

**MEDICARE-MEDICAID  
CAPITATED FINANCIAL ALIGNMENT MODEL  
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 11):  
ILLINOIS-SPECIFIC MEASURES**

Effective as of January 1, 2016; Issued October 12, 2017;  
Updated December 5, 2023

**Attachment D**  
**Illinois Quality Withhold Measure Technical Notes: Demonstration Years 2 through 11**

**Introduction**

The measures in this attachment are quality withhold measures for all Medicare-Medicaid Plans (MMPs) in the Illinois Medicare-Medicaid Alignment Initiative for Demonstration Years (DY) 2 through 11. These state-specific measures directly supplement the [Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 12](#).

DY 2 through 11 in the Illinois Medicare-Medicaid Alignment Initiative are defined as follows:

Year	Dates Covered
DY 2	January 1, 2016 – December 31, 2016
DY 3	January 1, 2017 – December 31, 2017
DY 4	January 1, 2018 – December 31, 2018
DY 5	January 1, 2019 – December 31, 2019
DY 6	January 1, 2020 – December 31, 2020
DY 7	January 1, 2021 – December 31, 2021
DY 8	January 1, 2022 – December 31, 2022
DY 9	January 1, 2023 – December 31, 2023
DY 10	January 1, 2024 – December 31, 2024
DY 11	January 1, 2025 – December 31, 2025

Information about the applicable demonstration years for each state-specific measure, as well as benchmarks and other details, can be found in the measure descriptions below. Note that CMS and the State may elect to adjust the benchmarks or other details based on additional analysis or changes in specifications. Stakeholders will have the opportunity to comment on any substantive changes prior to finalization.

***Applicability of the Gap Closure Target to the State-Specific Quality Withhold Measures***

The gap closure target methodology as described in the CMS Core Quality Withhold Technical Notes **will not** apply to the state-specific measures for DY 2 through 5, but **will** apply to the state-specific measures for DY 6 through 11 unless otherwise noted in the measure descriptions below.

**Illinois-Specific Measures: Demonstration Years 2 through 5**

**Measure: ILW4 – Care for Older Adults**

Description:	The percentage of adults 66 years and older who had each of the following during the measurement year: <ul style="list-style-type: none"><li>• Advance care planning</li><li>• Medication review</li><li>• Functional status assessment</li><li>• Pain assessment</li></ul>
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)

HEDIS Label: Care for Older Adults (COA)  
 CMIT #: 110 (Medication Review)  
 Applicable Years: DY 2 through 5  
 Utilizes Gap Closure: No

Benchmarks:	Metric	DY 2	DY 3	DY 4	DY 5
	Advance care planning	24%	25%	31%	37%
	Medication review	57%	59%	64%	69%
	Functional status assessment	48%	50%	54%	58%
	Pain assessment	56%	57%	63%	69%

Notes: The upper 95 percent confidence interval around the MMP's HEDIS rate will be used when determining if the MMP met each benchmark. The upper 95 percent confidence interval will be calculated according to the guidelines in the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year.

The MMP must meet or exceed the benchmark for all four metrics in order to pass the measure as a whole.

This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

#### Measure: ILW5 – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

Measure Steward/  
Data Source: NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)

HEDIS Label: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

CMIT #: 394

Applicable Years: DY 2 through 5

Utilizes Gap Closure: No

Benchmarks:

Metric	DY 2	DY 3	DY 4	DY 5
Initiation of AOD Treatment	52%	52%	54%	56%
Engagement of AOD Treatment	12%	12%	12%	12%

Notes:

The upper 95 percent confidence interval around the MMP's HEDIS rate will be used when determining if the MMP met each benchmark. The upper 95 percent confidence interval will be calculated according to the guidelines in the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year.

The MMP must meet or exceed the benchmark for both metrics in order to pass the measure as a whole.

This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

#### **Measure: ILW6 – Movement of Members within Service Populations**

Description:	The number and percentage of members: <ul style="list-style-type: none"><li>• In Long Term Care (LTC) on January 1 of the measurement year</li><li>• In LTC on December 31 of the measurement year</li><li>• Not in LTC on January 1 of the measurement year</li><li>• Not in LTC on December 31 of the measurement year</li></ul>
Metric:	Measure IL3.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Illinois-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
CMIT #:	N/A
Applicable Years:	DY 2 through 5
Utilizes Gap Closure:	No
Benchmark:	Timely and accurate reporting according to the IL3.6 measure specifications

#### **Illinois-Specific Measures: Demonstration Years 6 through 11**

#### **Measure: ILW7 – Adults' Access to Preventive/Ambulatory Health Services**

Description:	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	Adults' Access to Preventive/Ambulatory Health Services (AAP)
CMIT #:	36
Applicable Years:	DY 6 through 11

Utilizes Gap Closure:	Yes
Benchmark:	95%
Notes:	This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

#### **Measure: ILW8 – Initiation of Substance Use Disorder Treatment**

Description:	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	Initiation and Engagement of Substance Use Disorder Treatment (IET)
CMIT #:	394
Applicable Years:	DY 6 through 11, excluding DY 8 and 9 <sup>1</sup>
Utilizes Gap Closure:	Yes
Benchmarks:	DY 6: 48% DY 7: 50% DY 10 and 11: 50%
Notes:	This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

#### **Measure: ILW9 – Engagement of Substance Use Disorder Treatment**

Description:	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	Initiation and Engagement of Substance Use Disorder Treatment (IET)
CMIT #:	394
Applicable Years:	DY 6 through 11, excluding DY 8 and 9 <sup>1</sup>
Utilizes Gap Closure:	Yes
Benchmark:	12%

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<sup>1</sup> Due to significant specification changes as of the 2022 measurement year, these measures are temporarily suspended from the quality withhold analysis for DY 8 (CY 2022) and DY 9 (CY 2023).

Notes: This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

**Measure: ILW10 – Movement of Members within Service Populations**

Description:	The number and percentage of members: <ul style="list-style-type: none"> <li>• In Long Term Care (LTC) on January 1 of the measurement year</li> <li>• In LTC on December 31 of the measurement year</li> <li>• Not in LTC on January 1 of the measurement year</li> <li>• Not in LTC on December 31 of the measurement year</li> </ul>
Metric:	Measure IL3.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Illinois-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
CMIT #:	N/A
Applicable Years:	DY 6 through 11
Utilizes Gap Closure:	No
Benchmark:	Timely and accurate reporting according to the IL3.6 measure specifications