case Management (Standard VI)
- ◆ Grievances (Standard IX)
- ◆ Appeals (Standard IX)
- ◆ Denials (Standard X)

### **Conclusions Drawn from the Data**

For each MCO, HSAG calculated compliance scores for the review of standards, the review of records, and the overall compliance score. Further, HSAG compared compliance standards scores for 2006 and 2008 for each MCO.

**FHN**'s overall compliance increased from 64 percent in 2006 to 79 percent in 2008. While **FHN** has made progress, its overall compliance is below the Department's expectations.

**Harmony**'s overall compliance declined slightly from 86 percent in 2006 to 83 percent in 2008. There is an opportunity for improvement in several compliance monitoring standards for **Harmony**.

Both MCOs' scores on the 2005–2006 compliance review resulted in a large number of required corrective actions. Both plans worked on CAPs throughout 2007. A re-review indicated significant improvements in some areas and the need for continued quality improvement efforts in other areas.

## Plan-Specific Findings and Recommendations

### Family Health Network

For the review of the standards, **FHN** received a score of *Met* on 233 of 294 applicable elements for a compliance score of 79 percent. For the review of records, **FHN** was in compliance with 416 of 556 applicable elements for a compliance score of 75 percent. For the review of the standards and records combined, **FHN** was in compliance with 649 of 850 applicable elements for an overall compliance score of 76 percent.

Table 3-1 presents results achieved by **FHN** for the 11 QAP standards reviewed in 2006 compared with the results achieved in 2008.

Table 3-1—FHN Comparison of Scores for the Standards—2006 and 2008				
Standard #	Description of Standard	2006 Score (% of Compliant Elements)	2008 Score (% of Compliant Elements)	Direction of Change
I	Quality Assurance Program (QAP)	64	69	↑
II	Systematic Process of Quality Assessment and Improvement	70	75	↑
III	QAP Structure	70	80	↑
IV	Monitoring of Delegated Activities	71	57	↓
V	Credentialing/Rec credentialing	17	74	↑
VI	Continuity of Care and Case Management	33	0	↓
VII	Coordination of QAP Activity With Other Management Activities	0	60	↑
VIII	Medical Records Standards	96	100	↑
IX	Enrollee Information, Rights, and Protections	78	97	↑
X	Utilization Management	52	90	↑
XI	Access and Availability—Service Delivery	89	82	↓
<b>Overall</b>		<b>64</b>	<b>79</b>	<b>↑</b>

**FHN** worked on a CAP throughout 2008. The following improvements, which a re-review identified, showed that **FHN**:

- ◆ Improved performance on Coordination of QAP Activity With Other Management Activity, an area in which **FHN** did not achieve compliance with any of the compliance review elements in 2006 but demonstrated 60 percent compliance for the re-review. Addressed deficiencies in the credentialing and rec credentialing process, an area in which **FHN** improved performance from 17 percent to 74 percent of the required elements. Worked on adding resources and expanding

system capabilities to support data collection, analysis, and reporting activities; managing the data necessary for supporting and verifying the accuracy of data used to evaluate quality improvement (QI) activities; and identifying factors that affect delivery of care and health outcomes.

- ◆ Ensured participation by physicians in the Quality Assurance/Utilization Management (QA/UM) Committee, that the QA/UM and Peer Review committees met the required number of times as described in the QA program description, and that all QI activities, monitoring, and follow-up actions were documented in the appropriate committee meeting minutes. **FHN** implemented its UM plan and the peer-review process and established a periodic review of progress toward UM goals and objectives. Further, **FHN** developed a process to gather data from its delegated vendors and is establishing a monitoring and review process for collection and review of utilization data.
- ◆ Ensured that the Peer Review Committee assigned responsibility for follow up on corrective actions.
- ◆ Continued to develop and implement targeted interventions, including an effective monitoring program to collect and analyze performance measure data and strategies for improving encounter data reporting.
- ◆ Implemented a mechanism to monitor member satisfaction with access to and the quality of behavioral health services.
- ◆ Revised procedures for monitoring and evaluating the implementation of delegated functions and for verifying the actual quality of care provided.
- ◆ Ensured that the QA/UM evaluation addressed the work plan for the year and delegated functions. **FHN** implemented and monitored the CAPs of its delegated vendors to ensure correction of delegated oversight deficiencies.
- ◆ Implemented a mechanism to follow up on all remedial actions, including documentation and follow-up.
- ◆ Provided greater detail in the annual report regarding medical record reviews, PIPs, HEDIS measures, utilization of services, and delegated oversight activities, including a summary of results, barriers identified, and goals for the subsequent year identified in the QI work plan.
- ◆ Developed a policy to ensure compliance with the requirement that the MCO maintain all business and professional records that are required by HFS in accordance with generally accepted business and accounting principles.
- ◆ Established a mechanism to track and trend complaints/grievances received by the Member Services Department to be in compliance with 42 CFR 438, and established a grievance committee with appropriate representation and membership, as well as a formal, structured system to handle complaints/grievances.
- ◆ Established a time frame for all aspects of the appeals process and tracking of the timeliness of appeal determinations.
- ◆ Listed all members' rights and responsibilities in the member handbook to ensure that all members are properly informed of their rights and the plan's expectations of members.
- ◆ Provided information to the membership that specifically states how members may obtain benefits from the Illinois Medical Assistance Program.

- ◆ Implemented a mechanism to assess the consistency with which UM criteria are applied to UM decisions.
- ◆ Developed a policy and procedure to ensure compliance with standard authorization extension requirements.
- ◆ Specified in contracts with PCPs and women's health care providers (WHCPs) that providers identify maternity cases presenting the potential for high-risk maternal or neonatal complications and arrange appropriate referrals to physician specialists or transfers to Level III perinatal facilities, as required.
- ◆ Established policies concerning physical access standards for enrollees with disabilities.

The re-review identified areas that require continued quality improvement efforts. **FHN** must:

- ◆ Continue development and implementation of, at a minimum, a basic system that promotes continuity of care and case management.
- ◆ Continue development and implementation of a disease management program.
- ◆ Enhance its ability to manage the data necessary to support the measurement aspects of QI activities. **FHN** must have the ability to apply statistical analysis to data and derive meaning from statistical analysis.
- ◆ Continue to implement mechanisms to track and trend QI issues over time and monitor performance on the activities. The annual program report should be expanded to include trending of performance and barrier analysis to determine the effectiveness of interventions and established performance goals. To facilitate comparative analysis, the evaluation must include trended data using charts, graphs, or tables for displaying the information.
- ◆ Continue to work with its behavioral health vendor to identify additional methods for assessing member satisfaction with access to and the quality of behavioral health services.
- ◆ Continue to work with its behavioral health vendor to implement a process to ensure appropriate documentation in care treatment plans and coordination of care for behavioral health clients.

The Compliance Monitoring Report for Family Health Network, Inc. (June 2008), contains complete details.

### Harmony Health Plan

For the review of the standards, **Harmony** received a score of *Met* on 243 of 292 applicable elements for a compliance score of 83 percent. For the review of records, **Harmony** was in compliance with 756 of 882 applicable elements for a compliance score of 86 percent. For the review of the standards and records combined, **Harmony** was in compliance with 999 of 1,174 applicable elements for an overall compliance score of 85 percent.

Table 3-2 presents results achieved by **Harmony** for the 11 QAP standards reviewed in 2006 compared with the results achieved in 2008.

Table 3-2—Harmony Comparison of Scores for the Standards—2006 and 2008				
Standard #	Description of Standard	2006 Score (% of Compliant Elements)	2008 Score (% of Compliant Elements)	Direction of Change
I	Quality Assurance Program (QAP)	100	96	↓
II	Systematic Process of Quality Assessment and Improvement	77	72	↓
III	QAP Structure	100	100	No change
IV	Monitoring of Delegated Activities	93	64	↓
V	Credentialing/Recredentialing	88	88	No change
VI	Continuity of Care and Case Management	33	0	↓
VII	Coordination of QAP Activity With Other Management Activities	80	80	No change
VIII	Medical Records Standards	74	91	↑
IX	Enrollee Information, Rights, and Protections	85	85	No change
X	Utilization Management	95	90	↓
XI	Access and Availability—Service Delivery	93	96	↑
<b>Overall</b>		<b>86</b>	<b>83</b>	<b>↓</b>

**Harmony** worked on a CAP throughout 2008. The following improvements, which a re-review identified, showed that **Harmony**:

- ◆ Was addressing deficiencies in continuity of care and case management. At the time of the re-review **Harmony** was in the process of implementing a case management/disease management software system, which appeared to include the capabilities and data fields necessary to implement an effective case management system.
- ◆ Revised the annual report to include an evaluation of the results of medical record reviews for the QI improvement studies and to explain how IRR was maintained during the data collection process for the studies.

- ◆ Revised the annual report to include a discussion of monitoring of delegated activities and a work plan for monitoring subcontractors, including a schedule for formal reviews. Revised the language in the delegation agreements to include specific timelines for submitting required reports to the plan.
- ◆ Corrected the current recredentialing process to ensure that the recredentialing cycle occurs at least once every 36 months, as required by the contract.
- ◆ Included language within applicable policies and procedures as to the processes to be followed in providing proper notification to HFS regarding physician terminations due to quality-of-care issues.
- ◆ Strengthened the recredentialing process to include reviews of grievances and complaints and UM reports.
- ◆ Revised medical record review policies and procedures to include a social history, family history, and obstetrical history (if any) and/or profile.
- ◆ Revised the medical record review policy so that referral information will be available for review by the MCO.
- ◆ Revised the medical record review policy to state that health education is provided and includes members who are more than 2 years of age. The policy also was revised to include a provision for family planning and/or counseling.
- ◆ Revised the termination of enrollment policy to state that **Harmony** will not initiate voluntary disenrollment procedures based on uncooperative/disruptive behavior resulting from the enrollee's special needs.
- ◆ Specified in contracts with PCPs and WHCPs that providers must identify maternity cases presenting the potential for high-risk maternal or neonatal complications and arrange appropriate referrals to physician specialists or transfers to Level III perinatal facilities, as required.
- ◆ Revised provider manual policies and procedures to state that same-day appointments are available for serious problems not deemed an emergency medical condition.

The re-review identified areas that require continued quality improvement efforts. **Harmony** must:

- ◆ Continue development and implementation of, at a minimum, a basic system that promotes continuity of care and case management.
- ◆ Continue development and implementation of a disease management program.
- ◆ Revise policies and procedures to include timely identification of beneficiaries with complex and serious medical conditions.
- ◆ Revise the case management process to ensure that members receive a comprehensive health needs assessment. The results of the assessment should be used as a basis for developing the care treatment plan.
- ◆ Implement a process to ensure that individual care treatment plans are developed for members requiring behavioral health services. Continue efforts to implement the Intensive Case Management Program and the Medical-Behavioral Case Management Program.

- ◆ Enhance its ability to manage the data necessary to support the measurement aspects of QI activities. **Harmony** should conduct a barrier analysis and appropriately evaluate its performance improvement efforts to determine their effectiveness and revise them as necessary. This type of analysis should be used to evaluate the effectiveness of the quality improvement activities described in the annual program report. Performance goals should be established and monitored through the QI work plan.
- ◆ Evaluate resources and access to analytics/reporting to provide more detailed and robust reports from which **Harmony** can track, trend, and correlate outcomes of care.
- ◆ Continue to implement mechanisms to track and trend QI issues over time and monitor performance on the activities.
- ◆ Continue to implement behavioral health care and oversight by Harmony Behavioral Health (HBH) to identify additional methods for assessing member satisfaction with access to and the quality of behavioral health services.
- ◆ Expand the provider network evaluation through the inclusion of review of additional data sources such as practitioner language and ethnicity data, review of open and closed panels within the network, results of member satisfaction survey, review of complaints and grievances related to access, and a review of member services logs.
- ◆ Revise credentialing and recredentialing policies and procedures to align with actual practice.
- ◆ Revise the medical record review policy to include weight- and age-appropriate growth charts.
- ◆ Establish a grievance committee to align with contract requirements.
- ◆ Evaluate the Utilization Management Program annually to assess program strengths, weaknesses, and opportunities for improvement.
- ◆ Establish a mechanism to ensure delegated agreements have the appropriate signatures and that reports submitted by the delegates are timely and accurate.

The Compliance Monitoring Report for Harmony Health Plan of Illinois, Inc. (December 2008), contains complete details.

## Validation of Performance Measures—HEDIS Compliance Audit— FY 2007–2008

### Objectives

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

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

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

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

- ◆ Information practices and control procedures
- ◆ Sampling methods and procedures
- ◆ Data integrity
- ◆ Compliance with HEDIS specifications
- ◆ Analytic file production

Furthermore, MCOs were required to prepare 2006–2007 quality improvement CAPs that identified opportunities for improvement in performance measure results. These plans were submitted to the Department for approval, with review and input provided to the Department by HSAG.

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NCQA HEDIS Compliance Audit<sup>™</sup> is a trademark of the National Committee for Quality Assurance (NCQA).

### **Technical Methods of Data Collection and Analysis**

During 2007, the Department required that an NCQA-licensed audit organization conduct an independent audit of each MCO's 2006 data. The State contracted with HSAG to audit **FHN**, while **Harmony** used another NCQA-licensed organization for its audit. The audits were conducted in a manner consistent with the *2007 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5*. The audits consisted of two main components:

- ◆ **IS capabilities:** A detailed assessment of the MCO's IS capabilities for collecting, sorting, analyzing, and reporting HEDIS information.
- ◆ **Compliance with HEDIS 2007 specifications:** A detailed review of the processes used to prepare HEDIS measures produced by the MCO. These processes include 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 in HEDIS data production and reporting.

For each MCO, a specific set of performance measures was selected. This selection was based on factors such as Department-required measures, a full year of data, previously audited measures, and past performance. While the set of selected measures varied by MCO, a common set of measures was included in each MCO review (childhood immunizations, well-child visits, prenatal and postpartum care, comprehensive diabetes care, use of asthma medications, and adult preventive screenings).

A number of different methods and information sources were used in conducting the audits, including:

- ◆ Both off- and on-site review of relevant documentation such as the MCO's response to the 2007 Baseline Assessment Tool published by NCQA; policies and procedures related to enrollment, claims, and information technology; and prior CAPs.
- ◆ On-site meetings, which, in addition to document review, included staff interviews, live system and procedure documentation, programming logic review and inspection of dated job logs, and primary HEDIS data source verification.
- ◆ Medical record abstraction, with comparison of results to the MCO's review determinations for the same records, if the hybrid method was used.
- ◆ Accuracy checks of the final HEDIS rates.
- ◆ Comparison of reported rates to the national Medicaid HEDIS 2006 benchmark rates. The HEDIS 50th percentile (median) was used as a benchmark to show how well a plan has performed (on average) compared with other Medicaid plans across the country.

Each of the HEDIS measures verified by the HSAG review team received a measure audit designation consistent with the NCQA categories listed Table 3-3.

**Table 3-3—HEDIS Measure Audit Findings**

Audit Findings	Description	Audit Designation
The rate or numeric result for the HEDIS measures was reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable Measure	R
The MCO followed the HEDIS specifications but the denominator was too small to report a valid rate.	Denominator <30	NA
The MCO did not offer the health benefits required by the measure.	No Benefit	NB
1) The MCO calculated the measure but the rate was materially biased <b>or</b> 2) The MCO chose not to report the measure.	Not Reportable	NR

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.) In addition, for some measures, more than one rate is required for HEDIS reporting (e.g., *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*). It is possible for the MCO to have prepared some of the rates required by the measure appropriately, but have had significant bias in others. According to NCQA guidelines, the MCO would receive an R designation for the measure as a whole, but significantly biased rates within the measure would receive an NR designation, where appropriate.

Upon completion of the audit, the NCQA-licensed organizations 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.

**Description of Data Obtained**

The HEDIS 2007 measures selected for validation through the HEDIS compliance audits were the following:

- ◆ *Childhood Immunization Status*
- ◆ *Prenatal and Postpartum Care*
- ◆ *Well-Child Visits in the First 15 Months of Life (0 Visits and 6 or More Visits)*

The three HEDIS measures identified above were validated and determined to be in compliance with the *HEDIS 2008 Technical Specifications*. **FHN** and **Harmony** reported on other HEDIS measures that were not validated during the audit, although the processes for collecting and

calculating each measure were validated. The rates for these HEDIS measures are included in this report and consist of the following performance measures:

- ◆ *Breast Cancer Screening*
- ◆ *Cervical Cancer Screening*
- ◆ *Comprehensive Diabetes Care*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*
- ◆ *Adolescent Well-Care Visits*
- ◆ *Lead Screening in Children*
- ◆ *Appropriate Use of Antibiotics for Children With Upper Respiratory Infection (URI)*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners*
- ◆ *Adults' Access to Preventative/Ambulatory Care*
- ◆ *Controlling High Blood Pressure*
- ◆ *Chlamydia Screening in Women*
- ◆ *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*
- ◆ *Follow-up After Hospitalization for Mental Illness*

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

### **Conclusions Drawn from the Data**

The following section provides information on the HEDIS rates for the combined total for the HFS MCOs and the individual MCO rates. The individual MCO sections also include a summary of the HEDIS audit findings, along with an examination of encounter data completeness.

The Medicaid HEDIS 2008 rates for each MCO, the overall rates, and the national Medicaid 2007 HEDIS 50th and 90th percentiles are presented below (Table 3-4). As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile, while those in green were above the 90th percentile.

Table 3-4—HEDIS 2008 Rates

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2007 HEDIS Percentiles	
				50th	90th
<b>Child and Adolescent Care</b>					
<i>Childhood Immunizations—Combo 2</i>	68.9	53.8	61.7	75.2	84.8
<i>Childhood Immunizations—Combo 3</i>	53.0	42.8	48.1	62.6	74.5
<i>Lead Screening in Children</i>	70.4	65.9	68.3	NA**	NA**
<i>Appropriate Treatment for Children With URI</i>	97.5	86.2	90.8	84.3	92.6
<i>Children’s Access to PCPs (12–24 Months)</i>	77.3	82.5	80.7	95.8	98.0
<i>Children’s Access to PCPs (25 months–6 Years)</i>	65.2	65.7	65.6	86.7	91.4
<i>Children’s Access to PCPs (7–11 Years)</i>	52.4	60.7	59.1	87.2	93.3
<i>Adolescents’ Access to PCPs (12–19 Years)</i>	48.4	58.7	57.2	85.3	91.4
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	10.0	9.2	9.6	1.4*	0.4*
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	29.0	21.7	25.5	56.6	75.2
<i>Well-Child Visits (3–6 Years)</i>	68.4	57.4	63.2	67.5	79.9
<i>Adolescent Well-Care Visits</i>	32.2	37.7	34.8	42.1	58.9
<b>Adults’ Access to Preventive/Ambulatory Care</b>					
<i>20–44 Years of Age</i>	56.6	57.5	57.3	79.1	88.0
<i>45–64 Years of Age</i>	48.6	54.6	53.7	85.5	89.8
<b>Preventive Screening for Women</b>					
<i>Breast Cancer Screening (42–51 Years of Age)</i>	28.3	34.3	32.5	45.6	57.2
<i>Breast Cancer Screening (52–69 Years of Age)</i>	NA***	45.5	39.7	54.9	65.2
<i>Breast Cancer Screening (Combined Rate)</i>	27.8	35.5	33.2	49.2	59.6
<i>Cervical Cancer Screening</i>	68.0	59.1	63.8	66.5	77.4
<i>Chlamydia Screening (16–20 Years of Age)</i>	47.7	45.1	45.6	50.3	64.8
<i>Chlamydia Screening (21–25 Years of Age)</i>	47.7	53.3	52.0	56.3	69.9
<i>Chlamydia Screening (Combined Rate)</i>	47.7	49.3	48.9	52.8	66.0
<b>Maternity-Related Measures</b>					
<i>Frequency of Ongoing Prenatal Care (&lt;21% Visits)*</i>	29.4	21.9	25.8	7.6*	2.3*
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	33.4	31.4	32.4	62.9	78.6
<i>Timeliness of Prenatal Care</i>	45.4	56.4	50.6	84.2	91.5
<i>Postpartum Care</i>	32.3	35.0	33.6	59.7	71.1
<b>Chronic Conditions/Disease Management</b>					
<i>Controlling High Blood Pressure (Combined Rate)</i>	45.3	34.3	35.8	55.4	65.8
<i>Diabetes Care (HbA1C Testing)</i>	68.5	57.7	59.6	79.3	89.1
<i>Diabetes Care (Poor HbA1c Control)*</i>	56.5	72.7	64.0	46.7*	32.1*
<i>Diabetes Care (Good HbA1c Control)</i>	12.0	15.6	14.9	31.3	40.9
<i>Diabetes Care (Eye Exam)</i>	22.8	9.0	11.5	53.6	68.3
<i>Diabetes Care (LDL-C Screening)</i>	56.5	52.3	53.1	72.8	81.0
<i>Diabetes Care (LDL-C Level &lt;100 mg/Dl)</i>	15.2	12.4	12.9	31.3	44.1
<i>Diabetes Care (Nephropathy Monitoring)</i>	57.6	59.9	59.4	76.6	85.5
<i>Diabetes Care (BP &lt;140/90)</i>	51.1	45.0	46.1	60.1	69.3
<i>Diabetes Care (BP &lt;130/80)</i>	22.8	23.6	23.5	30.6	41.4

**Table 3-4—HEDIS 2008 Rates**

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2007 HEDIS Percentiles	
				50th	90th
<i>Appropriate Medications for Asthma (5–9 Years)</i>	85.5	85.8	85.8	91.7	96.3
<i>Appropriate Medications for Asthma (10–17 Years)</i>	77.1	84.7	84.0	88.8	93.0
<i>Appropriate Medications for Asthma (18–56 Years)</i>	73.6	82.0	80.8	85.4	90.9
<i>Appropriate Medications for Asthma (Combined Rate)</i>	79.3	84.1	83.4	88.4	92.0
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	56.4	20.0	28.7	35.8	66.2
<i>Follow-up After Hospitalization for Mental Illness—30 Days</i>	67.9	32.3	40.7	57.3	79.8
<p>* Lower rates indicate better performance for these measures and the 90th percentile uses the 10th percentile.            ** This measure was new for HEDIS 2008; therefore, national Medicaid percentiles were not available.            *** FHN had fewer than 30 eligible cases for this measure; therefore, the rate was not calculated.</p>					

### Plan-Specific Findings and Recommendations

The following section provides a summary of this year’s HEDIS compliance audit findings and HEDIS rates for each MCO, along with results from the previous three years. The results are presented separately for **FHN** and **Harmony**.

The HEDIS measures reported this year include new measures not previously reported. In addition, several HEDIS measures were new or had significant changes in the *HEDIS 2008 Technical Specifications*. These new and/or updated HEDIS measures are not included in the trended results section because they are not comparable to prior years.

### Family Health Network

The 2007–2008 HEDIS compliance audit indicated that **FHN** was in full compliance with the *HEDIS 2008 Technical Specifications* (Table 3-5 below). 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 3-5—FHN 2008 HEDIS Compliance Audit Results			
Main Information Systems			Selected 2007 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an <i>R</i> audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

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

#### IS 1.0—Sound Coding Methods for Medical Data

**FHN** was found to be fully compliant with IS Standard 1.0. **FHN** used State-specific codes for a small number of inpatient services and these codes were appropriately cross-walked to standard codes. Primary and secondary diagnosis codes were identified and captured as appropriate within the health plan’s data system.

#### IS 2.0—Data Capture, Transfer, and Entry—Medical and Service Data

**FHN** was found to be fully compliant with IS Standard 2.0. **FHN** used standard submission forms for both paper and electronic claims, which captured all necessary data elements for HEDIS reporting.

**FHN** worked to improve data completeness through provider incentives and provider education based on provider health organization (PHO) quarterly reports. **FHN** should consider implementing methods to obtain lab values. This will also improve data completeness.

The volume of internal claims processing continues to increase; therefore, **FHN** should explore the acquisition of a claims adjudication system and may consider updating its information technology data warehousing structure.

**FHN** should implement policies and procedures to establish benchmarks and implement additional studies of PHO data completeness. Provider benchmarks could be added to the PHO quarterly reports that are sent to the PHO directors. **FHN** should also obtain documentation from PHOs and clearinghouses as to how IRR is performed for data entry (or if data entry audits are performed) and how file counts are reconciled.

**FHN** continued to add new built-in edits to the medical record review (MRR) tools that supported data integrity. The MRR process continued to improve from the previous year. Updates to the MRR tool and instructions were made appropriately. **FHN** passed medical record validation. **FHN** should implement training with IRR staff on critical versus noncritical issues.

### ***IS 3.0—Data Capture, Transfer, and Entry—Membership Data***

**FHN** was found to be fully compliant with IS Standard 3.0. **FHN** performed internal audits on membership data forms to ensure accuracy. **FHN** received monthly 834 files, which were uploaded and reconciled appropriately. **FHN** saw an increase in its membership during the year due to an MCO leaving the Medicaid market and took excellent strides in addressing the impact it had on its business operations.

### ***IS 4.0—Data Capture, Transfer, and Entry—Practitioner Data***

**FHN** was fully compliant with this IS standard. There were no major concerns with the provider system or the credentialing and recredentialing processes. **FHN** formally documented policies and procedures for provider database processing, including IRR. This process did not occur in 2007; however, it has begun in 2008.

### ***IS 5.0—Data Integration Required to Meet the Demands of Accurate HEDIS Reporting***

**FHN** was fully compliant with IS Standard 5.0. **FHN** continued to demonstrate growing knowledge of HEDIS methodologies compared to previous years. Repository structure and formatting were suitable for HEDIS measures, and there were no concerns with data transfers from service data systems to the HEDIS repository.

### ***IS 6.0—Control Procedures That Support HEDIS Reporting Integrity***

**FHN** was found to be fully compliant with IS Standard 6.0. **FHN** had sound reporting processes in place and managed the production of reports efficiently.

**FHN Trended Results**

Table 3-6 below provides the results of trended performance measures. Only HEDIS measures reported for at least the last two years are included in the table. The last column of the table denotes the difference in the rates between the first reportable HEDIS rate and HEDIS 2008 results.

Table 3-6—FHN Trended HEDIS Results					
HEDIS Measures	HEDIS 2005	HEDIS 2006	HEDIS 2007	HEDIS 2008	Difference from Baseline
Childhood Immunizations—Combo 2	47.2	67.0	72.4	68.9	21.7
Childhood Immunizations—Combo 3	NA	38.5	59.4	53.0	14.5
Well-Child Visits in the First 15 Months (0 Visits)*	27.7	19.0	18.8	10.0	-17.7
Well-Child Visits in the First 15 Months (6+ Visits)	18.5	28.9	21.2	29.0	10.5
Well-Child Visits (3–6 Years)	53.0	64.5	70.0	68.4	15.4
Adolescent Well Care Visits	NA	38.2	37.7	32.2	-6.0
Adults’ Access (20–44 Years)	NA	NA	60.2	56.6	-3.6
Adults’ Access (45–64 Years)	NA	NA	44.1	48.6	4.5
Breast Cancer Screening (42–51 Years)	NA	NA	25.0	28.3	3.3
Breast Cancer Screening (52–69 Years)	NA	NA	21.4	NA	NA
Breast Cancer Screening (Combined Rate)	NA	NA	24.7	27.8	3.1
Cervical Cancer Screening	52.0	53.6	60.7	68.0	16.0
Chlamydia Screening in Women (Combined Rate)	NA	NA	56.7	47.7	-9.0
Frequency of Ongoing Prenatal Care (<21% Visits)*	NA	NA	31.8	29.4	-2.4
Frequency of Ongoing Prenatal Care (81-100% Visits)	NA	NA	26.3	33.4	7.1
Timeliness of Prenatal Care	29.9	50.3	48.1	45.4	15.5
Postpartum Care	23.1	23.2	26.3	32.3	9.2
Controlling High Blood Pressure (Combined Rate)	NA	NA	46.7	45.3	-1.4
Diabetes Care (HbA1C Testing)	33.3	49.2	65.1	68.5	35.2
Diabetes Care (Poor HbA1c Control)*	80.0	75.4	80.7	56.5	-23.5
Diabetes Care (Good HbA1c Control)	NA	NA	9.6	12.0	2.4
Diabetes Care (Eye Exam)	8.0	1.6	25.3	22.8	14.8
Diabetes Care (LDL-C Screening)	22.7	44.3	55.4	56.5	33.8
Diabetes Care (LDL-C Level <100 mg/dL)	9.3	14.8	18.1	15.2	5.9
Diabetes Care (Nephropathy Monitoring)	0.0	21.3	71.1	57.6	57.6
Diabetes Care (BP <140/90)	NA	NA	31.3	51.1	19.8
Diabetes Care (BP <130/80)	NA	NA	55.4	22.8	-32.6
Appropriate Medications for Asthma (5–9 Years)	NA	NA	81.4	85.5	4.1
Appropriate Medications for Asthma (10–17 Years)	NA	NA	80.5	77.1	-3.4
Appropriate Medications for Asthma (18–56 Years)	NA	NA	87.3	73.6	-13.7
Appropriate Medications for Asthma (Combined Rate)	NA	87.1	83.1	79.3	-7.8
Follow-up After Hospitalization for Mental Illness—7 Days	NA	NA	55.8	56.4	0.6
Follow-up After Hospitalization for Mental Illness—30	NA	NA	69.8	67.9	-1.9

\* Lower rates indicate better performance for these measures.

The results show that 23 measures improved since **FHN** initially reported them. The measures related to *Comprehensive Diabetes Care* demonstrated the most improvement, with four measures increasing by more than 20 percentage points (i.e., *HbA1c Testing*, *Poor HbA1c Control*, *LDL-C*

*Screening, and Monitoring Nephropathy*). *Cervical Cancer Screening* has improved by 16.0 percentage points since HEDIS 2005 and exceeded the national HEDIS 2007 Medicaid 50th percentile this year.

Despite the improvements over time, results for the majority of the rates were still well below the national Medicaid 2007 HEDIS 50th percentiles. Rates for 9 measures decreased since initially reported, and rates for 6 of the 23 measures that have improved overall since first reported (for HEDIS 2005) decreased this year.

Rates for the maternity-related measures, especially *Postpartum Care*, continued to be low and generally showed very little improvement on a year-to-year basis. *Postpartum Care* did improve 6.0 percentage points over last year, but the current rate was still below the 10th percentile. The rate for *Timeliness of Prenatal Care* decreased 2.7 percentage points from last year. Because *Timeliness of Prenatal Care* and *Postpartum Care* were part of an ongoing statewide collaborative PIP, HSAG expected that the rates for these measures would improve. Based on these results, **FHN** should focus improvement efforts on maternity-related care.

## Harmony Health Plan

The 2007–2008 HEDIS compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2008 Technical Specifications* (Table 3-7 below). 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 3-7—Harmony 2007 HEDIS Compliance Audit Results			
Main Information Systems			Selected 2007 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an <i>R</i> audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

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

### *IS 1.0—Sound Coding Methods for Medical Data*

**Harmony** was found to be fully compliant with IS Standards 1.1 and 1.2. **Harmony** consistently captured industry standard codes within the PÉRADIGM system, including CPT II codes. Principal codes were identified and secondary codes were captured as submitted.

### *IS 2.0—Data Capture, Transfer, and Entry—Medical and Service Data*

The processing of claims and encounter data (IS 2.1, 2.2, and 2.3), including control of paper and electronic claims data, met standards with one exception: due to certain subcapitation payment arrangements, some encounters submitted to **Harmony** did not include the rendering provider information. **Harmony** passed the medical record validation for both selected measures. Encounter data submission monitoring met standards (IS 2.5). **Harmony** runs per-member-per-month calculations to ensure that encounter data submission patterns are acceptable compared with expected volumes per provider.

### *IS 3.0—Data Capture, Transfer, and Entry—Membership Data*

**Harmony** was found to be compliant with membership data (IS 3.0). Paper enrollment forms were processed for the first month of 2007 and data entry audits were determined to be sufficient. Enrollments were then processed directly online. All processes in place met standards. The processes used to load and reconcile the monthly enrollment file also met standards.

### ***IS 4.0—Data Capture, Transfer, and Entry—Practitioner Data***

The PÉRADIGM system captured the necessary provider-related data elements, including the provider type and PCP flag. The processes in place to collect the necessary provider data met standards (IS 4.1 and 4.2).

### ***IS 5.0—Data Integration Required to Meet the Demands of Accurate HEDIS Reporting***

**Harmony** was fully compliant with IS Standards 5.1 (data integration) and 5.3 (HEDIS repository structure) and used NCQA-certified software for the generation of the HEDIS measures. To resolve the issue related to unidentified provider types, **Harmony** manually verified all PCP relationships, and those that were not confirmed as PCPs were excluded as numerator hits for those measures that required a PCP. Another workaround was performed for lab visits that appeared to be a well-child visit. **Harmony** also excluded these visits from the numerator.

### ***IS 6.0—Control Procedures That Support HEDIS Reporting Integrity***

**Harmony** was determined to be fully compliant with IS Standards 6.2 (HEDIS reporting software management) and 6.3 (control procedures). For IS 6.1 (report production management), issues related to rendering provider type, duplicate visit dates, and lab encounter issues resulted in multiple submissions of HEDIS reports and medical record review numerator positive case listings. **Harmony**, however, resolved these issues at the conclusion of the reporting process, and the rates were accepted as reportable.

### ***Harmony Trended Results***

Table 3-8 below provides the results of trended performance measures. Only HEDIS measures reported for at least the last two years are included in the table. The last column of the table denotes the difference in the rates between the first reportable HEDIS rate and HEDIS 2008 results.

Table 3-8—Harmony Trended HEDIS Results

HEDIS Measures	HEDIS 2005	HEDIS 2006	HEDIS 2007	HEDIS 2008	Difference from Baseline
<i>Childhood Immunizations—Combo 2</i>	49.5	49.5	58.6	53.8	4.3
<i>Childhood Immunizations—Combo 3</i>	NA	22.6	38.2	42.8	20.2
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	16.5	10.0	6.3	9.2	-7.3
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	14.6	36.0	41.1	21.7	7.1
<i>Well-Child Visits (3–6 Years)</i>	55.8	58.9	64.5	57.4	1.6
<i>Adolescent Well-Care Visits</i>	NA	NA	36.5	37.7	1.2
<i>Adults' Access (20–44 Years)</i>	NA	NA	62.1	57.5	-4.6
<i>Adults' Access (45–64 Years)</i>	NA	NA	55.7	54.6	-1.1
<i>Breast Cancer Screening (42–51 Years)</i>	NA	NA	25.8	34.3	8.5
<i>Breast Cancer Screening (52–69 Years)</i>	NA	36.5	51.6	45.5	9.0
<i>Breast Cancer Screening (Combined Rate)</i>	NA	NA	27.7	35.5	7.8
<i>Cervical Cancer Screening</i>	55.1	56.5	50.4	59.1	4.0
<i>Chlamydia Screening in Women (Combined Rate)</i>	NA	NA	52.8	49.3	-3.5
<i>Frequency of Ongoing Prenatal Care (&lt;21% Visits)*</i>	NA	NA	24.1	21.9	-2.2
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	NA	NA	33.8	31.4	-2.4
<i>Timeliness of Prenatal Care</i>	55.4	59.1	53.5	56.4	1.0
<i>Postpartum Care</i>	36.8	37.0	34.3	35.0	-1.8
<i>Controlling High Blood Pressure (Combined Rate)</i>	NA	NA	26.0	34.3	8.3
<i>Diabetes Care (HbA1C Testing)</i>	48.3	54.2	62.6	57.7	9.4
<i>Diabetes Care (Poor HbA1c Control)*</i>	90.0	76.0	79.8	72.7	-17.3
<i>Diabetes Care (Good HbA1c Control)</i>	NA	NA	8.8	15.6	6.8
<i>Diabetes Care (Eye Exam)</i>	13.1	9.4	13.1	9.0	-4.1
<i>Diabetes Care (LDL-C Screening)</i>	60.6	60.8	55.3	52.3	-8.3
<i>Diabetes Care (LDL-C Level &lt;100 mg/dL)</i>	15.4	14.9	12.4	12.4	-3.0
<i>Diabetes Care (Nephropathy Monitoring)</i>	NA	NA	62.1	59.9	-2.2
<i>Diabetes Care (BP &lt;140/90)</i>	NA	NA	31.6	45.0	13.4
<i>Diabetes Care (BP &lt;130/80)</i>	NA	NA	14.4	23.6	9.2
<i>Appropriate Medications for Asthma (5–9 Years)</i>	NA	76.1	78.2	85.8	9.7
<i>Appropriate Medications for Asthma (10–17 Years)</i>	NA	87.1	86.8	84.7	-2.4
<i>Appropriate Medications for Asthma (18–56 Years)</i>	NA	88.5	84.2	82.0	-6.5
<i>Appropriate Medications for Asthma (Combined Rate)</i>	NA	82.4	83.4	84.1	1.7
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	NA	NA	47.9	20.0	-27.9
<i>Follow-up After Hospitalization for Mental Illness—30</i>	NA	NA	65.1	32.3	-32.8

\* Lower rates indicate better performance for these measures.

The results show that 20 measures improved since initially reported, and that eight of the 12 measures initially reported in 2005 have improved. *Childhood Immunizations—Combo 3* showed the greatest improvement, gaining 20.2 percentage points since 2006. Two *Diabetes Care* measures improved by more than 10 percentage points: *Poor HbA1c Control* and *Blood Pressure <140/90*.

Despite the improvements over time, results for the majority of the rates were still well below the national Medicaid 2007 HEDIS 50th percentiles, and most of the improvements averaged less than 3 percentage points a year. The rates for 13 measures have decreased since initially reported, and the rates for 5 of the 20 measures that have improved overall since the baseline decreased for this year.

Compared to last year, 15 of the 33 measures improved, 17 measures reported a decline in the rate, while one measure (*Diabetes Care—LDL-C Level <100*) remained unchanged. The most significant declines were for *Well-Child Visits in the First 15 Months of Life* (down 19.4 percentage points), and *Follow-up After Hospitalization for Mental Illness—7 Days and 30 Days* (down 27.9 and 32.8 percentage points, respectively).

The rates for *Well-Child Visits in the First 15 Months of Life* and *Follow-up After Hospitalization for Mental Illness* had a significant decline for this year. **Harmony** has indicated the declines were due to a data issue related to an inability to identify the provider type. Given the HEDIS reporting time constraints, **Harmony** chose to exclude encounter data for well-child visits and behavioral health visits with an unknown provider type, resulting in lower rates. The rates for HEDIS 2009 are expected to be higher and more representative of their population.

The rates for the maternity-related measures, especially *Postpartum Care*, have continued to be low and have decreased since 2005. *Timeliness of Prenatal Care* and *Postpartum Care* are still below the 10th percentiles. Because *Timeliness of Prenatal Care* and *Postpartum Care* were part of an ongoing statewide collaborative PIP, HSAG expected that the rates for these measures would improve. Based on these results, Harmony should focus improvement efforts on maternity-related care.

### ***Harmony Trended Results—Cook vs. Southern Illinois Counties***

Table 3-9 below displays a distinct difference in the delivery of services between Cook County and the Southern Illinois counties. Except for two rates, the Southern area had higher rates for every measure. This finding is consistent with results from prior years and indicates that **Harmony** should continue to report results by these two service areas. Furthermore, to realize a significant increase in their rates, **Harmony** should conduct a barrier analysis for Cook County and specifically target members in this service area.

**Table 3-9—Harmony Rates By Area**

HEDIS Measures	Harmony's Rates by Area			Difference Between Service Areas
	Overall	Cook	South	
<i>Appropriate Treatment for Children with URI</i>	86.2	86.7	83.0	3.7
<i>Children's Access to PCPs (12–24 Months)</i>	82.5	81.3	93.2	11.9
<i>Children's Access to PCPs (25 months–6 Years)</i>	65.7	63.8	79.9	16.1
<i>Children's Access to PCPs (7–11 Years)</i>	60.7	59.4	68.2	8.8
<i>Adolescents' Access to PCPs (12–19 Years)</i>	58.7	56.7	71.5	14.8
<i>Adult's' Access (20–44 Years)</i>	57.5	56.0	67.3	11.3
<i>Adults' Access (45–64 Years)</i>	54.6	53.3	65.3	12.0
<i>Chlamydia Screening in Women (16–20 Years)</i>	45.1	43.7	54.4	10.7
<i>Chlamydia Screening in Women (21–25 Years)</i>	53.3	52.5	58.6	6.0
<i>Chlamydia Screening in Women (Combined Rate)</i>	49.3	48.2	56.4	8.2
<i>Appropriate Medications for Asthma (5–9 Years)</i>	85.8	85.1	88.7	3.6
<i>Appropriate Medications for Asthma (10–17 Years)</i>	84.7	85.4	81.8	3.5
<i>Appropriate Medications for Asthma (18–56 Years)</i>	82.0	79.9	91.4	11.5
<i>Appropriate Medications for Asthma (Combined Rate)</i>	84.1	83.4	87.0	3.6
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	20.0	16.8	46.0	29.2
<i>Follow-up After Hospitalization for Mental Illness—30</i>	32.3	29.1	58.0	28.9

### Overall Performance Measures Recommendations

Most improvements since 2005 have been small, showing an average of less than 3 percentage points per year. HSAG recommends the following for the MCOs:

- ◆ Conduct a barrier analysis for maternity-related measures to determine the causes for noncompliance by both providers and members, and develop and implement targeted interventions for achieving improvement on these measures.
- ◆ Continue to educate providers on EPSDT services and members on the importance of obtaining these services. EPSDT services impact multiple HEDIS measures, including well-child visits and immunizations.
- ◆ Establish a monitoring program that routinely collects and analyzes data on the performance measures, providing interpretation of these data to practitioners. Consider a pay-for-performance bonus program for providers.
- ◆ Develop a detailed work plan to improve reporting of encounter data. Consider, for example, contracting with individual providers on a fee-for-service basis for those who do not submit a sufficient amount of encounter data.

The last recommendation, improving the reporting of encounter data, was recommended in last year's EQR technical report, and continues to be a significant issue with the MCOs. This was apparent when comparing administrative and hybrid rates (i.e., rates derived from administrative

data and MRR) for the same measures. When an MCO has complete encounter data, there should be very little difference between administrative rates and hybrid rates. For **FHN** and **Harmony**, the differences between their administrative and hybrid rates were significant. The lack of encounter data may have a ripple effect. Without enough encounter data, an MCO may be unaware of issues, which makes it difficult to implement effective interventions and target specific areas. HSAG strongly recommends that **FHN** and **Harmony** focus on the submission and capture of encounter data. Ensuring accurate and complete encounter data should improve rates and allow the MCOs to follow the above recommendations more effectively.

## Validation of Performance Improvement Projects—FY 2007–2008

### Objectives

As part of its quality assessment and performance improvement program, the Department requires each health plan to conduct PIPs in accordance with 42 CFR 438.240. The purpose of PIPs 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 EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted MCOs and prepaid inpatient health plans (PIHPs). The Department contracted with HSAG to meet this validation requirement.

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

- ◆ Measurement of 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.

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.

Beginning in 2004–2005, the Department required each MCO to participate in a mandatory statewide PIP focused on improving performance related to EPSDT screenings and visits, including the content of care for children younger than 3 years of age. Following the baseline EPSDT study, the MCOs were required to implement interventions to improve EPSDT rates. The intervention period was to be conducted during SFY 2005–2006, with a remeasurement phase scheduled for SFY 2006–2007. Based on the findings from the baseline EPSDT study, however, the Department and the HFS MCOs decided to continue their intervention efforts through SFY 2006–2007. Furthermore, the Department and the MCOs agreed that an EPSDT provider survey should be conducted in SFY 2006–2007 to help identify potential barriers providers may encounter in providing EPSDT services. With the results of this analysis, the HFS MCOs could pinpoint areas to

target for intervention. Administration of the survey was initiated on May 4, 2007, and completed on July 20, 2007. A remeasurement of the baseline EPSDT PIP study indicators will occur during SFY 2007–2008. It is anticipated that the results of the remeasurement will show statistically significant improvement and demonstrate that the MCO interventions have positively impacted the EPSDT services provided to HFS MCO beneficiaries. The aggregate results of the remeasurement of the EPSDT PIP will be included as an addendum to this report.

In 2005–2006, the Department implemented a requirement that each MCO participate in a statewide PIP with a study topic and methodology established by the Department in collaboration with the MCOs. The 2005–2006 Department-specified PIP, which continued in 2006–2007, focused on perinatal care and depression screening. During 2006–2007 the MCOs were in the intervention phase of the perinatal care and depression screening PIP. This phase included planning both provider and member interventions, and should have been fully implemented in 2007. The remeasurement period occurred in SFY 2008 for women who had live births between November 6, 2006, and November 5, 2007. The aggregate results of the remeasurement of the perinatal care and depression screening PIP will be included as an addendum to this report.

The MCOs also conducted PIPs in 2005–2006 and 2006–2007 on asthma care (i.e., increasing the use of appropriate medications for members with asthma). **FHN** and **Harmony** each conducted three PIPs in 2007–2008.

To continue the objective of enhancing the MCOs' knowledge and expertise in conducting PIPs, HSAG provided ongoing technical assistance to the Department and the MCOs on the development of the study methodology, including selection of the study question, identification of study indicators, and establishment of the data analysis plan throughout the PIP process. Further, through a statewide collaborative, HSAG served as an advisor to the MCOs and provided technical assistance on sampling methodology, medical record abstraction, and data submission format.

### **Technical Methods of Data Collection and Analysis**

The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with the Department, 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 the Department's input and approval, developed a PIP validation tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS PIP Protocol activities:

- ◆ Activity I. Appropriate Study Topic
- ◆ Activity II. Clearly Defined, Answerable Study Question
- ◆ Activity III. Clearly Defined Study Indicator(s)

- ◆ Activity IV. Correctly Identified Study Population
- ◆ Activity V. Valid Sampling Techniques (if Sampling Was Used)
- ◆ Activity VI. Accurate/Complete Data Collection
- ◆ Activity VII. Appropriate Improvement Strategies
- ◆ Activity VIII. Sufficient Data Analysis and Interpretation
- ◆ Activity IX. Real Improvement Achieved
- ◆ Activity X. Sustained Improvement Achieved

HSAG calculated the percentage score of evaluation elements met for each MCO by dividing the total elements *Met* by the total elements *Met*, *Partially Met*, and *Not Met*. Any evaluation element that received a *Not Applicable* or *Not Assessed* designation was not included in the overall score. While all elements are important in assessing a PIP, HSAG designated some elements as critical to producing valid and reliable results and for demonstrating high confidence in the PIP findings. These critical elements must be *Met* for the PIP to be in compliance. The percentage score of critical elements *Met* was calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*. A *Partially Met* validation status indicates low confidence in the reported PIP results.

**Description of the Data Obtained**

HSAG obtained the data needed to conduct the PIP validation from the MCO’s PIP Summary Form. This form provided detailed information about each health plan’s PIP as it related to the 10 activities reviewed and evaluated.

Table 3-10—Description of MCO Data Sources		
Data Obtained	Time Period to Which the Data Applied	
	FHN	Harmony
Perinatal Care/Depression Screening PIP Summary Form (Completed by the MCO)	11/6/2004 to 11/5/2007	11/6/2006 to 11/6/2007
Asthma PIP Summary Form (Completed by the MCO)	1/1/2004 to 12/31/2006	1/1/2005 to 12/31/2007
EPSDT Screening PIP Summary Form (Completed by the MCO)	1/1/2007 to 12/31/2007	1/1/2005 to 12/31/2006

**FHN** and **Harmony** completed the Illinois 2007–2008 PIP summary forms for the perinatal care and depression screening, asthma, and EPSDT screening PIPs. Some evaluation elements were not assessed because activities that take place later in the studies had not yet occurred.

### **Data Aggregation, Analysis, and How Conclusions Were Drawn**

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP review team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *NA*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

HSAG assigned all PIPs a validation status as follows:

- ◆ *Met*: All critical elements were *Met* **and** 80 to 100 percent of all critical and noncritical elements were *Met*.
- ◆ *Partially Met*: All critical elements were *Met* and 60 to 79 percent of all critical and noncritical elements were *Met*, **or** one critical element or more was *Partially Met*.
- ◆ *Not Met*: All critical elements were *Met* and less than 60 percent of all critical and noncritical elements were *Met*, **or** one critical element or more was *Not Met*.
- ◆ *NA*: Elements (including critical elements if they were not assessed) were removed from all scoring. (For example, an administrative study would not include MRR. Elements related to MRR would be given an *NA* validation status and not be included in any scores).

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements), which HSAG calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*. HSAG then calculated a critical element percentage score by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- ◆ *Met*: Confidence/high confidence in reported PIP results
- ◆ *Partially Met*: Low confidence in reported PIP results
- ◆ *Not Met*: Reported PIP results not credible

The health plans had an opportunity to resubmit studies following the initial review and evaluation results. HSAG offered technical assistance to the health plans prior to the resubmission, if requested. The HSAG PIP Review Team re-reviewed the study and finalized the PIP Validation Tool.

After completing the validation review, HSAG prepared a report of the findings and recommendations for each validated PIP. HSAG forwarded these reports, which complied with 42 CFR 438.364, to the Department and the appropriate MCO.

### Conclusions Drawn from the Data

A summary follows of the conclusions drawn from the findings of the validation of PIP activities. The validation activities are designed to assess the process used by the MCOs in designing, conducting, and reporting the results of the PIPs.

### Plan-Specific Findings

#### Family Health Network

##### Asthma PIP

**FHN** received a *Met* score for 89 percent of the total possible evaluation elements and 100 percent of the critical elements for its 2007–2008 asthma PIP, achieving a *Met* validation status. Activities I–IX were assessed for this PIP validation cycle. Table 3-11 displays the number of evaluation elements *Met*, *Partially Met*, or *Not Met* and the total critical elements *Met*. Based on the validation of this PIP study, HSAG’s assessment determined confidence in the results.

Table 3-11—FHN 2007–2007 Asthma PIP Validation Report Element Scores				
Number <i>Met</i>	Number <i>Partially Met</i>	Number <i>Not Met</i>	Total Possible Critical Elements Assessed	Total Critical Elements <i>Met</i>
34	3	1	13	10*
*Three critical elements were <i>NA</i> .				

The score of 89 percent of the total possible evaluation elements *Met* represents a decline from the 2006–2007 score of 100 percent, although **FHN** received a *Met* score for 100 percent of critical elements in 2007–2008, as it had in 2006–2007. In 2005–2006 **FHN** received a *Met* score for 92 percent of the total possible evaluation elements and 80 percent of the critical elements for its asthma PIP, achieving a *Partially Met* validation status.

##### EPSDT Screening PIP

**FHN** received a score of 95 percent for total possible evaluation elements *Met* and a 100 percent score for critical elements *Met* for its 2007–2008 EPSDT screening PIP, achieving a *Met* validation status. HSAG assessed Activities I–VIII for this PIP validation cycle. Table 3-12 displays the number of evaluation elements *Met*, *Partially Met*, or *Not Met* and the total critical elements *Met*. Based on the validation of this PIP study, HSAG’s assessment determined confidence in the results.

Table 3-12—FHN 2007–2008 EPSDT Screening PIP Validation Report Element Scores				
Number <i>Met</i>	Number <i>Partially Met</i>	Number <i>Not Met</i>	Total Possible Critical Elements Assessed	Total Critical Elements <i>Met</i>
37	1	1	13	13

The score of 95 percent of the total possible evaluation elements *Met* represents a decline from the 2006–2007 score of 100 percent, although **FHN** received a *Met* score for 100 percent of critical elements in 2007–2008, as it had in 2006–2007. In 2005–2006 **FHN** received a *Met* score for 93 percent of the total possible evaluation elements and 100 percent of the critical elements for its EPSDT screening PIP, achieving a *Met* validation status.

**Perinatal Care and Depression Screening PIP**

**FHN** received a score of 94 percent for the total possible evaluation elements *Met* and a 100 percent score for critical elements *Met* for its 2007–2008 perinatal care and depression screening PIP, achieving a *Met* validation status. HSAG assessed Activities I–IX for this PIP validation cycle. Table 3-13 displays the number of evaluation elements *Met*, *Partially Met*, or *Not Met* and the total critical elements *Met*. Based on the validation of this PIP study, HSAG’s assessment determined confidence in the results.

Table 3-13—FHN 2007–2008 Perinatal Care and Depression Screening PIP Validation Report Element Scores				
Number <i>Met</i>	Number <i>Partially Met</i>	Number <i>Not Met</i>	Total Possible Critical Elements Assessed	Total Critical Elements <i>Met</i>
48	3	0	13	13

The score of 94 percent of the total possible evaluation elements *Met* represents a decline from the 2006–2007 score of 100 percent, although **FHN** received a *Met* score for 100 percent of critical elements in 2007–2008, as it had in 2006–2007. **FHN** received a score for 100 percent of the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its 2005–2006 perinatal care and depression screening PIP, achieving a *Met* validation status.

## Harmony Health Plan

### Asthma PIP

**Harmony** received a score of 79 percent for the total possible evaluation elements *Met* and a score of 92 percent for critical elements *Met* for its 2007–2008 asthma PIP, achieving a *Partially Met* validation status. HSAG assessed Activities I–X for this PIP validation cycle. Table 3-14 displays the number of evaluation elements *Met*, *Partially Met*, or *Not Met* and the total critical elements *Met*. Based on the validation of this PIP study, HSAG’s assessment determined low confidence in the results.

Number <i>Met</i>	Number <i>Partially Met</i>	Number <i>Not Met</i>	Total Possible Critical Elements Assessed	Total Critical Elements <i>Met</i>
38	9	1	13	11*
*One critical element was <i>NA</i> .				

This represents a decline from 2006–2007, when **Harmony** received a score of 100 percent for the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its asthma PIP. In 2005–2006 **Harmony** received a score of 87 percent for the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its asthma PIP, achieving a *Met* validation status.

### EPSDT Screening PIP

**Harmony** received a score of 92 percent for the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its 2007–2008 EPSDT screening PIP, achieving a *Met* validation status. HSAG assessed Activities I–VIII for this PIP validation cycle. Table 3-15 displays the number of evaluation elements *Met*, *Partially Met*, or *Not Met* and the total critical elements *Met*. Based on the validation of this PIP study, HSAG’s assessment determined confidence in the results.

Number <i>Met</i>	Number <i>Partially Met</i>	Number <i>Not Met</i>	Total Possible Critical Elements Assessed	Total Critical Elements <i>Met</i>
36	2	1	13	13

This represents a decline from 2006–2007, when **Harmony** received a score of 100 percent for the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its EPSDT screening PIP. In 2005–2006 **Harmony** received a score of 98 percent for the total possible

evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its EPSDT screening PIP, achieving a *Met* validation status.

**Perinatal Care and Depression Screening PIP**

**Harmony** received a score of 84 percent for the total possible evaluation elements *Met* and a score of 92 percent for critical elements *Met* for its 2007–2008 perinatal care and depression screening PIP, achieving a *Partially Met* validation status. HSAG assessed Activities I–IX for this PIP validation cycle. Table 3-16 displays the number of evaluation elements *Met*, *Partially Met*, or *Not Met* and the total critical elements *Met*. Based on the validation of this PIP study, HSAG’s assessment determined low confidence in the results.

Table 3-16—Harmony 2007–2008 Perinatal Care and Depression Screening PIP Validation Report Element Scores				
Number <i>Met</i>	Number <i>Partially Met</i>	Number <i>Not Met</i>	Total Possible Critical Elements Assessed	Total Critical Elements <i>Met</i>
43	7	1	13	12

This represents a decline from 2006–2007, when **Harmony** received a score of 100 percent for the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its perinatal care and depression screening PIP. **Harmony** also received a score of 100 percent for the total possible evaluation elements *Met* and a score of 100 percent for critical elements *Met* for its 2005–2006 perinatal care and depression screening PIP, achieving a *Met* validation status.

**Overall PIP Recommendations**

Both MCOs should continue to use technical assistance to enhance compliance with PIP standards and ensure scientifically sound data to help improve the health outcomes of beneficiaries. Both MCOs also have opportunities for improvement in the documentation of reported PIP results, including providing an interpretation of the extent of which the study was successful and data to indicate whether actual improvement in outcomes of care had occurred. In addition, both MCOs should strengthen their focus on improving clinical outcomes and the quality of care and services to HFS beneficiaries.

## EPSDT Provider Survey

Following the baseline EPSDT PIP, the MCOs were required to implement interventions to improve EPSDT rates. The intervention period was to be conducted during SFY 2005–2006, with a remeasurement phase scheduled for SFY 2006–2007. Based on the findings from the baseline EPSDT study, however, the Department and the HFS MCOs decided to continue their intervention efforts through SFY 2006–2007. Furthermore, the Department and the MCOs agreed that an EPSDT provider survey should be conducted in SFY 2006–2007 to help identify potential barriers providers may encounter in providing EPSDT services. Results of the survey would help the MCOs pinpoint and target areas for intervention.

During the baseline EPSDT PIP reporting period, the Department contracted with five HFS MCOs to provide health care services to HFS managed care beneficiaries: **AmeriChoice**; **AMERIGROUP, Illinois (AMERIGROUP)**; **Family Health Network, Inc. (FHN)**; **Harmony Health Plan of Illinois, Inc. (Harmony)**; and **Humana**. However, **AmeriChoice**, **AMERIGROUP**, and **Humana** have since terminated their HFS contracts and are no longer participating in the EPSDT PIP. Therefore, **FHN** and **Harmony** conducted the EPSDT Provider Survey, and this report presents the results of that survey. At the direction of HFS, HSAG assisted **FHN** and **Harmony** with the design and administration of the EPSDT Provider Survey.

The purpose of the EPSDT Provider Survey was to:

- ◆ Assess PCPs' knowledge regarding the components for documentation and coding of EPSDT services.
- ◆ Identify potential targets for additional performance improvement activities.

The administration of the survey was initiated on May 4, 2007, and was completed on July 20, 2007. The population included PCPs contracted with **FHN** and **Harmony**. For the purposes of this survey, PCPs were defined as physicians practicing in the following specialty areas: general practice (GP), family practice (FP), internal medicine (IM), and pediatrics (PEDS). Although an obstetrician/gynecologist (OB/GYN) can be selected as a PCP, this specialty was not included in the survey because a number of EPSDT services (e.g., blood lead testing) would not be relevant for the age group visiting an OB/GYN.

The survey included all PCPs contracted with **FHN** and **Harmony**. Since providers may contract with both MCOs, creating the potential for duplication in the sample, each provider received only one survey. The providers were then identified as those who contracted with **FHN** only, **Harmony** only, or both MCOs. PCPs who no longer contracted with either MCO, or who did not see patients younger than 21 years of age, were excluded from the survey. Surveys were sent to a total of 1,018 providers. Twenty-seven of the providers no longer contracted with either of the two MCOs and were excluded from the survey. The final adjusted population consisted of 991 providers. Providers returned a total of 208 surveys for a response rate of 20.0 percent.

**Table 3-17—Survey Response Rates**

MCO	Original Population Size	Invalid Surveys*	Adjusted Population Size	Number of Surveys Returned	Response Rate (%)	Excluded Surveys*	Final Surveys
FHN	92	7	85	38	44.7%	6	32
Harmony	661	11	650	104	16.0%	24	80
Both	265	9	256	66	25.8%	14	52
<b>Total</b>	<b>1,018</b>	<b>27</b>	<b>991</b>	<b>208</b>	<b>21.0%</b>	<b>44</b>	<b>164</b>

\* Surveys from providers who no longer contracted with FHN or Harmony (N=27) were considered invalid. Exclusions consisted of 44 surveys from providers who did not provide services to HFS beneficiaries younger than 21 years of age.

The following are highlights of the primary findings based on the provider survey responses:

- ◆ Overall, 65.8 percent of the providers stated they received information identifying the beneficiaries who needed an EPSDT examination, and nearly 78.5 percent of providers indicated that they would like to receive this information.
- ◆ Overall, 55.3 percent of the providers indicated they received information concerning EPSDT examination requirements from their contracted MCOs, and 71.8 percent of the providers indicated that they would like to receive this information.
- ◆ Not all providers recognized the EPSDT components that require objective assessments instead of subjective assessments.
- ◆ The majority of providers (73.8 percent) stated they routinely submit claims/encounter forms to the MCOs for all EPSDT services they perform. However, 23.2 percent responded that they were *not sure* if their office submitted forms for all EPSDT services performed. This may also indicate that the provider was not sure of the services included in an EPSDT examination.
- ◆ More than half of the providers recognized four out of six EPSDT services that could be coded separately. However, providers also mistakenly identified four out of five EPSDT services that cannot be coded separately more than 20.0 percent of the time.
- ◆ The majority of providers recognized the importance of screening new mothers for depression.
- ◆ The majority of providers indicated that they would like to receive more information concerning coding and encounter data submission (59.2 percent) and referral resources (51.8 percent). The third-most-requested item, at 48.2 percent, was to receive additional information about tools for objective vision and hearing screenings.
- ◆ Overall, 44.5 percent of the providers indicated that they had problems performing comprehensive, objective developmental screenings during EPSDT examinations. The majority of providers considered time constraints in their current practices as the greatest barrier to conducting objective developmental screenings. However, lack of staff to perform the screenings, lack of knowledge regarding referral options (for positive screenings), and lack of training in developmental screenings were all among the top five reasons that providers gave for not conducting comprehensive screenings. In addition, 8.2 percent of the providers indicated that objective developmental screenings were not required during EPSDT examinations.

The following recommendations are based on results from the baseline EPSDT PIP study and the findings from this provider survey:

- ◆ Lack of knowledge about EPSDT requirements poses a challenge to improving EPSDT rates. **FHN** and **Harmony** should consider increasing provider education regarding EPSDT requirements and should continue sending information detailing EPSDT rates and member-level EPSDT examination information to providers on a regular basis (e.g., monthly or quarterly).
- ◆ **FHN** and **Harmony** should continue to conduct provider education regarding coding and submitting claims/encounters for EPSDT services.
- ◆ **FHN** and **Harmony** should encourage providers to participate in the Vaccines for Children (VFC) Program. Information about the VFC Program can be found on the HFS Web site at <http://www.hfs.illinois.gov/providerprograms/vaccine.html> or by telephone at **1-800-526-4372**. Providers in Chicago should contact the Chicago VFC Program at **312-746-5940**.
- ◆ The fact that providers recognized that objective assessments, including developmental assessments, are components of an EPSDT examination is encouraging and should be reinforced by **FHN** and **Harmony**. Since providers indicated that they would like to receive information about the assessments, **FHN** and **Harmony** need to continue to include information on objective assessments in their provider newsletters or send the information directly to the providers.
- ◆ **FHN** and **Harmony** should continue to use provider newsletters to remind pediatricians, family practitioners, and internists about the essential components of an EPSDT examination. The MCOs can provide this information through ongoing provider newsletters, meetings, or trainings.
- ◆ **FHN** and **Harmony** should continue to encourage providers to perform EPSDT preventive services, such as immunizations, during office visits other than those specifically devoted to EPSDT examinations. Providers should be encouraged to create standing orders for nursing personnel to perform the immunization, dental, nutritional, vision, and hearing assessments when an EPSDT examination has not been performed within the past year. The physician will then be able to review the findings, complete the physical examination, and complete the necessary health education/anticipatory guidance during his or her session with member.
- ◆ The MCOs should continue to encourage the use of standardized forms to assist in determining the components of age-appropriate physician examinations and health education/anticipatory guidance like those published by the National Center for Education in Maternal and Child Health found at [www.brightfutures.org](http://www.brightfutures.org). The contents of the forms would need to be reviewed to be sure they include the health screenings required by the State of Illinois. The forms for each age group could be color-coded to enhance ease of location in the medical record.
- ◆ The MCOs should examine the quality of provider documentation for EPSDT services. It is not possible to separate issues regarding incomplete documentation from the lack of delivery of various preventive health services. Thus, the MCOs should continue to encourage the appropriate documentation of services performed during an EPSDT examination.
- ◆ The response rate for **FHN** was 45 percent, while **Harmony** had a 16 percent response rate, providing an overall response rate of 26 percent. This survey response rate was lower than expected due, in part, to incorrect provider addresses and telephone numbers for the providers contracted with **Harmony**. Both **FHN** and **Harmony** should update and maintain their provider databases on a regular basis.

Based on the results from the EPSDT study conducted in SFY 2004–2005 and the results from this survey, **FHN** and **Harmony** will be expected to develop and implement appropriate interventions to improve EPSDT rates in the State of Illinois. A remeasurement of the baseline EPSDT PIP study indicators will occur during SFY 2007–2008. HSAG anticipates that the results of the remeasurement will show a statistically significant improvement and demonstrate that the MCO interventions have positively impacted the EPSDT services provided to HFS MCO beneficiaries.

The 2006-2007 Statewide Collaborative PIP—EPSDT Provider Survey Report (November 2007) contains complete details of the survey.

## **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys—FY 2007–2008**

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **FHN** and **Harmony** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. **FHN's** and **Harmony's** results were forwarded to HSAG for analysis.

### **Objectives**

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on patients' levels of satisfaction with their health care experiences.

### **Technical Methods of Data Collection and Analysis**

For **FHN** and **Harmony**, the adult Medicaid and child Medicaid populations were surveyed. The Myers Group administered the CAHPS surveys on behalf of **FHN** and **Harmony**.

The technical method of data collection was through administration of the CAHPS 4.0H Adult Medicaid Survey to the adult population and the CAHPS 3.0H Child Medicaid Survey (without the children with chronic conditions measurement set) to the child population. Both plans used a mixed methodology for data collection, which included both a mail and telephone phase for data collection.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was "Not Applicable" (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was

referred to as a question summary rate (or top-box response). 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 (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices in the adult Medicaid survey fell into one of the following two categories 1) “Never,” “Sometimes,” “Usually,” and “Always” or 2) “Definitely No,” “Somewhat No,” “Somewhat Yes,” and “Definitely Yes.” For the child Medicaid survey, response choices fell into one of the following two categories: 1) “Never,” “Sometimes,” “Usually,” and “Always” or 2) “A Big Problem,” “A Small Problem,” and “Not a Problem.”

A positive or top-box response for the composites was defined as a response of “Always,” “Not a Problem,” or “Definitely Yes.” The percentage of top-box responses was referred to as a global proportion for the composite scores.

In addition to the global proportion, a three-point mean was calculated for each of the composite scores. Scoring was based on a three-point scale. Responses of “Always,” “Not a Problem,” and “Definitely Yes” were given a score of 3, responses of “Usually,” “A Small Problem,” or “Somewhat Yes” 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.

### ***Description of the Data Obtained***

Annual adult and child satisfaction survey results and analyses from the 2008 data were obtained for **FHN** and **Harmony**.

### ***Conclusions Drawn from the Data***

A summary follows of the findings of from the CAHPS results.

**Plan-Specific Findings**

**Family Health Network**

**Adult Medicaid**

FHN’s 2008 adult Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-18, along with NCQA’s 2007 CAHPS national averages.

Table 3-18—FHN Adult Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	NA	NA	47.3%
<i>Getting Care Quickly</i>	71.4%	2.198	54.0%
<i>How Well Doctors Communicate</i>	83.7%	2.469	66.8%
<i>Customer Service*</i>	NA	NA	*
<i>Shared Decision Making</i>	NA	†	58.4%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	60.2%	2.077	46.6%
<i>Rating of Personal Doctor</i>	77.7%	2.413	60.5%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	59.7%
<i>Rating of Health Plan</i>	53.6%	2.018	52.8%
<p>A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.</p> <p>† The Myers Group did not report a three-point mean for the <i>Shared Decision Making</i> composite.</p> <p>* Due to changes in the <i>Customer Service</i> composite, a 2007 NCQA CAHPS national average was not calculated for this measure.</p>			

FHN scored above the 2007 NCQA CAHPS national average for all five of the comparable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rates for *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor* were greater than the national averages by more than 10 percentage points, representing areas of strength.

**Child Medicaid**

FHN’s 2008 child Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-19, along with NCQA’s 2007 CAHPS national averages.

Table 3-19—FHN Child Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	79.0%	2.702	80.3%
<i>Getting Care Quickly</i>	68.9%	2.139	50.9%
<i>How Well Doctors Communicate</i>	89.8%	2.587	66.3%
<i>Courteous and Helpful Office Staff</i>	89.6%	2.571	67.9%
<i>Customer Service</i>	NA	NA	73.6%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	80.1%	2.505	64.0%
<i>Rating of Personal Doctor</i>	81.8%	2.520	64.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	61.9%
<i>Rating of Health Plan</i>	76.1%	2.440	63.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

FHN scored above the 2007 NCQA CAHPS national averages for six of the seven comparable CAHPS child measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. In addition, the rates for the six measures were greater than the national averages by more than 10 percentage points, representing areas of strength. Although the rate for the *Getting Needed Care* measure was less than the national average, this difference was not substantial, suggesting that this was not an area of major weakness. However, this area of care should continue to be monitored since it has an impact on members’ satisfaction.

## Harmony Health Plan

### Adult Medicaid

Harmony’s 2008 adult Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-20, along with NCQA’s 2007 CAHPS national averages.

Table 3-20—Harmony Adult Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	60.8%	2.081	47.3%
<i>Getting Care Quickly</i>	71.3%	2.217	54.0%
<i>How Well Doctors Communicate</i>	84.9%	2.548	66.8%
<i>Customer Service*</i>	80.5%	2.382	*
<i>Shared Decision Making</i>	67.5%	†	58.4%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	56.3%	2.098	46.6%
<i>Rating of Personal Doctor</i>	66.7%	2.333	60.5%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	59.7%
<i>Rating of Health Plan</i>	55.4%	2.075	52.8%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			
† The Myers Group did not report a three-point mean for the <i>Shared Decision Making</i> composite.			
* Due to changes in the <i>Customer Service</i> composite, a 2007 NCQA CAHPS national average was not calculated for this measure.			

Harmony scored above the 2007 NCQA CAHPS national averages for all seven of the comparable measures. The rates for *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* were greater than the national averages by more than 10 percentage points, representing areas of strength.

### Child Medicaid

Harmony’s 2008 child Medicaid CAHPS top-box percentages and three-point means are presented in Table 3-21, along with NCQA’s 2007 CAHPS national averages.

Table 3-21—Harmony Child Medicaid CAHPS Results			
	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	70.0%	2.545	80.3%
<i>Getting Care Quickly</i>	69.4%	2.219	50.9%
<i>How Well Doctors Communicate</i>	88.4%	2.588	66.3%
<i>Courteous and Helpful Office Staff</i>	88.4%	2.573	67.9%
<i>Customer Service</i>	74.0%	2.684	73.6%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	71.7%	2.377	64.0%
<i>Rating of Personal Doctor</i>	72.2%	2.394	64.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	61.9%
<i>Rating of Health Plan</i>	65.4%	2.219	63.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

**Harmony** scored above the 2007 NCQA CAHPS national averages for seven of the eight comparable CAHPS child measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rates for *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* were greater than the national averages by more than 10 percentage points, representing areas of strength. The rate for the *Getting Needed Care* measure was less than the national average by greater than 10 percentage points, representing an area of opportunity for **Harmony**. Therefore, quality improvement activities should target this area of care.

## Technical Assistance

As requested by the Department, HSAG has continued to provide technical guidance to the MCOs to assist them in conducting the mandatory EQR activities, particularly to establish scientifically sound PIPs.

### ***Illinois Quality Strategy for Managed Care***

HSAG provided technical assistance to the Department in an assessment of the level of compliance of HFS' Quality Strategy with the requirements of 42 CFR 438.202.

The evaluation identified that the Quality Strategy developed by HFS closely follows information in the Centers for Medicare & Medicaid Services (CMS) State Quality Strategy Tool Kit for State Medicaid Agencies (October 2006). The Quality Strategy satisfied the requirements set forth in 42 CFR 438.202. The strategy appeared to be compliant with the CMS tool kit elements, although some additional details and information would further improve compliance. HFS provided a high level of detail regarding federal citations and relevant contract provisions. The strategy has evolved over time based on community concerns and feedback, participant health needs, federal and State law, industry standards, lessons learned, and best practices, and in collaboration with the MCOs to establish objectives, priorities, and achievable timelines.

CMS provided a review to HFS on May 28, 2008, and invited HFS to provide any corrections or new information, and to share any interesting new quality strategies in Illinois that might be useful to other states. On August 13, 2008, HFS provided a response to each question or request. A summary of the State's Quality Strategy objectives and incentives, the CMS review of the strategy, and the HFS response to CMS is included in Section 2 of this report.

### ***Validation of PCCM Performance Measures***

HFS contracted with HSAG to conduct the validation of 16 performance measures for PCCM for SFY 2007–2008. Under a PCCM model, each HFS beneficiary has a medical home with a PCP. HFS beneficiaries may pick their own primary care doctor or clinic as their PCP if that provider is enrolled with HFS as a PCP.

The following summarizes the on-site validation and subsequent findings for the PCCM performance measures. The validation overview describes the validation process and provides findings related to both HEDIS and non-HEDIS performance measures.

### **Validation Overview**

HSAG conducted the PCCM validation in a manner consistent with the *2008 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5*. This validation, however, included performance measures that were non-HEDIS as well as several HEDIS measures

(see Addendum A for a list of the PCCM performance measures). The performance measure validation consisted of two main components:

- ◆ IS capabilities: A detailed assessment of the IS capabilities for collecting, sorting, analyzing, and reporting performance measures.
- ◆ Compliance with technical specifications: A detailed review of the processes used to prepare HEDIS measures and other performance measures. These processes included computer programming and query logic used to access the data and calculate measures, databases and files used to store information, and any manual processes employed in the performance measure data production and reporting.

HSAG used a number of different methods and information sources in conducting the validation, including:

- ◆ Both off- and on-site review of relevant documentation, such as the PCCM's response to the 2008 Information Systems and Capabilities Assessment Tool (ISCAT), and policies and procedures related to enrollment, claims, and information technology.
- ◆ Source code (programming logic) review of each performance measure and the technical specifications.
- ◆ An on-site meeting, which, in addition to document review, included staff interviews, live system and procedure documentation, programming logic review and inspection of dated job logs, and primary source verification.
- ◆ Comparison of reported HEDIS rates to the national Medicaid HEDIS 2007 benchmark rates. This allowed comparison of the reported rates with other Medicaid plans across the country and provided a quick check for reasonableness of the rates for the performance measures.

Table 3-22 below provides a summary of the validation findings, along with the recommended corrective actions.

Table 3-22—Summary of Review Findings	
Finding	Recommended Corrective Action
It was difficult to determine whether some source code was the latest version or not, why changes had been made to the source code, who made the changes, when the changes were made, who validated the source code, and who ensured that the measure technical specifications were correct. This could potentially lead to version control issues, and, ultimately, the wrong set of source code could be used to run the rates.	A formal documentation process should be maintained for each performance measure. In addition, changes to the source code should be documented within the source code.
Anchor dates were not fully understood and, therefore, were not used as intended. This resulted in the inclusion of members in the denominator who were not actually eligible for the measure.	Whenever there is an anchor date for a performance measure the member must be enrolled on that date. Even though most measures tend to allow for a gap in enrollment, this gap can never occur on the anchor date. Therefore, the source code should include logic to account for the anchor date.
Denied claims/encounters may have been captured in the system, but were not used in the measure calculations. Payment does not affect whether or not the member received the service, and the service should, therefore, count, regardless of the payor. Not using these claims may result in lower rates for the PCCM.	Denied claims/encounters for actual services rendered should be included.
The source code showed that members with possible exclusions were removed from the measures regardless of whether or not they had already received the service, or numerator event. For example, a child may receive his or her MMR immunization, then have an allergic reaction. The child becomes contraindicated for <i>future</i> MMR immunizations. The source code removed this child from the measure, but the child should be counted as immunized for MMR.	Potential exclusions should first be examined for the numerator event prior to being excluded. If the member had the service, or numerator event, then he or she should remain in the measure and count favorably for the PCCM rate. If the member had an exclusion and did not receive the service, then he or she should be removed.
Continuous enrollment was evaluated using the calendar year for most measures, regardless of the technical specifications. This could lead to the inclusion of members in the denominator who were not in PCCM when the services should have occurred (e.g., prior to the child’s second birthday for childhood immunizations). This results in lower rates.	For some measures, continuous enrollment is based on a moving anchor date (e.g., the child’s second birthday), rather than the calendar year. As noted for the issue regarding anchor dates, the technical specifications for continuous enrollment should be followed for measures that do not have anchor dates at the end of the year.
The HFS technical specifications for some measures either conflicted with the HEDIS technical specifications for that measure or were unclear and/or missing important information.	A formal documentation process was recommended to determine which specifications should be followed and to properly update the specifications when needed.

Following these validation findings and recommendations, the source code and technical specifications were updated and/or revised, then resubmitted to HSAG for validation. Feedback was provided to HFS to ensure that source code and technical specifications were accurately corrected. As of the date of this report, all 16 performance measures have been approved.

## Performance Tracking Tool (PTT)

In 2008, a PTT was developed for each MCO. The PTT was designed to be used by the MCOs as a mechanism for monitoring and trending the results of each performance measure identified in the tool. In addition, the PTT was a functional tool that included tracking and monitoring of all the activities the MCOs perform during the year. The PTT included:

- ◆ Key timeline dates for reporting requirements.
- ◆ Compliance monitoring activities, including areas for targeted improvement for the MCOs.
- ◆ A simplified process for entering rates for the various activities (e.g., HEDIS, CAHPS, PIPs).
- ◆ Links to automatically trend, graph, determine HEDIS percentile rankings, determine next goals, and calculate incentive payment qualification.
- ◆ PIP summary tables to determine validation status and improvements on individual PIP quality indicators.
- ◆ A Chi-square and *p* value calculator to facilitate the MCOs' ability to determine if changes were statistically significant.

The PTT will facilitate tracking and monitoring of rates and activities, quality improvement efforts, comparisons to benchmarks, setting and achieving goals, and internal and external reporting. The MCOs, as well as HFS and the EQRO, will use the PTT. Specifically, HFS will be able to use the PTT to enhance reporting to CMS and to the State legislature, as well as to enhance other inter-departmental reporting and determine areas that need focused attention (e.g., HFS can use the PTT to develop collaborative PIPs). The PTT may also be expanded to include PCCM, facilitating comparisons between the MCOs and PCCM.

## 4. Plan Comparisons and Recommendations

### Introduction

In this section of the report contains comparisons between the results of two MCOs for four EQR activities (compliance monitoring CAPs, validation of performance measures, validation of PIPs, and assessment of consumer satisfaction surveys). As a result of the comparative analysis, HSAG offers recommendations to facilitate the continued quality and timeliness of, and access to, services available to Illinois Medical Assistance Program beneficiaries.

The methodology used for the comparison of the MCOs' results for each of the EQR activities involved an analysis of the MCOs' overall performance scores as well as the specific standards and/or elements used to assess the MCOs' performance. Common areas for improvement between the MCOs were also identified for each EQR activity by reviewing all previous report findings.

The validity of this type of comparative analysis is possible due to the systematic, methodological approach, including the use of standardized data collection tools by HSAG in conducting the EQR activities.

### Compliance Monitoring—QAP Structure and Operations—2007–2008

HSAG compared the compliance monitoring scores of **FHN** and **Harmony** in 2006 and 2008.

### Comparison of Compliance Monitoring Results

**FHN**'s overall score improved compared to 2006 and **Harmony**'s overall score declined. Scores for each standard are presented in Table 4-1.

**Table 4-1—MCO Comparison of Scores for the Standards—2006 and 2008**

Standard #	Description of Standard	Percentage of Compliant Elements			
		FHN		Harmony	
		2006	2008	2006	2008
I	Quality Assurance Program (QAP)	64	69	100	96
II	Systematic Process of Quality Assessment and Improvement	70	75	77	72
III	QAP Structure	70	80	100	100
IV	Monitoring of Delegated Activities	71	57	93	64
V	Credentialing/Recredentialing	17	74	88	88
VI	Continuity of Care and Case Management	33	0	33	0
VII	Coordination of QAP Activity With Other Management Activities	0	60	80	80
VIII	Medical Records Standards	96	100	74	91
IX	Enrollee Information, Rights, and Protections	78	97	85	85
X	Utilization Management	52	90	95	90
XI	Access and Availability—Service Delivery	89	82	93	96
<b>Overall</b>		<b>64</b>	<b>79</b>	<b>86</b>	<b>83</b>

Overall, **FHN** showed improvement on 8 out of 11 standards, and its score improved from 64 percent in 2006 to 79 percent in 2008. **FHN** demonstrated considerable improvement for the following standards: Credentialing and Recredentialing; Coordination of QAP Activity With Other Management Activities; Enrollee Information, Rights, and Protections; and Utilization Management. Three standards showed a decline compared to 2006. The lowest-performing area of compliance was Continuity of Care and Case Management. Monitoring of Delegated Activities also had a large decline in performance.

**Harmony** demonstrated improvement on 2 out of the 11 standards and remained the same on 4 other standards. Harmony demonstrated a stronger level of compliance with the Medical Records Standards and Access and Availability—Service Delivery. In addition, QAP Structure was an area of strong performance, achieving 100 percent compliance in both 2006 and 2008. The lowest-performing area of compliance was Continuity of Care and Case Management. Monitoring of Delegated Activities also had a large decline in performance. Five standards showed a decline compared to 2006, and the overall compliance score dropped from 86 percent to 83 percent between 2006 and 2008. However, five of the standards received scores of 90 percent or more.

Both MCOs had substantial opportunities to improve compliance with their respective contracts with the State and federal regulations.

HSAG recommends that both MCOs invest attention and resources to effectively implement the activities required by their respective CAPs. Special attention should be focused on the standards for Continuity of Care and Case Management, and Monitoring of Delegated Activities.

## Validation of Performance Measures—HEDIS Compliance Audit— FY 2007–2008

The State contracted with HSAG to conduct HEDIS compliance audits for **FHN** and **Harmony**. Both MCOs received a final audit statement indicating that the selected performance measures for the audit were prepared in accordance with the *HEDIS 2007 Technical Specifications* and presented fairly the MCO’s performance with respect to these specifications. HSAG found that **FHN** and **Harmony** had:

- ◆ Information systems that met HEDIS standards with no significant impact on the reliability of HEDIS reporting.
- ◆ Valid MRR processes.
- ◆ Performance measures (for those included in the audit) that followed HEDIS specifications and provided a reportable rate for the measure.

This section of the report compares the performance measure results for **FHN** and **Harmony** based on the HEDIS 2008 measures listed in Table 4-2. The measures have been grouped into related categories for discussion purposes.

Category	HEDIS 2007 Measure
Child and Adolescent Care	<i>Childhood Immunization Status (Combinations 2 and 3)</i>
	<i>Lead Screening in Children</i>
	<i>Appropriate Treatment in Children With URI</i>
	<i>Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)</i>
	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
	<i>Adolescent Well-care Visits</i>
Access to Care	<i>Children and Adolescents’ Access to Primary Care Practitioners</i>
	<i>Adults’ Access to Preventative/Ambulatory Care</i>
Maternity-Related Care	<i>Frequency of Ongoing Prenatal Care (0–21 percent and 81–100 percent of Visits)</i>
	<i>Timeliness of Prenatal Care</i>
	<i>Postpartum Care</i>
Preventative Screening for Women	<i>Breast Cancer Screening</i>
	<i>Cervical Cancer Screening</i>
	<i>Chlamydia Screening in Women (Combined Rate)</i>
Chronic Conditions/Disease Management	<i>Controlling High Blood Pressure (Combined Rate)</i>
	<i>Comprehensive Diabetes Care</i>
	<i>Use of Appropriate Medications for People With Asthma (Combined Rate)</i>
	<i>Follow-up After Hospitalization for Mental Illness (7 Days and 30 Days)</i>

### Child and Adolescent Care

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

### Childhood Immunization Status

Figure 4-1 displays comparative rates for *Childhood Immunizations—Combination 2* (i.e., diphtheria, tetanus toxoids, and acellular pertussis/diphtheria-tetanus toxoid [DTaP/DT]; inactivated poliovirus vaccine [IPV]; measles-mumps-rubella [MMR]; Haemophilus influenzae type b [HIB]; hepatitis B [Hep B]; and varicella-zoster virus [VZV]) for the past four years.

Overall, **FHN** gained 21.7 percentage points since 2005 for an average increase of 7.2 percentage points each year. However, **FHN** had a 3.5 percentage-point decline this year. The rate for **Harmony** has increased 4.3 percentage points between 2005 and 2008, with an average increase of 1.4 percentage points per year. **Harmony**'s rate declined this year by 4.8 percentage points.

**Figure 4-1—Comparison of HFS MCO Performance for Childhood Immunizations—Combination 2**

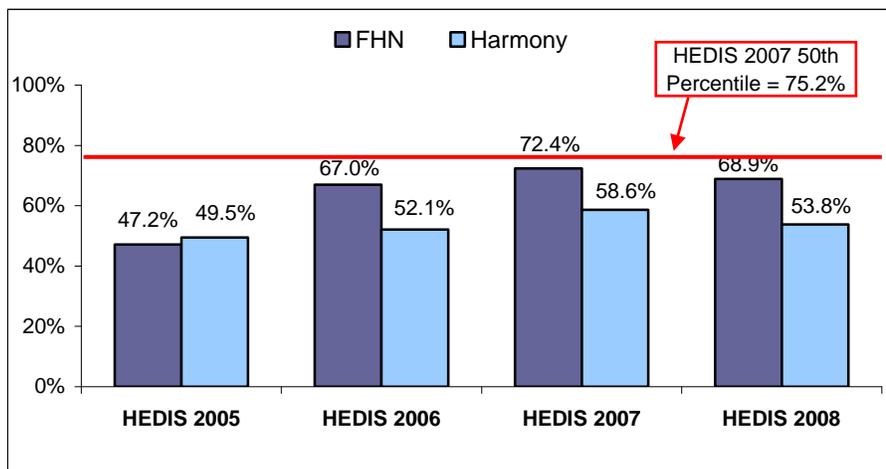
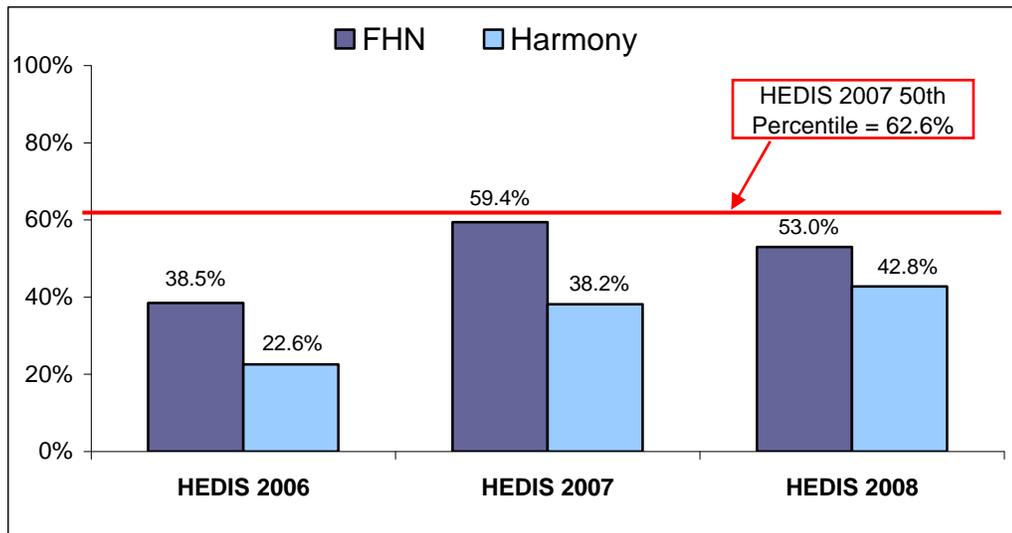


Figure 4-2 displays comparative rates for *Childhood Immunizations—Combination 3* (i.e., DTaP/DT, IPV, MMR, Hib, Hep B, VZV, and pneumococcal conjugate vaccine [PCV]). This measure was new for HEDIS 2006, so comparisons were limited to three years.

FHN’s rate declined 6.4 percentage points this year, but remained 14.5 percentage points higher than the baseline rate. Harmony’s rate has continued to improve for this measure each year, gaining 20.2 percentage points since HEDIS 2006. The rate for Harmony was still more than 10 percentage points below FHN’s rate, though the gap between the two rates was closing.

**Figure 4-2—Comparison of HFS MCO Performance for Childhood Immunizations—Combination 3**

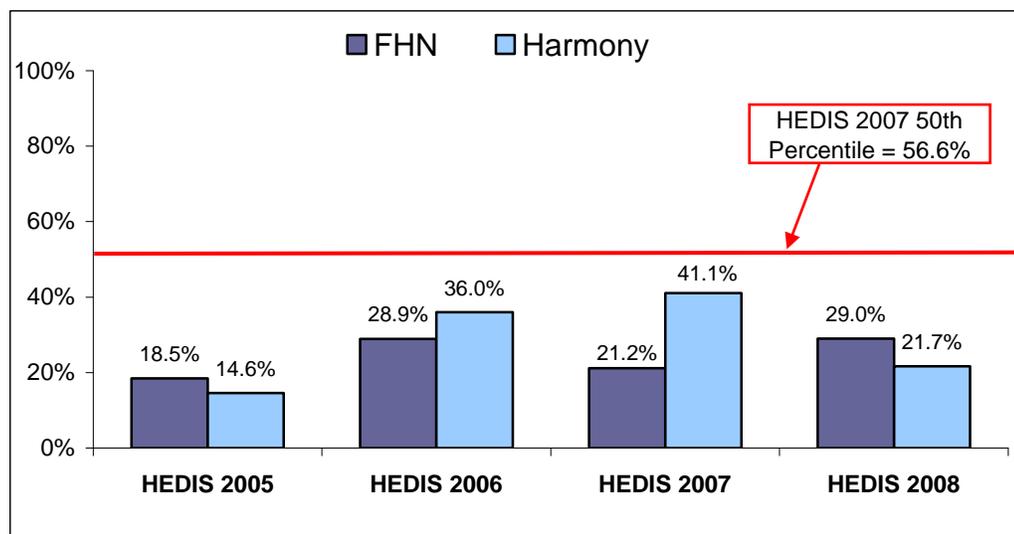


### Well-Child Visits in the First 15 Months of Life

Figure 4-3 presents the comparative performance of the MCOs for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*. Neither MCO achieved a rate above the national HEDIS 2007 Medicaid 50th percentile of 56.6 percent.

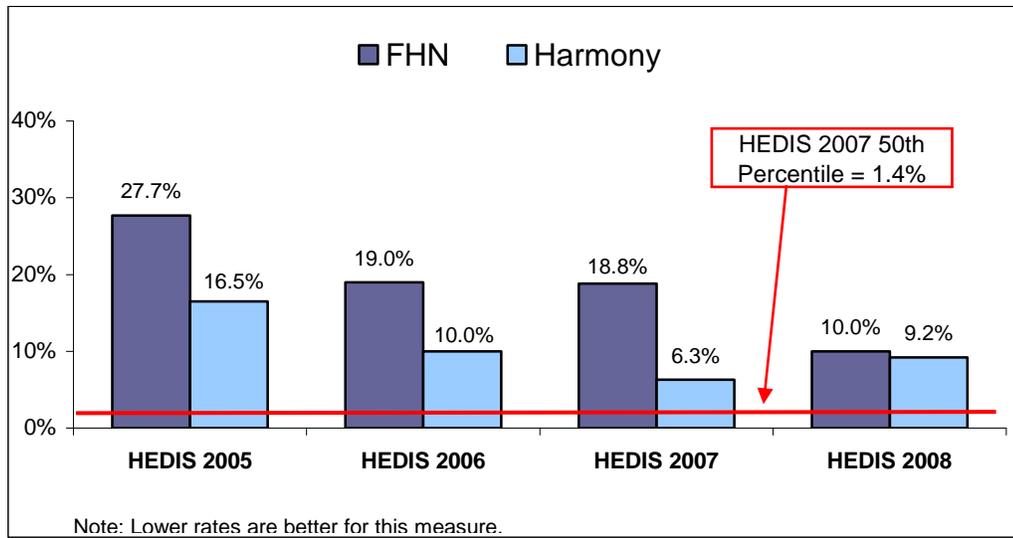
The rate for **FHN** improved by 7.8 percentage points this year, after reporting a decline last year. **Harmony**'s rate declined by 19.4 percentage points this year. **Harmony** indicated the decline was due to a data issue related to the inability to identify the provider type. Given the HEDIS reporting time constraints, **Harmony** chose to exclude specific encounter data for well-child visits with an unknown provider type, resulting in significantly lower rates. Regardless, both **FHN** and **Harmony** continue to report low rates for this measure. Both MCOs should conduct a barrier analysis to determine appropriate methods to improve these rates. The State should also consider CAPs for low performance on these cornerstone measures.

**Figure 4-3—Comparison of HFS MCO Performance for Well-Child Visits During the First 15 Months of Life—Six or More Visits**



For the *Zero Visits* measure, lower rates indicate better performance. **FHN** has continued to improve on this measure, and this year the gap between the rates for **FHN** and **Harmony** was less than 1 percentage point. Nevertheless, this measure indicated that approximately 10 percent of children 15 months of age in the two MCOs did not see their provider for a well-child visit.

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

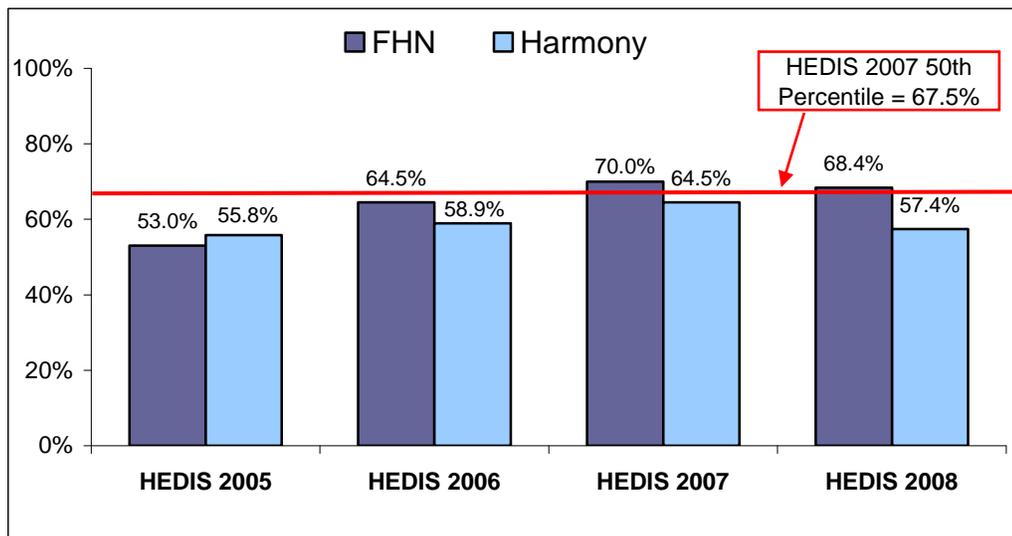


Considering the two measures for *Well-Child Visits in the First 15 Months of Life* together, **FHN** demonstrated improvement by increasing the rate of children who received six or more visits while decreasing the percentage of children who did not receive a well-child visit. However, both MCOs need to increase efforts to improve this measure.

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

Figure 4-5 presents the comparative rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*. Although the rate for **FHN** has decreased by 1.6 percentage points this year, the rate has improved each year, and **FHN**'s current rate is above the national HEDIS 2007 Medicaid 50th percentile. The rate for **Harmony** decreased 7.1 percentage points this year, which was 1.6 percentage points higher than the rate in 2005.

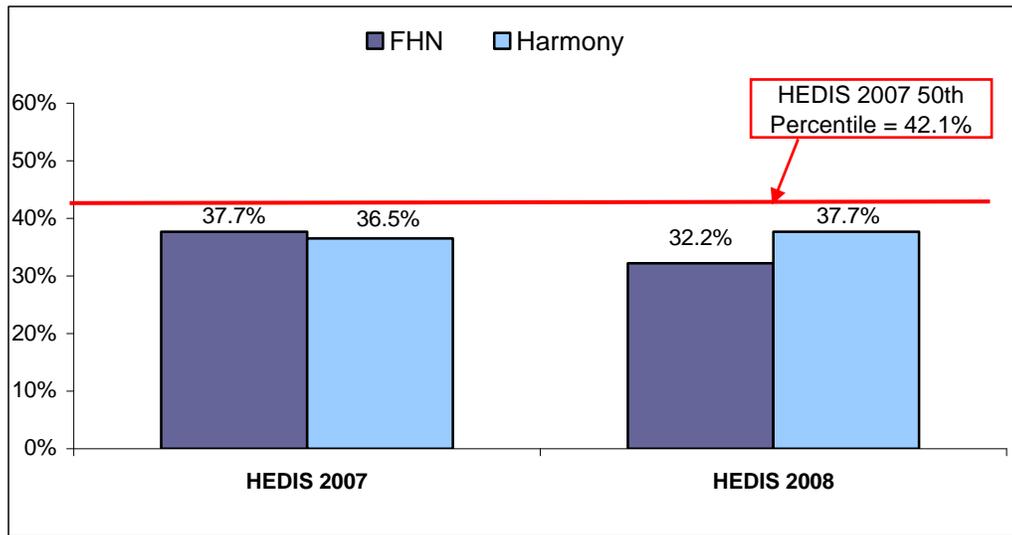
**Figure 4-5—Comparison of HFS MCO Performance for Well-Child Visits During the Third, Fourth, Fifth, and Sixth Year of Life**



**Adolescent Well-care Visits**

Figure 4-6 presents the comparative rates for *Adolescent Well-care Visits*. Although **FHN** and **Harmony** internally calculate this HEDIS measure each year, the MCOs did not publicly report this rate until HEDIS 2007. **FHN**'s rate this year declined 5.5 percentage points over last year, while **Harmony**'s rate increased 1.2 percentage points. Both MCOs reported rates below the national Medicaid HEDIS 2007 50th percentile of 42.1 percent.

**Figure 4-6—Comparison of HFS MCO Performance for Adolescent Well-care Visits**



**Adults' Access to Preventative/Ambulatory Care**

Figure 4-7 presents the comparative rates for *Adults' Access to Preventative/Ambulatory Care (Ages 20–44)*. The MCOs first reported this measure for HEDIS 2007. Rates for both MCOs declined this year and remained well below the national Medicaid 50th percentile.

**Figure 4-7—Comparison of HFS MCO Performance for Adults' Access to Preventative/Ambulatory Care (Ages 20–44)**

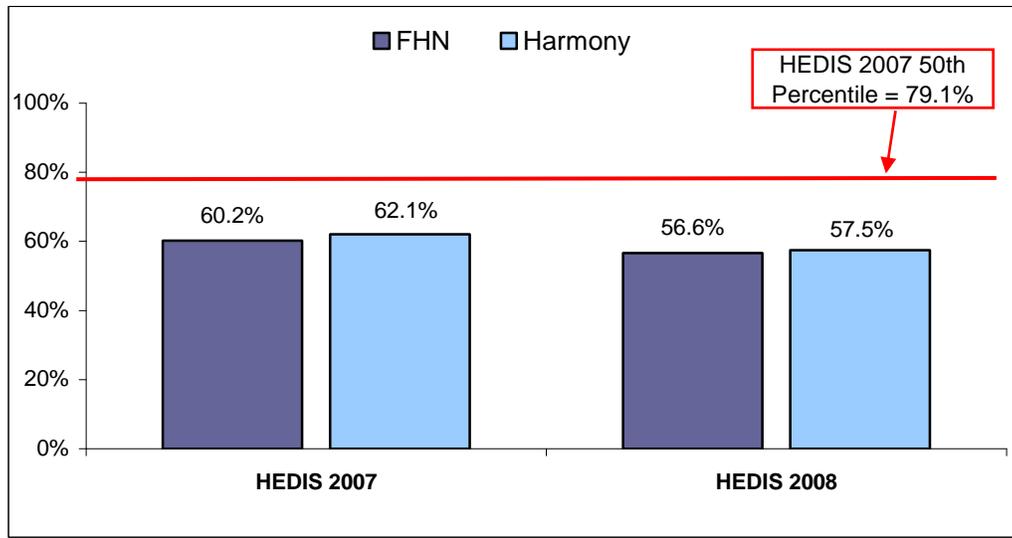
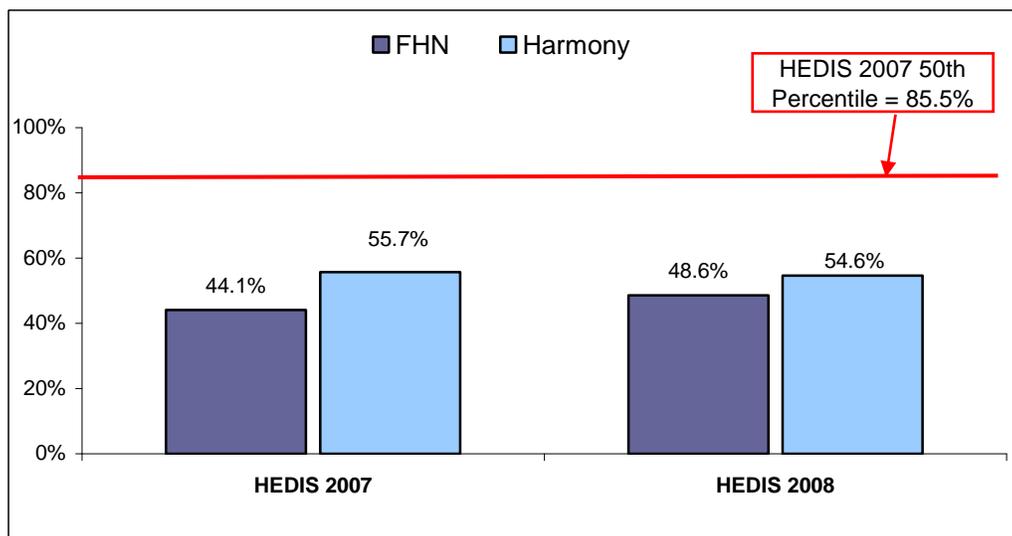


Figure 4-8 presents the comparative rates for *Adults' Access to Preventative/Ambulatory Care (Ages 45–64)*. The rates for **FHN** and **Harmony** differed by 6.0 percentage points this year, compared to 11.6 percentage points last year. Both MCOs reported rates well below the national Medicaid HEDIS 2007 50th percentile of 85.5 percent.

**Figure 4-8—Comparison of HFS MCO Performance for Adults' Access to Preventative/Ambulatory Care (Ages 45–64)**



The low rates for these two measures of *Adults' Access to Preventative/Ambulatory Care* indicated that both **FHN** and **Harmony** need to improve access to care. Although a portion of this low rate may be attributed to member noncompliance, there may also be internal factors that need to be addressed, such as provider noncompliance and access-to-care barriers. Similar results can be found in other rates that are dependent on access to care, such as the maternity-related measures and preventive screenings for women. The adult Medicaid CAHPS indicated members were relatively satisfied with *Getting Needed Care*; however, since this is a voluntary program and participants who are not satisfied may disenroll, member satisfaction is expected to be higher. Both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers, and evaluate internal policies regarding member and provider education.

### Preventive Screenings for Women

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

#### Breast Cancer Screening

Figure 4-9 compares the *Breast Cancer Screening* rates for women 42–51 years of age and enrolled in **FHN** or **Harmony**. The MCOs first reported rates for this age group for HEDIS 2007. Last year, the rates were nearly identical at 25.0 for **FHN** and 25.8 percent for **Harmony**. This year, **FHN**'s rate improved by 3.3 percentage points while **Harmony**'s rate increased by 8.5 percentage points. Although both MCOs demonstrated some improvement, the rates for both were well below the national Medicaid 50th percentile of 45.6 percent.

**Figure 4-9—Comparison of HFS MCO Performance for Breast Cancer Screening (42–51 Years of Age)**

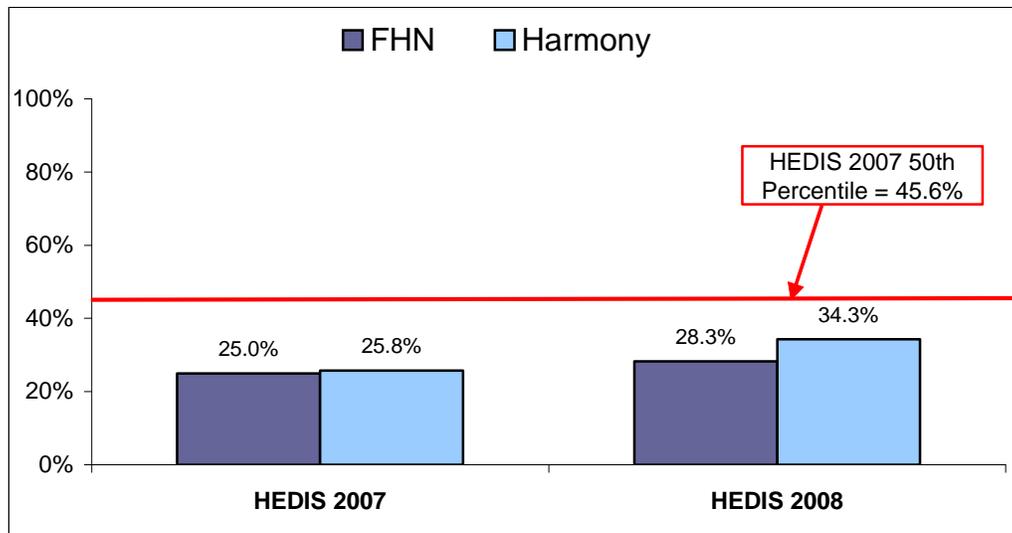


Figure 4-10 compares *Breast Cancer Screening* for women 52–69 years of age for **FHN** and **Harmony**. Except for HEDIS 2007, **FHN** had fewer than 30 members in its population eligible for this measure each year. Therefore, NA was reported. This year, the rate for **Harmony** decreased 6.1 percentage points.

**Figure 4-10—Comparison of HFS MCO Performance for Breast Cancer Screening (52–69 Years of Age)**

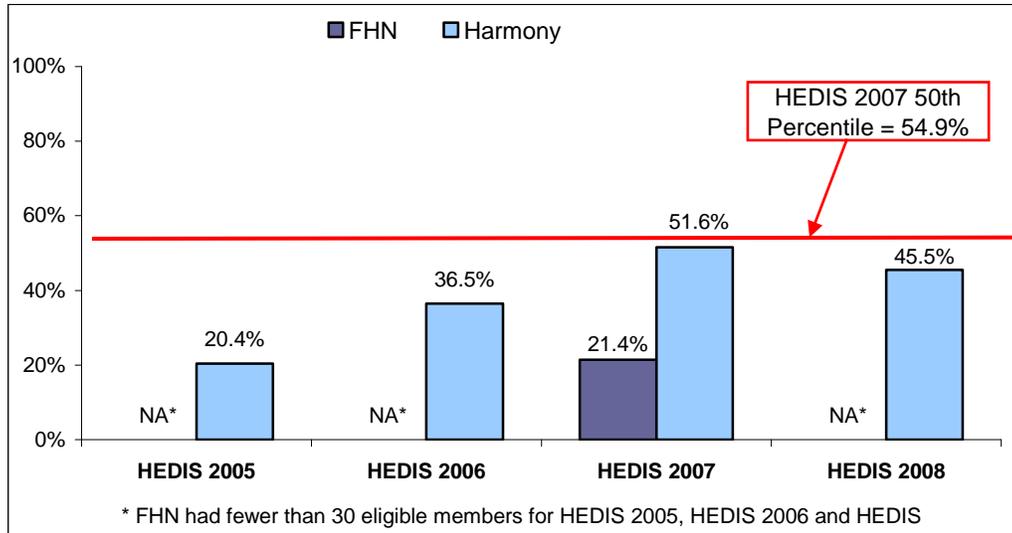
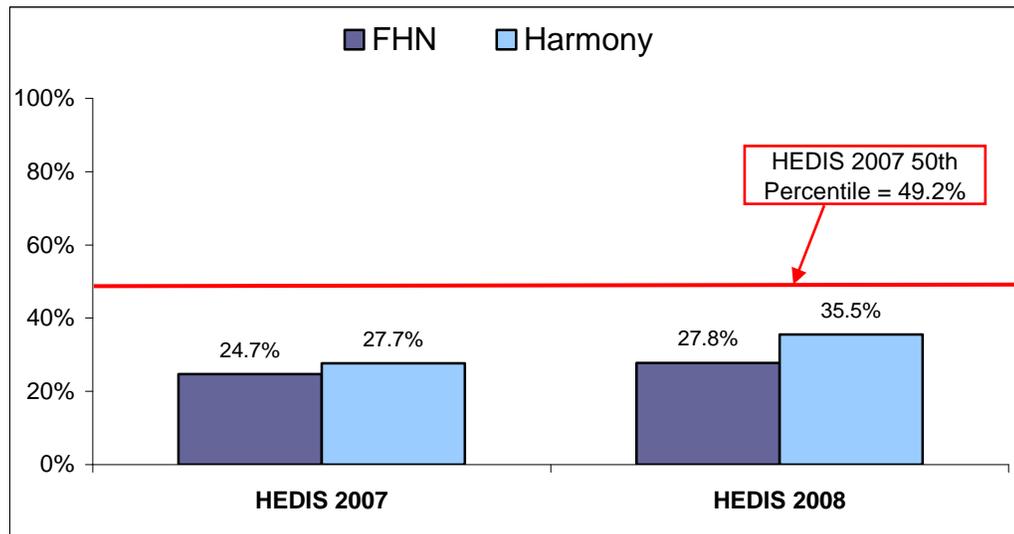


Figure 4-11 compares the combined rate for the *Breast Cancer Screening* for **FHN** and **Harmony**. Overall, the rates for **FHN** improved by 3.1 percentage points while **Harmony**'s rate improved by 7.8 percentage points.

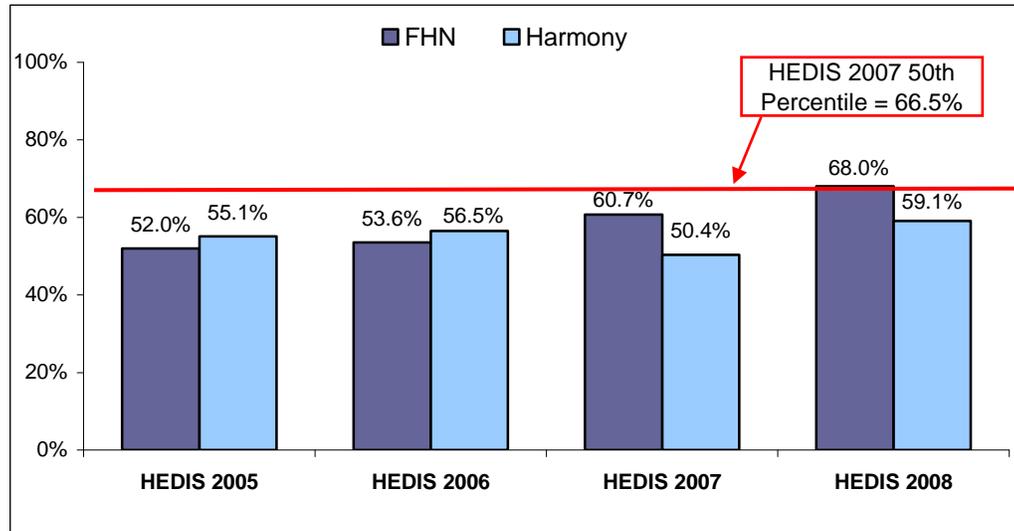
**Figure 4-11—Comparison of HFS MCO Performance for Breast Cancer Screening (Combined Rate)**



**Cervical Cancer Screening**

The rates for *Cervical Cancer Screening* are displayed in Figure 4-12. **FHN**'s rates have steadily improved, exceeding the national Medicaid 50th percentile of 66.5 percent for this measure. **Harmony**'s rate rebounded after a decline last year, increasing by 8.7 percentage points over last year.

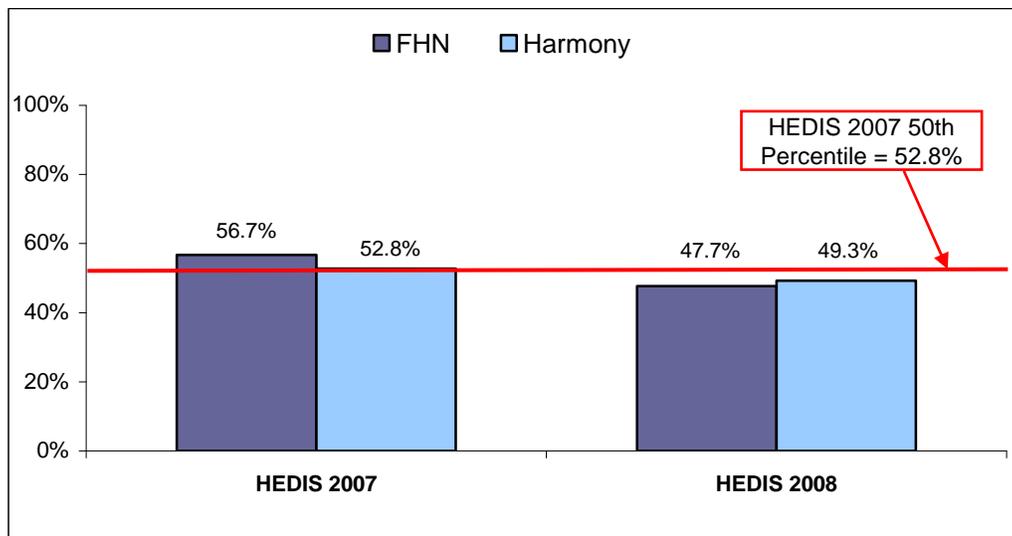
**Figure 4-12—Comparison of HFS MCO Performance for Cervical Cancer Screening**



*Chlamydia Screening in Women*

Figure 4-13 presents the comparative rates for *Chlamydia Screening in Women*. The MCOs first reported this measure for HEDIS 2007. The rates for **FHN** and **Harmony** differed by just 3.9 percentage points in 2007, and both MCOs reported rates above the national Medicaid HEDIS 2006 50th percentile of 51.2 percent. Although the MCOs' rates were still close this year, the rates for **FHN** and **Harmony** declined. Meanwhile, national Medicaid rates have continued to improve, increasing the Medicaid HEDIS 2007 national 50th percentile. Rates for both MCOs this year were below the national Medicaid HEDIS 2007 50th percentile of 52.8 percent.

**Figure 4-13—Comparison of HFS MCO Performance for Chlamydia Screening in Women (Combined Rate)**



## Maternity-Related Care

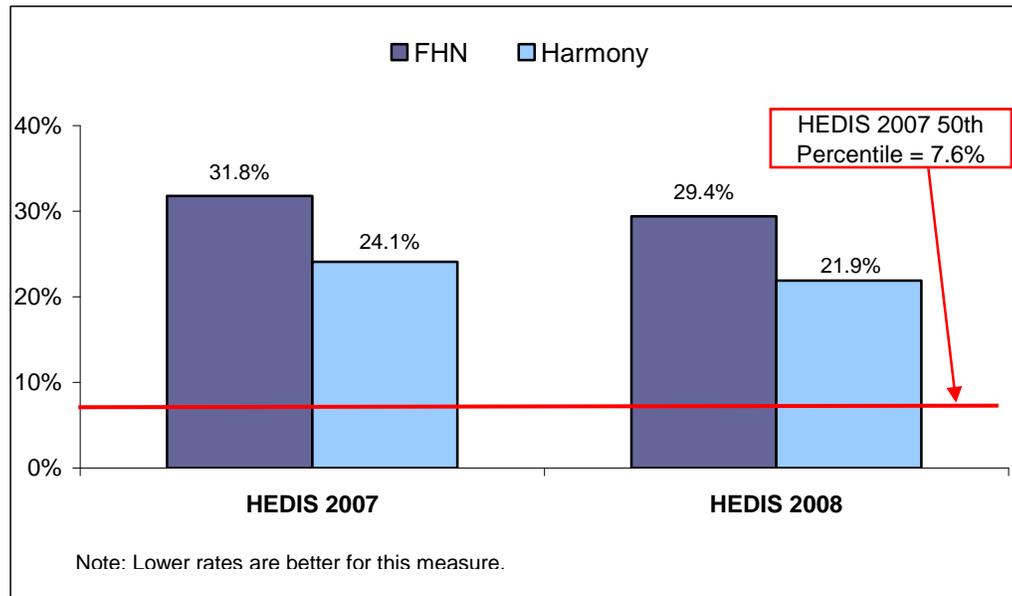
This section addresses HEDIS measures related to maternity care. The HEDIS measures were *Frequency of Ongoing Prenatal Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*.

### Frequency of Ongoing Prenatal Care

Figure 4-14 presents the comparative rates for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)*. The MCOs first reported this measure for HEDIS 2007.

Lower rates are better for this measure since this measure evaluates the percentage of women who received 0–21 percent of their total recommended prenatal care visits. Both MCOs reported rates above the national Medicaid HEDIS 2007 50th percentile of 7.6 percent. **FHN**'s rate improved by 2.4 percentage points and **Harmony**'s rate improved by 2.2 percentage points over last year.

**Figure 4-14—Comparison of HFS MCO Performance For Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)**

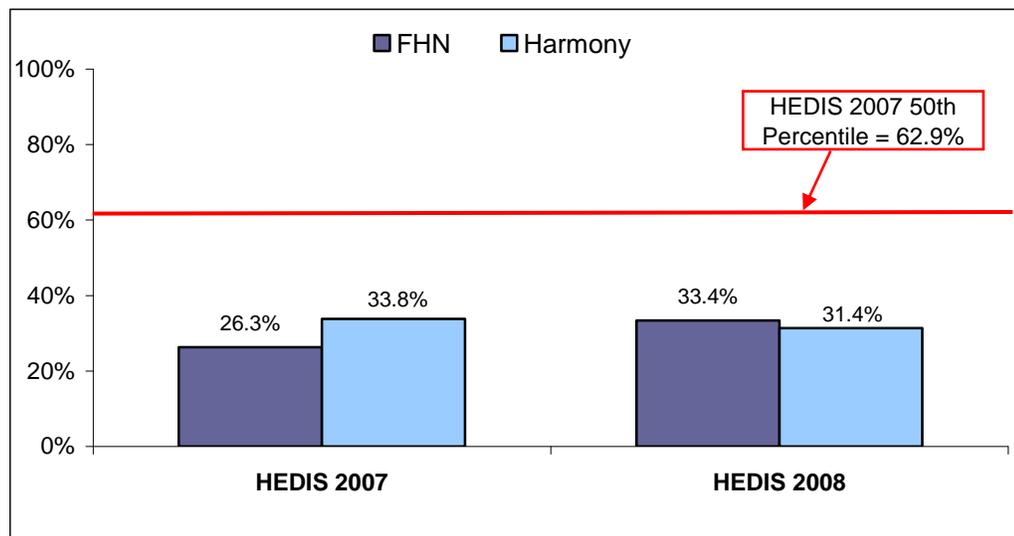


The relatively high rates for this measure represent an area of concern. There were several potential issues: the encounter data may have been incomplete, the MCO may have had difficulty identifying pregnant members, there may have been an issue with access to OB/GYNs, there may have been an issue with member compliance, or there may have been a combination of these factors. Both MCOs should explore this issue to determine the reason for low compliance and develop interventions to improve this rate.

Figure 4-15 presents the comparative rates for *Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)*. The MCOs first reported this measure for HEDIS 2007. In contrast to the previous measure (0–21 percent of visits), higher rates are better for this measure.

Although the rates for **FHN** and **Harmony** differed by just 2.0 percentage points, **FHN**'s rate increased by 7.1 percentage points, while **Harmony**'s rate declined by 2.4 percentage points this year. The rates for both were still well below the national Medicaid HEDIS 2007 50th percentile of 62.9 percent.

**Figure 4-15—Comparison of HFS MCO Performance  
For Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)**



*Timeliness of Prenatal Care*

Figure 4-16 presents the comparative performance of the HFS MCOs for *Timeliness of Prenatal Care*. Although **FHN** has shown some progress since 2005, its rate declined slightly this year. **Harmony**'s rate has improved by 1 percentage point since 2005. **Harmony**'s rate improved slightly this year, after declining slightly last year. Both MCOs were well below the national HEDIS 2007 Medicaid 50th percentile of 84.2 percent. Both MCOs were also below the national 10th percentile of 70.3 percent for the fourth consecutive year.

**Figure 4-16—Comparison of HFS MCO Performance for *Timeliness of Prenatal Care***

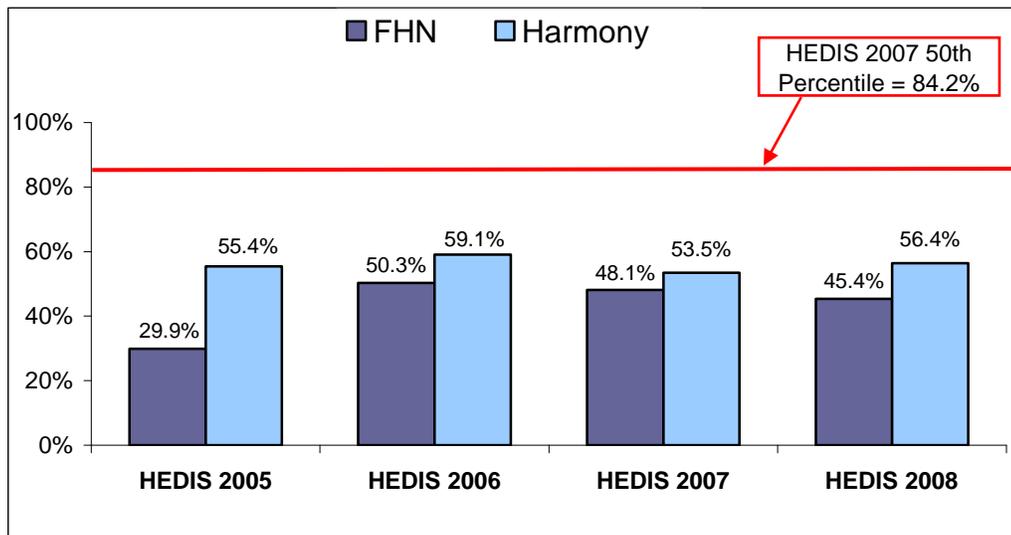
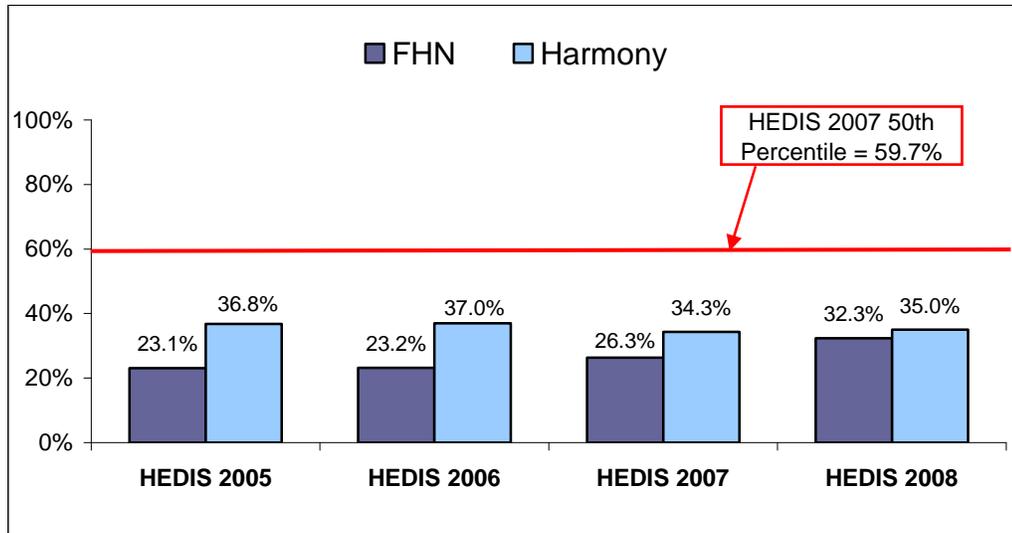


Figure 4-17 presents the comparative performance of the HFS MCOs for *Postpartum Care*. **FHN**'s rate increased by 6.0 percentage points over last year's rate, while **Harmony**'s rate increased by less than 1 percentage point. Overall, **FHN**'s rate has improved 9.2 percentage points since 2005 while **Harmony**'s rate was 3.8 percentage points below the baseline rate. Both MCOs were well below the national HEDIS 2007 Medicaid 50th percentile of 59.7 percent. Both MCOs were also below the national 10th percentile rate of 47.4 for the fourth consecutive year.

**Figure 4-17—Comparison of HFS MCO Performance for *Postpartum Care***



To improve these maternity-related measures, the State and the MCOs began a collaborative perinatal depression screening PIP in 2006–2007. All of these maternity-related measures were included as part of the PIP, as well as several non-HEDIS measures addressing depression and follow-up (for positive depression screening) for these women. The first remeasurement period for the PIP occurred this year. The interventions **FHN** and **Harmony** have implemented are expected to result in higher rates for these HEDIS measures for HEDIS 2009, when interventions will have had more time to impact rates. Nevertheless, given these low rates, both **FHN** and **Harmony** should conduct a barrier analysis to determine why these rates are low and how they can be improved.

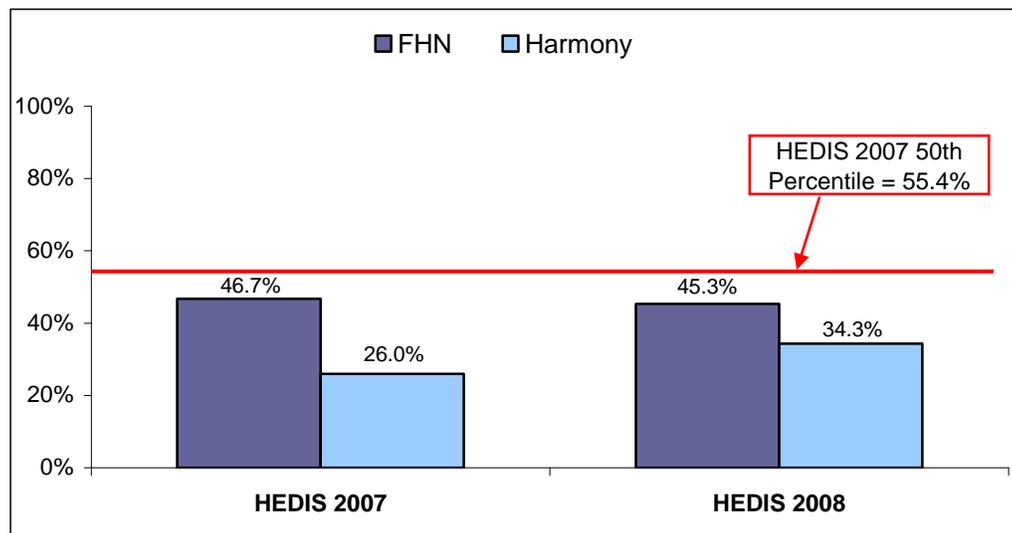
### Chronic Conditions/Disease Management

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

#### Controlling High Blood Pressure

Figure 4-18 presents the comparative rates for *Controlling High Blood Pressure*. The MCOs first reported this measure for HEDIS 2007. **FHN**'s rate was higher than **Harmony**'s rate by 11.0 percentage points. However, the rate for **FHN** declined 1.4 percentage points this year while **Harmony**'s rate increased 8.3 percentage points. Neither MCO had a rate above the national Medicaid HEDIS 2007 50th percentile of 55.4 percent.

**Figure 4-18—Comparison of HFS MCO Performance for Controlling High Blood Pressure (Combined Rate)**



**Comprehensive Diabetes Care**

Figure 4-19 through Figure 4-26 show comparisons for the performance measures under *Comprehensive Diabetes Care*. The performance measures were *HbA1c Testing*, *Poor HbA1c Control*, *Eye Exam*, *LDL-C Screening*, *LDL-C Level <100 mg/dL*, *Monitoring for Diabetic Nephropathy*, *Blood Pressure <140/90*, and *Blood Pressure < 130/80*.

Figure 4-19 presents the comparative rates for *Comprehensive Diabetes Care—HbA1c Testing*. Neither MCO had a rate above the national Medicaid HEDIS 2007 50th percentile of 79.3 percent. **FHN**'s rates have consistently improved, gaining 35.2 percentage points with this measure since HEDIS 2005. Although **Harmony**'s rate declined 4.9 percentage points from last year, the MCO's performance has made gains each year, improving 9.4 percentage points since HEDIS 2005.

**Figure 4-19—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—HbA1c Testing**

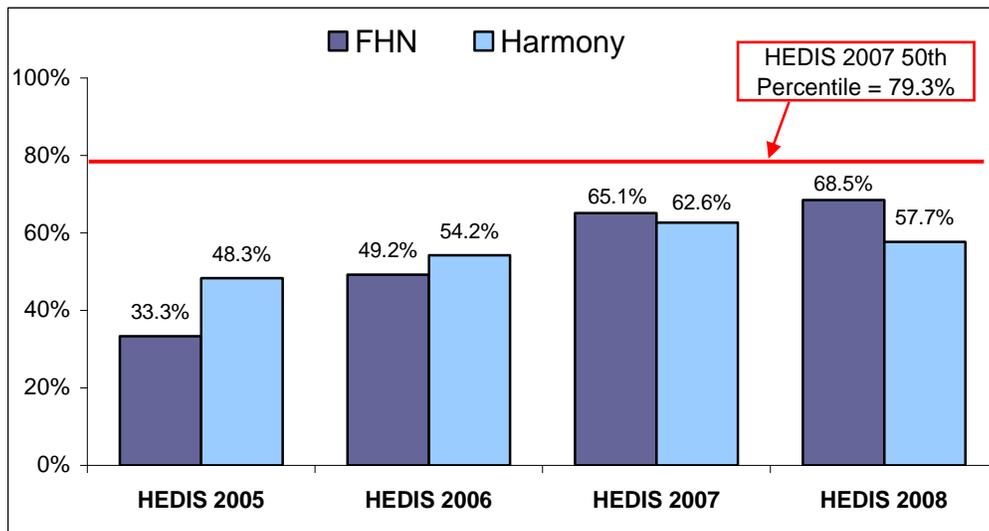


Figure 4-20 presents the comparative rates for *Comprehensive Diabetes Care—Good HbA1c Control*. The MCOs first reported this measure for HEDIS 2007. The rate for **FHN** increased by 2.4 percentage points while **Harmony**'s rate improved by 6.8 percentage points. Both rates were below the national Medicaid HEDIS 2007 50th percentile of 31.3 percent.

**Figure 4-20—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—Good HbA1c Control**

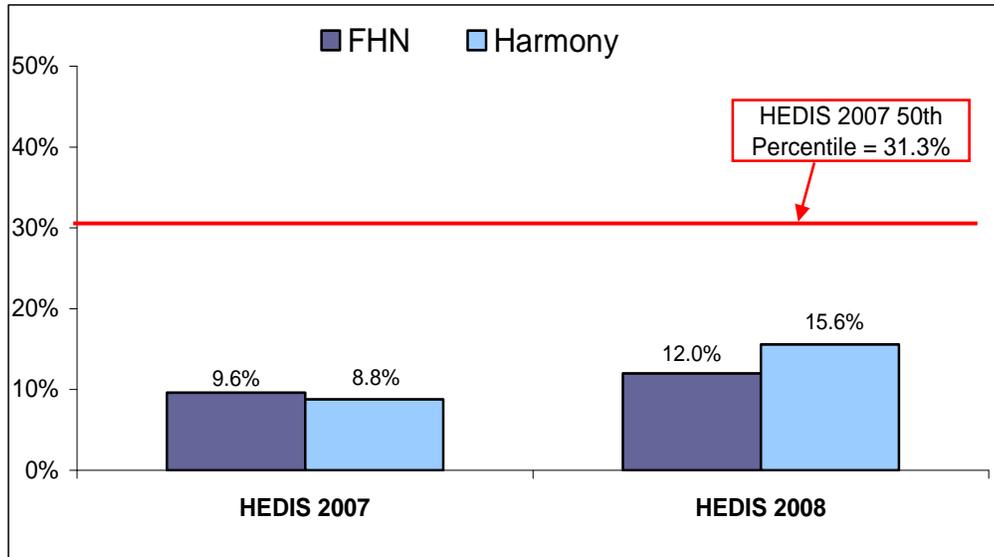


Figure 4-21 presents the comparative rates for *Comprehensive Diabetes Care—Poor HbA1c Control*. Lower rates are better for this measure since this measure evaluates the percentage of members who were in poor control of their diabetes. **FHN** decreased its percentage of members in poor HbA1c control, which correlated well with the improvement in its HbA1c testing rate. The rate for **FHN** decreased by 23.5 percentage points since 2005. **Harmony** has also demonstrated improvement with this measure, decreasing its rate by 17.3 percentage points since HEDIS 2005.

**Figure 4-21—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—Poor HbA1c Control**

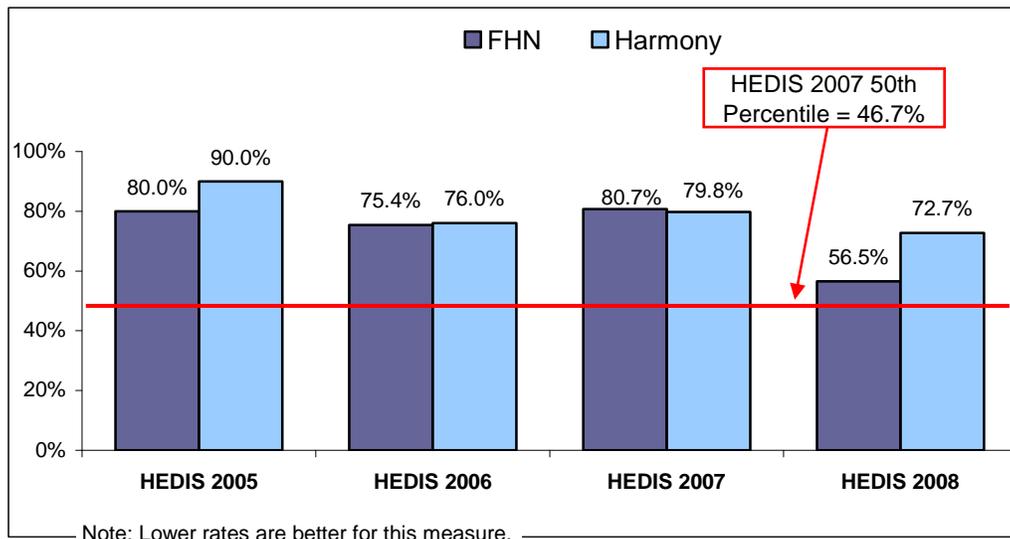


Figure 4-22 presents the comparative rates for *Comprehensive Diabetes Care—Eye Exam*. FHN’s rate declined 2.5 percentage points from last year, but has improved since HEDIS 2005. The rate for **Harmony** declined to levels below its baseline rate in 2005. Both MCOs had rates well below the national Medicaid HEDIS 2007 50th percentile of 53.6 percent.

**Figure 4-22—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—Eye Exam**

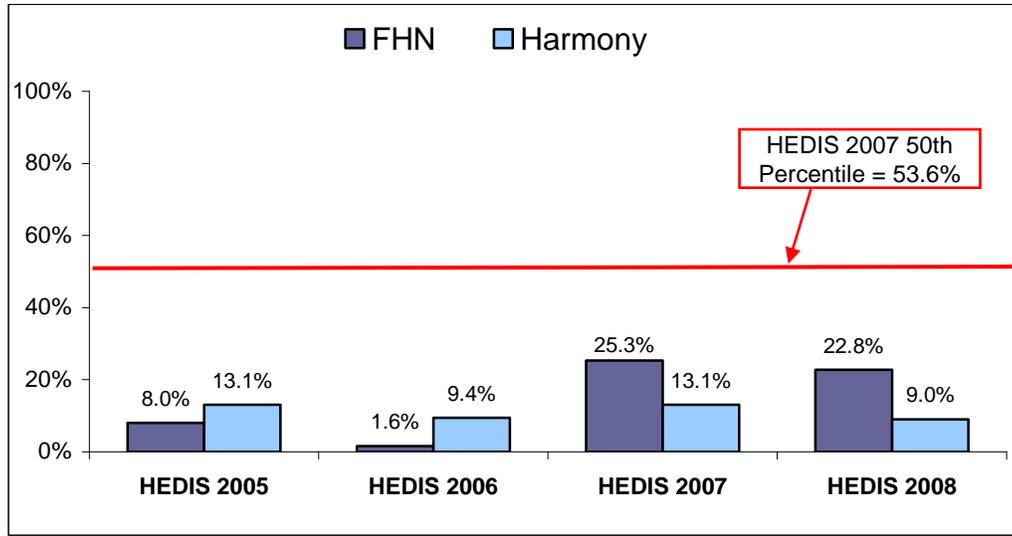


Figure 4-23 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Screening*. **FHN**'s rate has continued to improve each year and has improved significantly (33.8 percentage points) since HEDIS 2005. **Harmony**'s rate has declined each year and was 8.3 percentage points lower than 2005. Both MCOs had rates well below the national Medicaid HEDIS 2007 50th percentile of 72.8 percent.

**Figure 4-23—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—LDL-C Screening**

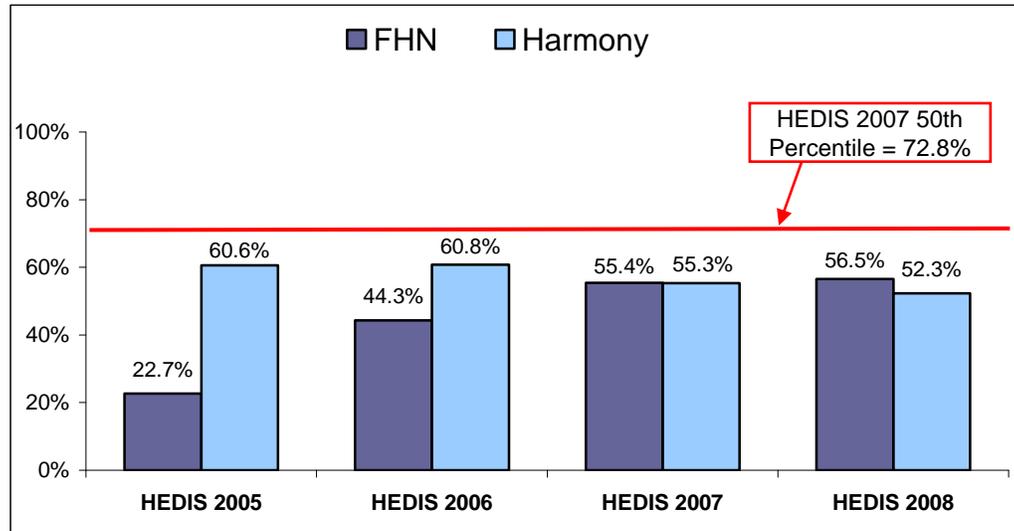


Figure 4-24 presents the comparative rates for *Comprehensive Diabetes Care—LDL-C Level <100mg/DL*. Neither **FHN** nor **Harmony** has demonstrated significant improvement in this measure since HEDIS 2005. Both MCOs had rates well below the national Medicaid HEDIS 2007 50th percentile of 31.3 percent.

**Figure 4-24—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—LDL-C Level <100mg/DL**

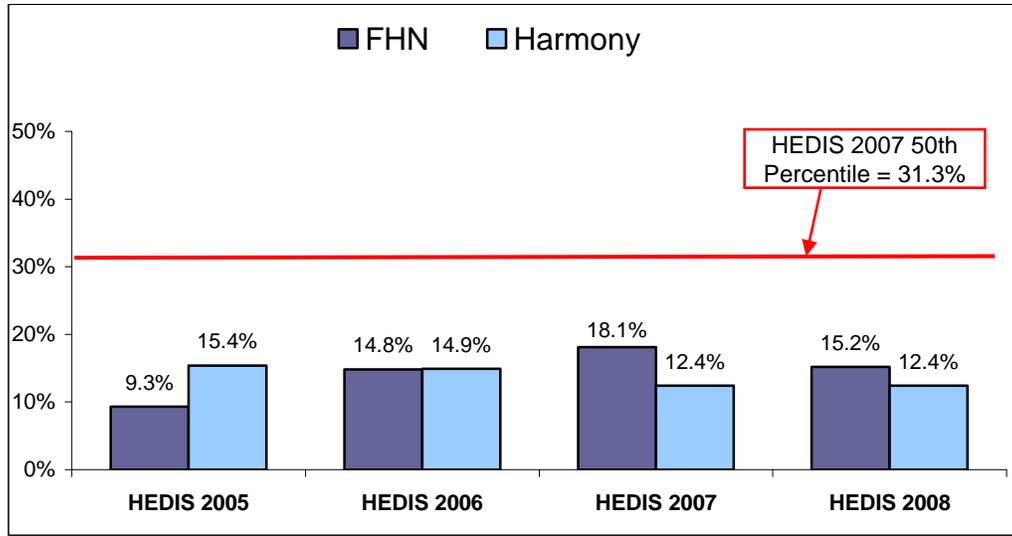


Figure 4-25 presents the comparative rates for *Comprehensive Diabetes Care—Monitoring for Nephropathy*. The HEDIS technical specifications for this measure changed for HEDIS 2007; therefore, the HEDIS 2007 rates are not comparable to HEDIS 2006. Rates for both MCOs declined this year. The decline in **FHN**'s rate of 13.5 percentage points was significant.

**Figure 4-25—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—Monitoring for Nephropathy**

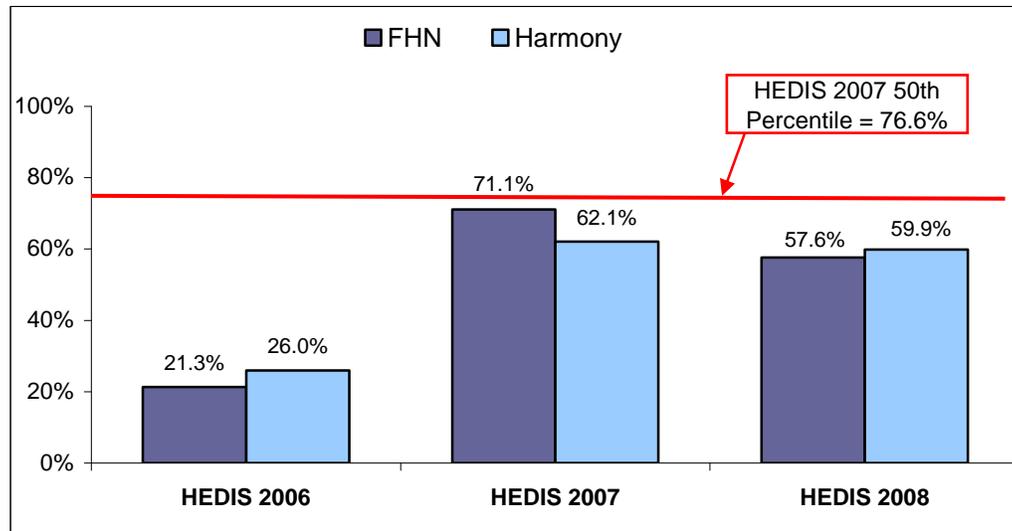


Figure 4-26 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure (Less than 140/90 and 130/80)*. The MCOs first reported these two measures for HEDIS 2007. While **FHN**'s rate declined 4.3 percentage points this year, **Harmony**'s rate improved by 13.6 percentage points.

**Figure 4-26—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—Blood Pressure <140/90**

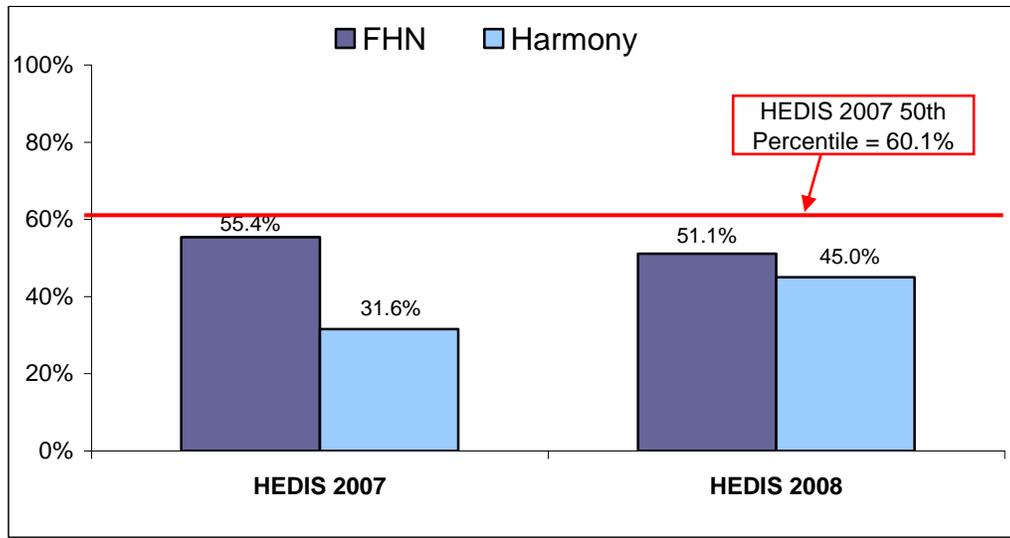
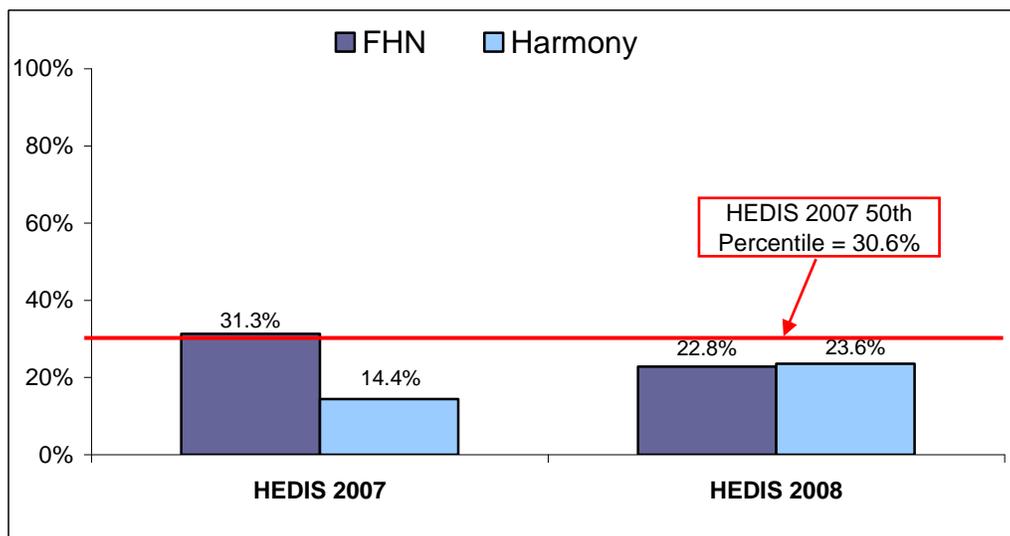


Figure 4-27 presents the comparative rates for *Comprehensive Diabetes Care—Blood Pressure <130/80*. The rate for **FHN** declined 8.5 percentage points and fell below the national Medicaid HEDIS 2007 50th percentile of 30.6 percent. The rate for **Harmony** improved 9.2 percentage points and now exceeds **FHN**'s rate.

**Figure 4-27—Comparison of HFS MCO Performance for Comprehensive Diabetes Care—Blood Pressure <130/80**

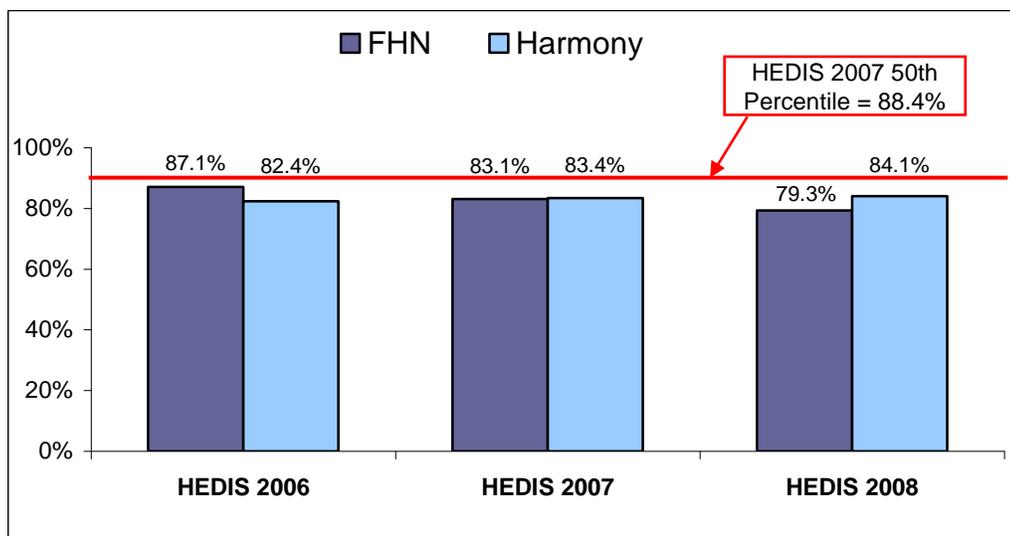


*Use of Appropriate Medications for People With Asthma*

Figure 4-28 presents the comparative performance of **FHN** and **Harmony** for *Use of Appropriate Medications for People With Asthma (Combined)*. The HEDIS technical specifications changed for this measure beginning with HEDIS 2006, so trending was limited to three years.

**FHN** has reported a slight but steady decline in this rate, from 87.1 percent for HEDIS 2006 to 79.3 percent for HEDIS 2008. In contrast, **Harmony** has shown a slight but steady increase in its rate for the past two years. **Harmony**'s rate is now 4.8 percentage points higher than **FHN**'s rate, after starting 4.7 percentage points below **FHN** for HEDIS 2006.

**Figure 4-28—Comparison of HFS MCO Performance for Use of Appropriate Medications for People With Asthma (Combined)**

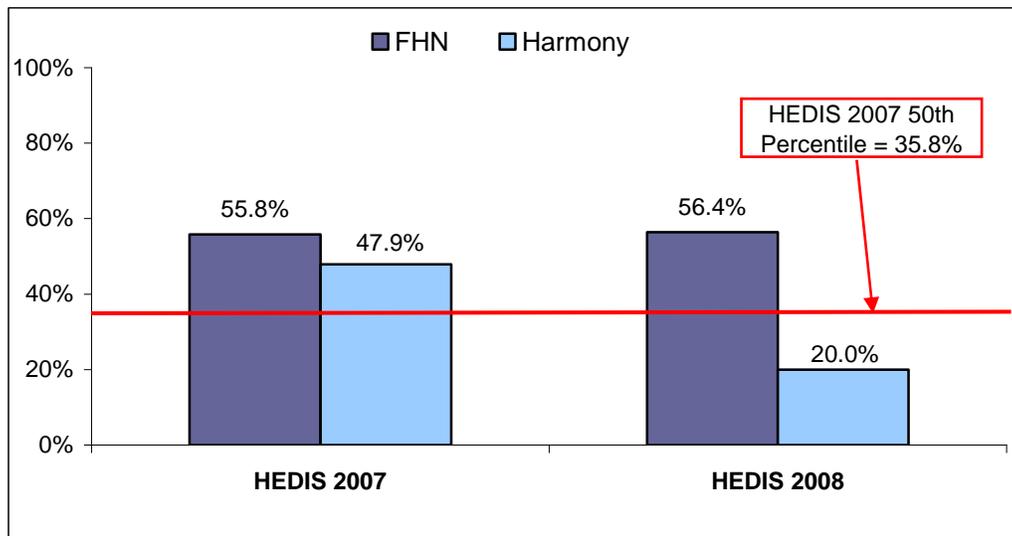


***Follow-up After Hospitalization for Mental Illness***

Figure 4-29 and Figure 4-30 below present the comparative rates for *Follow-up After Hospitalization for Mental Illness (7 Days and 30 Days)*. The MCOs first reported these measures for HEDIS 2007.

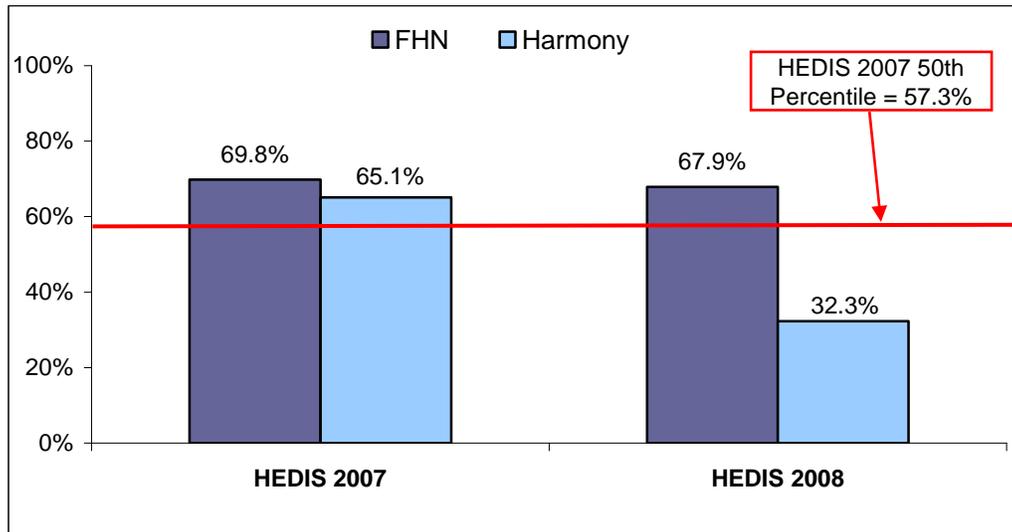
**FHN**'s rate of 56.4 percent was above the national Medicaid HEDIS 2007 50th percentile of 35.8 percent, and was close to the 75th percentile of 58.0 percent (see Appendix B). Harmony's rate declined significantly this year by 27.9 percentage points, falling from 47.9 percent to 20.0 percent.

**Figure 4-29—Comparison of HFS MCO Performance for Follow-up After Hospitalization for Mental Illness (7 Days)**



For 30-day follow-up, **FHN**'s rate declined from 69.8 percent to 67.9 percent, but was well above the national Medicaid HEDIS 2007 50th percentile of 57.3 percent. **Harmony**'s rate fell sharply from 65.1 percent to 32.3 percent.

**Figure 4-30—Comparison of HFS MCO Performance for Follow-up After Hospitalization for Mental Illness (30 Days)**



These two measures related to mental health appear to be an area of strength for **FHN**. However, **Harmony**'s decline for these two measures was significant. **Harmony** has indicated the declines were due to a data issue related to an inability to identify the provider type. Given the HEDIS reporting time constraints, **Harmony** chose to exclude encounter data for behavioral health visits with an unknown provider type, resulting in lower rates.

### Encounter Data Completeness

Table 4-3 provides an estimate of the data completeness for the hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last two columns indicates that the encounter data was complete for that HEDIS measure.

Performance Measures	Final HEDIS Rate		Percent Encounter Data	
	FHN	HAR	FHN	HAR
<i>Childhood Immunizations—Combo 2</i>	68.9	53.8	5.4	<b>45.7</b>
<i>Childhood Immunizations—Combo 3</i>	53.0	42.8	2.1	<b>44.9</b>
<i>Lead Screening in Children</i>	70.4	65.9	60.5	<b>84.1</b>
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	29.0	21.7	31.3	<b>73.0</b>
<i>Well-Child Visits (3–6 Years)</i>	68.4	57.4	79.4	<b>93.2</b>
<i>Adolescent Well-Care Visits</i>	32.2	37.7	63.0	<b>63.2</b>
<i>Cervical Cancer Screening</i>	68.0	59.1	<b>53.6</b>	30.0
<i>Frequency of Ongoing Prenatal Care (81–100%)</i>	33.4	31.4	6.0	<b>62.8</b>
<i>Timeliness of Prenatal Care</i>	45.4	56.4	20.0	<b>47.0</b>
<i>Postpartum Care</i>	32.3	35.0	23.3	<b>62.5</b>
<i>Diabetes Care (HbA1c Testing)</i>	68.5	57.7	7.9	<b>30.4</b>
<i>Diabetes Care (Eye Exam)</i>	22.8	9.0	<b>57.1</b>	43.2
<i>Diabetes Care (LDL-C Screening)</i>	56.5	52.3	7.7	<b>36.6</b>
<i>Diabetes Care (Nephropathy Monitoring)</i>	57.6	59.9	37.7	<b>45.1</b>

\* Harmony did not use the hybrid method for this HEDIS measure.

**FHN** reported a higher final HEDIS rate than **Harmony** for 10 of the 14 measures presented in the table. However, the percentage of the rate that was captured in administrative encounter data was substantially higher for **Harmony** in 12 measures. These results indicate that **FHN** continues to have difficulty obtaining complete encounter data. This concern was mentioned in the prior EQR technical report, and **FHN** is strongly encouraged to focus efforts on improving encounter data submission.

The encounter data for **Harmony** were generally more complete, although the data were substantially less complete than HEDIS 2007 results. Compared to **FHN**, **Harmony**'s encounter data submission was much higher, especially for the measures related to maternity care. Since encounter data submission apparently decreased, **Harmony** should reinforce efforts to improve submission of encounter data. **Harmony** should also focus efforts on improving services provided to HFS beneficiaries, including conducting a barrier analysis and implementing corrective action plans, as needed.

## Summary of the Validation of Performance Measures

The following is a brief summary based on the findings discussed for the performance measures in this report:

- ◆ The rates for *Childhood Immunizations* and *Well-Child Visits* have increased since HEDIS 2005, though the MCOs' rates did not improve much this year for these measures.
- ◆ The low rates for *Adults' Access to Preventative/Ambulatory Care* services indicate that both **FHN** and **Harmony** need to improve access to care.
- ◆ The rates for maternity care (*Timeliness of Prenatal Care*, *Frequency of Ongoing Prenatal Care*, and *Postpartum Care*) did not improve, and were once again very low.
- ◆ Except for cervical cancer screening, the rates for measures in the preventative screenings for women category either declined or remained about the same as last year.
- ◆ The diabetes measures for HbA1c testing and control continue to improve each year for both MCOs. However, rates for other measures related to diabetes care (i.e., *Eye Exams*, *LDL-C Screening*, *LDL-C Level*, and *Monitoring Nephropathy*) have declined.
- ◆ The rates for the asthma measures have declined each year for **FHN**, but improved each year for **Harmony**.
- ◆ The rates for **FHN** were higher than the rates for **Harmony** for most measures in the categories of child and adolescent care and chronic conditions/disease management.
- ◆ The rates for **Harmony** were higher than the rates for **FHN** for most measures in the categories of adults' access to preventative/ambulatory care, and maternity-related care.
- ◆ The two measures related to mental health appeared to be a strength for **FHN**. The rates for **Harmony** declined significantly this year, falling by more than 50 percent. **Harmony** should investigate to determine the reason for the decline and consider providing more oversight of its new vendor.
- ◆ Encounter data submission was still low for **FHN** while **Harmony's** encounter data submission has declined significantly from last year. Both MCOs should reinforce efforts to improve submission of encounter data.

**FHN's** rates have improved for 13 out of 14 trended measures since 2005, but the rates improved less this year. For the 30 measures reported last year, **FHN's** rates improved on 15 out of 29 measures, with one measure not applicable. **FHN** continued to improve rates for childhood immunizations, well-child visits, and measures related to chronic conditions/disease management, but struggled with rates for maternity care, access to care, and preventative screening for women. **FHN** should also concentrate efforts on improving encounter data submission from providers.

**Harmony's** rates improved for 11 out of 15 trended measures since 2005, but rates declined for the majority of the measures this year. For the measures reported last year, **Harmony's** rates improved on 14 out of 30 measures. Encounter data submission declined, which may have impacted the rates. In contrast to last year, encounter data completeness appeared to be a concern for **Harmony** this year. **Harmony** should determine the reason for the low encounter data submission to improve it to its former level. **Harmony** should also conduct a barrier analysis and appropriately evaluate its performance improvement efforts to determine their effectiveness and revise them as needed.

### Comparison of HEDIS Measures (MCO and PCCM)

At the time of this report, the PCCM validation for the performance measures was completed for 11 of the 16 measures. Following the validation findings and recommendations, HFS will update and/or revise the source code and technical specifications, then resubmit them to HSAG for final approval. The rates for the performance measures will then be generated and provided as an addendum to this report.

## Validation of Performance Improvement Projects—FY 2007–2008

### Validation of Asthma PIP

As shown in Table 4-4, **FHN** achieved *Met* validation status and **Harmony** achieved *Partially Met* validation status for the 2007–2008 asthma PIPs.

Table 4-4—Comparison of 2007–2008 Asthma PIPs		
Results	FHN	Harmony
Activities Completed	I–IX	I–X
Number of Elements <i>Met</i>	34	38
Number of Elements <i>Partially Met</i>	3	9
Number of Elements <i>Not Met</i>	1	1
Total Possible Critical Elements Assessed	13	13
Total Critical Elements <i>Met</i>	10*	11**
Percentage of Total Possible Evaluation Elements <i>Met</i>	89%	79%
Percentage of Critical Elements <i>Met</i>	100%	92%
Validation Status	<i>Met</i>	<i>Partially Met</i>
*Three critical elements were <i>NA</i> .		
** One critical element was <i>NA</i> .		

Validation of the asthma PIPs indicated that both **FHN** and **Harmony** have opportunities to improve the statistical analysis of data and achieve improvements in outcomes of care for beneficiaries with asthma.

- ◆ **FHN**'s documented improvements in three of the four age groups for Study Indicator 2 appeared to be the result of planned interventions. HSAG suggested that the MCO perform a second causal/barrier analysis after the first remeasurement period to determine what changes **FHN** should make to the existing improvement strategies and interventions to achieve the desired outcomes for the study indicators. Further, **FHN** should provide the *p* values from statistical testing of differences between measurement periods as part of the PIP submission.

- ◆ **Harmony** did not clearly indicate the type of statistical testing performed in the resubmitted PIP documentation. Because **Harmony** provided *p* values without supporting numerators or denominators, HSAG was unable to replicate or validate the *p* values provided for what appeared to be Study Indicator 1. The resubmission did not include updated data or *p* values for Study Indicator 2. Data for each measurement period should be complete, consistent, and clearly labeled. The resubmitted documentation included a brief interpretation of statistical significance; however, the interpretation of findings should discuss the individual results for each measurement period for each study indicator. **Harmony** should provide an interpretation of the extent to which the study was successful and data to indicate whether actual improvement in outcomes of care had occurred.

### Validation of EPSDT Screening PIP

As shown in Table 4-5, both **FHN** and **Harmony** achieved *Met* validation status for the 2007–2008 EPSDT screening PIPs.

Results	FHN	Harmony
<b>Activities Completed</b>	I–VIII	I–VIII
<b>Number of Elements <i>Met</i></b>	37	36
<b>Number of Elements <i>Partially Met</i></b>	1	2
<b>Number of Elements <i>Not Met</i></b>	1	1
<b>Total Possible Critical Elements Assessed</b>	13	13
<b>Total Critical Elements <i>Met</i></b>	13	13
<b>Percentage of Total Possible Evaluation Elements <i>Met</i></b>	95%	92%
<b>Percentage of Critical Elements <i>Met</i></b>	100%	100%
<b>Validation Status</b>	<i>Met</i>	<i>Met</i>

**FHN** and **Harmony** have the opportunity to reach the level of high confidence in the reported EPSDT screening PIP results by improving several noncritical evaluation elements.

- ◆ **FHN**’s documentation did not discuss the interrater reliability process in Activity VI or provide an interpretation of baseline findings in Activity VIII. The PIP documentation should include a discussion of each EPSDT component (study indicator) result and **FHN**’s follow-up activities based on the results.
- ◆ **Harmony** did not document the acceptable margin of error in Activity V, although the sampling technique and sample size were appropriate. The resubmitted PIP document discussed the overall performance for Southern Illinois and Cook County. Southern Illinois’ rates were fairly consistent while Cook County’s rates were below average. The PIP documentation did not include what Cook County’s rates were compared to and how it was determined that Southern Illinois’ rates were consistent. In addition, individual indicator results comparing the two areas were not discussed. Further, **Harmony** did not align the data reported in Activity IX with the study indicators in Activity III. The data reported must align with the study indicators. HSAG

anticipates that Remeasurement 1 data will be reported for 2007–2008 with the next annual submission.

### Validation of Perinatal Care and Depression Screening PIP

As shown in Table 4-6, **FHN** achieved *Met* validation status and **Harmony** achieved *Partially Met* validation status for the 2007–2008 perinatal care and depression screening PIPs.

Results	FHN	Harmony
Activities Completed	I–IX	I–IX
Number of Elements <i>Met</i>	48	43
Number of Elements <i>Partially Met</i>	3	7
Number of Elements <i>Not Met</i>	0	1
Total Possible Critical Elements Assessed	13	13
Total Critical Elements <i>Met</i>	13	12
Percentage of Total Possible Evaluation Elements <i>Met</i>	94%	84%
Percentage of Critical Elements <i>Met</i>	100%	92%
Validation Status	<i>Met</i>	<i>Partially Met</i>

While **FHN**’s perinatal care and depression screening PIP results indicated progress in achieving improved outcomes of care, the validation of **Harmony**’s PIP showed substantial opportunities for improvement in the reliability of reported study results.

- ◆ **FHN**’s documented improvements in some of the study indicators appeared to be the result of planned interventions. HSAG suggested that **FHN** perform a second causal/barrier analysis after the first remeasurement period to determine what changes the MCO should make to the existing improvement strategies and interventions to achieve the desired outcomes for the study indicators.
- ◆ **Harmony** did not complete the data analysis according to the plan in the study. Data tables were not clearly labeled or complete. **Harmony** provided a very general interpretation of the results for what appeared to be Study Indicators 1, 2, and 3, but no data, *p* values, or interpretation were provided for Study Indicator 4, and the *p* values provided did not indicate corresponding statistical significance. While there was documented improvement in three of the five components for frequency of ongoing prenatal care (Study Indicator 3), there was a decline in the rates from baseline to Remeasurement 1 for Study Indicators 1 and 2.

The validation of the Perinatal Care and Depression Screening and the EPDST PIPs does not include a discussion of the rates for the study indicators. This section only considers the validity and reliability of the PIP. The study indicators are typically addressed in a separate section under performance measures. However, for this technical report, the rates for the Perinatal and Depression Screening and EPDST study indicators were not yet completed and, therefore, an addendum to this report will be forthcoming with the actual rates and discussion for the study indicators.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys—FY 2007–2008

### Plan Comparisons

#### Adult Medicaid

Table 4-7 presents the 2008 adult Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2007 NCQA national averages.

Table 4-7—2008 Adult Medicaid CAHPS Results			
	FHN	Harmony	2007 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	NA	60.8%	47.3%
<i>Getting Care Quickly</i>	71.4%	71.3%	54.0%
<i>How Well Doctors Communicate</i>	83.7%	84.9%	66.8%
<i>Customer Service*</i>	NA	80.5%	*
<i>Shared Decision Making</i>	NA	67.5%	58.4%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	60.2%	56.3%	46.6%
<i>Rating of Personal Doctor</i>	77.7%	66.7%	60.5%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	59.7%
<i>Rating of Health Plan</i>	53.6%	55.4%	52.8%
<p>A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.</p> <p>* Due to changes in the <i>Customer Service</i> composite, a 2007 NCQA CAHPS national average was not calculated for this measure.</p>			

**FHN** outperformed **Harmony** on three of the comparable measures: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*, and showed particular strength for *Rating of Personal Doctor*. **FHN**'s rate of 77.7 percent was substantially higher than **Harmony** and the NCQA national average.

**Harmony** outperformed **FHN** on two of the comparable measures: *How Well Doctors Communicate* and *Rating of Health Plan*.

**FHN** and **Harmony** both scored above the 2007 NCQA national averages for four of the comparable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rates for *Getting Care Quickly* and *How Well Doctors Communicate* were greater than the national averages by more than 10 percentage points, representing areas of strength for both plans.

**Child Medicaid**

Table 4-8 presents the 2008 child Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2007 NCQA national averages.

Table 4-8—2008 Child Medicaid CAHPS Results			
	FHN	Harmony	2007 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	79.0%	70.0%	80.3%
<i>Getting Care Quickly</i>	68.9%	69.4%	50.9%
<i>How Well Doctors Communicate</i>	89.8%	88.4%	66.3%
<i>Courteous and Helpful Office Staff</i>	89.6%	88.4%	67.9%
<i>Customer Service</i>	NA	74.0%	73.6%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	80.1%	71.7%	64.0%
<i>Rating of Personal Doctor</i>	81.8%	72.2%	64.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	61.9%
<i>Rating of Health Plan</i>	76.1%	65.4%	63.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

**FHN** outperformed **Harmony** on six of the comparable measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, and showed particular strength for *Rating of Health Plan*. **FHN**'s rate of 76.1 percent was substantially higher than **Harmony** and the NCQA national average.

**Harmony** outperformed **FHN** on one of the measures, *Getting Care Quickly*.

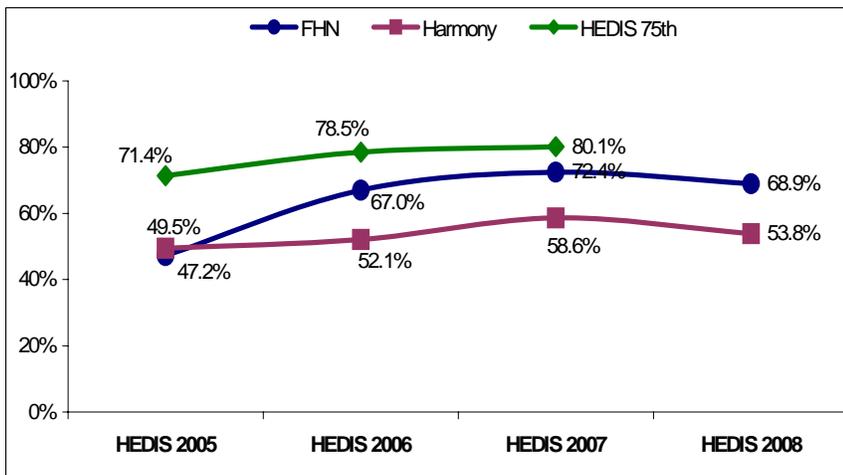
**FHN** and **Harmony** both scored above the 2007 NCQA national averages for six of the comparable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rates for *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* were greater than the national averages by more than 10 percentage points, representing areas of strength for both plans. However, both **FHN** and **Harmony** scored below the national average for the *Getting Needed Care* measure.

## Summary Recommendations

- ◆ **FHN's** and **Harmony's** 2008 child Medicaid CAHPS results indicated that quality improvement initiatives should focus on improving *Getting Needed Care*. Examples in the CAHPS literature for improving *Getting Needed Care* results include providing the most up-to-date information in provider directories, streamlining the referral process to expedite patients' access to care, and assuring receipt of care by the appropriate physician.

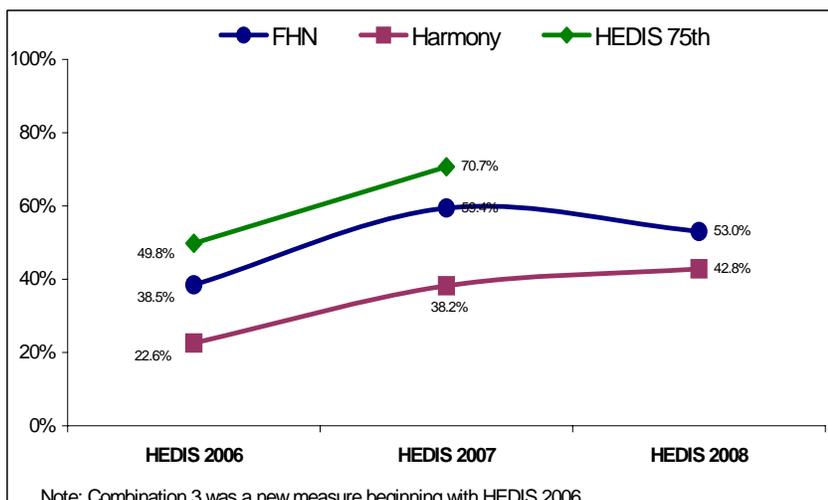
This appendix displays trended line graphs for the performance measures with at least two years of HEDIS reporting compared to the national Medicaid HEDIS 75th percentile for each reporting year. These graphs use the HEDIS 75th percentile since this is the level the MCOs must achieve to receive withhold (incentive) payments. The national Medicaid HEDIS percentiles for each year are provided beside each graph. Medicaid HEDIS 2008 percentiles will be available in February 2009.

Figure A-1—Childhood Immunizations—Combination #2



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	47.8	56.6	66.0	71.4	75.7
2006	53.8	62.7	72.4	78.5	82.7
2007	58.7	68.3	75.2	80.1	84.8

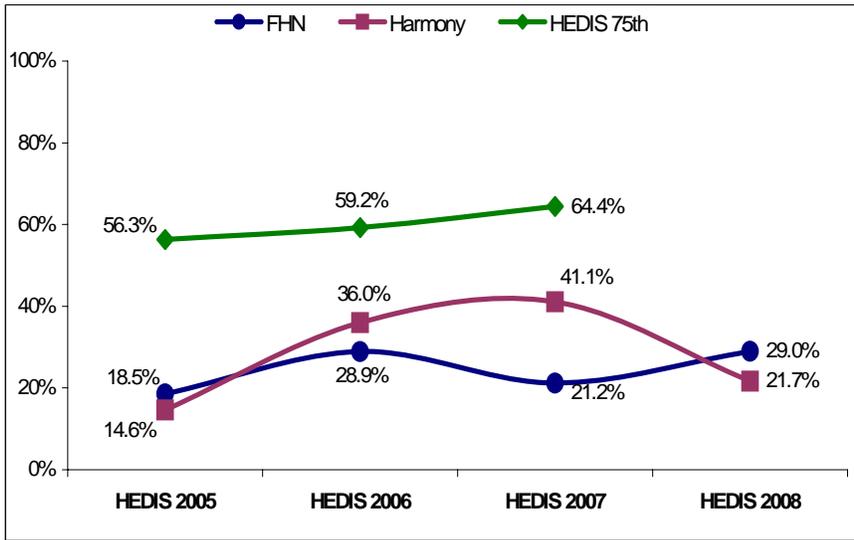
Figure A-2—Childhood Immunizations—Combination #3



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	NA	NA	NA	NA	NA
2006	25.1	33.8	42.3	49.8	57.8
2007	41.8	54.3	62.6	70.7	74.5

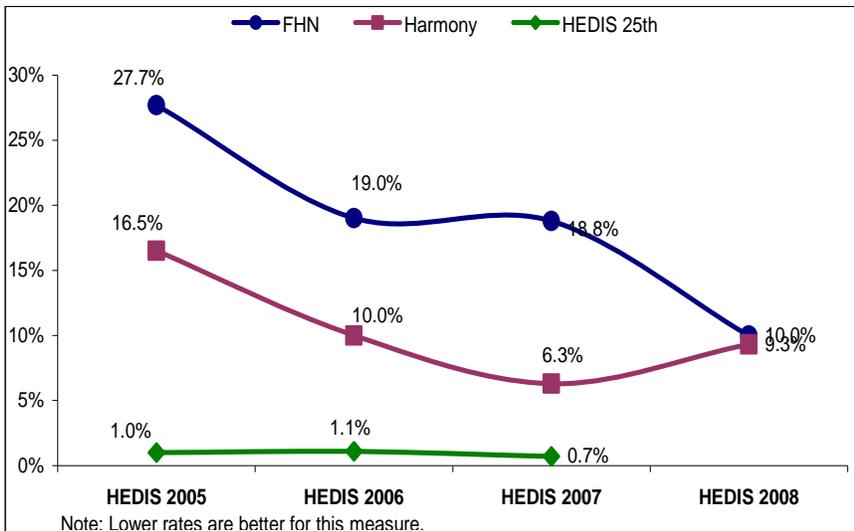
Note: Combination 3 was a new measure beginning with HEDIS 2006.

Figure A-3—Well-Child Visits in the First 15 Months of Life (6+ Visits)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	15.2	38.7	46.4	56.3	65.7
2006	22.4	41.6	50.0	59.2	68.6
2007	38.0	46.6	56.6	64.4	75.2

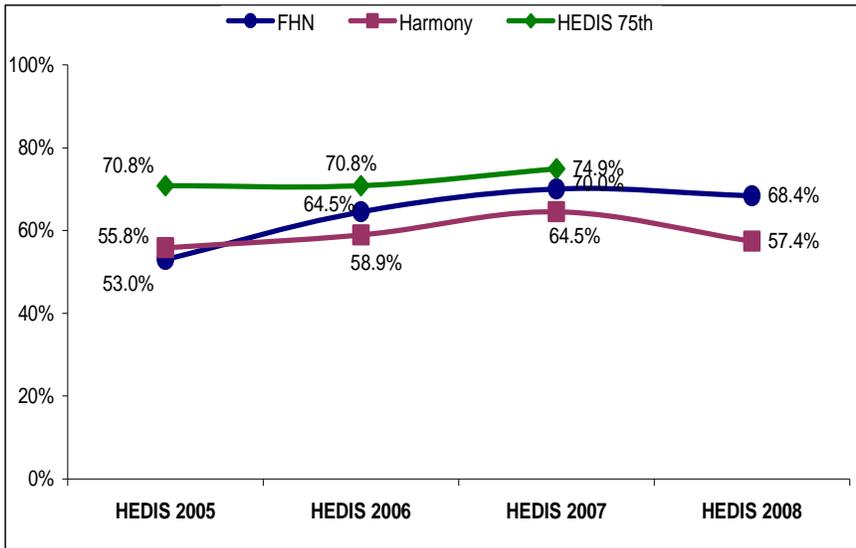
Figure A-4—Well-Child Visits in the First 15 Months of Life (No Visits)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	0.5	1.0	2.1	3.9	13.1
2006	0.5	1.1	2.0	3.9	10.0
2007	0.4	0.7	1.4	2.9	6.8

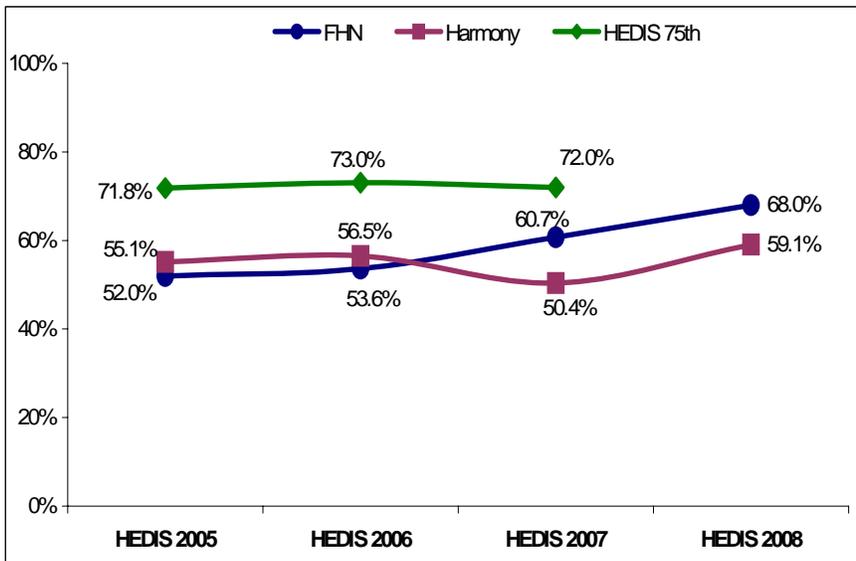
Note: Lower rates are better for this measure.

Figure A-5—Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life



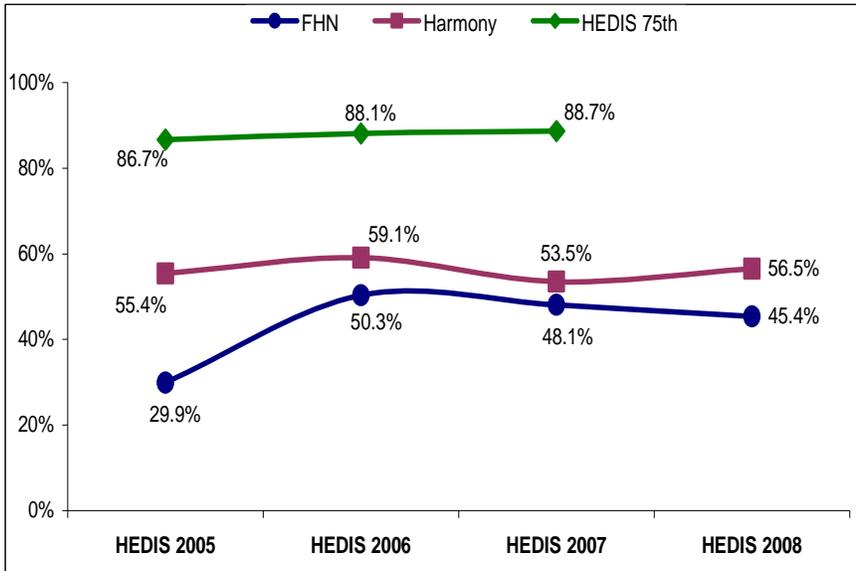
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	48.6	56.3	64.1	70.8	76.7
2006	50.1	56.7	64.8	70.8	77.5
2007	55.7	62.7	67.5	74.9	79.9

Figure A-6—Cervical Cancer Screening



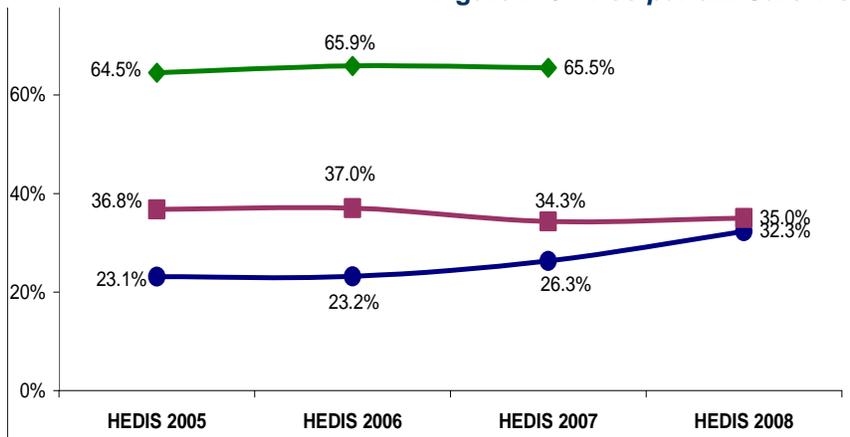
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	51.1	58.6	64.5	71.8	76.6
2006	49.9	59.7	66.1	73.0	76.6
2007	53.7	60.2	66.5	72.0	77.4

Figure A-7—Timeliness of Prenatal Care



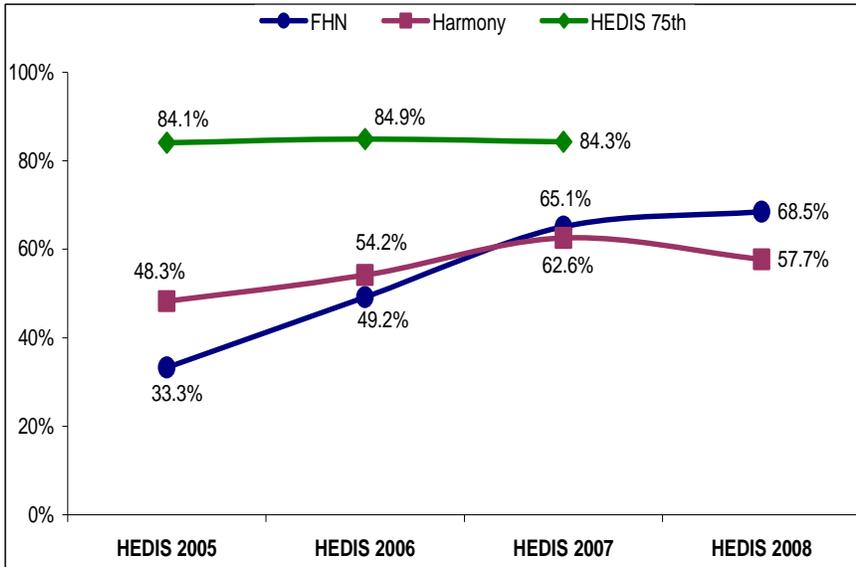
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	63.7	73.8	81.5	86.7	89.5
2006	61.1	74.2	83.3	88.1	91.5
2007	70.3	77.0	84.2	88.7	91.5

Figure A-8—Postpartum Care Visits



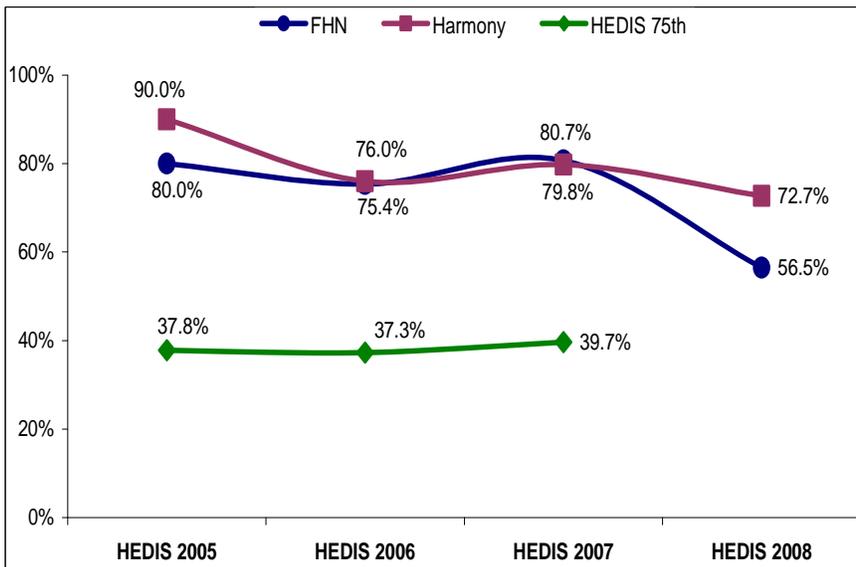
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	40.9	51.1	58.4	64.5	69.7
2006	41.8	49.7	58.8	65.9	71.0
2007	47.4	54.3	59.7	65.5	71.1

Figure A-9—Comprehensive Diabetes Care—HbA1c Testing



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	56.9	69.8	78.4	84.1	88.8
2006	64.0	71.1	77.4	84.9	88.8
2007	67.6	74.4	79.3	84.3	89.1

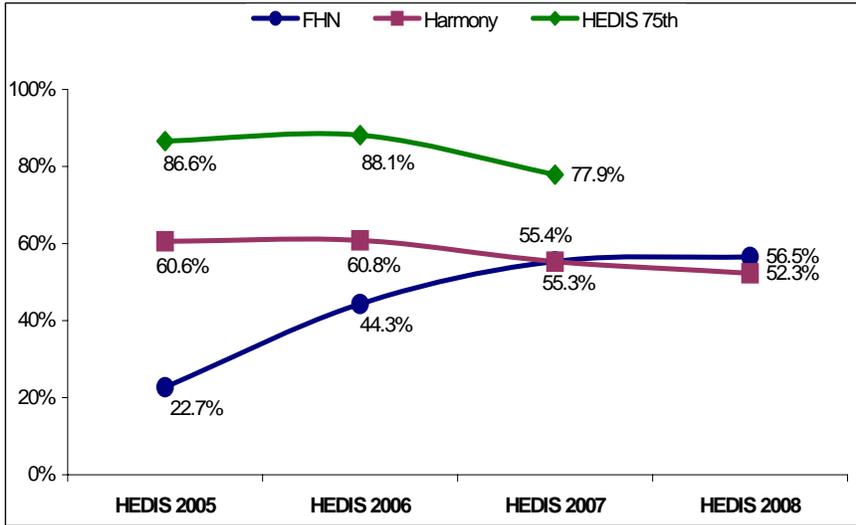
Figure A-10—Comprehensive Diabetes Care—Poor HbA1c Control



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	31.1	37.8	47.5	58.5	76.6
2006	30.3	37.3	45.2	60.1	74.3
2007	32.1	39.7	46.7	57.4	69.6

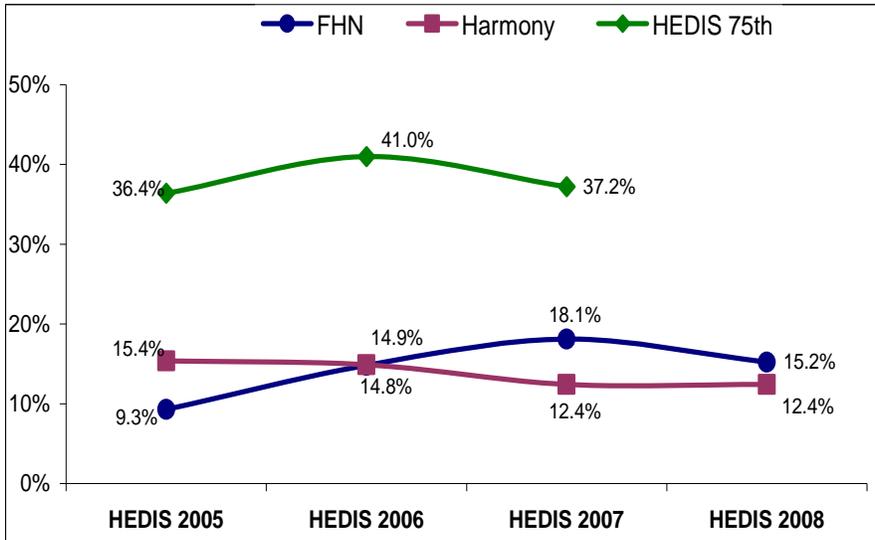
Note: Lower rates are better for this measure.

Figure A-11—Comprehensive Diabetes Care—LDL-C Screening



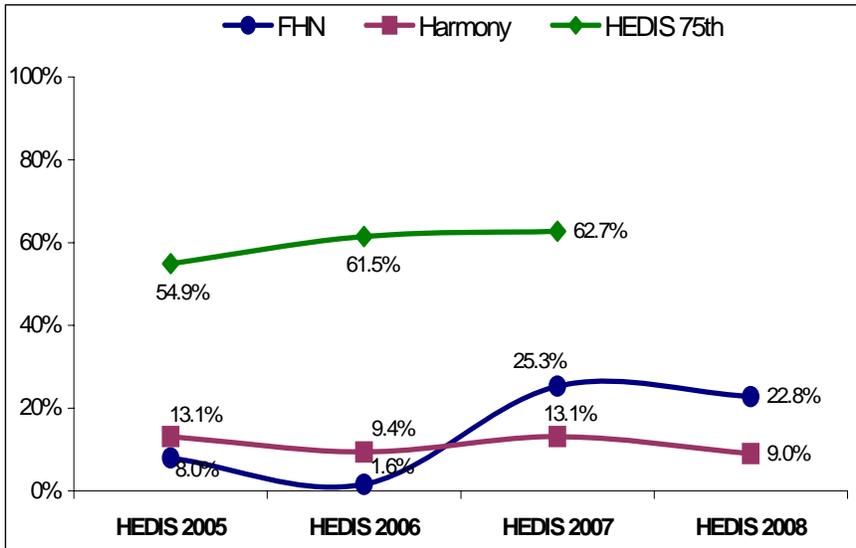
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	61.8	73.0	81.4	86.6	91.4
2006	66.3	76.2	83.3	88.1	90.8
2007	58.7	66.9	72.8	77.9	81.0

Figure A-12—Comprehensive Diabetes Care—LDL-C Level <100



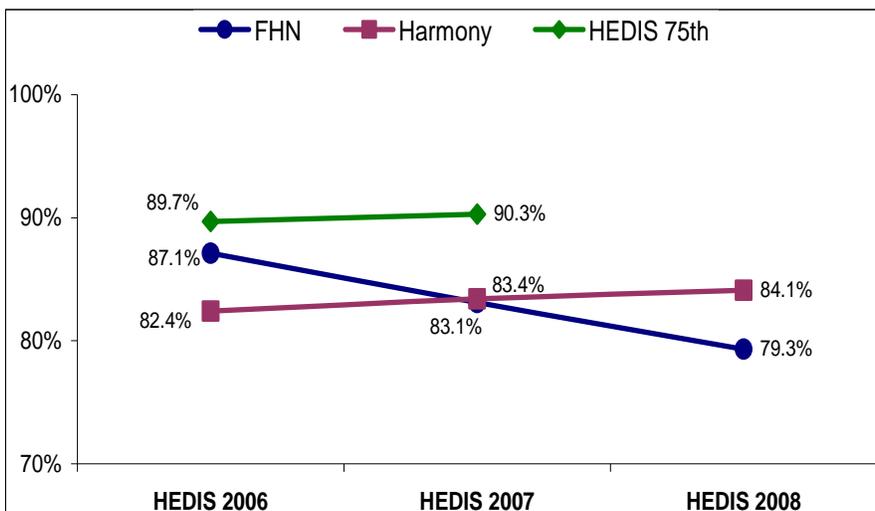
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	14.4	23.7	31.7	36.4	41.6
2006	14.4	26.5	34.1	41.0	46.5
2007	15.2	24.1	31.3	37.2	44.1

Figure A-13—Comprehensive Diabetes Care—Eye Exams



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	18.5	35.3	46.9	54.9	60.9
2006	25.5	35.2	50.8	61.5	68.1
2007	30.6	42.1	53.6	62.7	68.3

Figure A-14—Use of Appropriate Medications for People With Asthma (Combined Rate)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2005	NA	NA	NA	NA	NA
2006	78.4	84.0	87.1	89.7	92.5
2007	81.5	85.6	88.4	90.3	92.0

Note: HEDIS Technical Specifications changed starting with HEDIS 2006.

Note: The HEDIS Technical Specifications for this measure changed beginning with HEDIS 2006, so comparisons cannot be made to HEDIS 2005.

## Summary of Trending Graphs

Rates have steadily increased nationwide for *Childhood Immunizations*; *Well-Child Visits in the First 15 Months of Life (6+ Visits)*; *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life*; and *Comprehensive Diabetes Care (Eye Exams)*. Therefore, improvement at the MCO level must be constant and at a faster pace than the national trend to reach and/or maintain rates at the 50th or 75th percentiles.

Rates have remained about the same nationwide for *Well-Child Visits in the First 15 Months of Life (0 Visits)*, *Cervical Cancer Screening*, *Timeliness of Prenatal Care*, *Postpartum Care*, *Comprehensive Diabetes Care (HbA1c Testing)*, *Comprehensive Diabetes Care (Poor HbA1c Control)*, *Comprehensive Diabetes Care (LDL-C Level <100)*, and *Use of Appropriate Medications for People With Asthma (Combined Rate)*. It may be difficult for the MCOs to demonstrate improvement without significant efforts in outreach and case management/disease management for these measures. However, MCO improvements in these rates would likely be substantial. For example, for *Comprehensive Diabetes Care (HbA1c Testing)*, rates for both FHN and Harmony improved while rates nationwide remained constant, as illustrated by the trending graph.

Rates nationwide have decreased for *Comprehensive Diabetes Care (LDL-C Screening)*. This represents an opportunity for the MCOs to improve their rates while the national trend is for these rates to decline. The MCOs' rates for this measure were low, which may be partially due to incomplete lab data. It may be difficult for the MCOs to demonstrate improvement without significant efforts to improve the submission of lab data and case management/disease management.

## Appendix B. Illinois HEDIS 2008 Medicaid Rates

This appendix displays the Medicaid HEDIS 2008 rates for each MCO, the overall rates, and the national Medicaid 2007 HEDIS 50th and 90th percentiles. The color coding scheme is presented at the end of the table and illustrates the various national Medicaid percentiles for the reported rates.

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2007 HEDIS Percentiles	
				50th	90th
<b>Child and Adolescent Care</b>					
<i>Childhood Immunizations—Combo 2</i>	68.9	53.8	61.7	75.2	84.8
<i>Childhood Immunizations—Combo 3</i>	53.0	42.8	48.1	62.6	74.5
<i>Lead Screening in Children</i>	70.4	65.9	68.3	NA**	NA**
<i>Appropriate Treatment for Children with URI</i>	97.5	86.2	90.8	84.3	92.6
<i>Children’s Access to PCPs (12-24 Months)</i>	77.3	82.5	80.7	95.8	98.0
<i>Children’s Access to PCPs (25 months – 6 Years)</i>	65.2	65.7	65.6	86.7	91.4
<i>Children’s Access to PCPs (7 – 11 Years)</i>	52.4	60.7	59.1	87.2	93.3
<i>Adolescent’s Access to PCPs (12-19 Years)</i>	48.4	58.7	57.2	85.3	91.4
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	10.0	9.2	9.6	1.4*	0.4*
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	29.0	21.7	25.5	56.6	75.2
<i>Well-Child Visits (3–6 Years)</i>	68.4	57.4	63.2	67.5	79.9
<i>Adolescent Well-Care Visits</i>	32.2	37.7	34.8	42.1	58.9
<b>Adults’ Access to Preventive/Ambulatory Care</b>					
<i>20–44 Years of Age</i>	56.6	57.5	57.3	79.1	88.0
<i>45–64 Years of Age</i>	48.6	54.6	53.7	85.5	89.8
<b>Preventive Screening for Women</b>					
<i>Breast Cancer Screening (42–51 Years of age)</i>	28.3	34.3	32.5	45.6	57.2
<i>Breast Cancer Screening (52–69 Years of age)</i>	NA***	45.5	39.7	54.9	65.2
<i>Breast Cancer Screening (Combined Rate)</i>	27.8	35.5	33.2	49.2	59.6
<i>Cervical Cancer Screening</i>	68.0	59.1	63.8	66.5	77.4
<i>Chlamydia Screening (16–20 Years of Age)</i>	47.7	45.1	45.6	50.3	64.8
<i>Chlamydia Screening (21–25 Years of Age)</i>	47.7	53.3	52.0	56.3	69.9
<i>Chlamydia Screening (Combined Rate)</i>	47.7	49.3	48.9	52.8	66.0
<b>Maternity-Related Measures</b>					
<i>Frequency of Ongoing Prenatal Care (&lt;21% Visits)*</i>	29.4	21.9	25.8	7.6*	2.3*
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	33.4	31.4	32.4	62.9	78.6
<i>Timeliness of Prenatal Care</i>	45.4	56.4	50.6	84.2	91.5
<i>Postpartum Care</i>	32.3	35.0	33.6	59.7	71.1
<b>Chronic Conditions/Disease Management</b>					
<i>Controlling High Blood Pressure (Combined Rate)</i>	45.3	34.3	35.8	55.4	65.8
<i>Diabetes Care (HbA1C Testing)</i>	68.5	57.7	59.6	79.3	89.1
<i>Diabetes Care (Poor HbA1c Control)*</i>	56.5	72.7	64.0	46.7*	32.1*
<i>Diabetes Care (Good HbA1c Control)</i>	12.0	15.6	14.9	31.3	40.9
<i>Diabetes Care (Eye Exam)</i>	22.8	9.0	11.5	53.6	68.3
<i>Diabetes Care (LDL-C Screening)</i>	56.5	52.3	53.1	72.8	81.0

HEDIS Measures	FHN	HAR	Total for HFS MCOs	2007 HEDIS Percentiles	
				50th	90th
<i>Diabetes Care (LDL-C Level &lt;100 mg/Dl)</i>	15.2	12.4	12.9	31.3	44.1
<i>Diabetes Care (Nephropathy Monitoring)</i>	57.6	59.9	59.4	76.6	85.5
<i>Diabetes Care (BP &lt; 140/90)</i>	51.1	45.0	46.1	60.1	69.3
<i>Diabetes Care (BP &lt; 130/80)</i>	22.8	23.6	23.5	30.6	41.4
<i>Appropriate Medications for Asthma (5–9 Years)</i>	85.5	85.8	85.8	91.7	96.3
<i>Appropriate Medications for Asthma (10–17 Years)</i>	77.1	84.7	84.0	88.8	93.0
<i>Appropriate Medications for Asthma (18–56 Years)</i>	73.6	82.0	80.8	85.4	90.9
<i>Appropriate Medications for Asthma (Combined Rate)</i>	79.3	84.1	83.4	88.4	92.0
<i>Follow-up After Hospitalization for Mental Illness-7 Days</i>	56.4	20.0	28.7	35.8	66.2
<i>Follow-up After Hospitalization for Mental Illness-30 Days</i>	67.9	32.3	40.7	57.3	79.8

\* Lower rates indicate better performance for these measures and the 90th percentile uses the 10th percentile.  
 \*\* This measure was new for HEDIS 2008; therefore, national Medicaid percentiles were not available.  
 \*\*\* FHN had fewer than 30 eligible cases for this measure; therefore, the rate was not calculated.

**Key:**

Green	≥90th
Blue	74–89th
Yellow	50–74th
White (no color)	25–49th (or not applicable [NA])
Orange	10–25th
Red	≤10th

## Appendix C. Medicaid HEDIS 2007 Means and Percentiles

Medicaid HEDIS 2007 Means and Percentiles						
	Mean	P10	P25	P50	P75	P90
Childhood Immunizations (Combo 2)	73.4	58.7	68.3	75.2	80.1	84.8
Childhood Immunizations (Combo 3)	60.9	41.8	54.3	62.6	70.7	74.5
Well-Child Visits in the First 15 Months of Life (0 Visits)*	3.8	0.4	0.7	1.4	2.9	6.8
Well-Child Visits in the First 15 Months of Life (6+ Visits)	55.6	38.0	46.6	56.6	64.4	75.2
Well-Child Visits (3–6 Years)	66.8	55.7	62.7	67.5	74.9	79.9
Adolescent Well-Care Visits	43.6	31.3	35.3	42.1	51.4	58.9
Annual Dental Visit (Combined)	42.5	27.9	36.5	42.8	50.6	57.3
Children's and Adolescents' Access to Primary Care Practitioners (12–24 Months)	94.1	90.2	93.0	95.8	97.4	98.0
Children's and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years)	84.9	77.9	82.4	86.7	89.4	91.4
Children's and Adolescents' Access to Primary Care Practitioners (7–11 Years)	85.9	77.0	83.4	87.2	90.5	93.3
Children's and Adolescents' Access to Primary Care Practitioners (12–19 Years)	83.2	73.9	80.1	85.3	89.2	91.4
Timeliness of Prenatal Care	81.2	70.3	77.0	84.2	88.7	91.5
Frequency of Ongoing Prenatal Care (<21%)*	13.5	2.3	4.4	7.6	17.5	32.0
Frequency of Ongoing Prenatal Care (81–100%)	58.6	33.0	49.4	62.9	71.7	78.6
Postpartum Care	59.1	47.4	54.3	59.7	65.5	71.1
Use of Appropriate Medications for People With Asthma (5–9 Years)	89.6	83.1	88.6	91.7	94.6	96.3
Use of Appropriate Medications for People With Asthma (10–17 Years)	87.0	80.2	86.2	88.8	91.4	93.0
Use of Appropriate Medications for People With Asthma (18–56 Years)	84.7	76.4	82.6	85.4	88.2	90.9
Use of Appropriate Medications for People With Asthma (Total)	87.1	81.5	85.6	88.4	90.3	92.0
Comprehensive Diabetes Care (HbA1c Testing)	78.0	67.6	74.4	79.3	84.3	89.1
Comprehensive Diabetes Care (Poor HbA1c Control)*	48.7	32.1	39.7	46.7	57.4	69.6
Comprehensive Diabetes Care (Good HbA1c Control)	30.2	14.9	24.4	31.3	36.6	40.9
Comprehensive Diabetes Care (Eye Exams)	51.4	30.6	42.1	53.6	62.7	68.3
Comprehensive Diabetes Care (LDL-C Screening)	71.1	58.7	66.9	72.8	77.9	81.0
Comprehensive Diabetes Care (LDL-C Level <100)	30.6	15.2	24.1	31.3	37.2	44.1
Comprehensive Diabetes Care (BP <130/80)	30.4	19.2	25.1	30.6	35.5	41.4
Comprehensive Diabetes Care (BP <140/90)	57.3	41.1	50.6	60.1	65.5	69.3
Comprehensive Diabetes Care (Monitoring Nephropathy)	74.6	60.3	68.6	76.6	81.8	85.5
Follow-up After Hospitalization for Mental Illness (7 Days)	39.1	11.4	26.0	35.8	58.0	66.2
Follow-up After Hospitalization for Mental Illness (30 Days)	57.7	17.1	48.2	57.3	75.9	79.8

\* A lower rate indicates better performance (i.e., a rate in the 10th percentile is better than a rate in the 90th percentile).