





Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

EXTERNAL QUALITY REVIEW ANNUAL REPORT

State Fiscal Years 2021-2022
(July 1, 2021-June 30, 2022)

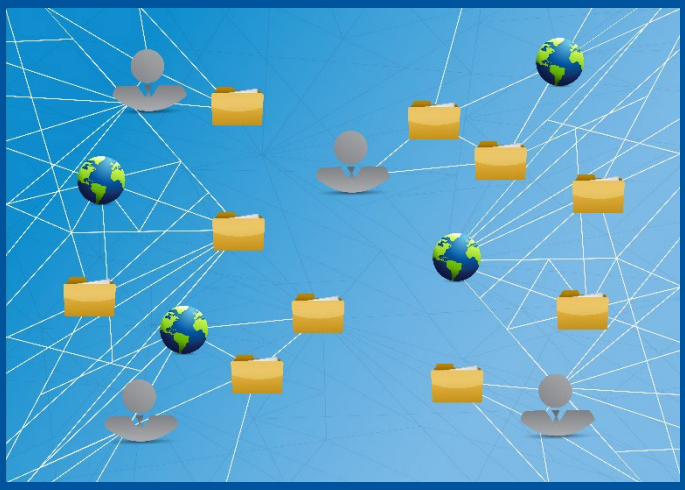
Illinois Department of Healthcare
and Family Services
Division of Medical Programs

Summary of Contents

1. Executive Summary

Overview

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). As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364, HFS contracted with HSAG to prepare an annual, independent technical report that provides a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the Medicaid managed care health plans (health plans). The CFR requires that states contract with an EQRO to conduct an annual evaluation of health plans that serve Medicaid beneficiaries to determine each health plan's compliance with federal quality assessment and performance improvement (QAPI) standards.



Purpose of This Report

The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO. This state fiscal year (SFY) 2022 External Quality Review (EQR) Technical Report focuses on federally mandated EQR activities that HSAG performed from July 1, 2021, to June 30, 2022. See the federal requirements for this report in Appendix A1.

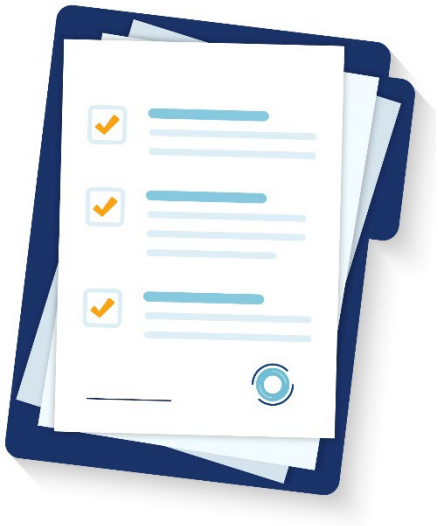
Scope of Report

In accordance with 42 CFR §438.364, this report describes the EQR results for the mandatory and optional EQR activities set forth in §438.356. This report includes methodologically appropriate, comparative information to provide an assessment of each health plans' strengths and opportunities for improvement with respect to the quality of, timeliness of, and access to healthcare services furnished to Medicaid beneficiaries and recommendations for improving quality of healthcare services. In Appendix A2, this report includes an assessment of the degree to which each health plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Illinois Medicaid Overview

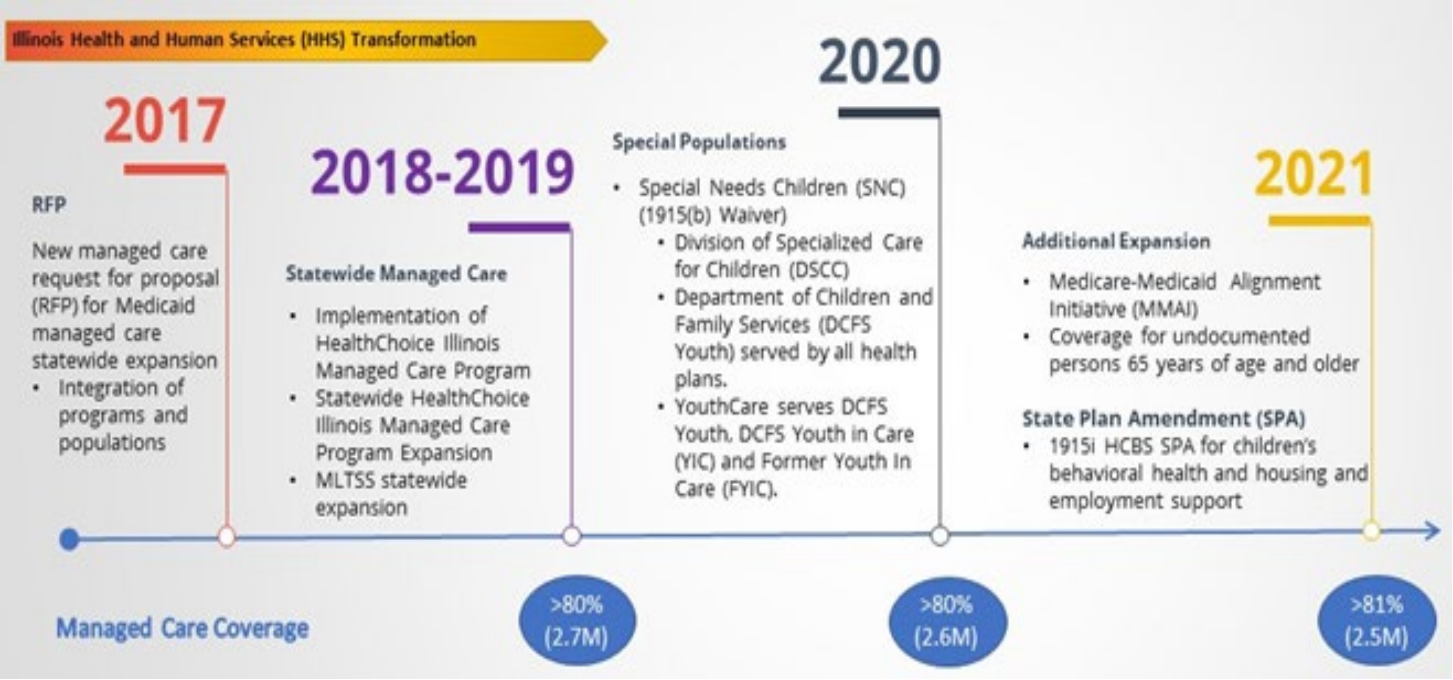
Illinois Medicaid Expansion

As shown in Figure 1-1 below, HFS implemented both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148). In 2018, HFS expanded its managed care program to cover all counties with the statewide launch of the HealthChoice Illinois Managed Care Program (HealthChoice Illinois) to serve approximately 2.6 million residents. The full spectrum of Medicaid covered services is provided through HealthChoice Illinois.



HealthChoice Illinois' statewide expansion included other populations, such as children in the care of the Department of Children and Family Services (DCFS), including those formerly in care who have been adopted or who entered a guardianship (DCFS Youth) and Managed Long Term Services and Supports (MLTSS) and waiver services.

Figure 1-1—Illinois Medicaid Expansion



Impact of COVID-19 Pandemic

The coronavirus disease 2019 (COVID-19) pandemic has had a significant impact on healthcare services. Many provider offices were closed or deferred elective visits and had limited telehealth services. Depending on state and local regulations, members often deferred going to the doctor's office for routine care, including primary care, preventive care, and screenings. COVID-19 impacted health plan business operations, including potential effects on medical record data collection due to imposed travel bans, limited access to provider offices, quarantines, and risk to health plan staff. Though health plans and provider offices modified their practices to increase the use of telemedicine, members may not have chosen or had the ability to access care during 2021 due to health concerns and factors relating to the pandemic, which may have impacted health plans' performance across the EQR activities presented in this report.

Medicaid Managed Care Health Plans (Health Plans)

HealthChoice

HealthChoice Illinois is served by five health plans and one specialty plan. Five of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only, as shown in Table 1-1 below.

Table 1-1—HealthChoice Illinois Health Plans for SFY 2022

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Community Health Plans	BCBSIL
CountyCare Health Plan (serves Cook County only)	CountyCare
Meridian	Meridian
Molina Healthcare of Illinois	Molina
YouthCare Specialty Plan	YouthCare

YouthCare is a specialty plan that administers benefits for DCFS Youth, DCFS Youth in Care (YiC), and Former Youth in Care (FYiC). Working with the youth's caseworker, YouthCare is designed to improve access to care through active coordination and a more robust provider network. With YouthCare, enrollees receive additional benefits, such as care coordination for behavioral health (BH) needs, including trauma-informed care, and a specialized program for adoptive families, including an adoption-competent network of therapists to support the different phases of adoption and child development.

Medicare-Medicaid Alignment Initiative

HFS contracted with five health plans to administer the Illinois Medicare-Medicaid Alignment Initiative (MMAI), a demonstration designed to improve healthcare for dually eligible beneficiaries in Illinois. Jointly administered by CMS and HFS, MMAI allows eligible beneficiaries in Illinois to receive their Medicare Parts A and B benefits, Medicare Part D benefits, and Medicaid benefits from a single Medicare-Medicaid Plan. Table 1-2 displays the MMAI health plans.

Table 1-2—MMAI Health Plans for SFY 2022

Health Plan Name	Abbreviation
Aetna Better Health Premier Plan	Aetna
Blue Cross Community MMAI	BCBSIL
Humana Gold Plan Integrated	Humana
Meridian Complete	Meridian
Molina Dual Options Medicare-Medicaid Plan	Molina

Quality Strategy

In 2021, in accordance with 42 CFR §438.200 et seq., HFS developed a transformative, person-centered, integrated, equitable Comprehensive Medical Programs Quality Strategy (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level. The Quality Strategy included 12 quality framework goals as shown in Figure 1-2.[1-1]

Figure 1-2—Quality Framework Goals

Better Care

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

Healthy People/Healthy Communities

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

Affordable Care

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

[1-1] Illinois Department of Healthcare & Family Services. 2021–2024 Comprehensive Medical Programs Quality Strategy. Available at: https://www2.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf. Accessed on: Feb 22, 2023.

The Quality Strategy identified five pillars of improvement inclusive of the populations served by Medicaid, including women and infant health, consumers with behavioral health needs, consumers with chronic conditions, and healthy children and adults with a central focus on health equity. Vision for improvement program goals were identified for each pillar, as shown in Figure 1-3. This report provides a review of health plan performance in comparison to the Quality Strategy goals.

Figure 1-3—Vision for Improvement Program Goals[1-2]

[1-2] Ibid.

Aggregating and Analyzing Statewide Data

42 CFR §438.364(a)(1) requires this technical report to include a description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the health plans. HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each plan, as well as the program overall.

Step 1: HSAG analyzes the quantitative results obtained from each EQR activity for each plan to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the plan for the EQR activity.

Step 2: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions about overall quality, timeliness, and accessibility of care and services furnished by the plans.

Step 3: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of quality, timeliness, and access to care and services furnished by the plans.

Step 4: HSAG identifies any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Detailed information about each activity's methodology is provided in the appendices of this report. For a comprehensive discussion of the strengths, opportunities for improvement, conclusions, and recommendations for each health plan, please refer to the results of each activity in Sections 2 through 7 of this report, as well as in Appendix A3 for health plan-specific analyses.

Please note, program-level and health plan-specific "strengths" are identified throughout this report in alignment with CMS guidance. However, rather than identifying "weaknesses," HSAG, in advisement from HFS, has designated "opportunities for improvement" throughout the report, which include areas where program or health plan performance was identified as needing improvement and recommendations were made to address performance.

Performance Domains

Results are presented to demonstrate the overall strengths and opportunities for improvement regarding the quality, timeliness, and accessibility of the care provided by the health plans serving Illinois' Medicaid beneficiaries. Descriptions of the three performance domains can be found in Appendix A1.

Scope of External Quality Review (EQR) Activities

HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS.[1-3] The purpose of these activities, in general, is to improve states' ability to oversee and manage plans they contract with for services and help health plans improve their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate state efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and Children's Health Insurance Program (CHIP) members. For the SFY 2022 assessment, HSAG used findings from the mandatory EQR activities displayed in Table 1-3 below and the optional activities described in sections 6 and 7 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each health plan.

Table 1-3—EQR Mandatory Activities

Activity	Description	CMS Protocol
Mandatory Activities		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures (PMs) calculated by a health plan are accurate based on the measure specifications and State reporting requirements.	**Protocol 2.** Validation of Performance Measures
Compliance With Standards	This activity determines the extent to which a Medicaid and CHIP health plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance With Medicaid and CHIP Managed Care Regulations
Validation of Network Adequacy*	CMS' network adequacy validation (NAV) protocol is currently reserved. See Section 5 for more information about HFS' network adequacy activities.	**Protocol 4.** Validation of Network Adequacy

* This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 22, 2023.

HealthChoice Illinois (HCI) Performance Snapshot

Table 1-4 and Table 1-5 provide a high-level snapshot of statewide performance for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] measures, compliance monitoring, PIPs, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-5] results for SFY 2022. The HEDIS results represent the HFS priority measures (listed in Appendix A1), and percentiles refer to national Medicaid percentiles. Additional details about these results can be found in subsequent sections of this report.

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

[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 1-4—HCI Performance Snapshot SFY 2022

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	55 Quality Measure Indicator Rates[i]	31 Timeliness Measure Indicator Rates[ii]	36 Access Measure Indicator Rates[iii]
Strengths 	Compliance	The forthcoming Compliance Review will include applicable federal and State regulations and laws and the requirements set forth in the Medicaid Model Contract and Illinois MMAI Demonstration Contract, as they relate to the scope of the review.		
	PIPs	The health plans submitted two new state-mandated PIPs for validation: *Improving timeliness of Prenatal Care* and *Improving Transportation Services*.		
	CAHPS	Although member experience survey results did not show a statistically significant improvement from the prior year, adult member experience survey results for *How Well Doctors Communicate* improved from the prior year and were at or between the 50th and 74th percentiles; and child member experience survey results for *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles.		
	HEDIS	**90th Percentile and Above** • 1 of 55 measure rates (1.82%) ○ *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 5 of 55 measure rates (9.09%) ○ *Immunizations for Adolescents (IMA)—Combination 1* ○ *Statin Therapy for Patients With Diabetes (SPD)—Received Statin Therapy* ○ *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)—7-Day Follow-Up—Ages 65+* ○ *FUM—30-Day Follow-Up—Ages 6–17* ○ *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing—Total* **Between the 50th and 74th Percentiles** • 17 of 55 measure rates (30.91%) ○ *Child and Adolescent Well-Care Visits (WCV)—Total*	**90th Percentile and Above** • 1 of 31 measure rates (3.23%) ○ *FUM—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 2 of 31 measure rates (6.45%) ○ *FUI—7-Day Follow-Up—Ages 65+* ○ *FUM—30-Day Follow-Up—Ages 6–17* **Between the 50th and 74th Percentiles** • 12 of 31 measure rates (38.71%) ○ *PPC—Timeliness of Prenatal Care* and *Postpartum Care* ○ *FUA—7-Day Follow-Up—Ages 18+, 30-Day Follow-Up—Ages 13–17,* and *30-Day Follow-Up—Ages 18+* ○ *FUM—7-Day Follow-Up—Ages 18–64* and *30-Day Follow-Up—Ages 18–64* ○ *FUI—7-Day Follow-Up—Ages 18–64, 30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *IET—Initiation of AOD Treatment—Ages 13–17* and *18+ Years*	**90th Percentile and Above** • 1 of 36 measure rates (2.78%) ○ *FUM—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 2 of 36 measure rates (5.56%) ○ *FUI—7-Day Follow-Up—Ages 65+* ○ *FUM—30-Day Follow-Up—Ages 6–17* **Between the 50th and 74th Percentiles** • 14 of 36 measure rates (39.89%) ○ *Annual Dental Visit (ADV)* ○ *Child and Adolescent Well-Care Visits (WCV)* ○ *PPC—Timeliness of Prenatal Care* and *Postpartum Care* ○ *FUA—7-Day Follow-Up—Ages 18+* and *30-Day Follow-Up—Ages 18+* ○ *FUM—7-Day Follow-Up—Ages 18–64* and *30-Day Follow-Up—Ages 18–64* ○ *FUI—7-Day Follow-Up—Ages 18–64, 30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *IET—Initiation of AOD Treatment—Ages 13–17* and *Ages 18+*

Indicators of Performance	Overall Domain Performance		
	Quality	Timeliness	Access
HEDIS	55 Quality Measure Indicator Rates[i]	31 Timeliness Measure Indicator Rates[ii]	36 Access Measure Indicator Rates[iii]
	○ *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* ○ *Comprehensive Diabetes Care (CDC)—HbA1c Testing* ○ *SPD—Statin Adherence 80%* ○ *Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)—7-Day Follow-Up—Ages 18+* and *30-Day Follow-Up—Ages 13–17* and *Ages 18+* ○ *FUM—7-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 18–64* ○ *FUI—7-Day Follow-Up—Ages 18–64, 30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Ages 13–17* and *18+ Years* ○ *APM–Cholesterol Testing–Total* and *Blood Glucose and Cholesterol Testing–Total*		

i. HEDIS results are based on the statewide weighted average (inclusive of all health plans). The quality measures reported for this table are those that could be compared to NCQA's Quality Compass® national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2020. (Quality Compass® is a registered trademark of the NCQA.) Refer to Appendix A1 for a list of the performance measure indicators that are included in the quality, timeliness, and access domains. Twenty-nine quality measure indicator rates (12 measures) are also included in the timeliness and access domains.

ii. Thirty-one timeliness measure rates were compared to national Medicaid percentiles for HEDIS MY 2020, but please note that all 31 measure rates are also included in the quality and access domains.

iii. Thirty-six access measure rates were compared to national Medicaid percentiles for HEDIS MY 2020; 31 of the 36 access measure rates are also included in either the quality or access domain, and two of the 36 access measure rates are also included in the quality domain.

Table 1-5—HCI Performance Snapshot SFY 2022

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	55 Quality Measures Rates[i]	31 Timeliness Measures Rates[ii]	36 Access Measures Rates[iii]
Opportunities for Improvement 	Compliance	Opportunities for improvement will be identified in the next three-year Compliance Review cycle scheduled to begin in SFY 2023.		
	PIPs	No opportunities for improvement were identified.		
	CAHPS	Adult member experience survey results were below the 50th percentile for every measure except *How Well Doctors Communicate,* which indicates that members perceive a lack of access to and timeliness of care, as well as an overall lack of quality of care. Child member experience survey results were below the 25th percentile for every measure except *Customer Service*, indicating that parents/caretakers of child members may perceive a lack of access to and timeliness of care for their child, as well as an overall lack of quality of care and services from providers and the programs.		
	HEDIS	**Below the 25th Percentile** • 13 of 55 measure rates (23.64%) ○ *Childhood Immunization Status (CIS)—Combination 3* and *Combination 10* ○ *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* ○ *Breast Cancer Screening (BCS)* ○ *Controlling High Blood Pressure (CBP)* ○ *FUM—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *Pharmacotherapy for Opioid Use Disorder (POD)—Ages 16–64* and *Total—Ages 16+* ○ *FUI—7-Day Follow-Up—Ages 13–17* and *30-Day Follow-Up—Ages 13–17* **Between the 25th and 49th Percentiles** • 19 of 55 measure rates (34.55%) ○ *IMA—Combination 2* ○ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile*	**Below the 25th Percentile** • 8 of 31 measure rates (25.81%) ○ *FUM—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *POD—Ages 16–64* and *Total (Ages 16+)* ○ *FUI—7-Day Follow-Up—Ages 13–17* and *30-Day Follow-Up—Ages 13–17* **Between the 25th and 49th Percentiles** • 8 of 31 measure rates (25.81%) ○ *FUM—7-Day Follow-Up—Ages 6–17, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 6–17,* and *30-Day Follow-Up—Ages 65+*	**Below the 25th Percentile** • 9 of 36 measure rates (25.00%) ○ *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* ○ *FUH—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *POD—Ages 16–64* and *Total (Ages 16+)* ○ *FUI—7-Day Follow-Up—Ages 13–17* and *30-Day Follow-Up—Ages 13–17* **Between the 25th and 49th Percentiles** • 10 of 36 measure rates (27.78%)

Table 1-5—HCI Performance Snapshot SFY 2022

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	55 Quality Measures Rates[i]	31 Timeliness Measures Rates[ii]	36 Access Measures Rates[iii]
		Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total* ○ *W30—Well-Child Visits in the First 15 Months—Six or More Visits* ○ *Cervical Cancer Screening (CCS)* ○ *Chlamydia Screening in Women (CHL)* ○ *CDC—HbA1c Control (<8.0%), HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* ○ *FUM—7-Day Follow-Up—Ages 65+* and *30-Day Follow-Up—Ages 65+* ○ *IET—Engagement of AOD Treatment— Ages 13–17* and *18+ Years* ○ *POD—Ages 65+* ○ *FUA—7-Day Follow-Up—Ages 13–17* ○ *FUH—7-Day Follow-Up—Ages 6–17* and *30-Day Follow-Up—Ages 6–17*	○ *IET—Engagement of AOD Treatment—Ages 13–17* and *18+ Years* ○ *POD—Ages 65+* ○ *FUA—7-Day Follow-Up—Ages 13–17*	○ *Adults' Access to Preventive/Ambulatory Health Services (AAP)* ○ *W30—Well-Child Visits in the First 15 Months of Life—Six or More Visits* ○ *FUM—7-Day Follow-Up—Ages 65+* and *30-Day Follow-Up—Ages 65+* ○ *IET—Engagement of AOD Treatment— Ages 13–17* and *Ages 18+* ○ *POD—Ages 65+* ○ *FUA—7-Day Follow-Up—Ages 13–17* ○ *FUH—7-Day Follow-Up—Ages 6–17* and *30-Day Follow-Up—Ages 6–17*

i. HEDIS results are based on the statewide weighted average (inclusive of all health plans). The quality measures reported for this table are those that could be compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2020. Refer to Appendix A1 for a list of the performance measure indicators that are included in the quality, timeliness, and access domains. Twenty-nine quality measure indicator rates (12 measures) are also included in the timeliness and access domains.

ii. Thirty-one timeliness measure rates were compared to national Medicaid percentiles for HEDIS MY 2020, but please note that all 31 measure rates are also included in the quality and access domains.

iii. Thirty-six access measure rates were compared to national Medicaid percentiles for HEDIS MY 2020; 31 of the 36 access measure rates are also included in either the quality or access domains, and two of the 36 access measure rates are also included in the quality domain.

Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2022 to comprehensively assess the health plans' performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP members. For each health plan reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the health plan's performance, which can be found in sections 2 through 7 of this report. The overall findings and conclusions for all health plans were also compared and analyzed to develop overarching conclusions and recommendations. Table 1-6 highlights substantive findings and actionable state-specific recommendations, when applicable, for HFS to further promote its Quality Strategy goals and objectives.

Table 1-6—Substantive Findings

Program Strengths	
+	**Quality** • Child and adolescent members received screening, counseling, and immunizations (as all five health plans ranked at or above the 50th percentile for *Child and Adolescent Well-Care Visits* and *Immunizations for Adolescents—Combination 1*). • HEDIS performance indicates that members with diabetes were receiving statin therapy, which helps reduce the risk of cardiovascular disease. • A majority of adult members with diabetes had an HbA1c test during the year, suggesting good management of diabetes. • Health plans were ensuring that members seen in the emergency department with a mental health diagnosis or a principal diagnosis of alcohol or other drug (AOD) abuse or dependence were receiving timely follow-up care (as indicated by several HEDIS measure indicators across age groups). • A majority of child and adolescent members with ongoing antipsychotic medication use were receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood. • Member experience survey results indicated that adult members perceived that their provider satisfactorily communicated and addressed their needs. • Member experience survey results for *Customer Service* indicated that parents/caretakers of child members perceived better quality of care from their health plan when they needed assistance (from 2021 to 2022). • Most health plans achieved a *Reportable* designation for PMV activities, indicating effective systems to calculate and report performance measures. • Most health plans demonstrated compliance with case management staffing and training requirements, including qualifications and related experience, caseload assignments, and training. • Overall, health plans had effective systems and processes to identify, report, address, and seek to prevent critical incidents (CIs) as determined by quarterly reviews of CI records. • Three of five health plans in both HealthChoice and MMAI performed at or above 90 percent in demonstrating compliance to CMS HCBS performance measures, and three of the five waiver types averaged greater than 90 percent compliance, as identified via the quarterly HCBS record reviews.

Program Strengths	
⊕	**Access and/or Timeliness** • HealthChoice Illinois, including MLTSS and MMAI health, contracted with a sufficient number of required provider types within each service region as verified by the analysis and monitoring of the provider networks. • Members had access to most types of providers within a reasonable amount of time or distance as validated by the time/distance analysis which included adult and child PCPs, behavioral health providers, pharmacies, hospitals, and a variety of specialty types.
⊕	**Quality, Access, and Timeliness** • HEDIS performance suggests that a majority of woman who gave birth received timely and adequate access to prenatal and postpartum care. • Members 13 years of age and older with a new diagnosis of AOD abuse or dependence received timely treatment following the new diagnosis.

Program Weaknesses	
⊖	**Quality** • Illinois' youngest children were not receiving well-care visits which provide an opportunity for providers to assess physical, emotional, and social development (as indicated by low rates for *Well-Child Visits in the First 30 Months of Life*). • Statewide rates for *Childhood Immunization Status* declined, suggesting that children were not receiving these immunizations, which are a critical aspect of preventable care for children. • Women were not receiving timely access to mammograms to screen for breast cancer. All five health plans and the statewide average continued to demonstrate a decrease in *Breast Cancer Screening* rates in MY 2021. Rates for two of five health plans decreased more than 5 percentage points. • Room for improvement was indicated for all of the MCOs on completing fully documented care plans with LTSS members in a specified time frame and successfully transitioning Medicaid MLTSS members in long-term facilities to the community.
⊖	**Access and/or Timeliness** • Adult members were not obtaining preventive or ambulatory visits, indicating that acute issues were not being addressed or chronic conditions were not being managed (as demonstrated by decreased rates for *Adults' Access to Preventive/Ambulatory Health Services—Total*). This measure continued to rank below the 50th percentile; three of the five plans ranked below the 25th percentile. • In an access and availability survey with specialty provider types, HSAG was unable to reach almost 40 percent of sampled cases and was only able to obtain an appointment date with 14.5 percent of the sampled locations. • The time/distance study identified regional gaps in access to oral surgery providers and pharmacies.
⊖	**Quality, Access, and Timeliness** • Adult members who were hospitalized for mental illness were not accessing or receiving timely follow-up care for mental illness, as indicated by low performance across all five health plans for *Follow-Up After Hospitalization for Mental Illness* (as demonstrated by several HEDIS measure indicators across age groups).

Program Weaknesses	
	• Child member experience survey results showed a statistically significant decline from last year for *Rating of All Health Care*, indicating that parents/caretakers of child members perceived a lack of access to and timeliness of care, as well as an overall lack of quality of care. • None of the adult or child member experience survey results showed a statistically significant improvement from the prior year. • General child experience survey results for the All Kids program and Illinois Medicaid program were below the 50th percentile for all measures.

Recommendations for Targeting Goals and Objectives in the Quality Strategy

Domain	Program Recommendations	Quality Strategy Goal and/or Objective
Quality	Require health plans to conduct a root cause analysis or focus study to determine why child members are not receiving the recommended well-child visits or immunizations. • Require health plans to use analysis to implement targeted outreach and/or incentives to those members not receiving services.	**Goal 1:** Improve population health. **Goal 4:** Improve participation in preventive care and screenings.
	Require health plans to conduct a root cause analysis or focus study to determine why members are not receiving breast cancer screenings. • Require health plans to use analysis to implement targeted outreach and/or incentives to those members not receiving services.	
	Monitor health plans to encourage: • System enhancements to increase the number of reportable fields for the care coordination data, and to ensure all required elements are located within the care plan template. • Review of the process for identifying the eligible LTSS population and data sources for institutional facility claims. • Evaluation of the clinical review process for continued stay requests to look for opportunities to initiate transition planning as early as possible to improve the rate of successful discharges from a long-term institutional stay.	**Goal 3:** Increase effective coordination of care.
Access and Timeliness	Lead a programwide focus group that includes members of each health plan to identify barriers/facilitators to members accessing preventive or ambulatory visits, including how to increase utilization of telehealth services.	**Goal 2:** Improve access to care. **Goal 4:** Improve participation in preventive care and screenings.
	To address potential opportunities to improve access: • Supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the access and availability survey calls. • Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. • Review provider office procedures for ensuring appointment availability standards are being met, address questions, or reeducate providers and office staff on HFS standards and incorporate appointment availability standards into educational materials.	**Goal 2:** Improve access to care. **Goal 6:** Create consumer-centric healthcare delivery system.

Domain	Program Recommendations	Quality Strategy Goal and/or Objective
Quality, Access, and Timeliness	To improve follow-up after hospitalization for mental illness: • Require health plans to evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Lead a programwide focus group that includes members of each health plan and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. • Encourage health plans to enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.	**Goal 2:** Improve access to care. **Goal 5:** Promote integration of behavioral and physical healthcare.
	Lead a programwide focus group that includes health plan enrollees to address results of child and adult CAHPS experience surveys and identify barriers/facilitators to obtaining access to care or treatment, as well as difficulty scheduling care with a provider or at a facility in a timely manner.	**Goal 2:** Improve access to care. **Goal 6:** Create consumer-centric healthcare delivery system.

2. Performance Measures

Overview

HSAG validates performance measures for each health plan to assess the accuracy of performance measures reported by the health plans, determine the extent to which these measures follow HFS' specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the performance measure rates.

HFS assesses strengths, needs, and challenges to identify target populations and prioritize improvement efforts.

In alignment with HFS' Quality Strategy, results from selected HEDIS measures are presented in this section to provide a snapshot of performance of Illinois' Medicaid health plans in the Pillars of Care domains:

- Access to Care
- Child Health
- Women's Health
- Maternal Health
- Living With Illness
- Adult Behavioral Health
- Child Behavioral Health

Section Contents

HealthChoice Illinois (HCI)

Health Plans

Table 2-1 displays the HCI health plans for which performance measures were reported in SFY 2022.[2-1]

Table 2-1—HCI Health Plans for HEDIS MY 2021 Measure Performance

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

Performance Measure Validation (PMV)—HEDIS

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's MY 2021 data. HFS contracted with HSAG to conduct an audit for each HCI health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 2021, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, which outlines the accepted approach for auditors to use when conducting an Information Systems Capabilities Assessment (ISCA) and an evaluation of compliance with HEDIS specifications for a health plan. HFS selected a specific set of performance measures for HSAG's validation based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. Additional details about the methodology and measure selection for PMV are in Appendix B.

Results

HSAG conducted a MY 2021 NCQA HEDIS Compliance Audit of the health plans' data collection and reporting processes for the HCI population. As shown in Table 2-2 HSAG determined all health plans were fully compliant with all HEDIS Information System (IS) standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased, and all performance measures required by HFS received an *R (*i.e., *Reportable)* designation.

[2-1] HFS established performance measures for YouthCare in SFY 2021, and SFY 2022 is the first reporting year for YouthCare. YouthCare's PMV is scheduled to be completed in SFY 2023.

Table 2-2—MY 2021 NCQA HEDIS Compliance Audit Results for All Health Plans

Information Systems Capabilities Assessment						
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**MRR Processes**	**Supplemental Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Performance Measure Results

Understanding Results

HEDIS is a nationally recognized set of performance measures used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.[2-2] To evaluate performance levels and to provide an objective, comparative review of Illinois health plans' quality-of-care outcomes and performance measures, HFS required its health plans to report results following NCQA's HEDIS protocols.

A key element of improving healthcare services is easily understood, comparable information on the performance of health plans. 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 health plans to make informed judgments about the effectiveness of existing processes, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives. HFS requires health plans to monitor and evaluate the quality of care using HEDIS performance measures. This section of the report displays results for measures selected by HFS that demonstrate health plan performance in domains of care that HFS prioritizes for improvement.

HFS contracted with five health plans to provide healthcare services to the general HCI population in SFY 2022. Four of the HCI health plans serve beneficiaries statewide, and one health plan serves beneficiaries in Cook County only.

In this report, Illinois health plans' performance for required HEDIS measurement year (MY) 2021 measures is compared to NCQA's Quality Compass®[2-3] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2020, when available, which is an indicator of health plan performance on a national level (referred to as "percentiles" throughout this section of the report). Details regarding the methodology are provided in Appendix B of this report.

Benchmarking data (e.g., Quality Compass) are the proprietary intellectual property of NCQA; therefore, this report does not display actual percentile values. As a result, rate comparisons to

[2-2] NCQA. HEDIS & Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Jan 27, 2023.

[2-3] Quality Compass® is a registered trademark of the NCQA.

benchmarks are illustrated within this report using proxy displays. Since the HEDIS process is retrospective, HEDIS MY 2020 results are calculated using calendar year (CY) 2020 data and HEDIS MY 2021 results are calculated using CY 2021 data.

Star Ratings

Star ratings represent the following percentile comparisons.

Table 2-3—Star Ratings

Stars	Percentiles
★★★★★	*90th percentile and above*
★★★★	*75th to 89th percentile*
★★★	*50th to 74th percentile*
★★	*25th to 49th percentile*
★	*Below 25th percentile*

COVID-19-Related Considerations

The COVID-19 pandemic impacted enrollee care during MY 2020 and MY 2021. To support the increased use of telehealth services necessitated by the pandemic and to align with telehealth guidance from the Centers for Medicare & Medicaid Services (CMS) and other stakeholders, NCQA updated 40 HEDIS measure specifications in MY 2020 to include the use of telehealth services. In addition, HFS continued to allow health plans to choose the appropriate data collection methodology for reporting measures with hybrid and administrative specifications as it has for several years, which allowed health plans to determine the method that yields higher performance rates based on the health plans' structure and practices.

NCQA continued to monitor the impact of COVID-19 on health plan business operations during MY 2021, including its potential effect on medical record data collection due to imposed travel bans, limited access to provider offices, quarantines, and risk to health plan staff. Due to the pandemic, healthcare practices deferred elective visits, modified their practices to safely accommodate in-person visits, and increased the use of telemedicine; however, members may not have chosen or had the ability to access care during 2020 and 2021 due to health concerns and factors relating to the pandemic, which may have impacted health plans' HEDIS performance measure results.

Although pandemic restrictions gradually subsided during 2021, health plans' HEDIS performance measure results may have continued to be impacted.

Measures

Table 2-4 identifies the measures in each of the Pillars of Care domains that are presented in this section of the report. HFS selected these measures as priorities for improvement.

Table 2-4—HFS-Required Measures by Pillars of Care Domains for HEDIS MY 2021

Measures
Access to Care
Adults' Access to Preventive/Ambulatory Health Services
Total
Ambulatory Care—Per 1,000 Member Months
Emergency Department (ED) Visits—Total
Outpatient Visits—Total
Child Health
Annual Dental Visit
Total
Child and Adolescent Well-Care Visits
Total
Childhood Immunization Status
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1 (Meningococcal, Tdap)
Combination 2 (Meningococcal, Tdap, HPV)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Body Mass Index (BMI) Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Well-Child Visits in the First 30 Months of Life
Well-Child Visits in the First 15 Months—Six or More Visits
Well-Child Visits for Age 15 Months–30 Months—Two or More Visits

Measures
Women's Health
Breast Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Total
Maternal Health
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care
Living With Illness
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Control (<8.0%)
HbA1c Poor Control (>9.0%)
HbA1c Testing
Eye Exam (Retinal) Performed
Blood Pressure Control (<140/90 mm Hg)
Controlling High Blood Pressure
Controlling High Blood Pressure
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Statin Adherence 80%
Adult Behavioral Health
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
7-Day Follow-Up—Ages 18+
30-Day Follow-Up—Ages 18+
Follow-Up After Emergency Department Visit for Mental Illness
7-Day Follow-Up—Ages 18–64
7-Day Follow-Up—Ages 65+

Measures
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Follow-Up After High-Intensity Care for Substance Use Disorder
7-Day Follow-Up—Ages 18–64
7-Day Follow-Up—Ages 65+
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Ages 18–64
7-Day Follow-Up—Ages 65+
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
Initiation of AOD Treatment—18+ Years
Engagement of AOD Treatment—18+ Years
Mental Health Utilization
Any Service—Ages 18–64
Any Service—Ages 65+
Any Service—Unknown
Inpatient—Ages 18–64
Inpatient—Ages 65+
Inpatient—Unknown
Intensive Outpatient or Partial Hospitalization—Ages 18–64
Intensive Outpatient or Partial Hospitalization—Ages 65+
Intensive Outpatient or Partial Hospitalization—Unknown
Outpatient—Ages 18–64
Outpatient—Ages 65+
Outpatient—Unknown
ED—Ages 18–64
ED—Ages 65+
ED—Unknown

Measures
Telehealth—Ages 18–64
Telehealth—Ages 65+
Telehealth—Unknown
Pharmacotherapy for Opioid Use Disorder
Ages 16–64
Ages 65+
Total (Ages 16+)
Child Behavioral Health
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
7-Day Follow-Up—Ages 13–17
30-Day Follow-Up—Ages 13–17
Follow-Up After Emergency Department Visit for Mental Illness
7-Day Follow-Up—Ages 6–17
30-Day Follow-Up—Ages 6–17
Follow-Up After High-Intensity Care for Substance Use Disorder
7-Day Follow-Up—Ages 13–17
30-Day Follow-Up—Ages 13–17
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Ages 6–17
30-Day Follow-Up—Ages 6–17
Initiation and Engagement of AOD Abuse or Dependence Treatment
Initiation of AOD Treatment—Ages 13–17
Engagement of AOD Treatment—Ages 13–17
Mental Health Utilization
Any Service—Ages 0–12
Any Service—Ages 13–17
Inpatient—Ages 0–12
Inpatient—Ages 13–17
Intensive Outpatient or Partial Hospitalization—Ages 0–12
Intensive Outpatient or Partial Hospitalization—Ages 13–17
Outpatient—Ages 0–12

Measures
Outpatient—Ages 13–17
ED—Ages 0–12
ED—Ages 13–17
Telehealth—Ages 0–12
Telehealth—Ages 13–17
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose Testing—Total
Cholesterol Testing—Total
Blood Glucose and Cholesterol Testing—Total

Summary of HCI Performance

Access to Care

Access to and utilization of primary and preventive care is essential for Illinois Medicaid beneficiaries to achieve the best health outcomes. Obtaining good access to care often requires Medicaid beneficiaries to find a trusted primary care practitioner (PCP) to meet their needs. Medicaid beneficiaries should utilize their PCP to help them prevent illnesses and encourage healthy behaviors through needed services.[2-4]

Table 2-5 presents the HEDIS MY 2020 and HEDIS MY 2021 rates for the measures in the Access to Care domain for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that member access to care due to restrictions from the pandemic may have impacted health plans' MY 2020 and MY 2021 performance.

Table 2-5—Access to Care Domain Results for HEDIS MY 2020 and HEDIS MY 2021

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	MY 2020	★ 71.43%	★★ 78.20%	★★ 73.63%	★★ 77.32%	★ 71.91%	★★ 75.24%
	MY 2021	★ 69.89%	★★ 75.90%	★ 71.44%	★★ 74.81%	★ 71.06%	★★ 73.27%
Ambulatory Care (per 1,000 Member Months)							
*ED Visits—Total**	MY 2020	★ 48.95	★★★ 38.70	★★ 45.73	★★ 41.63	★ 48.03	★★ 43.50
	MY 2021	★ 51.03	★★ 42.90	★ 48.00	★★ 45.30	★ 51.30	★★ 46.74
Outpatient Visits—Total	MY 2020	★★★ 303.73	★★★★ 381.10	★★ 271.31	★★ 279.90	★ 249.65	★★★ 301.74
	MY 2021	★★ 272.44	★★★★ 354.89	★★ 287.11	★★ 288.60	★★ 276.55	★★ 300.21

** Indicates this is a "lower is better" measure.*

[2-4] Agency for Healthcare Research and Quality. National Healthcare Disparities Report, 2011. Available at: https://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap9.html#. Accessed on: Jan 25, 2023.

Strengths	• BCBSIL continued to perform at or above the 75th percentile for the *Ambulatory Care—Outpatient Visits—Total* measure rate, indicating members are consistently utilizing preventive services, which can significantly reduce nonurgent ED visits. • Molina demonstrated a significant increase in performance for the *Ambulatory Care—Outpatient Visits—Total* measure, indicating its commitment to improving preventive care for members, which can help reduce the need for nonurgent ED visits.
Opportunities for Improvement	**Opportunity:** All five health plans and the statewide average continued to demonstrate a decrease in performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure and continued to rank below the 50th percentile; three of the five plans ranked below the 25th percentile. **Why the Opportunity Exists:** Although adults appear to have access to PCPs for preventive and ambulatory services, members are not consistently obtaining preventive or ambulatory services, which can significantly reduce nonurgent ED visits. This also indicates that acute issues are not being addressed or chronic conditions are not being managed. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.

Child Health

Illinois Medicaid provides healthcare to over 1.4 million children, nearly half of the population HFS serves.[2-5] Appropriate standardized measures of health are needed to improve the overall quality of child healthcare, as the health status of children and adolescents is important for society, helping to determine the health of the next generation.[2-6]

Table 2-6 presents the HEDIS MY 2020 and HEDIS MY 2021 rates for the measures in the Child Health domain for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that due to the pandemic, health plans' MY 2020 and MY 2021 performance may have been impacted for preventive care measures that required in-person visits.

Table 2-6—Child Health Domain Results for HEDIS MY 2020 and HEDIS MY 2021

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Child Health							
Annual Dental Visit							
Annual Dental Visit	MY 2020	★★ 37.45%	★★★★ 53.08%	★★★ 47.50%	★★ 43.38%	★★ 37.02%	★★ 44.68%
	MY 2021	★★ 43.31%	★★ 36.46%	★★★ 52.15%	★★★ 49.77%	★★★★ 54.47%	★★★ 46.61%
Child and Adolescent Well-Care Visits							
Total	MY 2020	★★ 39.53%	★★★ 49.54%	★★ 43.10%	★★★ 47.81%	★★ 42.75%	★★★ 45.79%
	MY 2021	★★★ 46.07%	★★★ 52.70%	★★★★ 53.86%	★★★ 52.41%	★★★ 50.18%	★★★ 51.60%
Childhood Immunization Status							
Combination 3	MY 2020	★ 60.83%	★★ 63.50%	★★ 67.64%	★ 56.93%	★ 58.15%	★ 60.33%
	MY 2021	★ 53.77%	★ 60.34%	★ 60.10%	★ 54.74%	★ 58.88%	★ 57.15%

[2-5] Illinois Department of Healthcare and Family Services. Annual Report, April 1, 2021. Available at: https://www2.illinois.gov/hfs/SiteCollectionDocuments/2021MedicalAssistanceAnnualReportFinal.pdf. Accessed on: Jan 27, 2023.

[2-6] National Quality Forum. Pediatric measures: Final Report, June 15, 2016. Available at: https://www.qualityforum.org/Publications/2016/06/Pediatric_Measures_Final_Report.aspx. Accessed on: Jan 27, 2023.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Combination 10	MY 2020	★ 25.79%	★★ 32.36%	★★★ 39.66%	★ 31.39%	★ 26.76%	★ 31.57%
	MY 2021	★ 22.14%	★ 31.39%	★★ 34.79%	★ 26.03%	★ 26.28%	★ 28.08%
Immunizations for Adolescents							
Combination 1 (Meningococcal, Tdap)	MY 2020	★★★★ 88.08%	★★★★ 88.81%	★★★ 85.16%	★★★★ 88.08%	★★★★★ 89.05%	★★★★ 87.88%
	MY 2021	★★★★★ 89.29%	★★★★★ 90.02%	★★★ 84.67%	★★★★ 88.56%	★★★ 85.69%	★★★★ 88.12%
Combination 2 (Meningococcal, Tdap, HPV)	MY 2020	★ 30.66%	★★★ 38.44%	★★★★ 46.72%	★ 30.66%	★★★ 37.23%	★★ 35.44%
	MY 2021	★ 26.03%	★★ 34.79%	★★★ 40.15%	★ 27.98%	★★ 31.43%	★★ 31.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile Documentation—Total	MY 2020	★ 58.15%	★ 66.18%	★★ 70.49%	★ 66.67%	★★★ 76.64%	★ 66.98%
	MY 2021	★ 65.94%	★★★ 77.62%	★★★★ 83.17%	★ 60.83%	★★★ 80.54%	★★ 70.85%
Counseling for Nutrition—Total	MY 2020	★ 50.61%	★ 56.93%	★★ 65.63%	★ 59.61%	★★ 65.94%	★ 59.28%
	MY 2021	★★ 63.75%	★★★ 72.26%	★★★★ 81.52%	★ 53.77%	★★ 68.13%	★★ 64.97%
Counseling for Physical Activity—Total	MY 2020	★ 46.72%	★ 49.88%	★★ 61.81%	★ 55.72%	★★ 65.69%	★ 55.04%
	MY 2021	★★ 62.77%	★★★ 68.13%	★★★★ 77.56%	★ 49.39%	★★★ 68.13%	★★ 61.62%
Well-Child Visits in the First 30 Months of Life							
Well-Child Visits in the First 15 Months—Six or More Visits	MY 2020	★★★ 55.92%	★ 39.27%	★★★ 55.23%	★★★ 58.24%	★★★ 60.00%	★★ 54.00%
	MY 2021	★★ 51.24%	★★ 50.15%	★★ 51.70%	★★ 50.33%	★★★ 58.51%	★★ 51.49%
Well-Child Visits for Age 15 Months–30 Months—Two or More Visits	MY 2020	★ 63.23%	★★ 68.20%	★ 65.17%	★★ 69.96%	★ 63.38%	★★ 67.49%
	MY 2021	★ 57.82%	★ 63.31%	★ 59.49%	★ 60.53%	★ 59.84%	★ 60.48%

Strengths

- Four of five health plans (i.e., Aetna, BCBSIL, CountyCare, and Molina) and the statewide average demonstrated an increase in performance for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators. Of note, BCBSIL ranked between the 50th and 74th percentiles, and CountyCare ranked between the 75th and 89th percentiles for each measure indicator. This performance demonstrates the health plans' commitment to monitoring weight problems in their children

and adolescent members, which may lower the risk of becoming obese and developing related diseases, which can become a lifelong health issue.

- All five health plans and the statewide average ranked at or above the 50th percentile for the *Child and Adolescent Well-Care Visits* measure, demonstrating their commitment to providing screening and counseling to children and adolescent members, which is critical in influencing health and development. Of note, CountyCare ranked at or above the 75th percentile.
- All five health plans and the statewide average ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 1* measure. Of note, Aetna and BCBSIL ranked at or above the 90th percentile, indicating their adolescent members are at a lower risk for contracting serious diseases that can cause breathing difficulties, heart problems, nerve damage, pneumonia, seizures, and even death.
- Four of five health plans and the statewide average demonstrated an increase in performance for the *Annual Dental Visit* measure, indicating the health plans' commitment to their members' oral health, which is essential to overall health. Of note, Molina demonstrated an increase in performance of 17.45 percentage points and ranked at or above the 75th percentile.
- BCBSIL demonstrated an increase in performance of more than 10 percentage points for the *Well-Child Visits in the First 30 Months of Life—Six or More Visits* measure, demonstrating a commitment to ensuring its child members are receiving the recommended well-care visits in the first 15 months of life.

Opportunities for Improvement

Opportunity: BCBSIL's performance for the *Annual Dental Visit* measure showed a decline of more than 15 percentage points from the prior MY, and the percentile ranking changed from the 75th to 89th percentile to the 25th to 49th percentile, suggesting its child members are not receiving regular dental visits. Regular preventive dental care helps keep children's teeth healthy and allows providers to address any tooth decay or dental problems before they become more serious.

Why the Opportunity Exists: Decreased performance may potentially be due to lingering effects of the COVID-19 pandemic during 2021. Factors that may have contributed to the decline during this time include site closures. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking preventive dental care.

Recommendation: HSAG recommends that BCBSIL conduct a root cause analysis or focus study to determine why its child members are not receiving regular dental visits. Upon identification of a root cause, BCBSIL should implement appropriate interventions to improve performance related to the *Annual Dental Visit* measure.

Opportunity: Four of five health plans demonstrated a decrease in performance for the *Well-Child Visits in the First 30 Months of Life—Six or More Visits* measure. Additionally, all five health plans ranked below the 25th percentile for the *Well-Child Visits in the First 30 Months of Life—Age 15 Months–30 Months—Two or More Visits* indicator. This performance indicates that children are not receiving well-care visits which provide an opportunity for providers to assess physical, emotional, and social development, which is important at every stage of life, particularly with children.

Why the Opportunity Exists: Well-child visit declines may have been due to lingering effects of the COVID-19 pandemic during 2021. Factors that may have contributed to the declines during this time include site closures and the temporary suspension of nonurgent services due to the pandemic. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including well-child visits.

Recommendation: HSAG recommends that the health plans conduct a root cause analysis or focus study to determine why its child members are not receiving the recommended well-child visits. Health plans could consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to well-child visits.

Opportunity: Four of five health plans and the statewide average continued to demonstrate a decline in performance for the *Childhood Immunization Status—Combination 3* measure. Additionally, all five health plans and the statewide average demonstrated a decline in performance for the *Childhood Immunization Status—Combination 10* measure, suggesting that children are not receiving these immunizations, which are a critical aspect of preventable care for children.

Why the Opportunity Exists: Immunization declines may have been due to lingering effects of the pandemic during 2021. Factors that may have contributed to the declines during this time include site closures and the temporary suspension of nonurgent services due to the pandemic. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations.

Recommendation: HSAG recommends that the health plans conduct a root cause analysis or focus study to determine why child members are not receiving all recommended vaccines. Health plans could consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Health plans could also consider if a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, health plans should implement appropriate interventions to improve the performance related to these measures.

Women's and Maternal Health

Quality in women's healthcare is assessed with preventive measures such as *Breast Cancer Screening* and obstetrical measures such as *Prenatal and Postpartum Care*. Appropriate cancer screenings for women can lead to early detection and more effective treatment.[2-7]

Table 2-7 presents the HEDIS MY 2020 and HEDIS MY 2021 rates for the measures in the Women's Health and Maternal Health domains for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that due to the pandemic, health plans' MY 2020 and MY 2021 performance may have been impacted for preventive care measures that required in-person visits.

Table 2-7—Women's Health and Maternal Health Domain Results for HEDIS MY 2020 and HEDIS MY 2021

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Women's Health							
Breast Cancer Screening							
Breast Cancer Screening	MY 2020	★★ 48.07%	★★ 53.27%	★★ 53.50%	★★ 52.29%	★★ 49.45%	★★ 51.83%
	MY 2021	★ 42.41%	★★ 50.93%	★★ 50.89%	★ 46.41%	★ 47.47%	★ 47.80%
Cervical Cancer Screening							
Cervical Cancer Screening	MY 2020	★ 45.50%	★★ 52.80%	★★★ 60.71%	★★★ 60.10%	★★★ 59.12%	★★ 56.08%
	MY 2021	★ 45.50%	★★ 56.93%	★★★ 60.00%	★ 48.26%	★★ 56.69%	★★ 52.83%
Chlamydia Screening in Women							
Total	MY 2020	★★ 54.07%	★★★ 54.91%	★★★ 61.61%	★ 45.01%	★★★ 56.10%	★★ 52.63%
	MY 2021	★★★ 56.80%	★★★ 55.31%	★★★ 61.37%	★ 43.89%	★★★ 56.38%	★★ 52.87%

[2-7] The Community Guide. *Cancer Screening: Evidence-Based Interventions for Your Community*. Available at: https://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed on: Mar 1, 2023.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Maternal Health							
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	MY 2020	★★★ 86.86%	★★★★ 91.00%	★ 77.78%	★★★★ 89.54%	★★ 84.91%	★★★ 87.30%
	MY 2021	★★ 83.70%	★★★ 87.83%	★★ 82.16%	★★★ 85.89%	★★★★ 90.27%	★★★ 86.10%
Postpartum Care	MY 2020	★★ 75.18%	★★★★ 80.54%	★★★ 76.90%	★★★ 79.08%	★★★ 76.64%	★★★ 78.29%
	MY 2021	★★ 72.02%	★★★★ 81.27%	★★★★ 79.82%	★★★★ 79.56%	★★★★ 79.56%	★★★ 78.96%

Strengths

- Four of five health plans and the statewide average continued to demonstrate an increase in performance for *Prenatal and Postpartum Care—Postpartum Care*. Additionally, these four plans ranked between the 75th and 89th percentiles and all four showed improvement from the prior MY.
- Molina demonstrated an increase of more than 5 percentage points for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and ranked at or above the 75th percentile.

Opportunities for Improvement

Opportunity: All five health plans and the statewide average continued to demonstrate a decrease in *Breast Cancer Screening* rates in MY 2021. Two of five health plans had a decrease of more than 5 percentage points. Additionally, three health plans and the statewide average ranked below the 25th percentile.

Why the Opportunity Exists: Women are not receiving timely access to mammograms to screen for breast cancer. Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower healthcare costs. In addition, screening declines may have been due to the lingering effects of the pandemic during 2021.

Recommendation: HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their female members are not receiving timely screenings for breast cancer. Health plans could also consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to the *Breast Cancer Screening* measure.

Opportunity: Meridian's performance for the *Cervical Cancer Screening* measure showed a decline of more than 10 percentage points from the prior MY and ranked below the 25th percentile.

Why the Opportunity Exists: This decline in performance suggests that Meridian's female members are not receiving timely access to screen for cervical cancer. Effective screening and early detection of cervical pre-cancers have led to a significant reduction in the death rate.

Recommendation: HSAG recommends that Meridian conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for cervical cancer. Meridian could also consider if there are disparities within its population that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, Meridian should implement appropriate interventions to improve performance related to the *Cervical Cancer Screening* measure.

Living With Illness

For Medicaid beneficiaries living with illness (i.e., chronic conditions), it is essential to effectively manage the care provided to those beneficiaries and improve health outcomes for those beneficiaries.[2-8]

Table 2-8 presents the HEDIS MY 2020 and HEDIS MY 2021 rates for the measures in the Living With Illness domain for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that although telehealth was added to several HEDIS measures, due to the pandemic, health plans' MY 2020 and MY 2021 performance may have been impacted.

Table 2-8—Living With Illness Domain Results for HEDIS MY 2020 and HEDIS MY 2021

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Living with Illness							
Comprehensive Diabetes Care							
HbA1c Control (<8.0%)	MY 2020	★ 26.03%	NR	★ 34.79%	★ 35.77%	★★ 39.66%	★ 33.93%
	MY 2021	★★ 42.34%	★★★ 47.69%	★★ 40.39%	★ 35.28%	★★ 42.34%	★★ 40.98%
*HbA1c Poor Control (>9.0%)**	MY 2020	★ 68.61%	NR	★★★ 38.93%	★ 57.18%	★ 52.55%	★ 54.61%
	MY 2021	★★ 50.61%	★★★ 40.39%	★★ 50.85%	★ 58.64%	★★ 47.45%	★★ 50.47%
Hemoglobin A1c (HbA1c) Testing	MY 2020	★★ 82.24%	★★★★ 86.62%	★★★ 83.94%	★★ 80.29%	★★ 82.73%	★★★ 82.99%
	MY 2021	★★★ 85.64%	★★★★★ 90.27%	★★★ 85.64%	★★★ 83.45%	★★★★ 86.13%	★★★ 86.11%
Eye Exam (Retinal) Performed	MY 2020	★ 44.53%	★★★ 52.31%	★★★ 52.07%	★★ 45.01%	★ 44.04%	★★ 47.87%
	MY 2021	★★★ 51.58%	★★ 48.18%	★★ 50.85%	★ 41.61%	★ 42.82%	★★ 46.43%

[2-8] Kronick RG, Bella M, Gilmer TP, et al. Faces of Medicaid II: Recognizing the care needs of people with multiple chronic conditions. October 2007. Available at: https://www.chcs.org/resource/the-faces-of-medicaid-ii-recognizing-the-care-needs-of-people-with-multiple-chronic-conditions/. Accessed on: Jan 25, 2023.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Blood Pressure Control (<140/90 mm Hg)	MY 2020	★ 42.09%	NR	★ 43.80%	★ 47.93%	★★ 57.66%	★ 46.84%
	MY 2021	★★ 54.74%	★★★ 64.72%	★ 52.07%	★ 46.96%	★★★ 60.34%	★★ 54.73%
Controlling High Blood Pressure							
Controlling High Blood Pressure	MY 2020	★ 36.01%	★ 44.53%	★ 43.80%	★ 43.80%	★★ 51.09%	★ 43.35%
	MY 2021	★ 49.88%	★★★ 57.66%	★ 45.50%	★ 43.80%	★★★ 60.10%	★ 50.03%
Statin Therapy for Patients With Diabetes							
Received Statin Therapy	MY 2020	★★★ 68.80%	★★★★★ 72.41%	★★★★ 70.56%	★★★ 68.51%	★★★ 66.54%	★★★★ 69.71%
	MY 2021	★★★ 67.87%	★★★★ 71.74%	★★★★ 71.27%	★★★ 69.26%	★★★ 68.28%	★★★★ 69.95%
Statin Adherence 80%	MY 2020	★★ 68.44%	★★ 67.02%	★★★★ 73.83%	★★★ 71.72%	★★ 65.17%	★★★ 70.04%
	MY 2021	★★★ 69.15%	★★ 67.55%	★★★ 73.17%	★★ 67.79%	★★ 65.57%	★★★ 68.84%

** Indicates this is a "lower is better" measure.*
NR indicates the health plan chose not to report the measure.

Strengths

- Three of five health plans and the statewide average demonstrated an increase in performance of more than 5 percentage points for the *Controlling High Blood Pressure* measure. Of note, the rates for Aetna and BCBSIL increased more than 10 percentage points, and BCBSIL and Molina ranked between the 50th and 74th percentiles.
- All five health plans and the statewide average continued to meet or exceed the 50th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator for MY 2021. Additionally, the statewide average and two of the five health plans met or exceeded the 75th percentile. This performance indicates members are receiving statin therapy, which helps reduce the risk of cardiovascular disease, which is elevated for people with diabetes.
- All five health plans and the statewide average ranked at or above the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator. Of note, BCBSIL ranked at or above the 90th percentile, and Molina ranked at or above the 75th percentile. This performance suggests their members are managing diabetes and avoiding complications including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.
- Two of five health plans and the statewide average demonstrated an increase of more than 5 percentage points for the *HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators. Of note,

BCBSIL ranked at or above the 50th percentile for both indicators. Additionally, two health plans demonstrated an increase in performance of more than 5 percentage points for the *HbA1c Poor Control (>9.0%)* indicator, and one plan demonstrated an increase of more than 5 percentage points for the *Eye Exam (Retinal) Performed* indicator.

Opportunities for Improvement

Opportunity: CountyCare demonstrated a decrease in performance of more than 10 percentage points for the *HbA1c Poor Control (>9.0%)* indicator.

Why the Opportunity Exists: This decline in performance indicates CountyCare's members are not receiving proper diabetes management. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.

Recommendation: HSAG recommends that CountyCare conduct a root cause analysis or focus study to determine why its diabetic members' blood sugar levels were not properly controlled. CountyCare could consider if there are disparities within its population that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, CountyCare should implement appropriate interventions to improve performance related to the *HbA1c Poor Control (>9.0%)* indicator.

Adult and Child Behavioral Health

Good mental health is important for productivity, building relationships, and personal well-being. Mental illnesses, such as anxiety and depression, affect physical health by hindering health-promoting behaviors.[2-9]

Table 2-9 and Table 2-10 present the HEDIS MY 2020 and HEDIS MY 2021 rates for the measures in the Adult and Child Behavioral Health domains for the health plans and the statewide average, which represents the average of all health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that due to the pandemic, health plans' MY 2020 and MY 2021 performance may have been impacted for behavioral health measures due to pandemic restrictions as well as the general increase in people with behavioral health issues that may have been caused by social isolation and disconnectedness as a direct result of the pandemic.

Adult Behavioral Health Results

Table 2-9—Adult Behavioral Health Domain Results for HEDIS MY 2020 and HEDIS MY 2021

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Adult Behavioral Health							
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence							
7-Day Follow-Up—Ages 18+	MY 2020	★★★ 14.91%	★★★ 16.25%	★★ 11.79%	★★★ 15.46%	★★★ 15.24%	★★★ 14.90%
	MY 2021	★★★ 16.40%	★★★ 16.85%	★★ 11.92%	★★★ 16.02%	★★★★ 20.46%	★★★ 16.29%
30-Day Follow-Up—Ages 18+	MY 2020	★★★ 22.13%	★★★ 23.58%	★★ 17.49%	★★★ 22.53%	★★★ 22.39%	★★★ 21.84%
	MY 2021	★★★ 23.50%	★★★ 23.98%	★★ 16.73%	★★★ 22.39%	★★★★ 28.31%	★★★ 22.95%

[2-9] U.S. Department of Health and Human Services. 2021 Topics & Objectives: Mental Health and Mental Disorders. Available at: https://www.healthypeople.gov/2021/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: Jan 25, 2023.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Follow-Up After Emergency Department Visit for Mental Illness							
7-Day Follow-Up—Ages 18–64	MY 2020	★★★★ 51.17%	★★★★ 46.09%	★★ 33.09%	★★★★ 50.56%	★★★★ 50.55%	★★★★ 48.35%
	MY 2021	★★★★ 46.61%	★★★ 43.01%	★★★ 34.65%	★★★★ 46.26%	★★★★ 49.72%	★★★ 45.10%
7-Day Follow-Up—Ages 65+	MY 2020	NA	NA	NA	NA	NA	★★★★ 43.75%
	MY 2021	NA	NA	NA	★★ 31.94%	NA	★★ 31.50%
30-Day Follow-Up—Ages 18–64	MY 2020	★★★★ 60.48%	★★★ 56.69%	★★ 41.91%	★★★★ 61.07%	★★★★ 60.06%	★★★ 58.34%
	MY 2021	★★★ 56.20%	★★★ 53.98%	★★ 44.14%	★★★ 55.96%	★★★★ 60.54%	★★★ 55.20%
30-Day Follow-Up—Ages 65+	MY 2020	NA	NA	NA	NA	NA	★★★★ 56.25%
	MY 2021	NA	NA	NA	★★ 45.83%	NA	★★ 43.31%
Follow-Up After High-Intensity Care for Substance Use Disorder							
7-Day Follow-Up—Ages 18–64	MY 2020	★★★ 40.47%	★★★★ 44.22%	★★★ 38.33%	★★★ 37.81%	★★★ 42.13%	★★★ 40.01%
	MY 2021	★★★ 38.03%	★★★ 39.49%	★★★ 39.27%	★★★ 39.77%	★★★ 39.75%	★★★ 39.28%
7-Day Follow-Up—Ages 65+	MY 2020	NA	NA	★★★★ 33.33%	NA	NA	★★★★ 32.94%
	MY 2021	NA	NA	★★★★ 42.86%	★★★★ 40.63%	NA	★★★★ 36.89%
30-Day Follow-Up—Ages 18–64	MY 2020	★★★ 56.91%	★★★ 60.01%	★★ 53.99%	★★★ 55.03%	★★★ 55.51%	★★★ 56.01%
	MY 2021	★★ 53.71%	★★★ 56.31%	★★ 54.37%	★★★ 55.27%	★★★ 55.68%	★★★ 55.04%
30-Day Follow-Up—Ages 65+	MY 2020	NA	NA	★★★ 45.45%	NA	NA	★★★ 44.71%
	MY 2021	NA	NA	★★★★ 52.38%	★★★ 46.88%	NA	★★★ 48.36%
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Ages 18–64	MY 2020	★ 24.21%	★ 20.67%	★ 20.05%	★★ 29.78%	★ 24.97%	★ 24.57%
	MY 2021	★★ 26.67%	★ 25.69%	★ 18.52%	★ 21.26%	★ 24.26%	★ 23.24%
7-Day Follow-Up—Ages 65+	MY 2020	NA	NA	★★ 18.18%	★★★ 26.67%	NA	★★ 23.21%
	MY 2021	NA	★★★ 26.47%	★ 15.38%	★ 5.45%	NA	★ 16.46%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
30-Day Follow-Up—Ages 18–64	MY 2020	★ 40.25%	★ 37.75%	★ 35.16%	★★ 51.82%	★ 44.32%	★ 42.88%
	MY 2021	★★ 45.27%	★★ 45.79%	★ 34.72%	★ 37.24%	★★ 45.75%	★ 41.34%
30-Day Follow-Up—Ages 65+	MY 2020	NA	NA	★ 30.30%	★★ 46.67%	NA	★ 38.39%
	MY 2021	NA	★ 38.24%	★ 28.21%	★ 23.64%	NA	★ 32.91%
Initiation and Engagement of AOD Abuse or Dependence Treatment							
Initiation of AOD Treatment—18+ Years	MY 2020	★★ 41.91%	★★ 43.76%	★★★★★ 59.95%	★★ 42.99%	★★ 41.89%	★★★ 45.27%
	MY 2021	★★ 43.68%	★★ 44.07%	★★★★★ 63.36%	★★ 43.80%	★★ 43.66%	★★★ 46.50%
Engagement of AOD Treatment—18+ Years	MY 2020	★★★ 14.83%	★★★ 14.09%	★★ 12.03%	★★ 12.77%	★★ 11.80%	★★ 13.20%
	MY 2021	★★ 13.67%	★★ 13.54%	★★ 10.68%	★★ 13.06%	★★ 12.44%	★★ 12.86%
Mental Health Utilization[1]							
Any Service—Ages 18–64	MY 2020	NC 14.26%	NC 12.60%	NC 11.47%	NC 15.03%	NC 14.24%	NC 13.68%
	MY 2021	NC 12.82%	NC 10.79%	NC 10.43%	NC 11.36%	NC 12.27%	NC 11.44%
Any Service—Ages 65+	MY 2020	NC 9.48%	NC 6.90%	NC 8.21%	NC 9.24%	NC 10.50%	NC 8.61%
	MY 2021	NC 8.45%	NC 6.10%	NC 7.84%	NC 8.74%	NC 8.67%	NC 8.01%
Any Service—Unknown	MY 2020	—	—	—	—	—	NA
	MY 2021	—	—	—	—	—	NA
Inpatient—Ages 18–64	MY 2020	NC 2.50%	NC 1.93%	NC 1.85%	NC 1.90%	NC 1.94%	NC 2.01%
	MY 2021	NC 2.10%	NC 1.68%	NC 1.65%	NC 1.73%	NC 1.69%	NC 1.76%
Inpatient—Ages 65+	MY 2020	NC 3.90%	NC 1.84%	NC 1.76%	NC 3.27%	NC 6.47%	NC 3.06%
	MY 2021	NC 3.77%	NC 1.68%	NC 1.64%	NC 5.28%	NC 5.27%	NC 3.77%
Inpatient—Unknown	MY 2020	—	—	—	—	—	NA
	MY 2021	—	—	—	—	—	NA
Intensive Outpatient or Partial Hospitalization—Ages 18–64	MY 2020	NC 0.49%	NC 0.46%	NC 0.00%	NC 0.51%	NC 0.68%	NC 0.43%
	MY 2021	NC 0.50%	NC 0.45%	NC 0.00%	NC 0.46%	NC 0.56%	NC 0.40%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Intensive Outpatient or Partial Hospitalization—Ages 65+	MY 2020	NC 0.06%	NC 0.03%	NC 0.00%	NC 0.08%	NC 0.06%	NC 0.05%
	MY 2021	NC 0.10%	NC 0.04%	NC 0.00%	NC 0.08%	NC 0.06%	NC 0.06%
Intensive Outpatient or Partial Hospitalization—Unknown	MY 2020	—	—	—	—	—	NA
	MY 2021	—	—	—	—	—	NA
Outpatient—Ages 18–64	MY 2020	NC 12.51%	NC 10.83%	NC 8.53%	NC 13.40%	NC 11.44%	NC 11.65%
	MY 2021	NC 10.66%	NC 9.19%	NC 7.38%	NC 9.62%	NC 9.81%	NC 9.36%
Outpatient—Ages 65+	MY 2020	NC 5.75%	NC 5.00%	NC 5.63%	NC 6.18%	NC 3.95%	NC 5.46%
	MY 2021	NC 4.58%	NC 4.49%	NC 5.42%	NC 3.58%	NC 3.32%	NC 4.16%
Outpatient—Unknown	MY 2020	—	—	—	—	—	NA
	MY 2021	—	—	—	—	—	NA
ED—Ages 18–64	MY 2020	NC 0.12%	NC 0.03%	NC 0.08%	NC 0.17%	NC 1.06%	NC 0.22%
	MY 2021	NC 0.13%	NC 0.04%	NC 0.07%	NC 0.08%	NC 1.02%	NC 0.19%
ED—Ages 65+	MY 2020	NC 0.05%	NC 0.01%	NC 0.08%	NC 0.08%	NC 0.21%	NC 0.07%
	MY 2021	NC 0.04%	NC 0.02%	NC 0.04%	NC 0.01%	NC 0.30%	NC 0.05%
ED—Unknown	MY 2020	—	—	—	—	—	NA
	MY 2021	—	—	—	—	—	NA
Telehealth—Ages 18–64	MY 2020	NC 3.74%	NC 3.58%	NC 4.80%	NC 3.76%	NC 4.45%	NC 3.96%
	MY 2021	NC 3.22%	NC 2.56%	NC 4.61%	NC 2.72%	NC 3.32%	NC 3.14%
Telehealth—Ages 65+	MY 2020	NC 1.75%	NC 1.23%	NC 2.54%	NC 1.47%	NC 1.04%	NC 1.62%
	MY 2021	NC 1.57%	NC 0.77%	NC 2.03%	NC 0.53%	NC 0.58%	NC 0.95%
Telehealth—Unknown	MY 2020	—	—	—	—	—	NA
	MY 2021	—	—	—	—	—	NA
Pharmacotherapy for Opioid Use Disorder							
Ages 16–64	MY 2020	★★ 26.83%	★★★ 31.53%	★★ 22.86%	★ 19.81%	★ 11.78%	★★ 22.25%
	MY 2021	★★ 25.77%	★★ 24.98%	★★ 23.54%	★★ 25.64%	★ 7.91%	★ 21.80%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Ages 65+	MY 2020	★★ 29.09%	★★ 28.13%	★ 25.81%	★ 11.90%	NA	★ 23.83%
	MY 2021	★★ 29.23%	★★ 35.44%	★★ 33.04%	★★ 34.94%	★ 2.86%	★★ 30.50%
Total (Ages 16+)	MY 2020	★★ 26.89%	★★★ 31.39%	★★ 22.99%	★ 19.70%	★ 11.69%	★ 22.29%
	MY 2021	★★ 25.86%	★★ 25.31%	★★ 23.92%	★★ 25.85%	★ 7.84%	★ 22.04%

[1] *Caution should be exercised when interpreting the star ratings for this measure as higher or lower rates do not necessarily indicate better or worse performance.*

NA indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

NC indicates that the measure was not compared to national percentiles due to NCQA's recommendation for a break in trending for this measure in HEDIS MY 2020.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending; therefore, the applicable rate is not displayed.

Child Behavioral Health Results

Table 2-10—Child Behavioral Health Domain Results for HEDIS MY 2020 and HEDIS MY 2021

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Child Behavioral Health							
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence							
7-Day Follow-Up—Ages 13–17	MY 2020	★★★★ 9.78%	★★★ 6.56%	★ 1.72%	★★★ 6.70%	★★★ 8.00%	★★★ 6.79%
	MY 2021	★★ 3.75%	★★ 5.22%	★★ 4.17%	★★★ 6.63%	★★★★ 10.91%	★★ 5.96%
30-Day Follow-Up—Ages 13–17	MY 2020	★★★ 14.13%	★★★ 10.66%	★ 5.17%	★★★ 12.29%	★★ 8.00%	★★★ 10.98%
	MY 2021	★★★ 8.75%	★★★ 12.69%	★★ 5.56%	★★★ 10.71%	★★★★ 14.55%	★★★ 10.61%
Follow-Up After Emergency Department Visit for Mental Illness							
7-Day Follow-Up—Ages 6–17	MY 2020	★★★★★ 77.61%	★★★★★ 78.52%	★★★★ 70.48%	★★★★★ 78.92%	★★★★★ 79.14%	★★★★★ 78.00%
	MY 2021	★★★★ 75.23%	★★★★★ 75.85%	★★★★ 66.03%	★★★★★ 77.88%	★★★★★ 76.12%	★★★★★ 75.98%
30-Day Follow-Up—Ages 6–17	MY 2020	★★★★ 81.97%	★★★★ 83.27%	★★★ 76.19%	★★★★★ 85.28%	★★★★★ 84.36%	★★★★ 83.51%
	MY 2021	★★★★ 81.75%	★★★★★ 84.15%	★★★ 71.29%	★★★★ 83.18%	★★★★★ 85.04%	★★★★ 82.58%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Follow-Up After High-Intensity Care for Substance Use Disorder							
7-Day Follow-Up—Ages 13–17	MY 2020	NA	NA	NA	NA	NA	★★ 15.15%
	MY 2021	NA	NA	NA	NA	NA	★ 6.67%
30-Day Follow-Up—Ages 13–17	MY 2020	NA	NA	NA	NA	NA	★ 18.18%
	MY 2021	NA	NA	NA	NA	NA	★ 10.00%
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Ages 6–17	MY 2020	★ 36.94%	★ 40.83%	★★ 49.59%	★★ 47.98%	★★ 48.69%	★★ 44.98%
	MY 2021	★★ 42.34%	★★ 48.92%	★★ 43.49%	★★ 42.05%	★★ 47.23%	★★ 44.46%
30-Day Follow-Up—Ages 6–17	MY 2020	★ 60.82%	★ 62.96%	★★ 70.95%	★★★ 75.51%	★★★ 76.35%	★★ 70.08%
	MY 2021	★★ 69.82%	★★★ 73.32%	★★ 67.71%	★★ 64.84%	★★★ 74.94%	★★ 69.08%
Initiation and Engagement of AOD Abuse or Dependence Treatment							
Initiation of AOD Treatment—Ages 13–17	MY 2020	★★★ 49.86%	★★★ 45.57%	★★★★ 56.20%	★★★ 50.66%	★★ 41.89%	★★★ 49.26%
	MY 2021	★★★ 46.81%	★★★★ 51.70%	★★★★★ 57.00%	★★★ 48.21%	★★★ 47.41%	★★★ 49.79%
Engagement of AOD Treatment—Ages 13–17	MY 2020	★★★ 13.22%	★★★ 12.87%	★★ 9.12%	★★ 9.89%	★ 5.41%	★★ 10.52%
	MY 2021	★ 7.48%	★★★ 15.09%	★ 4.10%	★★ 9.55%	★ 7.17%	★★ 9.55%
Mental Health Utilization[1]							
Any Service—Ages 0–12	MY 2020	NC 5.32%	NC 4.04%	NC 4.09%	NC 5.49%	NC 5.39%	NC 4.92%
	MY 2021	NC 4.64%	NC 3.89%	NC 3.82%	NC 4.25%	NC 5.07%	NC 4.25%
Any Service—Ages 13–17	MY 2020	NC 12.78%	NC 10.70%	NC 10.16%	NC 13.35%	NC 13.73%	NC 12.23%
	MY 2021	NC 12.20%	NC 10.66%	NC 10.59%	NC 11.82%	NC 13.17%	NC 11.56%
Inpatient—Ages 0–12	MY 2020	NC 0.26%	NC 0.16%	NC 0.18%	NC 0.21%	NC 0.21%	NC 0.20%
	MY 2021	NC 0.24%	NC 0.21%	NC 0.16%	NC 0.22%	NC 0.22%	NC 0.21%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Inpatient—Ages 13–17	MY 2020	NC 1.75%	NC 1.31%	NC 1.20%	NC 1.56%	NC 1.53%	NC 1.47%
	MY 2021	NC 1.68%	NC 1.56%	NC 1.27%	NC 1.68%	NC 1.63%	NC 1.59%
Intensive Outpatient or Partial Hospitalization—Ages 0–12	MY 2020	NC 0.58%	NC 0.44%	NC 0.00%	NC 0.48%	NC 0.52%	NC 0.41%
	MY 2021	NC 0.56%	NC 0.48%	NC 0.00%	NC 0.44%	NC 0.47%	NC 0.40%
Intensive Outpatient or Partial Hospitalization—Ages 13–17	MY 2020	NC 2.54%	NC 2.03%	NC 0.00%	NC 2.42%	NC 2.45%	NC 1.99%
	MY 2021	NC 2.55%	NC 2.16%	NC 0.00%	NC 2.36%	NC 2.35%	NC 1.99%
Outpatient—Ages 0–12	MY 2020	NC 5.00%	NC 3.71%	NC 3.36%	NC 5.19%	NC 4.74%	NC 4.51%
	MY 2021	NC 4.22%	NC 3.56%	NC 2.80%	NC 3.92%	NC 4.54%	NC 3.79%
Outpatient—Ages 13–17	MY 2020	NC 12.03%	NC 9.88%	NC 8.12%	NC 12.62%	NC 12.26%	NC 11.20%
	MY 2021	NC 11.03%	NC 9.74%	NC 7.86%	NC 10.90%	NC 11.58%	NC 10.26%
ED—Ages 0–12	MY 2020	NC 0.01%	NC 0.00%	NC 0.01%	NC 0.01%	NC 0.13%	NC 0.02%
	MY 2021	NC 0.01%	NC 0.00%	NC 0.01%	NC 0.01%	NC 0.11%	NC 0.02%
ED—Ages 13–17	MY 2020	NC 0.07%	NC 0.01%	NC 0.06%	NC 0.07%	NC 0.72%	NC 0.12%
	MY 2021	NC 0.05%	NC 0.02%	NC 0.06%	NC 0.06%	NC 0.71%	NC 0.12%
Telehealth—Ages 0–12	MY 2020	NC 0.90%	NC 0.86%	NC 1.46%	NC 0.93%	NC 1.33%	NC 1.04%
	MY 2021	NC 0.79%	NC 0.70%	NC 1.63%	NC 0.82%	NC 1.02%	NC 0.93%
Telehealth—Ages 13–17	MY 2020	NC 2.71%	NC 2.71%	NC 4.26%	NC 2.82%	NC 3.66%	NC 3.08%
	MY 2021	NC 2.57%	NC 2.30%	NC 4.78%	NC 2.52%	NC 3.26%	NC 2.89%
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose Testing—Total	MY 2020	★★★ 49.49%	★★★★ 59.73%	★★★★ 55.75%	★★★ 51.78%	★★ 48.15%	★★★ 52.40%
	MY 2021	★★★★ 61.25%	★★★★★ 62.80%	★★★★★ 62.73%	★★★★ 59.90%	★★★★ 56.85%	★★★★ 60.56%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Cholesterol Testing—Total	MY 2020	★ 25.47%	★★★★ 39.54%	★★★ 36.63%	★★ 29.07%	★ 25.05%	★★ 30.11%
	MY 2021	★★ 31.11%	★★★★ 40.69%	★★★ 38.48%	★★★ 33.26%	★★ 28.56%	★★★ 34.32%
Blood Glucose and Cholesterol Testing—Total	MY 2020	★★ 24.96%	★★★★ 38.81%	★★★ 35.82%	★★ 28.00%	★ 24.18%	★★ 29.24%
	MY 2021	★★ 30.54%	★★★★ 39.21%	★★★★ 37.58%	★★★ 32.67%	★★ 28.03%	★★★ 33.52%

[1] *Caution should be exercised when interpreting the star ratings for this measure as higher or lower rates do not necessarily indicate better or worse performance.*

NA indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

NC indicates that the measure was not compared to national percentiles due to NCQA's recommendation for a break in trending for this measure in HEDIS MY 2020.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending; therefore, the applicable rate is not displayed.

Strengths

- In the Child Behavioral Health domain, BCBSIL and Molina demonstrated an increase of more than 5 percentage points for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 13–17* indicator. Additionally, all five health plans and the statewide average met or exceeded the 50th percentile.
- In the Child Behavioral Health domain, Aetna and BCBSIL demonstrated an increase of more than 5 percentage points for the *Follow-Up After Hospitalization for Mental Illness* indicators. For the *30-Day Follow Up* indicator, two of five health plans met or exceeded the 50th percentile.
- In the Child Behavioral Health domain, Molina demonstrated an increase of more than 5 percentage points for the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up* indicator and ranked at or above the 75th percentile.
- In the Child Behavioral Health domain, all five health plans and the statewide average ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* indicator; of note, BCBSIL, Meridian, Molina, and the statewide average ranked at or above the 90th percentile. Additionally, four health plans and the statewide average ranked at or above the 75th percentile for the *30-Day Follow-Up* indicator, two of which ranked at or above the 90th percentile. This performance demonstrates a commitment to mental health services overall for health plans' child and adolescent members.
- In the Child Behavioral Health domain, for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* indicator, all five health plans and the statewide average ranked at or above the 75th percentile; of note; BCBSIL and CountyCare ranked at or above

the 90th percentile. Further, BCBSIL also ranked at or above the 75th percentile for the *Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* indicators. Additionally, Aetna demonstrated an increase of more than 5 percentage points for all three indicators. This demonstrates that child and adolescent members with ongoing antipsychotic medication use are receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood.

Opportunities for Improvement

Opportunity: In the Adult Behavioral Health domain, for the *Follow-Up After Hospitalization for Mental Illness* measure, overall performance was low across all five health plans; the statewide average ranked below the 25th percentile for all indicators.

Why the Opportunity Exists: The low performance indicates that health plans' adult members who were hospitalized for mental illness were not accessing or receiving timely follow-up care for mental illness.

Recommendations:

- Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions.
- Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.

PMV—Pay-for-Reporting

HFS directed HSAG to conduct PMV for the Pay-for-Reporting (P4R) program. The measures audited included CMS Adult Core Set, CMS MLTSS, and HFS custom measures. Table 2-11 lists the measures that HSAG audited based on the specifications.

Table 2-11—Performance Measures

Measure	Specifications
Pillar: Adult Behavioral Health	
Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up—18–64 Years and *65+ Years***	HEDIS*
Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up—18–64 Years and *65+ Years***	HEDIS*
*Pharmacotherapy for Opioid Use Disorder***	HEDIS*
Pillar: Child Behavioral Health	
Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents	HFS Custom
Repeat Behavioral Health (BH) Hospitalizations for Children and Adolescents	HFS Custom
Inpatient Utilization—BH Hospitalizations for Children and Adolescents	HFS Custom
Emergency Department (ED) Visits that Result in an Inpatient Admission for Children and Adolescents	HFS Custom
Pillar: Equity	
Gap in Human Immunodeficiency Virus (HIV) Medical Visits	HFS Custom
HIV Viral Load Suppression	CMS Adult Core Set
Prescription of HIV Antiretroviral Therapy	HFS Custom
Pillar: Improving Community Placement	
Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update	CMS MLTSS
LTSS Successful Transition After Long-Term Institutional Stay	CMS MLTSS
Pillar: Maternal and Child Health	
Annual Dental Visits—2–3 Years, *4–6 Years*, *7–10 Years*, *11–14 Years*, *15–18 Years*, and *19–20 Years*	HEDIS*
Child and Adolescent Well-Care Visits—3–11 Years, *12–17 Years*, and *18–21 Years***	HEDIS*
Childhood Immunization Status—Combination 10	HEDIS*
*Well-Child Visits in the First 30 Months of Life***	HEDIS*

* *Measures were reported in alignment with HFS' guidance requiring variations from HEDIS Technical Specifications due to quarterly reporting and required IL-specific demographic stratifications.*

** *The most current specifications were used to report performance measures for all historical measurement periods.*

Methodology and Technical Methods of Data Collection

Validation of Performance Measures

For the HealthChoice Illinois MCOs, HSAG conducted the validation activities as outlined in CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019[2-10] (EQR Protocol 2). The CMS protocol activities for PMV include the following methodology for data collection:

1. Conduct pre-virtual review activities including collecting and reviewing relevant documentation and rate review.
   - HSAG obtained a list of the indicators selected for validation as well as the indicator definitions from HFS for the validation team to review.
   - HSAG prepared a documentation request for the MCOs, which included the Information Systems Capabilities Assessment Tool (ISCAT). HSAG customized the ISCAT to collect data consistent with the Illinois service delivery model and forwarded the ISCAT to each organization with a timeline for completion and instructions for submission. HSAG responded to organizations' ISCAT-related questions during the pre-virtual phase.
2. Conduct virtual site visits using a webinar format with each organization.
   - HSAG collected information using several methods, including interviews with key staff, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports.
3. Conduct post-virtual site visit activities including compiling and analyzing findings, and reporting results to HFS.

How Data Were Aggregated and Analyzed

The CMS protocol activities for PMV include aggregation and analysis of documentation submitted by the organization including the ISCAT and supporting documentation, interviews with key staff during the virtual review, systems demonstrations during the virtual review, review of data output files, PSV of records used for denominator and numerator identification, observation of data processing, and review of data reports.

How Conclusions Were Drawn

Based on all validation activities with the MCOs, HSAG determined results for each performance measure. As set forth in CMS' EQR Protocol 2, HSAG gave a validation finding of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported* (see Table 2-12) to each performance measure. HSAG based

[2-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 25, 2023.

each validation finding on how significant the errors were in each measure's evaluation elements, not by the number of elements determined to be noncompliant. For example, it was possible that a single error could result in a designation of *Do Not Report* if the impact of the error biased the rate by more than 5 percentage points. Conversely, even if multiple errors were identified, if the errors had little or no impact on the rate, the indicator was given a designation of *Reportable*.

After completing the validation process, HSAG prepared a report of the PMV findings and recommendations for each MCO. HSAG forwarded these reports to HFS and the appropriate health plan. Finally, HSAG analyzed each health plan's performance based on measure rates and reviewed the rates in comparison to either national HEDIS benchmarks or the statewide average.

Table 2-12—Designation Categories for Performance Indicators

Reportable (R)	Measure was compliant with the specifications.
Do Not Report (DNR)	The rate was materially biased and should not be reported.
Not Applicable (NA)	The MCO was not required to report the measure.
Not Reported (NR)	The measure was not reported because the MCO did not offer the required benefit.

Performance Indicator Specific Findings and Recommendations

Validation Finding

HSAG determined that four MCOs' information systems and processes were compliant with IS standards and that the performance indicators calculated by the four MCOs had a status of *Reportable* based on the reporting requirements for MY 2021 PMV. Although Meridian's information systems and processes were compliant with IS standards, Meridian received a measure designation of *Do Not Report* for one of the performance indicators due to an inability to obtain any lab data from its vendors and/or providers by the required submission deadline.

Performance Measure Results

For MY 2018–Q2 2021, the MCOs calculated and reported 16 performance indicators. The MY 2020 and MY 2021 results for HEDIS measures were compared to NCQA's Quality Compass benchmarking data (MY 2018 and MY 2019 were not included in the comparison because the MCOs used MY 2021 specifications for historical reporting), and MY 2018–Q2 2021 results for non-HEDIS measures were compared to a calculated statewide average.

The following is a summary of HSAG's findings regarding performance on the measures, organized by Quality Improvement Pillar:

Adult Behavioral Health

This pillar contains the *Follow-Up After High-Intensity Care for Substance Use Disorder* and *Pharmacotherapy for Opioid Use Disorder* measures. HealthChoice members were receiving follow-up

outpatient care after intensive treatment at rates above the national Medicaid 50th percentile, which have steadily increased since 2018. However, the rates of members with diagnosed opioid use disorder receiving consistent pharmacotherapy were steadily declining to rates at or below the 25th percentile.

Child Behavioral Health

This pillar contains the *Inpatient Utilization—BH Hospitalizations for Children and Adolescents, Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents, ED Visits that Result in an Inpatient Admission for Children and Adolescents,* and *Repeat BH Hospitalizations for Children and Adolescents* measures. BH hospitalizations were stabilizing after 2019, and repeat admissions remained very flat at 18 percent of the population, but mobile crisis services and ED visits that result in hospital admission were increasing over time. Additionally, there was a high degree of variability between HealthChoice plans on inpatient utilization as well as mobile crisis response services and ED visits that result in hospital admission.

Maternal Child Health

This pillar contains the *Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Annual Dental Visit,* and *Childhood Immunization Status—Combination 10* measures. Well-child visits in the first 30 months of life were at or above the national Medicaid 50th percentile while all other age groups were between the 25th and 50th percentiles. The rates for well-child visits for all age groups were consistent, with a difference of only 10 percentage points between HealthChoice plans, but there was evidence of a downward trend starting in 2020 that is likely due to the COVID-19 pandemic. Dental visits showed a similar trend across all age groups, with a difference of 15 percentage points between plans. The statewide average for immunizations was steady over time at only 23 percent, with the COVID-19 pandemic having minimal impact on immunization rates.

Equity

This pillar contains the *Gap in HIV Medical Visits, Prescription of HIV Antiretroviral Therapy,* and *HIV Viral Load Suppression* measures. The rate of members receiving antiretroviral therapy remained above 90 percent on average, with a slight decrease starting in 2020 likely due to the COVID-19 pandemic. Gaps in medical visits were moving in a positive direction over time. However, viral load suppression was consistently low across all plans (i.e., between 10 percent and 20 percent).

Improving Community Placement

This pillar contains the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update* and *LTSS Successful Transition After Long-Term Institutional Stay* measures. The statewide average for the care plan measure was only 32 percent but was starting to increase in 2021. The statewide average for successful transitions to the community after long-term care was at 16 percent while the expected transition rate averaged 67 percent, indicating significant room for improvement.

Performance measure rates submitted by the five HealthChoice Illinois plans for MY 2018–Q2 MY 2021 are presented in Table 2-13.

Table 2-13—Performance Measure Rates

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Adult Behavioral Health						
1	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)					
2018	7-Day Follow-Up—Ages 18-64	33.48%	33.73%	34.99%	32.19%	33.55%
2019	7-Day Follow-Up—Ages 18-64	40.01%	35.28%	40.47%	43.14%	42.16%
2020	7-Day Follow-Up—Ages 18-64	41.66%	44.14%	38.33%	43.26%	42.17%
Q1 2021	7-Day Follow-Up—Ages 18-64	31.50%	31.91%	25.00%	37.02%	36.52%
Q2 2021	7-Day Follow-Up—Ages 18-64	35.29%	37.64%	34.88%	41.62%	37.46%
2018	7-Day Follow-Up—Ages 65+	NA	NA	27.66%	NA	NA
2019	7-Day Follow-Up—Ages 65+	NA	NA	33.33%	NA	NA
2020	7-Day Follow-Up—Ages 65+	NA	NA	33.33%	NA	NA
Q1 2021	7-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
Q2 2021	7-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
2018	7-Day Follow-Up—Total	33.45%	33.63%	34.90%	32.07%	33.55%
2019	7-Day Follow-Up—Total	39.86%	35.43%	40.34%	43.07%	42.06%
2020	7-Day Follow-Up—Total	41.72%	43.95%	38.26%	43.14%	42.27%
Q1 2021	7-Day Follow-Up—Total	31.25%	31.78%	24.81%	36.85%	36.52%
Q2 2021	7-Day Follow-Up—Total	35.28%	37.39%	34.87%	41.67%	37.44%
2018	30-Day Follow-Up—Ages 18-64	49.52%	49.97%	49.78%	47.52%	48.13%
2019	30-Day Follow-Up—Ages 18-64	54.88%	51.45%	55.71%	58.28%	56.77%
2020	30-Day Follow-Up—Ages 18-64	58.05%	59.97%	53.99%	59.56%	55.56%
Q1 2021	30-Day Follow-Up—Ages 18-64	47.64%	49.42%	38.30%	49.66%	50.67%
Q2 2021	30-Day Follow-Up—Ages 18-64	49.71%	54.16%	48.53%	55.63%	53.37%
2018	30-Day Follow-Up—Ages 65+	NA	NA	36.17%	NA	NA
2019	30-Day Follow-Up—Ages 65+	NA	NA	49.12%	NA	NA
2020	30-Day Follow-Up—Ages 65+	NA	NA	45.45%	NA	NA
Q1 2021	30-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
Q2 2021	30-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
2018	30-Day Follow-Up—Total	49.47%	49.82%	49.61%	47.47%	48.09%
2019	30-Day Follow-Up—Total	54.85%	51.71%	55.59%	58.21%	56.64%
2020	30-Day Follow-Up—Total	58.09%	59.80%	53.87%	59.34%	55.63%
Q1 2021	30-Day Follow-Up—Total	47.66%	49.22%	37.60%	49.89%	50.67%
Q2 2021	30-Day Follow-Up—Total	49.71%	53.91%	48.29%	55.76%	53.25%
2	Pharmacotherapy for Opioid Use Disorder (POD)					
2018	Ages 16-64	37.21%	34.10%	34.52%	24.39%	9.67%
2019	Ages 16-64	34.50%	28.72%	29.84%	99.91%	9.88%
2020	Ages 16-64	26.48%	31.44%	22.86%	19.81%	11.84%
Q1 2021	Ages 16-64	24.09%	26.06%	18.84%	6.44%	8.05%
Q2 2021	Ages 16-64	25.07%	27.57%	28.91%	9.01%	7.83%
2018	Ages 65+	NA	34.04%	40.32%	NA	NA
2019	Ages 65+	44.90%	24.53%	27.03%	100.00%	NA
2020	Ages 65+	27.08%	28.13%	25.81%	11.90%	NA
Q1 2021	Ages 65+	25.00%	25.35%	27.03%	5.36%	0.00%
Q2 2021	Ages 65+	24.59%	30.67%	31.18%	3.85%	0.00%
2018	Total	37.12%	34.10%	34.68%	24.02%	9.60%
2019	Total	34.72%	28.58%	29.76%	99.91%	9.71%
2020	Total	26.50%	31.30%	22.99%	19.70%	11.75%
Q1 2021	Total	24.11%	26.03%	19.16%	6.39%	7.93%
Q2 2021	Total	25.06%	27.68%	29.00%	8.88%	7.72%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Child Behavioral Health						
3	Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents (MCH)					
2018	Ages 0-5	NA	19.05%	11.48%	12.50%	0.00%
2019	Ages 0-5	17.24%	17.81%	4.60%	14.21%	0.00%
2020	Ages 0-5	16.13%	NA	NA	11.11%	NA
Q1 2021	Ages 0-5	NA	NA	NA	NA	NA
Q2 2021	Ages 0-5	NA	NA	NA	NA	NA
2018	Ages 6-11	18.93%	26.61%	10.04%	22.45%	5.98%
2019	Ages 6-11	23.60%	29.74%	10.66%	25.87%	7.56%
2020	Ages 6-11	27.42%	30.94%	12.20%	29.59%	9.36%
Q1 2021	Ages 6-11	33.67%	36.15%	18.75%	34.92%	15.52%
Q2 2021	Ages 6-11	30.20%	32.14%	11.36%	33.21%	12.88%
2018	Ages 12-17	32.03%	46.15%	18.87%	39.51%	7.72%
2019	Ages 12-17	34.97%	48.20%	22.58%	43.25%	9.18%
2020	Ages 12-17	40.23%	48.81%	25.94%	46.62%	12.49%
Q1 2021	Ages 12-17	43.09%	55.89%	26.21%	53.16%	20.58%
Q2 2021	Ages 12-17	40.37%	50.77%	25.93%	49.08%	19.17%
2018	Ages 18-20	50.32%	61.83%	32.69%	52.25%	14.58%
2019	Ages 18-20	44.42%	62.68%	34.68%	50.42%	14.47%
2020	Ages 18-20	45.45%	63.34%	36.76%	57.37%	11.95%
Q1 2021	Ages 18-20	52.56%	61.07%	45.28%	62.23%	24.14%
Q2 2021	Ages 18-20	45.56%	56.57%	43.86%	60.77%	22.05%
2018	Total	30.34%	41.42%	16.58%	36.16%	7.71%
2019	Total	32.95%	44.13%	19.30%	39.03%	9.20%
2020	Total	38.03%	47.42%	23.86%	44.07%	11.74%
Q1 2021	Total	42.36%	53.12%	28.34%	50.58%	20.10%
Q2 2021	Total	39.00%	48.52%	26.71%	47.37%	18.35%
4	Emergency Department (ED) Visits that Result in an Inpatient Admission for Children and Adolescents (BIA)					
2018	Ages 0-5	0.00%	NA	0.00%	6.67%	2.41%
2019	Ages 0-5	4.39%	NA	0.00%	23.08%	0.71%
2020	Ages 0-5	1.96%	NA	0.00%	NA	0.00%
Q1 2021	Ages 0-5	NA	NA	NA	NA	NA
Q2 2021	Ages 0-5	0.00%	NA	0.00%	NA	0.00%
2018	Ages 6-11	17.35%	32.96%	5.04%	31.10%	9.82%
2019	Ages 6-11	14.52%	43.43%	3.35%	35.52%	11.09%
2020	Ages 6-11	17.10%	36.10%	5.58%	40.33%	11.74%
Q1 2021	Ages 6-11	15.91%	48.57%	3.03%	41.32%	13.89%
Q2 2021	Ages 6-11	16.73%	32.35%	3.80%	37.64%	17.09%
2018	Ages 12-17	25.32%	46.91%	11.69%	43.70%	18.62%
2019	Ages 12-17	26.78%	48.96%	10.98%	45.80%	17.27%
2020	Ages 12-17	27.91%	46.46%	13.90%	43.59%	22.08%
Q1 2021	Ages 12-17	29.28%	49.28%	17.41%	46.75%	28.12%
Q2 2021	Ages 12-17	30.09%	46.83%	12.45%	45.04%	26.70%
2018	Ages 18-20	23.42%	47.38%	8.44%	44.58%	12.73%
2019	Ages 18-20	21.37%	49.32%	11.40%	43.99%	12.34%
2020	Ages 18-20	21.66%	49.25%	10.79%	51.24%	13.93%
Q1 2021	Ages 18-20	21.69%	59.04%	17.07%	48.48%	16.51%
Q2 2021	Ages 18-20	21.26%	50.00%	14.67%	48.53%	19.29%
2018	Total	22.62%	44.71%	9.09%	41.67%	14.77%
2019	Total	22.21%	48.12%	9.22%	43.78%	13.81%
2020	Total	23.55%	45.99%	11.04%	44.95%	17.15%
Q1 2021	Total	24.05%	51.62%	14.69%	46.52%	21.29%
Q2 2021	Total	24.37%	46.38%	11.19%	44.86%	21.92%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Child Behavioral Health						
5	Inpatient Utilization—Behavioral Health (BH) Hospitalization for Children and Adolescents (BIU)					
2018	Inpatient BH Utilization—Ages 0-5	0.84	0.03	0.02	0.02	0.03
2019	Inpatient BH Utilization—Ages 0-5	1.11	0.01	0.02	0.10	0.01
2020	Inpatient BH Utilization—Ages 0-5	1.27	0.02	0.01	0.01	0.01
Q1 2021	Inpatient BH Utilization—Ages 0-5	1.00	0.01	0.00	0.00	0.03
Q2 2021	Inpatient BH Utilization—Ages 0-5	0.99	0.01	0.00	0.00	0.02
2018	Inpatient BH Utilization—Ages 6-11	0.53	0.42	0.35	0.33	0.42
2019	Inpatient BH Utilization—Ages 6-11	0.59	0.48	0.29	0.36	0.44
2020	Inpatient BH Utilization—Ages 6-11	0.47	0.27	0.17	0.26	0.31
Q1 2021	Inpatient BH Utilization—Ages 6-11	0.44	0.33	0.12	0.22	0.23
Q2 2021	Inpatient BH Utilization—Ages 6-11	0.44	0.29	0.11	0.21	0.28
2018	Inpatient BH Utilization—Ages 12-17	1.71	1.75	1.15	1.69	1.40
2019	Inpatient BH Utilization—Ages 12-17	1.85	1.77	1.21	1.88	1.44
2020	Inpatient BH Utilization—Ages 12-17	1.71	1.43	0.90	1.55	1.38
Q1 2021	Inpatient BH Utilization—Ages 12-17	1.71	1.69	1.15	1.61	1.64
Q2 2021	Inpatient BH Utilization—Ages 12-17	1.77	1.64	0.85	1.55	1.55
2018	Inpatient BH Utilization—Ages 18-20	2.23	1.31	0.95	1.72	1.08
2019	Inpatient BH Utilization—Ages 18-20	2.28	1.41	0.99	1.64	1.29
2020	Inpatient BH Utilization—Ages 18-20	2.16	1.51	0.99	1.59	1.14
Q1 2021	Inpatient BH Utilization—Ages 18-20	1.86	1.62	0.90	1.58	1.11
Q2 2021	Inpatient BH Utilization—Ages 18-20	1.86	1.55	0.91	1.49	1.22
2018	Inpatient BH Utilization—Total	1.12	0.75	0.53	0.75	0.62
2019	Inpatient BH Utilization—Total	1.29	0.80	0.53	1.12	0.66
2020	Inpatient BH Utilization—Total	1.26	0.67	0.42	0.71	0.61
Q1 2021	Inpatient BH Utilization—Total	1.15	0.79	0.48	0.77	0.67
Q2 2021	Inpatient BH Utilization—Total	1.16	0.76	0.39	0.75	0.67
2018	Average Length of Stay—Ages 0-5	6.41	NA	NA	NA	NA
2019	Average Length of Stay—Ages 0-5	4.79	NA	NA	NA	NA
2020	Average Length of Stay—Ages 0-5	4.41	NA	NA	NA	NA
Q1 2021	Average Length of Stay—Ages 0-5	4.38	NA	NA	NA	NA
Q2 2021	Average Length of Stay—Ages 0-5	4.30	NA	NA	NA	NA
2018	Average Length of Stay—Ages 6-11	8.22	8.26	9.94	6.76	9.63
2019	Average Length of Stay—Ages 6-11	7.37	8.61	9.39	7.03	8.50
2020	Average Length of Stay—Ages 6-11	8.42	9.68	8.91	7.45	7.93
Q1 2021	Average Length of Stay—Ages 6-11	8.54	8.72	NA	7.76	8.31
Q2 2021	Average Length of Stay—Ages 6-11	8.39	8.64	NA	7.79	9.10
2018	Average Length of Stay—Ages 12-17	7.51	7.63	9.22	5.93	8.43
2019	Average Length of Stay—Ages 12-17	7.21	8.06	9.24	6.24	7.66
2020	Average Length of Stay—Ages 12-17	8.05	8.60	8.89	7.20	8.45
Q1 2021	Average Length of Stay—Ages 12-17	7.77	8.85	9.08	7.11	8.53
Q2 2021	Average Length of Stay—Ages 12-17	7.27	8.83	9.71	7.29	9.32
2018	Average Length of Stay—Ages 18-20	5.88	6.36	7.33	4.95	6.31
2019	Average Length of Stay—Ages 18-20	5.50	6.26	7.79	5.74	5.35
2020	Average Length of Stay—Ages 18-20	6.29	6.78	6.75	6.23	6.75
Q1 2021	Average Length of Stay—Ages 18-20	5.62	7.65	6.86	6.55	7.02
Q2 2021	Average Length of Stay—Ages 18-20	5.50	7.22	6.00	6.47	6.78
2018	Average Length of Stay—Total	7.11	7.61	9.07	5.87	8.39
2019	Average Length of Stay—Total	6.31	7.92	9.02	6.25	7.46
2020	Average Length of Stay—Total	6.70	8.31	8.36	7.00	8.05
Q1 2021	Average Length of Stay—Total	6.60	8.56	8.67	7.02	8.23
Q2 2021	Average Length of Stay—Total	6.34	8.42	8.59	7.12	8.77

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
	Pillar: Child Behavioral Health					
6	Repeat BH Hospitalizations for Children and Adolescents (RBH)					
2018	Repeat BH Hospitalizations—Ages 0-5	8.00	0.00	2.00	57.00	0.00
2019	Repeat BH Hospitalizations—Ages 0-5	16.00	0.00	1.00	0.00	0.00
2020	Repeat BH Hospitalizations—Ages 0-5	16.00	3.00	0.00	1.00	0.00
Q1 2021	Repeat BH Hospitalizations—Ages 0-5	12.00	3.00	0.00	0.00	0.00
Q2 2021	Repeat BH Hospitalizations—Ages 0-5	28.00	8.00	0.00	0.00	0.00
2018	Repeat BH Hospitalizations—Ages 6-11	20.00	39.00	24.00	0.00	18.00
2019	Repeat BH Hospitalizations—Ages 6-11	47.00	64.00	24.00	96.00	47.00
2020	Repeat BH Hospitalizations—Ages 6-11	44.00	44.00	9.00	90.00	21.00
Q1 2021	Repeat BH Hospitalizations—Ages 6-11	16.00	57.00	9.00	14.00	26.00
Q2 2021	Repeat BH Hospitalizations—Ages 6-11	36.00	56.00	10.00	49.00	26.00
2018	Repeat BH Hospitalizations—Ages 12-17	53.00	224.00	113.00	259.00	49.00
2019	Repeat BH Hospitalizations—Ages 12-17	147.00	243.00	112.00	511.00	81.00
2020	Repeat BH Hospitalizations—Ages 12-17	167.00	217.00	98.00	529.00	129.00
Q1 2021	Repeat BH Hospitalizations—Ages 12-17	42.00	321.00	96.00	74.00	141.00
Q2 2021	Repeat BH Hospitalizations—Ages 12-17	131.00	420.00	126.00	256.00	168.00
2018	Repeat BH Hospitalizations—Ages 18-20	10.00	32.00	23.00	58.00	6.00
2019	Repeat BH Hospitalizations—Ages 18-20	39.00	52.00	19.00	249.00	23.00
2020	Repeat BH Hospitalizations—Ages 18-20	76.00	107.00	35.00	150.00	27.00
Q1 2021	Repeat BH Hospitalizations—Ages 18-20	25.00	116.00	29.00	29.00	29.00
Q2 2021	Repeat BH Hospitalizations—Ages 18-20	49.00	142.00	25.00	86.00	45.00
2018	Repeat BH Hospitalizations—Total	91.00	295.00	162.00	374.00	73.00
2019	Repeat BH Hospitalizations—Total	249.00	359.00	156.00	856.00	151.00
2020	Repeat BH Hospitalizations—Total	303.00	371.00	142.00	770.00	177.00
Q1 2021	Repeat BH Hospitalizations—Total	95.00	497.00	134.00	117.00	196.00
Q2 2021	Repeat BH Hospitalizations—Total	244.00	626.00	161.00	391.00	239.00
2018	Percent of Members with Repeat BH Hospitalization—Ages 0-5	10.42%	NA	NA	18.55%	NA
2019	Percent of Members with Repeat BH Hospitalization—Ages 0-5	9.73%	NA	NA	NA	NA
2020	Percent of Members with Repeat BH Hospitalization—Ages 0-5	8.33%	NA	NA	NA	NA
Q1 2021	Percent of Members with Repeat BH Hospitalization—Ages 0-5	13.16%	NA	NA	NA	NA
Q2 2021	Percent of Members with Repeat BH Hospitalization—Ages 0-5	18.52%	NA	NA	NA	NA
2018	Percent of Members with Repeat BH Hospitalization—Ages 6-11	12.00%	14.69%	16.36%	NA	19.67%
2019	Percent of Members with Repeat BH Hospitalization—Ages 6-11	14.68%	20.79%	12.15%	22.01%	32.91%
2020	Percent of Members with Repeat BH Hospitalization—Ages 6-11	10.15%	17.21%	12.12%	21.31%	19.48%
Q1 2021	Percent of Members with Repeat BH Hospitalization—Ages 6-11	17.65%	22.31%	23.08%	11.50%	28.13%
Q2 2021	Percent of Members with Repeat BH Hospitalization—Ages 6-11	22.31%	28.46%	26.32%	21.58%	26.39%
2018	Percent of Members with Repeat BH Hospitalization—Ages 12-17	13.12%	20.53%	18.80%	19.60%	18.33%
2019	Percent of Members with Repeat BH Hospitalization—Ages 12-17	15.56%	20.10%	16.04%	20.20%	17.91%
2020	Percent of Members with Repeat BH Hospitalization—Ages 12-17	13.95%	19.21%	16.97%	22.31%	23.51%
Q1 2021	Percent of Members with Repeat BH Hospitalization—Ages 12-17	14.02%	24.84%	15.21%	10.20%	21.51%
Q2 2021	Percent of Members with Repeat BH Hospitalization—Ages 12-17	16.64%	26.45%	18.75%	16.04%	21.72%
2018	Percent of Members with Repeat BH Hospitalization—Ages 18-20	15.91%	15.58%	12.82%	15.24%	11.11%
2019	Percent of Members with Repeat BH Hospitalization—Ages 18-20	11.41%	16.36%	17.65%	18.32%	11.76%
2020	Percent of Members with Repeat BH Hospitalization—Ages 18-20	9.58%	19.77%	19.20%	21.08%	13.73%
Q1 2021	Percent of Members with Repeat BH Hospitalization—Ages 18-20	15.83%	19.38%	17.89%	11.25%	16.83%
Q2 2021	Percent of Members with Repeat BH Hospitalization—Ages 18-20	12.89%	20.54%	11.18%	15.29%	18.06%
2018	Percent of Members with Repeat BH Hospitalization—Total	12.87%	18.68%	17.70%	18.70%	17.44%
2019	Percent of Members with Repeat BH Hospitalization—Total	14.18%	19.59%	15.67%	19.83%	19.64%
2020	Percent of Members with Repeat BH Hospitalization—Total	11.95%	19.21%	16.90%	21.96%	20.93%
Q1 2021	Percent of Members with Repeat BH Hospitalization—Total	14.77%	23.33%	16.41%	11.25%	21.29%
Q2 2021	Percent of Members with Repeat BH Hospitalization—Total	16.73%	25.16%	17.25%	16.51%	21.27%
2018	Average Number of Repeat BH Hospitalizations Per Member—Ages 0-5	0.17	NA	NA	0.26	NA
2019	Average Number of Repeat BH Hospitalizations Per Member—Ages 0-5	0.14	NA	NA	NA	NA
2020	Average Number of Repeat BH Hospitalizations Per Member—Ages 0-5	0.11	NA	NA	NA	NA
Q1 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 0-5	0.16	NA	NA	NA	NA
Q2 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 0-5	0.26	NA	NA	NA	NA
2018	Average Number of Repeat BH Hospitalizations Per Member—Ages 6-11	0.20	0.22	0.22	NA	0.30
2019	Average Number of Repeat BH Hospitalizations Per Member—Ages 6-11	0.22	0.36	0.22	0.36	0.59
2020	Average Number of Repeat BH Hospitalizations Per Member—Ages 6-11	0.22	0.36	0.14	0.37	0.27
Q1 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 6-11	0.24	0.47	0.23	0.12	0.41
Q2 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 6-11	0.28	0.46	0.26	0.26	0.36
2018	Average Number of Repeat BH Hospitalizations Per Member—Ages 12-17	0.19	0.31	0.27	0.31	0.27
2019	Average Number of Repeat BH Hospitalizations Per Member—Ages 12-17	0.23	0.30	0.26	0.32	0.27
2020	Average Number of Repeat BH Hospitalizations Per Member—Ages 12-17	0.21	0.29	0.26	0.37	0.38
Q1 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 12-17	0.15	0.42	0.27	0.13	0.41
Q2 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 12-17	0.24	0.46	0.33	0.24	0.42
2018	Average Number of Repeat BH Hospitalizations Per Member—Ages 18-20	0.23	0.21	0.29	0.28	0.17
2019	Average Number of Repeat BH Hospitalizations Per Member—Ages 18-20	0.21	0.32	0.22	0.33	0.34
2020	Average Number of Repeat BH Hospitalizations Per Member—Ages 18-20	0.24	0.41	0.28	0.39	0.26
Q1 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 18-20	0.21	0.40	0.24	0.18	0.29
Q2 2021	Average Number of Repeat BH Hospitalizations Per Member—Ages 18-20	0.22	0.38	0.16	0.25	0.31
2018	Average Number of Repeat BH Hospitalizations Per Member—Total	0.19	0.28	0.27	0.29	0.26
2019	Average Number of Repeat BH Hospitalizations Per Member—Total	0.21	0.31	0.25	0.33	0.34
2020	Average Number of Repeat BH Hospitalizations Per Member—Total	0.21	0.33	0.25	0.37	0.34
Q1 2021	Average Number of Repeat BH Hospitalizations Per Member—Total	0.18	0.42	0.26	0.14	0.38
Q2 2021	Average Number of Repeat BH Hospitalizations Per Member—Total	0.24	0.44	0.28	0.24	0.39

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
	Pillar: Maternal and Child Health					
7	Well-Child Visits in the First 30 Months of Life (W30)					
2018	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.46%	40.53%	61.34%	58.16%	65.36%
2019	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.27%	56.33%	59.93%	60.79%	66.08%
2020	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	55.91%	39.27%	55.23%	66.00%	60.06%
Q1 2021	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	26.21%	25.86%	27.69%	32.97%	39.81%
Q2 2021	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	38.97%	39.59%	39.67%	46.21%	54.94%
2018	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	50.45%	76.51%	78.17%	77.04%	70.58%
2019	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	66.22%	74.80%	69.38%	74.76%	66.63%
2020	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	62.98%	68.21%	65.17%	70.13%	63.42%
Q1 2021	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	45.82%	51.48%	47.55%	54.05%	53.20%
Q2 2021	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	52.81%	59.00%	53.40%	59.12%	58.73%
8	Child and Adolescent Well-Care Visits (WCV)					
2018	Ages 3-11	57.36%	65.38%	63.97%	63.71%	60.86%
2019	Ages 3-11	55.43%	63.96%	63.82%	61.58%	57.54%
2020	Ages 3-11	44.19%	54.34%	48.44%	51.84%	47.15%
Q1 2021	Ages 3-11	7.15%	9.93%	10.29%	8.92%	16.96%
Q2 2021	Ages 3-11	17.32%	23.29%	21.81%	18.43%	41.80%
2018	Ages 12-17	55.40%	62.66%	58.04%	63.25%	56.99%
2019	Ages 12-17	53.78%	61.09%	57.52%	60.41%	56.18%
2020	Ages 12-17	40.89%	50.63%	42.77%	48.52%	44.20%
Q1 2021	Ages 12-17	6.29%	8.59%	9.33%	7.24%	14.44%
Q2 2021	Ages 12-17	14.74%	20.20%	19.23%	14.95%	40.52%
2018	Ages 18-21	28.67%	37.96%	34.23%	37.67%	30.80%
2019	Ages 18-21	27.35%	37.63%	33.95%	34.18%	27.71%
2020	Ages 18-21	20.00%	28.30%	23.51%	26.40%	21.61%
Q1 2021	Ages 18-21	3.83%	6.20%	5.72%	5.03%	9.36%
Q2 2021	Ages 18-21	9.22%	13.31%	11.36%	10.40%	18.35%
2018	Total	53.55%	61.73%	59.10%	61.30%	56.81%
2019	Total	51.51%	60.37%	58.62%	58.40%	53.97%
2020	Total	39.41%	49.54%	43.10%	47.54%	42.80%
Q1 2021	Total	6.25%	8.82%	9.22%	7.74%	14.88%
Q2 2021	Total	14.98%	20.49%	19.23%	16.00%	37.61%
9	Annual Dental Visit (ADV)					
2018	Ages 2-3	36.93%	46.59%	52.63%	35.80%	34.61%
2019	Ages 2-3	32.42%	45.69%	52.39%	31.89%	33.34%
2020	Ages 2-3	18.53%	30.72%	33.30%	22.33%	27.02%
Q1 2021	Ages 2-3	4.40%	6.32%	12.29%	2.06%	12.32%
Q2 2021	Ages 2-3	10.86%	13.90%	23.10%	2.17%	28.29%
2018	Ages 4-6	63.08%	74.59%	74.53%	63.36%	62.50%
2019	Ages 4-6	59.30%	73.69%	73.73%	60.33%	62.55%
2020	Ages 4-6	38.38%	54.39%	51.79%	45.35%	39.23%
Q1 2021	Ages 4-6	11.23%	15.70%	18.55%	5.45%	17.02%
Q2 2021	Ages 4-6	25.66%	31.06%	34.25%	5.67%	40.14%
2018	Ages 7-10	68.25%	78.59%	75.05%	68.96%	64.34%
2019	Ages 7-10	64.26%	78.75%	75.68%	65.06%	64.30%
2020	Ages 7-10	43.77%	60.42%	54.12%	50.53%	40.17%
Q1 2021	Ages 7-10	13.75%	19.18%	18.00%	7.25%	19.09%
Q2 2021	Ages 7-10	30.04%	35.86%	33.47%	28.12%	43.04%
2018	Ages 11-14	64.03%	75.50%	70.43%	64.33%	58.80%
2019	Ages 11-14	59.62%	75.71%	70.58%	60.59%	59.30%
2020	Ages 11-14	42.39%	60.20%	52.24%	49.13%	39.67%
Q1 2021	Ages 11-14	13.49%	18.82%	18.09%	6.91%	16.91%
Q2 2021	Ages 11-14	28.73%	34.96%	33.17%	7.18%	41.76%
2018	Ages 15-18	53.22%	64.10%	56.61%	53.49%	47.33%
2019	Ages 15-18	47.41%	64.01%	57.23%	48.98%	47.52%
2020	Ages 15-18	36.36%	52.57%	43.50%	42.12%	36.50%
Q1 2021	Ages 15-18	13.12%	18.21%	16.64%	6.95%	16.96%
Q2 2021	Ages 15-18	25.61%	31.90%	29.83%	7.31%	37.48%
2018	Ages 19-20	37.70%	46.42%	41.36%	37.81%	33.25%
2019	Ages 19-20	31.96%	46.83%	41.12%	34.32%	31.87%
2020	Ages 19-20	23.74%	36.83%	30.22%	29.27%	28.06%
Q1 2021	Ages 19-20	8.87%	11.95%	10.65%	4.99%	13.18%
Q2 2021	Ages 19-20	17.00%	21.11%	19.27%	5.17%	27.42%
2018	Total	59.17%	69.31%	66.81%	59.11%	55.27%
2019	Total	54.26%	69.12%	66.76%	55.08%	54.81%
2020	Total	37.26%	53.08%	47.50%	43.29%	37.03%
Q1 2021	Total	11.73%	16.33%	16.65%	6.06%	16.62%
Q2 2021	Total	24.92%	30.50%	30.57%	10.72%	38.35%
10	Childhood Immunization Status (CIS)—Combination 10					
2018	Total	14.24%	11.11%	35.71%	29.47%	34.77%
2019	Total	21.65%	6.46%	35.10%	28.59%	26.84%
2020	Total	23.46%	17.12%	35.53%	24.99%	26.65%
Q1 2021	Total	17.02%	13.82%	26.23%	13.33%	21.35%
Q2 2021	Total	19.97%	16.14%	29.10%	15.47%	23.06%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
	Pillar: Equity					
11	HIV Viral Load Suppression (HVL-AD)					
2018	Ages 18-64	NR	NR	NR	NR	1.27%
2019	Ages 18-64	NR	NR	NR	NR	16.59%
2020	Ages 18-64	8.56%	20.55%	12.22%	DNR	17.73%
Q1 2021	Ages 18-64	9.18%	17.60%	12.67%	DNR	17.23%
Q2 2021	Ages 18-64	14.54%	17.55%	12.62%	DNR	18.39%
2018	Ages 65+	NR	NR	NR	NR	NA
2019	Ages 65+	NR	NR	NR	NR	NA
2020	Ages 65+	13.79%	5.56%	11.81%	DNR	NA
Q1 2021	Ages 65+	NA	7.89%	12.77%	DNR	NA
Q2 2021	Ages 65+	12.50%	5.00%	13.64%	DNR	NA
2018	Total	NR	NR	NR	NR	1.43%
2019	Total	NR	NR	NR	NR	16.64%
2020	Total	8.79%	20.04%	12.21%	DNR	17.84%
Q1 2021	Total	9.27%	17.30%	12.67%	DNR	17.42%
Q2 2021	Total	14.46%	17.11%	12.66%	DNR	18.49%
12	Gap in Human Immunodeficiency Virus (HIV) Medical Visits (HGM)					
2018	Ages 0-17	NA	NA	NA	NA	NA
2019	Ages 0-17	NA	NA	NA	19.61%	NA
2020	Ages 0-17	NA	NA	NA	15.79%	NA
Q1 2021	Ages 0-17	NA	18.75%	NA	34.21%	NA
Q2 2021	Ages 0-17	NA	34.29%	NA	9.52%	NA
2018	Ages 18-64	29.19%	30.51%	68.55%	33.60%	23.71%
2019	Ages 18-64	24.40%	23.95%	63.57%	38.98%	23.83%
2020	Ages 18-64	28.00%	24.81%	36.98%	37.56%	21.54%
Q1 2021	Ages 18-64	33.08%	24.12%	38.95%	37.40%	22.15%
Q2 2021	Ages 18-64	39.47%	24.00%	41.21%	23.34%	20.60%
2018	Ages 65+	33.33%	40.82%	65.22%	23.08%	NA
2019	Ages 65+	9.52%	28.30%	70.00%	42.86%	NA
2020	Ages 65+	32.35%	38.46%	23.23%	28.85%	NA
Q1 2021	Ages 65+	34.29%	28.30%	30.39%	38.98%	NA
Q2 2021	Ages 65+	50.00%	25.35%	32.14%	25.81%	NA
2018	Total	29.20%	31.06%	68.44%	32.73%	23.95%
2019	Total	23.87%	24.31%	63.52%	38.49%	24.00%
2020	Total	28.31%	25.08%	36.37%	36.92%	21.50%
Q1 2021	Total	33.33%	24.15%	38.44%	37.38%	22.31%
Q2 2021	Total	39.90%	24.24%	40.88%	23.15%	21.33%
13	Prescription of HIV Antiretroviral Therapy (HAT)					
2018	Ages 0-17	NA	NA	NA	NA	NA
2019	Ages 0-17	NA	NA	NA	NA	NA
2020	Ages 0-17	NA	NA	NA	NA	NA
Q1 2021	Ages 0-17	NA	NA	NA	NA	NA
Q2 2021	Ages 0-17	NA	NA	NA	NA	NA
2018	Ages 18-64	96.96%	91.22%	95.30%	77.42%	95.19%
2019	Ages 18-64	98.81%	92.60%	96.44%	95.47%	94.48%
2020	Ages 18-64	96.30%	90.02%	94.02%	91.90%	86.36%
Q1 2021	Ages 18-64	91.34%	82.15%	90.86%	88.36%	87.10%
Q2 2021	Ages 18-64	96.09%	82.71%	93.18%	90.03%	90.35%
2018	Ages 65+	NA	NA	95.35%	NA	NA
2019	Ages 65+	100.00%	NA	94.44%	NA	NA
2020	Ages 65+	NA	97.22%	95.56%	NA	NA
Q1 2021	Ages 65+	NA	92.11%	87.80%	NA	NA
Q2 2021	Ages 65+	NA	92.31%	92.77%	NA	NA
2018	Total	96.90%	91.11%	95.16%	76.71%	94.87%
2019	Total	98.87%	92.48%	96.27%	95.15%	94.64%
2020	Total	96.31%	90.32%	94.13%	92.01%	86.43%
Q1 2021	Total	91.63%	82.45%	90.71%	88.13%	87.31%
Q2 2021	Total	96.19%	82.94%	93.11%	89.79%	90.52%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Improving Community Placement						
14	Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update (LTSS-CCP)					
2018	Care Plan with Core Elements	NR	NR	NR	NR	20.17%
2019	Care Plan with Core Elements	NR	NR	NR	NR	20.48%
2020	Care Plan with Core Elements	67.88%	26.03%	14.84%	18.00%	29.50%
Q1 2021	Care Plan with Core Elements	36.50%	26.76%	17.76%	19.46%	26.03%
Q2 2021	Care Plan with Core Elements	72.26%	23.60%	35.77%	18.00%	32.97%
2018	Care Plan with Supplemental Elements	NR	NR	NR	NR	20.17%
2019	Care Plan with Supplemental Elements	NR	NR	NR	NR	20.04%
2020	Care Plan with Supplemental Elements	67.40%	26.03%	14.36%	18.00%	29.50%
Q1 2021	Care Plan with Supplemental Elements	34.31%	26.76%	17.03%	18.73%	26.03%
Q2 2021	Care Plan with Supplemental Elements	71.78%	23.60%	35.52%	17.76%	32.97%
15	LTSS Successful Transition After Long-Term Institution Stay (LTSS-TRAN)					
2018	Observed Transition Rate - Total	NA	18.39%	31.57%	37.69%	NA
2019	Observed Transition Rate - Total	NA	14.75%	17.40%	18.43%	4.46%
2020	Observed Transition Rate - Total	NA	19.54%	18.60%	12.79%	5.10%
Q1 2021	Observed Transition Rate - Total	NA	19.32%	18.45%	12.81%	4.46%
Q2 2021	Observed Transition Rate - Total	46.03%	17.93%	19.51%	14.61%	4.79%
2018	Expected Transition Rate - Total	NA	76.79%	63.77%	58.57%	NA
2019	Expected Transition Rate - Total	NA	76.15%	68.95%	69.72%	57.11%
2020	Expected Transition Rate - Total	NA	75.19%	69.48%	59.54%	60.10%
Q1 2021	Expected Transition Rate - Total	NA	73.68%	69.25%	60.16%	58.02%
Q2 2021	Expected Transition Rate - Total	44.08%	74.49%	69.94%	60.57%	54.31%
2018	Observed/Expected Ratio - Total	NA	0.24	0.50	0.64	NA
2019	Observed/Expected Ratio - Total	NA	0.19	0.25	0.37	0.08
2020	Observed/Expected Ratio - Total	NA	0.26	0.27	0.21	0.08
Q1 2021	Observed/Expected Ratio - Total	NA	0.26	0.27	0.21	0.08
Q2 2021	Observed/Expected Ratio - Total	1.04	0.24	0.28	0.24	0.09

Note: Measures marked as not applicable (NA) for the measurement period had a denominator that was too small for calculating a valid rate, those marked *Not Reported* (*NR*) were not required to report during the measurement period, and those marked *Do Not Report* (*DNR*) did not have any reported data.

For HEDIS measure rates compared to NCQA benchmarks, the following color coding was applied.

- # = Below NCQA Quality Compass 25th percentile
- # = Between NCQA Quality Compass 25th percentile and 50th percentile
- # = Between NCQA Quality Compass 50th percentile and 75th percentile
- # = Above NCQA Quality Compass 75th percentile
- # = No NCQA Quality Compass benchmark available

For non-HEDIS measure rates, the following color coding was applied to provide a comparison of the MCO's current rate to the prior year's statewide average.

> 20% below baseline	10% - 20% below baseline	0 - 10% below baseline	0 - 10% above baseline	10% - 20% above baseline	> 20% above baseline
1	2	3	4	5	6

Strengths	• Aetna and Molina identified several improvements to their reporting process between the Readiness Review and 2021 PMV Review due to process improvement efforts, such as switching from point-in-time reporting to rolling annual reporting to account for claims lag that was impacting specific measures. • BCBSIL and CountyCare identified during readiness review activities that not all inpatient stays were being identified by the measure specifications for the four child behavioral health measures in the P4R program and made recommendations for adjustments to the inpatient provider requirements that were adopted by HFS prior to the 2021 PMV Review.
Opportunities for Improvement	**Opportunity:** The Aetna MY 2018 and MY 2019 Patient Level Detail files were missing a significant number of ZIP Codes, and Aetna reported no data for the *LTSS Successful Transition After Long-Term Institutional Stay* measure in MY 2018 or for eligible populations for MY 2019, MY 2020, and Q1 2021 that were too small to calculate a rate for the measure. **Why the Opportunity Exists:** Aetna reported that after the acquisition of the IlliniCare plan from Centene and the data migration from Centene systems, Aetna noticed some data loss. **Recommendation:** HSAG recommends that Aetna research the historical enrollment data migrated into the data warehouse against the historical raw 834 monthly audit files received from Centene to determine if any additional demographic or other enrollment data are incomplete and need to be filled in using the raw historical files. Additionally, HSAG recommends that Aetna research claims data for institutional stays in historical measurement periods within the Centene legacy system to determine whether data migrated into the data warehouse are complete and determine a mitigation strategy to address any lost data.
	Opportunity: While four of the five MCOs were able to report some data for the *HIV Viral Load Suppression* measure, many reported difficulty obtaining viral load data which may be leading to underreporting of performance on this measure. **Why the Opportunity Exists:** Access to lab values, and specifically lab data related to protected health information, often requires special data sharing agreements with lab vendors which can take time to establish if not already part of existing agreements. **Recommendation:** HSAG recommends monitoring medical claims data for members diagnosed with HIV to evaluate whether lab data for any of those members are missing and pursuing data sharing agreements with lab vendors as necessary to obtain the data.

Opportunity: Rates on the *LTSS Comprehensive Care Plan and Update* measure indicate some room for improvement for all of the MCOs.

Why the Opportunity Exists: Some of the care coordination data were not located in reportable fields, requiring a manual chart review of a sample to evaluate compliance which increases the risk for error. Additionally, some care plan elements were in the care plan notes but not in the care plan template, which could make locating required elements during chart reviews more challenging.

Recommendation: HSAG recommends that the MCOs pursue system enhancements to increase the number of reportable fields for the care coordination data, and to ensure all required elements are located within the care plan template.

Opportunity: Rates on the *LTSS—Successful Transition After Long-Term Institutional Stay* measure indicate room for improvement for all MCOs.

Why the Opportunity Exists: The MCOs may not be including all enrolled MLTSS members in the eligible population for this measure due to state-specific billing requirements for long-term institutional care, and/or may not be including Medicare institutional facility claims received in FFS historical claim files for Medicare-Medicaid Plan (MMP) Opt-Out members in the identification of the eligible population or calculation of observed discharges for the measure.

Recommendation: HSAG recommends that the MCOs review their process for identifying the eligible population and their data sources for institutional facility claims. Additionally, HSAG recommends that the MCOs evaluate their clinical review process for continued stay requests to look for opportunities to initiate transition planning as early as possible to improve the rate of successful discharges from a long-term institutional stay.

Medicare-Medicaid Alignment Initiative (MMAI)

Introduction

CMS allows HFS to validate quality withhold performance measures for the MMPs participating in the MMAI. Under the MMAI capitated model, CMS and the State withhold a percentage of their respective portion of the capitation rate paid to the MMP to ensure that the MMP's members receive high-quality care and to encourage quality improvement. The withheld amounts are repaid based on the MMP's reporting of specific core and state-specific quality withhold measures, which are a subset of the entire set of measures that MMPs are required to report.

HFS contracted with HSAG to conduct validation of one state-selected measure: *IL Measure 3.6: Movement of Members within Service Populations* (IL 3.6).

MMPs

Table 2-14 displays the MMPs for which IL 3.6 was reported in SFY 2022.

Table 2-14—MMAI Health Plans for MMAI Performance Measure Validation

Health Plan Name	Abbreviation
Aetna Better Health Premier Plan	Aetna
Blue Cross Community MMAI	BCBSIL
Humana Gold Plan Integrated	Humana
Meridian Complete	Meridian
Molina Dual Options Medicare-Medicaid Plan	Molina

Methodology

HSAG validated the data collection and reporting processes used by the MMPs to report the quality withhold performance measure data for Demonstration Year 6 (January 1, 2020, through December 31, 2020) in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019[2-11] (CMS Protocol 2). Additional details about the methodology are in Appendix B.

[2-11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 27, 2023.

Results

Validation Finding

The validation finding is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined as *NO*. Consequently, it is possible that an error for a single audit element may result in a designation of *Do Not Report* (*DNR*) because the impact of the error materially biased the reported performance measure. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and, thus the measure is *Reportable* (*R*) and considered compliant with state specifications. Table 2-15 displays HSAG's validation finding for all MMPs.

Table 2-15—Validation Findings for All MMPs

MMAI IL 3.6 Validation Finding				
Aetna	**BCBSIL**	**Humana**	**Meridian**	**Molina**
Reportable	*Reportable*	*Reportable*	*Reportable*	*Reportable*

MMP-specific reports were delivered to HFS and the MMPs and are available on request.

3. Evaluation of Administrative and Compliance Processes

This section presents a description of the activities HSAG conducted to comply with 42 CFR Part 438 Subpart E, which requires that specific review activities be performed by an EQRO related to required EQRs of a health plan's compliance with state and federal standards.

Administrative Compliance Reviews

One mandatory EQR requirement is a review, conducted within the previous three-year period, to determine the health plan's compliance with the standards set forth in Subpart D of 42 CFR §438.358 and the QAPI requirements described in 42 CFR §438.330.

In SFY 2020, the first year of a new three-year review cycle, HSAG conducted an Evaluation of Administrative Processes and Compliance Review (Compliance Review) in accordance with §438.358 on a subset of standards for HCI. The Compliance Review assessed each health plan's compliance with federal standards and the State contract requirements found in the HFS Model Contract 2018-24-001. In SFY 2021, the Compliance Review covered the remaining standards, thereby completing the required evaluation of the administrative and compliance process once in a three-year period.

In SFY 2021, HSAG also conducted a Compliance Review in accordance with §438.358 on a full set of standards for all Medicare-Medicaid Plans (MMPs). The Compliance Review assessed each health plan's compliance with federal standards and the State contract requirements found in the Illinois MMAI Contract.

HSAG used information and data derived from Compliance Reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care of Medicaid services provided to Medicaid enrollees. The results were reported in last year's technical report. In SFY 2022, HSAG worked closely with HFS to define the scope of the next three-year Compliance Review cycle scheduled to begin in SFY 2023. The forthcoming Compliance Review will include applicable federal and State regulations and laws and the requirements set forth in the Medicaid Model Contract and Illinois MMAI Contract, as they relate to the scope of the review.

Prior Review Cycle

HCI

Standards

The HCI Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards. A total of 17 standards were assessed. Table 3-1 displays the standards that were reviewed for each health plan in the prior three-year cycle.

Table 3-1—Review Standards for the Three-Year Period by Health Plan: SFY 2019–SFY 2021

			BCBSIL		CountyCare		IlliniCare (now Aetna)		Meridian		Molina		NextLevel	
#	CFR	Standard Name	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
I	438.206	Availability of Services*		✓		✓		✓		✓		✓		✓
II	438.207	Assurances of Adequate Capacity and Services		✓		✓		✓		✓		✓		✓
III	438.208	Coordination and Continuity of Care (including Transitions of Care)	✓		✓		✓		✓		✓		✓	
IV	438.210	Coverage and Authorization of Services	✓		✓		✓		✓		✓		✓	
V	438.214	Credentialing and Recredentialing		✓		✓		✓		✓		✓		✓
VI		CBH Services	✓		✓		✓		✓		✓		✓	
VIII	438.100	Enrollee Information/ Enrollee Rights		✓		✓		✓		✓		✓		✓
IX	438.224	Confidentiality		✓		✓		✓		✓		✓		✓
X	438.56	Enrollment and Disenrollment		✓		✓		✓		✓		✓		✓
XI	438.228	Grievance and Appeal Systems	✓		✓		✓		✓		✓		✓	
XII		Organization and Governance	✓		✓		✓		✓		✓		✓	
XIII		Fraud, Waste, and Abuse		✓		✓		✓		✓		✓		✓
XIV	438.242	Health Information Systems		✓		✓		✓		✓		✓		✓

			BCBSIL		CountyCare		IlliniCare (now Aetna)		Meridian		Molina		NextLevel	
#	CFR	Standard Name	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
XV	438.230	Subcontractual Relationships and Delegation	✓		✓		✓		✓		✓		✓	
XVI		Critical Incidents		✓		✓		✓		✓		✓		✓
XVII	438.236	Practice Guidelines and Minimum Standards of Care		✓		✓		✓		✓		✓		✓
XVIII	438.330	QAPI** Program	✓		✓		✓		✓		✓		✓	

* Standard I included Emergency and Poststabilization Services.

** QAPI = Quality Assessment and Performance Improvement

Final Results

All health plans successfully completed remediations for their compliance activities, resulting in full compliance for all standards for all health plans as shown in Table 3-2.

Table 3-2—Final Compliance Review Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

	BCBSIL	CountyCare	IlliniCare (now Aetna)	Meridian	Molina	NextLevel
TOTAL SCORE ***(all standards)***	100%	100%	100%	100%	100%	100%

MMAI

Standards

The MMAI Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards. A total of 16 standards were assessed. Table 3-3 displays the standards that were reviewed for each MMP in the prior three-year cycle.

Table 3-3—Review Standards for the Three-Year Period by MMP: SFY 2019–SFY 2021

			Aetna	BCBSIL	Humana	Meridian Complete	Meridian Total	Molina
#	CFR	Standard Name	2021	2021	2021	2021	2021	2021
I	438.206	Availability of Services*	✓	✓	✓	✓	✓	✓
II	438.207	Assurances of Adequate Capacity and Services	✓	✓	✓	✓	✓	✓
III	438.208	Care Coordination	✓	✓	✓	✓	✓	✓
IV	438.210	Coverage and Authorization of Services	✓	✓	✓	✓	✓	✓
V	438.214	Credentialing and Recredentialing	✓	✓	✓	✓	✓	✓
VIII	438.100	Enrollee Information/ Enrollee Rights	✓	✓	✓	✓	✓	✓
IX	438.224	Confidentiality	✓	✓	✓	✓	✓	✓
X	438.56	Enrollment and Disenrollment	✓	✓	✓	✓	✓	✓
XI	438.228	Grievance and Appeal Systems	✓	✓	✓	✓	✓	✓
XII		Organization and Governance	✓	✓	✓	✓	✓	✓
XIII		Fraud, Waste, and Abuse	✓	✓	✓	✓	✓	✓
XIV	438.242	Health Information Systems	✓	✓	✓	✓	✓	✓
XV	438.230	Subcontractual Relationships and Delegation	✓	✓	✓	✓	✓	✓
XVI		Critical Incidents	✓	✓	✓	✓	✓	✓
XVII	438.236	Practice Guidelines and Minimum Standards of Care	✓	✓	✓	✓	✓	✓
XVIII	438.330	QAPI Program	✓	✓	✓	✓	✓	✓

Final Results

All MMPs successfully completed remediations for their compliance activities, resulting in full compliance for all standards for all MMPs as shown in Table 3-4.

Table 3-4—Final MMAI Compliance Review Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

	Aetna	BCBSIL	Humana	Meridian Complete	Meridian Total	Molina
TOTAL SCORE ***(all standards)***	100%	100%	100%	100%	100%	100%

YouthCare Post-Implementation Review

In SFY 2021, HFS contracted HSAG to conduct a post-implementation review to evaluate YouthCare Specialty Plan's (YouthCare's) administrative processes to ensure compliance with Illinois' SNC 1915(b) waiver application and contract requirements. HSAG collaborated with HFS to define the scope of the post-implementation review to include applicable federal and State regulations and laws and the requirements set forth in the contract, as they relate to the scope of the review. The post-implementation review included the following activities:

- Conduct case management file reviews.
- Conduct a review of the enrollee portal.
- Review any findings or statuses of remediation requirements from continuous monitoring activities including staffing, training, and provider network adequacy, if applicable.
- Review the status of health plan remediation of findings from the SFY 2020 Access and Availability Provider Directory study and Pediatric Provider Network Time/Distance analysis.

Remediation

HSAG prepared a draft report for the health plan that described HSAG's post-implementation review findings, scoring, and assessment of the organization's compliance. As directed by HFS, the health plan was placed on a corrective action plan (CAP) to ensure remediation of findings and ongoing monitoring of the population. The health plan received direction to respond to high-priority areas within 15 days from the receipt of the CAP and within 30 days to all remaining noncompliant items. HFS required that the health plan complete these corrective actions and demonstrate compliance.

HSAG reviewed documentation submitted by the health plan and conducted webinar interviews and case management file reviews with health plan staff on December 15, 2021, and February 16, 2022, to monitor remediation efforts. The health plan provided evidence of compliance with contract requirements as of June 2022.

Methodology

Although compliance reviews were not conducted in SFY 2022, this section describes the methodology HSAG used to complete the Compliance Reviews conducted in the three-year cycle. HSAG followed the guidelines set forth in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[3-1]

Objectives for Conducting the Administrative Review

The primary objective of HSAG's administrative review was to provide meaningful information to HFS and the health plans regarding the evaluation of each health plan's administrative processes to ensure compliance with federal (42 CFR Parts 400, 434, and 438) and Illinois (215 ILCS 134/80) requirements for adherence to standards for organizational structure and operations that directly relate to quality of care. The Compliance Review included requirements that addressed standards in the following operational areas: access, structure and operations, and measurement and improvement.

Compliance Review Activities

Activity One: Establish Compliance Thresholds

HSAG performed a series of pre-planning steps to define levels of compliance for use throughout the compliance review, as shown in Table 3-5 below.

Table 3-5—Activity One: Establish Compliance Thresholds

For this step,	HSAG…
Step 1:	**Collected information from HFS.**
	Worked with HFS to define the scope of the review to include applicable federal and State regulations and laws and the requirements set forth in the Medicaid Model Contract, as they relate to the scope of the review.
Step 2:	**Determined review standards.**
	The Compliance Review included requirements that addressed the operational areas listed below.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 13, 2022.

For this step,	HSAG…	
	SFY 2020 Subset	**SFY 2021 Subset**
	Access Standard III—Coordination and Continuity of Care Standard IV—Coverage and Authorization of Services Standard VI—Children's Behavioral Health Services Structure and Operations Standard XI—Grievance and Appeal Systems Standard XII—Organization and Governance Standard XV—Subcontractual Relationships and Delegation Measurement and Improvement Standard XVIII—Quality Assessment and Performance Improvement Program (QAPI)	Access Standard I—Availability of Services Standard II—Assurances of Adequate Capacity and Services Standard V—Credentialing and Recredentialing Structure and Operations Standard VIII —Enrollee Information/Enrollee Rights Standard IX—Confidentiality Standard X—Enrollment and Disenrollment Measurement and Improvement Standard XIV—Health Information Systems Standard XVI—Critical Incidents Standard XVII—Practice Guidelines and Required Minimum Standards of Care Standard XIII—Fraud, Waste, and Abuse
For MMAI, all standards listed above were reviewed in SFY 2021 expect for Children's Behavioral Health, which is not applicable to the MMAI population.		
Step 3:	**Prepared the data collection tools for reviewing the standards.**	
	As a mechanism to assess the health plans compliance with the standards under the scope of the review, HSAG, in collaboration with HFS, developed hard copy compliance review tools, as well as specific file review tools. HSAG also developed a web-based application and process for the health plans to submit documentation and data for the review. This web-based application, the Illinois Compliance Review Tool, was used for documenting findings from the review. This electronic tool also has reporting capabilities.	
Step 4:	**Defined levels of compliance.**	
	HSAG assigned each element within the standards in the compliance monitoring tool a score of *Met*, *Not Met*, or *Not Applicable (NA)*. HSAG used scores of *Met* and *Not Met* to indicate the degree of compliance with the requirements by the health plans. HSAG used a designation of *NA* when a requirement was not applicable to an organization during the period covered by the review. *Met* indicates full compliance defined as both of the following: • All documentation listed under a regulatory provision or component thereof is present. • Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.	

For this step,	HSAG…
	Not Met indicates noncompliance defined as the following: • Not all documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
Step 5:	**Built timeline for review process.**
	HSAG worked with HFS to construct a timeline to ensure completion of all review activities and advance notice to health plans.

Activity Two: Perform Preliminary Review

HSAG performed a series of preliminary steps, including a desk review, as shown in Table 3-6 below.

Table 3-6—Activity Two: Perform Preliminary Review

For this step,	HSAG…
Step 1:	**Established early contact with the health plans.**
	HSAG coordinated with HFS and the health plans to set the schedule and identified members of the HSAG review team for each health plan.
Step 1a:	**Prepared and submitted the pre-assessment form to the health plans.**
	The pre-assessment form is to identify gaps in information necessary to ensure a comprehensive EQR process and efficient and productive interactions with the health plan during the site visit. The form required the health plans to describe their organization and its functions and contained a list of desk review documents that the health plans were required to submit prior to the virtual review, as well as a list of documents required for the virtual portion of the administrative compliance review. In addition, the pre-assessment form provided the health plans with the purpose, timelines, and instructions for submitting the data required for sampling for the file reviews.
Step 1b:	**Forwarded the review tool, file review tools, and web-based application access instructions to the health plans.**
	Health plan-specific tools and were provided to assist each health plan in preparing for the review.

<table>
<tr><th>For this step,</th><th>HSAG…</th></tr>
<tr><td>Step 1c:</td><td>Responded to the MCOs' questions related to the review and provided additional information needed before the review.</td></tr>
<tr><td></td><td>Prior to conducting the reviews, HSAG maintained contact with the health plans as needed to answer questions and to provide information to key members of the management staff. This telephone and/or e-mail contact gave health plan representatives the opportunity to ask for clarification about the request for documentation for HSAG's desk review and virtual review processes. HSAG communicated regularly with HFS about HSAG's discussions with the health plans and its responses to their questions.</td></tr>
<tr><td>Step 1d:</td><td>Received data files from the health plans and HFS, then selected and posted samples to HSAG's FTP site prepared for each health plan.</td></tr>
<tr><td></td><td>HSAG generated unique record review samples based on data files supplied by the health plans for each of the file reviews listed below. Specifications were also supplied for the program description reviews listed below.
HCI
<table>
<tr><th>Standard #</th><th>Standard</th><th>File Reviews</th></tr>
<tr><td colspan="3">Access Standards</td></tr>
<tr><td>I</td><td>Availability of Services</td><td>Provider Agreement</td></tr>
<tr><td>II</td><td>Assurances of Adequate Capacity and Services</td><td>Provider Directory</td></tr>
<tr><td>III</td><td>Coordination and Continuity of Care</td><td>Care Management (CM);
Care/Disease Management Program Description (PD)</td></tr>
<tr><td>IV</td><td>Coverage and Authorization of Services</td><td>Denials;
Utilization Management PD;
Peer Review PD</td></tr>
<tr><td>V</td><td>Credentialing and Recredentialing</td><td>None</td></tr>
<tr><td>VI</td><td>Children's Behavioral Health Services</td><td>Children's Behavioral Health Record Review</td></tr>
<tr><td colspan="3">Structure and Operations Standards</td></tr>
<tr><td>VIII</td><td>Enrollee Information/Enrollee Rights</td><td>Enrollee Handbook</td></tr>
<tr><td>IX</td><td>Confidentiality</td><td>None</td></tr>
<tr><td>X</td><td>Enrollment and Disenrollment</td><td>None</td></tr>
<tr><td>XI</td><td>Grievance and Appeal Systems</td><td>Appeals; Grievances; State Fair Hearing (SFH)/Independent Review Entity (IRE)</td></tr>
<tr><td>XII</td><td>Organization and Governance</td><td>None</td></tr>
<tr><td>XIII</td><td>Fraud, Waste, and Abuse</td><td>None</td></tr>
<tr><td>XIV</td><td>Health Information Systems</td><td>None</td></tr>
</table></td></tr>
</table>

For this step,	HSAG…

XV	Subcontractual Relationships and Delegation	Delegation Vendor File Review; Provider Complaints
Measurement and Improvement Standards		
XVI	Critical Incidents	None
XVII	Practice Guidelines and Required Minimum Standards of Care	None
XVIII	QAPI	Quality Assurance PD

MMAI

Standard #	Standard	File Reviews
Access Standards		
I	Availability of Services	Provider Agreement
II	Assurances of Adequate Capacity and Services	Provider Directory
III	Coordination and Continuity of Care	CM, CMPD
IV	Coverage and Authorization of Services	Denials, UM PD, and Peer Review PD
V	Credentialing and Recredentialing	None
Structure and Operations Standards		
VIII	Enrollee Information/Enrollee Rights	Enrollee Handbook
IX	Confidentiality	None
X	Enrollment and Disenrollment	None
XI	Grievance and Appeal Systems	Grievances Appeals State Fair Hearing (SFH)/Independent Review Entity (IRE)
XII	Organization and Governance	None
XIII	Fraud, Waste, and Abuse	None
XIV	Health Information Systems	None
XV	Subcontractual Relationships and Delegation	Delegated Vendors File Review
Measurement and Improvement Standards		
XVI	Critical Incidents	None
XVII	Practice Guidelines and Required Minimum Standards of Care	None
XVIII	QAPI	Quality Assurance PD

For this step,	HSAG…
Step 2:	**Perform a preliminary document review (desk review).**
	Received the health plans' documents for HSAG's desk review and evaluated the information before conducting the on-site/virtual review. HSAG reviewers used the documentation to gain insight into each health plan's processes for providing access to care for its members, structure and operations, and quality assessment and performance improvement program. HSAG also used the documentation to begin compiling preliminary findings before the on-site/virtual portion of the review. During the desk review process, reviewers: • Documented findings from the review of the materials submitted by the health plans as evidence of their compliance with the requirements. • Identified areas and issues requiring further clarification or follow-up during the on-site/virtual interviews. • Identified information not found in the desk review documentation that HSAG would request during the on-site/virtual administrative review.

Activity Three: Conduct Site Visits

HSAG conducted virtual site visits to collect the information necessary to assess the health plans' compliance with federal and State regulations. The steps of the site visit process are shown in Table 3-7 below.

Table 3-7—Activity Three: Conduct Site Visits

For this step,	HSAG…
Step 1:	**Determined the length of visit and the dates.**
	HFS determined that site visits would be scheduled for two consecutive business days with each health plan. Health plans were given scheduling options and the schedule was finalized in advance.
Step 2:	**Identify the number and types of reviewers needed.**
	The review team members that HSAG assigned were content area experts who had in-depth knowledge of that HFS' Medicaid systems and requirements, and who also have extensive experience and proven competency conducting the compliance reviews. To ensure interrater reliability, HSAG reviewers were trained on the review methodology to ensure that the determinations for each element of the review are made in the same manner. Members of HSAG's review teams were assigned specific standards, and communication and coordination were ongoing among the team members to ensure uniformity of the reviews. The team leader reviews the findings and scores for all standards to ensure accuracy and consistency of approach among reviewers.

For this step,	HSAG…
	HSAG assigned the number of reviewers based on the characteristics of the health plan. Factors that are considered by HSAG include the number of Medicaid enrollees, provider network, the health plan's history of compliance with required standards, and the scope of programs being contracted by the state Medicaid agency.
Step 3:	**Established an agenda for the visit.**
	The site visit agenda was developed to assist each health plan's staff in planning for participation in the virtual review, assembling requested documentation, and addressing logistical issues. The agenda set the tone, expectations, the objectives, and time frames for the review.
Step 4:	**Provided preparation instructions and guidance to the health plans.**
	HSAG representatives conducted a teleconference with the health plans and HFS to exchange information, confirm the dates for the desk and virtual review, and complete other planning activities to ensure that the Compliance Review was completed methodically and accurately. In addition, clear instructions and guidance were provided to each health plan prior to the site visit including: the scope of the assessment, how the review will be conducted, lists of required documents, instructions for the organization of document presentation; forms or other data gathering instruments that should be completed prior to arrival, reports from prior reviews and subsequent corrective actions, identification of expected interview participants and administrative needs of the reviewers and any other expectations or responsibilities.
Step 5:	**Conducted virtual document review.**
	During the virtual review, health plan staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information.
Step 6:	**Conducted virtual health plan interviews.**
	During the virtual review, HSAG: • Conducted interviews with health plan staff. HSAG used interviews to obtain a complete picture of compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the health plan's performance. • Reviewed information, documentation, and systems demonstrations. Throughout the virtual review process, reviewers used the administrative review tool to identify relevant information sources and to document findings regarding compliance with the standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. • Received and reviewed files designated for the file reviews. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the health plans' policies and procedures. • Summarized findings at the completion of the virtual review.

For this step,	HSAG…
Step 7:	**Conducted exit interviews.**
	As a final step, HSAG reviewers met with staff members and HFS to provide a high-level summary of the preliminary findings from the virtual review. The purpose of the exit interview allowed HSAG to clarify its understanding of the information collected throughout the compliance review process and provided the health plans the opportunity to respond to initial compliance issues to ensure the findings were due to true non-compliance and not due to misunderstanding or misinterpretation of health plan documents and interviews.

Activity Four: Compile and Analyze Findings

HSAG documented components of the review and the final compliance determinations for each regulatory provision via the steps outlined in Table 3-8 below. The documented findings served as evidence of the comprehensiveness of the EQR process and validity of the findings.

Table 3-8—Activity Four: Compile and Analyze Findings

For this step,	HSAG…
Step 1:	**Collect supplemental information.**
	HFS and HSAG established a post-review period in which the health plans could submit additional information or refer HSAG to supplemental information regarding compliance with requirements.
Step 2:	**Analyze findings.**
	HSAG reviewed all standards in the review tool for each health plan. HSAG analyzed the information to determine the organization's performance for each of the elements in the standards. HSAG assigned each element within the standards in the compliance monitoring tool a score of *Met*, *Not Met*, or *Not Applicable (NA)*.
	HSAG used scores of *Met* and *Not Met* to indicate the degree of compliance with the requirements by the health plans. HSAG used a designation of *NA* when a requirement was not applicable to an organization during the period covered by the review.

Activity Five: Report Results

HSAG drafted a report to HFS with the results of the review of the health plans' compliance with federal and State requirements using the steps shown in Table 3-9 below.

Table 3-9—Activity Five: Report Results

For this step,	HSAG…
Step 1:	**Submit a final determination report to the State.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepared a draft report for each health plan that described HSAG's Compliance Review findings, the scores it assigned for each requirement within the standards, and HSAG's assessment of the organization's compliance and any areas requiring corrective action. The reports were forwarded to HFS and the applicable health plan for their review and comment. Following HFS' approval of each draft report, HSAG issued final reports to HFS and the applicable MCO.

4. Performance Improvement Projects (PIPs)

Overview

As part of its quality assessment and performance improvement program, HFS requires health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), each PIP must include:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement (QI).
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. This structured method of assessing and improving health plan processes can have a favorable effect on member health outcomes and satisfaction.

Section Contents

Introduction to PIPs

Objectives

PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that a health plan serves. Health plans conduct PIPs to assess and improve the quality of clinical and nonclinical healthcare and services received by recipients.

Statewide Mandatory Topics

The health plans submitted two new state-mandated PIPs for validation: *Improving Timeliness of Prenatal Care* and *Improving Transportation Services*. The topics addressed CMS' requirements related to quality outcomes, specifically the timeliness of and access to care and services. The health plans submitted Steps 1 through 6 only this year (selecting the topic, defining the Aim statement, defining the population, sampling methodology, defining the performance indicator(s), and defining the data collection process); therefore, there are no interventions or outcomes included in this year's report.

Validation of PIPs

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* (CMS Protocol 1), October 2019. [4-1]

To assess and validate PIPs, HSAG used a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS Protocol 1. With HFS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of the PIP. See Appendix C—PIP/QIP Methodology for more information on validation scoring.

Implementation and Training

Prior to the health plans completing and submitting the new PIPs for validation, HSAG provided training to the health plans and HFS on requirements for completing the PIP Submission Form, as well as the validation criteria. The health plans were also provided the opportunity to seek individualized technical assistance throughout the PIP process.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 27, 2023.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's PIP Submission Form. Each health plan completed the form for PIP activities conducted during the measurement year and submitted it to HSAG for validation. The PIP Submission Form and accompanying PIP Completion Instructions present instructions for documenting information related to each of the steps in CMS Protocol 1. The health plans could also attach relevant supporting documentation with the PIP Submission Form.

The following table illustrates the data source for each health plan and PIP topic.

Table 4-1—Health Plan and PIP-Specific Data Source

Health Plan	PIP Topic	Data Source
Aetna	*Improving Timeliness of Prenatal Care*	HEDIS *Prenatal and Postpartum Care (PPC)* Measure: Administrative data through claims/encounters
Aetna	*Improving Transportation Services*	Transportation vendor data
BCBSIL	*Improving Timeliness of Prenatal Care*	HEDIS *PPC* Measure: Administrative data through claims/encounters
BCBSIL	*Improving Transportation Services*	Transportation vendor data
CountyCare	*Improving Timeliness of Prenatal Care*	HEDIS *PPC* Measure: Administrative data through claims/encounters
CountyCare	*Improving Transportation Services*	Transportation vendor data
Meridian	*Improving Timeliness of Prenatal Care*	HEDIS *PPC* Measure: Administrative data through claims/encounters
Meridian (includes YouthCare Specialty Plan)	*Improving Transportation Services*	Transportation vendor data: telephone service and call center data, appointment data, and access data
Molina	*Improving Timeliness of Prenatal Care*	HEDIS *PPC* Measure: Administrative data through claims/encounters, supplemental data
Molina	*Improving Transportation Services*	Transportation vendor data: telephone service and call center data, appointment data, and access data

Health Plan-Specific Validation Results

Table 4-2 and Table 4-3 summarize the health plans' performance for each PIP topic. The health plans' primary PIP activities this year were initiating new PIPs and completing the first six steps of the PIP Submission Form. For this year's validation, the PIPs had not progressed to reporting baseline data or the initiation of QI activities or interventions. These will be reported in the next annual EQR technical report.

For the annual validation, HSAG validated the first six steps that were completed (PIP design) for each new PIP submitted. The following table illustrates the validation scores and status for each health plan and PIP topic.

Improving Timeliness of Prenatal Care

Table 4-2—Health Plan-Specific Validation Results

Health Plan	PIP Aim Statement	Performance Indictor	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Aetna	By the end of remeasurement period 2 (ending October 7, 2023), targeted interventions will improve *Timeliness of Prenatal Care* HEDIS measure for the entire eligible population. Compliance will increase from 78.5% to at least the 50th percentile benchmark performance of 89.05%.	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	80%	67%	*Partially Met*
BCBSIL	Does performing targeted outreach to pregnant women within the first trimester or within 42 days of enrollment with BCBSIL increase the HEDIS *Timeliness of Prenatal Care* annual results?	The percentage of deliveries that deliver a live birth and received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the BCBSIL organization.	100%	100%	*Met*

Health Plan	PIP Aim Statement	Performance Indictor	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
CountyCare	Improved care coordination processes, increased outreach earlier in pregnancy by care management staff, and improved linkage to prenatal provider groups will result in improved linkage to timely prenatal care in the first trimester among pregnant members.	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	100%	100%	*Met*
Meridian	By 12/31/2023, Meridian aims to increase the percentage of prenatal care visits among women in their first trimester of pregnancy (within 280–176 days of delivery or estimated date of delivery), from 80.08% to 82.08% in CY2022 and to 84.08% in CY2023 (2.00% increase each year) through targeted interventions including, but not limited to, member and provider engagement and community partnerships to support the needs of this population.	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	100%	100%	*Met*
Molina	Do targeted interventions increase HEDIS *PPC* prenatal rates for Molina Medicaid members who deliver a live birth during the measurement year?	The percentage of deliveries who received a prenatal visit during the first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.	100%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Improving Transportation Services

For the *Improving Transportation Services* PIP, the health plans reported each population served in one PIP Submission Form; however, each population reported was validated independently with validation scores and outcomes. For this PIP, the health plans were provided HFS-defined specifications to follow.

The following table illustrates the validation scores and status for each health plan's reported population.

Table 4-3—Health Plan-Specific Validation Results

Health Plan	PIP Aim Statement (Same across all populations reported)	Performance Indictor (Same across all populations reported)	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Aetna HealthChoice	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests where the member was delivered to the provider/appointment location prior to or at the exact scheduled appointment time.	100%	100%	*Met*
Aetna MLTSS			100%	100%	*Met*
Aetna SNC			100%	100%	*Met*
BCBSIL HealthChoice	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*
BCBSIL MLTSS			100%	100%	*Met*
BCBSIL SNC			100%	100%	*Met*
CountyCare HealthChoice	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*
CountyCare MLTSS			100%	100%	*Met*
CountyCare SNC			100%	100%	*Met*
Meridian HealthChoice	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*
Meridian MLTSS			100%	100%	*Met*
Meridian SNC (includes YouthCare)			100%	100%	*Met*

Health Plan	PIP Aim Statement (Same across all populations reported)	Performance Indictor (Same across all populations reported)	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Molina HealthChoice	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the enrollee arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*
Molina MLTSS			100%	100%	*Met*
Molina SNC			100%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

As described in Table 4-2 and Table 4-3, the validation results for both *Improving Timeliness of Prenatal Care* and *Improving Transportation Services* PIPs show that all but one health plan received a validation status of *Met* and achieved 100 percent of the validation criteria for the first six steps submitted for validation. All PIPs were found to be methodologically sound. A sound design creates the foundation for the health plans to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. For Aetna's *Improving Timeliness of Prenatal Care* PIP, opportunities for improvement were identified with the documentation of its data collection process and reporting of accurate baseline data. Aetna is required to make the necessary corrections in the next annual submission.

Based on the validation of the health plans' submitted PIPs, HSAG has the following recommendations as the health plans progress to conducting QI activities and reporting remeasurement outcomes. The health plans should:

- Use QI tools such as a causal/barrier analysis, key driver diagram, process mapping, and/or failure modes and effects analysis (FMEA) to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help the health plans determine what interventions to test and implement.
- Develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.
- Develop a process or plan to evaluate the effectiveness of each individual intervention.
- Use Plan-Do-Study-Act (PDSA) cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- Revisit the causal/barrier analysis tools used at least annually to ensure the health plan remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.
- Use the PIP Completion Instructions as additional steps of the PIP process are completed. This will ensure all documentation requirements have been addressed.
- Seek technical assistance from HSAG as needed.

Interventions and Data Sources

HSAG's PIP process includes three stages—I. Design, II. Implementation, and III. Outcomes. During the 2021–2022 validation, interventions were not assessed because the health plans initiated new PIPs, completed only their design, and had not progressed to the point of conducting QI processes and initiating interventions. This information will be reported in the next annual EQR report.

Strengths, Opportunities for Improvement, and Recommendations

This section assesses the strengths and opportunities for improvement of health plan performance and makes recommendations for improvement.

Overall Program

Strengths	• All PIPs were found to be methodologically sound. • The new state-mandated PIP topics addressed both clinical and nonclinical focus areas and the quality, timeliness, and accessibility of care. • All but one health plan achieved all validation criteria for the first six steps of the PIP (selecting the PIP topic, defining the Aim statement, identifying the PIP population, sampling methodology, defining the performance indicator(s), and defining the data collection process) for both PIP topics. • The *Improving Transportation Services* PIP had state-defined specifications.
Opportunities for Improvement	**Opportunity:** One health plan, Aetna, had opportunities for improvement related to its documentation of the data collection process and reporting of accurate baseline data. **Why the Opportunity Exists:** Aetna did not accurately document the data collection process or report the correct baseline performance percentage based on the numerator and denominator documented. **Recommendation:** The health plan should ensure it addresses HSAG's validation feedback, references the PIP Completion Instructions, and seeks technical assistance for any questions or needed guidance.

Health Plan-Specific

Aetna Better Health

Improving Timeliness of Prenatal Care PIP

Strengths	• Designed a methodologically sound PIP.
Opportunities for Improvement	**Opportunity:** Inaccurate documentation of the data collection process and reporting of the baseline data. **Why the Opportunity Exists:** The health plan did not accurately document the data collection process or report the correct baseline performance percentage based on the numerator and denominator documented. **Recommendation:** Ensure all of HSAG's validation feedback is addressed, reference the PIP Completion Instructions, and seek technical assistance for any questions or needed guidance.

Improving Transportation Services PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Blue Cross Blue Shield of Illinois

Improving Timeliness of Prenatal Care PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Improving Transportation Services PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

CountyCare Health Plan

Improving Timeliness of Prenatal Care PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Improving Transportation Services PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

MeridianHealth

Improving Timeliness of Prenatal Care PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Improving Transportation Services PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Molina Healthcare of Illinois

Improving Timeliness of Prenatal Care PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Improving Transportation Services PIP

Strengths	• Designed a methodologically sound PIP. • Achieved all validation criteria for Steps 1 through 6 (PIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Introduction to Quality Improvement Projects (QIPs)

Objectives

QIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that the MMAI plan serves. MMAI plans conduct QIPs to assess and improve the quality of clinical and nonclinical healthcare and services provided to recipients.

Statewide Mandatory Topics

The MMAI plans submitted one new state-mandated QIP for validation: *Improving Transportation Services*. The topic addressed CMS' requirements related to quality outcomes, specifically the timeliness of and access to care and services. The MMAI plans submitted the first six steps only for the new QIP; therefore, there are no interventions or outcomes included in this year's report.

Validation of PIPs

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG validated the QIPs through an independent review process. In its QIP evaluation and validation, HSAG used CMS Protocol 1 cited earlier in this section of the report.

To assess and validate QIPs, HSAG used a standardized scoring methodology to rate a QIP's compliance with each of the nine steps listed in CMS Protocol 1. With HFS' input and approval, HSAG developed a QIP Validation Tool to ensure uniform assessment of the QIP. See Appendix C—PIP/QIP Methodology for more information on validation scoring.

Implementation and Training

Prior to the MMAI plans completing and submitting the new QIP for validation, HSAG trained the MMAI plans and HFS on requirements for completing the QIP Submission Form, as well as on the validation criteria. The MMAI plans were also provided the opportunity to seek individualized technical assistance throughout the QIP process.

Description of Data Obtained

HSAG obtained the data needed to conduct the QIP validation from each MMAI plan's QIP Submission Form. Each MMAI plan completed the form for QIP activities conducted during the measurement year and submitted it to HSAG for validation. The QIP Submission Form and accompanying QIP Completion Instructions present instructions for documenting information related to each of the steps in CMS Protocol 1. The MMAI plans could also attach relevant supporting documentation with the QIP Submission Form.

The following table illustrates the data source for each MMAI plan.

Table 4-4—MMAI Plan and QIP-Specific Data Source

Health Plan	PIP Topic	Data Source
Aetna Better Health Premier	Improving Transportation Services	Transportation vendor data
BCBSIL	Improving Transportation Services	Transportation vendor data
Humana	Improving Transportation Services	Transportation vendor data
Meridian	Improving Transportation Services	Transportation vendor data: telephone service and call center data, appointment data, and access data
Molina	Improving Transportation Services	Transportation vendor data: telephone service and call center data, appointment data, and access data

MMAI Plan-Specific Validation Results

Table 4-5 summarizes the MMAI plans' performance for the *Improving Transportation Services* QIP. The MMAI plans' primary QIP activities this year were initiating a new PIP and completing the first six steps of the submission form (selecting the topic, defining the Aim statement, identifying the population, sampling methodology, defining the performance indicator, and defining the data collection process). For this year's validation, the QIPs had not progressed to reporting baseline data or the initiation of QI activities or interventions. These will be reported in the next annual EQR technical report.

For the annual validation, HSAG validated the design only for the new QIP submitted. For this QIP, the MMAI plans were provided HFS-defined specifications to follow. The following table illustrates the validation scores and status for each MMAI plan.

Table 4-5—MMAI Plan-Specific Validation Results

MMAI Plan	QIP Aim Statement	Performance Indictor	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Aetna Better Health Premier	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests where the member was delivered to the provider/appointment location prior to or at the exact scheduled appointment time.	100%	100%	*Met*
BCBSIL	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*
Humana	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*

MMAI Plan	QIP Aim Statement	Performance Indictor	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Meridian	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the member arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*
Molina	Do targeted interventions increase the percentage of scheduled Leg A trip requests where the member was delivered before or on time for their scheduled appointment?	The percentage of scheduled Leg A trip requests that resulted in the enrollee arriving to their scheduled appointment on time during the measurement period.	100%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

As described in Table 4-5, the validation results for the *Improving Transportation Services* QIPs show that all MMAI plans received a validation status of *Met* and achieved 100 percent of the validation criteria for the first six steps submitted for validation. All QIPs were found to be methodologically sound. A sound design creates the foundation for the MMAI plans to progress to subsequent QIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.

Based on the validation of the MMAI plans' submitted QIPs, HSAG has the following recommendations as the MMAI plans progress to conducting QI activities and reporting remeasurement outcomes. The MMAI plans should:

- Use QI tools such as a causal/barrier analysis, key driver diagram, process mapping, and/or FMEA to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help the MMAI plans determine what interventions to test and implement.
- Develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.
- Develop a process or plan to evaluate the effectiveness of each individual intervention.
- Use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.

- Revisit the causal/barrier analysis tools used at least annually to ensure the health plan remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.
- Use the QIP Completion Instructions as additional steps of the QIP process are completed. This will ensure all documentation requirements have been addressed.
- Seek technical assistance from HSAG as needed.

Interventions and Data Sources

HSAG's QIP process includes three stages—I. Design, II. Implementation, and III. Outcomes. During the 2021–2022 validation, interventions were not assessed because the MMAI plans initiated a new QIP, completed only the first six steps (QIP design), and had not progressed to the point of conducting QI processes and initiating interventions. This information will be reported in the next annual EQR report.

Strengths, Opportunities for Improvement, and Recommendations

This section assesses the strengths and opportunities for improvement of MMAI plan performance and makes recommendations for improvement.

Overall Program

Strengths	• All QIPs were found to be methodologically sound. • The new state-mandated PIP topic addressed a nonclinical focus area and the quality, timeliness, and accessibility of care. • The *Improving Transportation Services* PIP had state-defined specifications.
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

MMAI Plan-Specific

Aetna Better Health Premier

Improving Transportation Services QIP

Strengths	• Designed a methodologically sound QIP. • Achieved all validation criteria for Steps 1 through 6 (QIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Blue Cross Blue Shield of Illinois

Improving Transportation Services QIP

Strengths	• Designed a methodologically sound QIP. • Achieved all validation criteria for Steps 1 through 6 (QIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Humana

Improving Transportation Services QIP

Strengths	• Designed a methodologically sound QIP. • Achieved all validation criteria for Steps 1 through 6 (QIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

MeridianHealth

Improving Transportation Services QIP

Strengths	• Designed a methodologically sound QIP. • Achieved all validation criteria for Steps 1 through 6 (QIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

Molina Healthcare of Illinois

Improving Transportation Services QIP

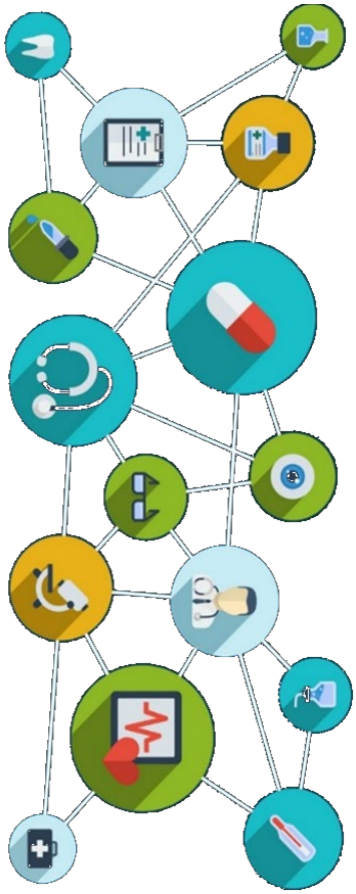
Strengths	• Designed a methodologically sound QIP. • Achieved all validation criteria for Steps 1 through 6 (QIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

5. Network Adequacy Validation

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While a federal protocol has yet to be released, HFS contracted HSAG to conduct several activities to validate and monitor the health plans' provider network adequacy during the preceding SFY to comply with federal and State requirements.

Section Contents

Network Adequacy Monitoring



HealthChoice Illinois Network Monitoring

Introduction

HFS and HSAG have established a process for health plans to submit provider network data. The process includes contracted providers within each health plan's service areas, including providers in contiguous counties that provide support to the health plan provider network. Each quarter, health plans are required to submit a Provider File Layout (PFL) that includes a range of provider types. HSAG uses the provider network data submissions to conduct biannual analyses and monitoring of the provider network to ensure compliance with the Medicaid Model contract and federal requirements.

For additional details of the network adequacy monitoring methodology see Appendix D1.

Results

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

Analysis and monitoring of the HealthChoice Illinois provider network throughout SFY 2022 verified that the health plans contracted with a sufficient number of required provider types within each service region. SFY 2022 biannual provider network reports are available upon request.

For more detailed results, see the regional comparison in Appendix D2.

Managed Long-Term Services and Supports (MLTSS) Network Monitoring

Introduction

HFS directed its EQRO to establish a process for health plans to submit provider network data quarterly for each of their service areas. The quarterly submission of MLTSS providers allows HFS to evaluate provider network capacity across the health plans using a multifaceted, iterative, and standardized

approach. These data are used to support ongoing monitoring, assessment, and reporting activities to evaluate provider network adequacy.

The EQRO maintains ongoing communication with the health plans and HFS regarding any findings and recommendations related to the MLTSS provider network. Health plans are required to address and correct any identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps. The EQRO monitors and reports to HFS the health plans' compliance in maintaining an adequate provider network for the MLTSS expansion.

Results

The analysis showed that all statewide health plans were compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. See Appendix D3 for detailed results.

Medicare-Medicaid Alignment Initiative (MMAI) Network Monitoring

Introduction

HFS and HSAG have established a process for health plans to submit provider network data. The process includes contracted providers within each health plan's service areas, including providers in contiguous counties that provide support to the health plan provider network. Each quarter, health plans are required to submit a PFL that includes a range of provider types. HSAG uses the provider network data submissions to conduct biannual analysis and monitoring of the provider network to ensure compliance with the MMAI Model contract and federal requirements.

Results

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

Analysis and monitoring of the MMAI provider network throughout SFY 2022 verified that the health plans contracted with a sufficient number of required provider types within each service region. SFY 2021 biannual provider network reports are available upon request.

For more detailed results, see the regional comparison in Appendix D4.

Access and Availability Telephone Survey

Introduction

As part of its provider network adequacy monitoring activities, HFS requested that HSAG conduct an access and availability survey of provider offices to evaluate the average time to an appointment for Illinois Medicaid enrollees.

HFS directed HSAG to conduct a revealed telephone survey among provider locations contracted with HealthChoice Illinois managed care plans and specializing in one of five select health specialties:

- Cardiologists
- Pulmonologists
- Allergy and immunologists
- Neurologists
- Licensed professional counselors

The goal of the Access and Availability Telephone Survey was to evaluate appointment availability among the health plans' networks of select specialty providers.

Specific survey objectives included the following:

- Determine whether specialty locations accept new patients.
- Determine whether specialty locations accept patients enrolled with a Medicaid health plan.
- Determine appointment availability with the sampled specialty locations for nonurgent services.

Findings

Results of the 2022 telephone survey of specialty providers indicate an overall response rate of 84.5 percent. While response rates varied slightly by specialty, all specialties had a response rate greater than 80.0 percent. Response rates ranged from 81.7 percent for cardiology to 88.4 percent for licensed professional counseling.

Of the contacted locations, 21.6 percent indicated they did not provide the requested specialty services, and 13.0 percent indicated the service location address was incorrect. Moreover, 3.2 percent of the providers did not accept the health plan, and 4.3 percent did not accept Medicaid. Additionally, 1.3 percent of all locations did not accept new patients.

For those cases that responded to the survey, were at the correct location, accepted the specialty category, and accepted Illinois Medicaid, 85.5 percent of the sampled locations were still contracted with the requested health plan. Of these locations, 93.2 percent were accepting new patients. Among cases in which an appointment was offered, 54.9 percent had no stated limitations, while 23.7 percent required a referral and 19.6 percent required pre-registration or personal information prior to confirming an appointment. Among cases unable to offer an appointment, 33.0 percent indicated the schedule/calendar was not available, 29.9 percent noted limitations unique to the sampled location or required a referral prior to scheduling, and 27.8 percent required pre-registration or personal information before a date could be provided.

Despite the limited number of cases with appointment availability, offices that could be reached and that offered appointments for new Medicaid patients were compliant with the contract standards for 81.1 percent of the offered appointments for licensed professional counseling and 80.8 percent for cardiology appointments. For new Medicaid patients requesting an appointment for allergy and immunology, these offices were compliant with the contract standards for 57.9 percent of the offered appointments. Pulmonology offices were compliant with contract standards for 43.9 percent of the offered appointments, while neurology offices were compliant for 35.8 percent of the offered appointments.

The average time to appointment varied greatly among the specialty categories. Overall, the average wait time for a new patient appointment was 39 days. Average wait times for a new patient ranged from 26 days for an appointment with a cardiologist or licensed professional counselor to 66 days for an appointment with a neurologist. The average wait time for an existing patient appointment was 23 days. Average wait times for an existing patient ranged from 13 days for an appointment with a licensed professional counselor to 41 days for an appointment with a neurologist.

Recommendations

Based on the survey results presented in this report, HSAG identified several opportunities for improvement related to accurate provider information, enrollees' ability to successfully schedule an appointment, and the timeliness of available appointments relative to enrollees' needs.

HSAG offers the following recommendations to address potential opportunities to improve access among enrollees covered by HealthChoice Illinois managed care plans:

- HSAG was unable to reach almost 40 percent of sampled cases for each health plan. In addition, key nonresponse reasons involved call attempts in which the address was incorrect or the office did not provide the requested services.
  - Since the health plans supplied HSAG with the provider data used for this survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls (e.g., disconnected telephone numbers or telephone numbers, addresses, and/or provider specialty information that do not correspond to the sampled provider location).
- HSAG was only able to obtain an appointment date with 14.5 percent of the sampled locations that were accepting the health plan, Medicaid, and new patients. The survey identified several barriers to

obtaining appointment dates, including pre-registration or requiring personal information before scheduling, Medicaid eligibility verification, requiring a referral, and medical record review. While some barriers pose unique limitations since the caller cannot provide the office personal information, other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments.
  - HFS and the health plans should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment.
  - In coordination with ongoing outreach and network management activities, the health plans should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS' standards, and incorporate appointment availability standards into educational materials.
- The overall compliance rate for all specialty categories was 63.1 percent. Compliance with appointment availability standards was low, especially in the areas of allergy and immunology (57.9 percent), pulmonology (43.9 percent), and neurology (35.8 percent).
  - The health plans should investigate the results of the study to identify whether enrollees appear to be systematic or associated with specific geographic areas. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
  - HFS should continue to monitor the health plans' compliance with existing State standards for appointment availability. Additionally, HFS should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability.

Detailed results of the Access and Availability Telephone Survey study were published in a final report located in Appendix D5.

Time/Distance Analysis

Introduction

As part of its provider network adequacy monitoring activities, HFS requested its EQRO, HSAG, to conduct a time/distance analysis between enrollees and providers in the health plans' networks. Specifically, the purpose of the SFY 2022 Time/Distance Analysis was to evaluate the degree to which health plans comply with network standards outlined in the Illinois Department of Healthcare and Family Services—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in the CMS rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol has yet to be released by CMS, time/distance analysis, as conducted in this analysis, aligns with current federal regulations, and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect.

The health plans assessed in this analysis are listed below:

- Aetna
- BCBSIL
- CountyCare
- Meridian
- Molina
- YouthCare

Methodology

The contract requirements state that the health plans must ensure that 90.0 percent of enrollees in each county of the contracting area have access within the stated time or distance standard, except for pharmacy services, wherein 100 percent of the enrollees must have access within the stated time or distance standard. Analyses were conducted by region to illustrate differences by region of the State. The access standards are defined separately for enrollees living in urban and rural areas. HSAG used the definitions for "urban" and "rural" counties as defined in the Medicaid Model Contract—Attachment II. Using those definitions, Illinois had 19 urban counties and 83 rural counties.

HFS and the health plans provided Medicaid enrollee demographic information and provider network files to HSAG for use in the time/distance analyses. The health plans submitted the provider data as part

of their regular, ongoing submissions to HSAG. HSAG submitted a detailed data requirements document to HFS requesting its Medicaid enrollee data, including data which met the following criteria:

- Enrollee demographic data as of February 5, 2022.
- Enrollee eligibility and enrollment data including start and end dates for enrollment with the health plan.

HSAG cleaned, processed, and used the data submitted to define unique lists of providers, provider locations, and enrollees for inclusion in the analyses. HSAG standardized and geocoded all Medicaid enrollee and provider addresses using Quest Analytics Suite software. Provider offices in the State of Illinois or in contiguous counties were included in the time/distance analyses. All provider office locations associated with a provider were included in the analyses. For example, if a single provider practiced at three locations, each location was considered a unique location for the time/distance analyses.

Additional details about the methodology for the time/distance analysis are in the SFY 2022 Time/Distance Analysis Report in Appendix D6.

Findings

The findings from the analysis of the percentage of enrollees residing within the time/distance standards defined by HFS are summarized below. The summary information includes the number of provider categories for which the percentage of enrollees met the time/distance standards for the provider category across all five regions of the State. The summary information also includes the health plans and regions where the time/distance standards were not met for each provider category with deficiencies. Finally, the summary information includes key findings from the analysis of enrollees stratified by age, sex, and residence in Disproportionately Impacted Area (DIA) ZIP Codes.

HSAG validated the time/distance requirements for 16 provider categories within each service region. The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers, for which the contract requires that 100 percent of enrollees have access to providers.

- Aetna, Meridian, and YouthCare were compliant with the contract standards for 13 provider categories across all service regions.
- Molina was compliant with the contract standards for 12 provider categories across all service regions.
- BCBSIL was compliant with the contract standards for nine provider categories across all service regions.
- CountyCare was compliant with the contract standards for all 16 provider categories.
- Across Aetna, BCBSIL, Meridian, Molina, and YouthCare, the provider networks for Pharmacy and Oral Surgery—Adult and Pediatric did not meet the time/distance standards in all regions.

- The BCBSIL and Molina provider networks for Allergy and Immunology—Pediatric and the BCBSIL provider networks for Allergy and Immunology—Adult did not meet the time/distance standards in all regions.
- The BCBSIL Neurosurgery—Adult and Pediatric provider networks did not meet the time/distance standards in all regions.

Health plans were noncompliant with contract standards for the provider categories in the regions summarized below.

Pharmacy

- BCBSIL: Regions 1, 2, and 5
- Aetna: Regions 1, 2, and 5
- Meridian: Regions 1, 2, and 5
- Molina: Regions 1, 2, and 5
- YouthCare: Regions 1 and 2

Allergy and Immunology—Adult

- BCBSIL: Regions 1, 2, and 3

Allergy and Immunology—Pediatric

- BCBSIL: Regions 1, 2, and 3
- Molina: Region 2

Neurosurgery—Adult

- BCBSIL: Region 1

Neurosurgery—Pediatric

- BCBSIL: Region 1

Oral Surgery—Adult

- BCBSIL: Regions 1, 2, and 3
- Aetna: Regions 1, 2, and 3
- Meridian: Region 3
- Molina: Region 3
- YouthCare: Region 3

Oral Surgery—Pediatric

- BCBSIL: Regions 1, 2, and 3

- Aetna: Regions 1, 2, and 3
- Meridian: Region 3
- Molina: Region 3
- YouthCare: Region 3

In addition to assessing the percentage of enrollees residing within the time/distance standards for 16 provider categories and within each service region, HSAG also assessed the results stratified at the enrollee level by urbanicity, age, sex, and whether or not the enrollee lived in a DIA ZIP Code.

Additional details about the findings are located in the SFY 2022 Time/Distance Analysis Report in Appendix D6.

Recommendations

HSAG recommends the following for HFS and the health plans to strengthen the HealthChoice Illinois Medicaid managed care provider networks and ensure enrollees' timely access to healthcare services:

- While most health plans are meeting the contract standards for most provider categories, HFS should collaborate with the health plans to continue to monitor the status of time/distance standards for all provider categories.
- HFS should continue to collaborate with those health plans that did not meet the time/distance standards in specific regions to contract with additional providers if available. Provider categories of concern include Pharmacy, Allergy and Immunology, Neurosurgery, and Oral Surgery.
- HFS should conduct an in-depth review of provider categories for which no health plans met the time/distance standards, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories for which providers may not be available or willing to contract with the health plans.
- As the time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should continue using appointment availability surveys to evaluate providers' availability. HSAG also recommends incorporating encounter data to assess enrollees' utilization of services to identify the active provider network and assess whether access to care among those providers that actually deliver services to enrollees still meet the defined time/distance standards.

MMAI Provider Network Post-Implementation Reviews

Introduction

Following implementation of the MMAI statewide expansion on July 1, 2021, the health plans were required to continue quarterly reporting and submission of provider network data files to HFS/HSAG. The quarterly provider data files included a range of provider types such as primary care, specialty, gynecology, behavioral health, ancillary, pharmacy, safety net providers, health clinics, hospitals, home- and community-based services (HCBS), and long-term services and supports (LTSS) providers. HSAG used the health plans' provider data submissions to validate and ensure continued compliance with HFS' requirements to maintain a sufficient number of contracted providers within the MMAI expansion service counties/regions. HSAG completed biannual reviews and quarterly monitoring of the provider network to validate compliance with HFS' requirements.

Ongoing Monitoring

HSAG completed health plan-specific biannual comparative network reports to identify the number of provider types within each region and county, which also included a review of contracted providers in state-specific contiguous counties. This analysis allowed HSAG to determine if significant changes in the health plans' provider network occurred between submissions. Any significant changes to the provider network that resulted in potential network gaps were communicated to HFS and required the health plans to address and correct any identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps.

In addition, HFS required the health plans to maintain contracted LTSS and behavioral health providers in at least 80 percent of the Illinois counties. HSAG conducted a thorough analysis of the LTSS and behavioral health provider network data files and completed reports summarizing findings by provider type/region/county. HSAG and HFS maintained ongoing communication with the health plans to address and correct any gaps in the MMAI LTSS and the behavioral health provider network.

Results

HSAG conducted a review of 16 LTSS provider categories across 102 Illinois counties and identified that all health plans contracted with one or more providers across multiple LTSS service categories for all regions. As such, all health plans met the HFS requirement for contracting with LTSS providers in at least 80 percent of the Illinois counties.

In addition, HSAG completed a review of the behavioral health network across 102 Illinois counties and identified that the health plans contracted with one or more behavioral health providers within all regions. Based on the results of the behavioral health network analysis, four of the five health plans were compliant with the HFS requirement to contract with behavioral health providers in at least 80 percent of Illinois counties. During the last quarter of SFY 2022, HSAG's review identified that one health plan did

not maintain compliance with the HFS requirement and therefore was placed on a CAP until the health plan complies with the HFS requirement. Once the health plan achieves compliance, HSAG will request approval from HFS to close the CAP for the behavioral health provider network.

Ad Hoc Provider Network Reporting

HSAG produces ad hoc network reports at the request of HFS. The reports are completed in a specified format to comply with HFS' requirements, and the information in these reports may include specific provider types for particular enrollee populations, Freedom of Information Act (FOIA) requests, research related to network adequacy, impact analysis due to provider network terminations, specific ZIP Code analysis, county-specific analysis for individual provider types, and assisting HFS with developing language for responses to questions from stakeholders within or outside HFS.

Analyses that were conducted in SFY 2022 in response to HFS provider network requests are listed below.

- Provider Network Data Files: The State received a request from the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) for a list of network providers contracted by Medicaid managed care plans serving Cook, Jo Daviess, and Stephenson counties. HSAG provided the State with a detailed provider network data file that included a list of multiple provider types contracted across Medicaid managed care plans.
- Naperville Ventures Psychiatric Hospital (Naperville Hospital): HSAG completed an analysis to determine the list of health plans contracted with Naperville Hospital for HCI and/or MMAI.
- HHS OIG Provider Network Data: HSAG provided the full health plan provider network data files to HFS as requested by the HHS OIG Department. The provider data files included the entirety of the health plan provider network for HCI and MMAI.
- Skilled Nursing Facility (SNF)ist Program and Provider Research: HSAG conducted research for HFS regarding the SNFist program and health plan-specific contracted SNFist providers.
- Senate Bill (SB) 0471: As directed by HFS, HSAG reviewed and verified network-related language, conducted research and responded to the requirements, and assisted HFS with developing responses to questions related to the network adequacy requirements of SB 0471.
- Nursing Facility Time/Distance: HSAG completed a Time/Distance analysis to determine the time/distance between nursing facilities and a focal group of nursing facilities.
- Member Access to Obstetrics/Gynecology (OB/GYN) Providers in Vermillion County: HSAG completed a provider-specific analysis to determine access to OB/GYN providers based on the health plans' provider network in Vermillion County and the surrounding counties.
- BCBSIL/Anderson Hospital Termination (Impact Analysis): HFS requested HSAG to conduct an impact analysis for the termination of the contract between BCBSIL and Anderson Hospital & Medical Group.

6. Beneficiary Experience With Care

Overview

A key HFS strategy for the oversight of health plans is to conduct an annual experience of care survey of Medicaid members. CAHPS surveys are designed to capture members' perspectives on healthcare quality. HFS uses CAHPS results to monitor health plan and provider performance, measure members' experiences with services and access to care, and evaluate program characteristics.

Each year, managed care members rate their overall experience with their health plans, healthcare services, personal doctor, and specialists. They also answer questions related to different aspects of care, such as getting the care they need, timeliness of care, and how well their doctors communicate. Member experience is assessed through the evaluation of eight performance measures.

Health plans are required to independently administer surveys which provide HFS with important feedback on performance and are used to initiate changes to improve members' experiences with the managed care programs. Additional details about CAHPS methodology are presented in Appendix E1, and detailed results are included in Appendix E2 of this report.

CAHPS Measures

The CAHPS surveys were administered to the adult and child Medicaid populations. The survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite measures. The global ratings reflected beneficiaries' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care.

For All Kids and Illinois Medicaid, the CAHPS survey also included the children with chronic conditions (CCC) measurement set of survey questions, which are categorized into five additional measures of experience. These measures include three CCC composite measures and two CCC individual item measures. The CCC composites and items depict different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

HealthChoice Illinois was served by five health plans in SFY 2022. Four of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only. Table 6-1 displays the health plans that reported CAHPS data for SFY 2022.

Table 6-1—HealthChoice Illinois Health Plans for 2022 CAHPS

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

HSAG performed three separate analyses on the survey results: top-box score calculations, national comparisons, and a trend analysis. The top-box scoring of the global ratings, composite measures, and CCC composites and items involved assigning top-box responses a score of 1 with all other responses receiving a score of 0. After applying this scoring methodology, the percentage of top-box responses was calculated to determine the top-box scores for the global ratings, composite measures, and CCC composites and items.

To evaluate trends in member experience, HSAG performed a trend analysis that compared the 2022 top-box scores to the corresponding 2021 top-box scores. Top-box score results that were statistically significantly higher in 2022 than in 2021 are noted with upward (▲) triangles. Top-box scores that were statistically significantly lower in 2022 than in 2021 are noted with downward (▼) triangles. Top-box scores in 2022 that were not statistically significantly higher or lower than scores in 2021 are not noted with triangles.

In addition to the trend analysis, HSAG compared the top-box scores for each measure to national Medicaid percentiles. HSAG used the percentile distributions shown in Table 6-2 to depict members' overall experience, where one star (★) is the lowest possible rating (i.e., poor performance) and five stars (★★★★★) is the highest possible rating (i.e., excellent performance):

Table 6-2—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Summary of Performance

Adult CAHPS Medicaid Results

To assess the adult population's experience of Medicaid services, health plans use NCQA-certified CAHPS survey vendors to survey a sample of adult beneficiaries. The aggregate results for all HealthChoice Illinois health plans combined are displayed in the table below; detailed results are available in Appendix E-2.

Table 6-3—Adult Aggregate Results

	2021	2022	Trending Results (2021–2022)
Composite Measures			
Getting Needed Care	83.1% ★★	82.3% ★★	—
Getting Care Quickly	80.5% ★★	78.8% ★	—
How Well Doctors Communicate	91.6% ★	93.8% ★★★	—
Customer Service	86.6% ★	88.2% ★★	—
Global Ratings			
Rating of All Health Care	59.3% ★★★	54.3% ★	—
Rating of Personal Doctor	67.3% ★★	67.7% ★★	—
Rating of Specialist Seen Most Often	70.0% ★★	67.0% ★★	—
Rating of Health Plan	58.6% ★★	59.3% ★★	—

▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
— Indicates the 2022 score is not statistically significantly higher or lower than the 2021 score.

Strengths	None of the experience survey results showed a statistically significant improvement from the prior year; however, experience survey results for *How Well Doctors Communicate* improved from the prior year and were at or between the 50th and 74th percentiles. This indicates that members perceived that their provider satisfactorily communicated and addressed their needs.
Opportunities for Improvement	**Opportunity:** Experience survey results were below the 50th percentile for every measure except *How Well Doctors Communicate,* which indicates that members perceive a lack of access to and timeliness of care, as well as an overall lack of quality of care. **Why the Opportunity Exists:** Members may have difficulty obtaining the care, tests, or treatment they need and getting an appointment with their provider or specialist in a timely manner. Additionally, providers and specialists may not be spending enough quality time with members. **Recommendation:** HSAG recommends that the HealthChoice Illinois health plans conduct root cause analyses or focus studies to determine why members are not getting timely care or the quality of care they need, or do not have access to care. The HealthChoice Illinois health plans could consider whether there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Child CAHPS Medicaid Results

To assess the child population's experience of Medicaid services, health plans used NCQA-certified CAHPS survey vendors to survey a sample of child beneficiaries. The aggregate results for all HealthChoice Illinois health plans combined are displayed in the table below; detailed results are available in Appendix E-2.

Table 6-4—Child Aggregate Results (Without CCC Survey)

	2021	2022	Trending Results (2021–2022)
Composite Measures			
Getting Needed Care	80.2% ★	79.4% ★	—
Getting Care Quickly	82.6% ★	82.4% ★	—
How Well Doctors Communicate	92.6% ★	93.5% ★★	—
Customer Service	86.0% ★	90.1% ★★★	—
Global Ratings			
Rating of All Health Care	73.8% ★★★	67.6% ★	▼
Rating of Personal Doctor	79.5% ★★★	77.1% ★★	—
Rating of Specialist Seen Most Often	71.9% ★★	67.1% ★	—
Rating of Health Plan	68.8% ★	69.0% ★★	—

▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
— Indicates the 2022 score is not statistically significantly higher or lower than the 2021 score.

Strengths	None of the experience survey results showed a statistically significant improvement from the prior year; however, experience survey results for *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles. This indicates that parents/caretakers of child members perceived better quality of care from their health plan when they needed assistance from 2021 to 2022.
Opportunities for Improvement	**Opportunity:** Experience survey results show a statistically significant decline from last year for *Rating of All Health Care*, which indicates that parents/caretakers of child members perceived a lack of access to and timeliness of care, as well as an overall lack of quality of care. **Why the Opportunity Exists:** Parents/caretakers of child members may have difficulty obtaining the care, tests, or treatment they need and getting an appointment with their provider or specialist in a timely manner. Additionally, providers and specialists may not be spending enough quality time with members or are not satisfactorily communicating and addressing members' needs. **Recommendation:** HSAG recommends that the HealthChoice Illinois health plans conduct root cause analyses or focus studies to determine why members are not getting timely care or the quality of care they need, or do not have access to care. The HealthChoice Illinois health plans could consider whether there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need. Additionally, HSAG recommends that the HealthChoice Illinois health plans determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.

Child Statewide Results

HSAG administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. These child CAHPS surveys include questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines, access to specialized services). Results are calculated for the population of children identified as having a chronic condition and for the general child population. HFS does not require the health plans to administer the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set; however, HSAG uses this survey for Illinois Medicaid and All Kids.

General Population

The Illinois statewide program aggregate (i.e., Illinois Medicaid and All Kids combined) CAHPS results for the general child population are displayed in Table 6-5.[6-1]

Table 6-5—Statewide Survey General Child Population Aggregate Results

	2021	2022	Trending Results (2021–2022)
Composite Measures			
Getting Needed Care	81.1% ★	78.5% ★	—
Getting Care Quickly	81.5% ★	79.5% ★	—
How Well Doctors Communicate	94.2% ★	93.6% ★★	—
Customer Service	86.3% ★	79.2% ★	▼
Global Ratings			
Rating of All Health Care	68.4% ★	66.3% ★	—
Rating of Personal Doctor	76.5% ★★	74.6% ★	—
Rating of Specialist Seen Most Often	70.6% ★	64.4% ★	—
Rating of Health Plan	61.8% ★	59.0% ★	—

▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
— Indicates the 2022 score is not statistically significantly higher or lower than the 2021 score.

[6-1] NCQA does not publish separate benchmarks for the CHIP population; therefore, caution should be exercised when interpreting the results of the national comparisons analysis (i.e., star ratings).

Strengths	None of the experience survey results showed a statistically significant improvement from the prior year.
Opportunities for Improvement	**Opportunity:** Experience survey results show a statistically significant decline from last year for *Customer Service*, which indicates that parents/caretakers of child members perceived a lack of quality of care from their health plan when they needed assistance from 2021 to 2022. **Why the Opportunity Exists:** Lower experience scores with customer service and the program overall are likely related to member materials, interactions with program staff, and the level of assistance that was provided when parents/caretakers of child members were in need. **Recommendation:** HSAG recommends that the Illinois Medicaid and All Kids programs conduct root cause analyses or focus studies to determine why parents/caretakers of child members are potentially perceiving a lack of access from customer service when assistance is needed.
	Opportunity: Experience survey results were below the 50th percentile for every measure, indicating that parents/caretakers of child members may perceive a lack of access to and timeliness of care for their child, as well as an overall lack of quality of care and services from providers and the programs. **Why the Opportunity Exists:** Lower ratings for each measure may indicate that parents/caretakers of child members have difficulty obtaining access to the care or treatment they need, as well as difficulty scheduling needed care with a provider or at a facility in a timely manner. When child members receive care, providers may not be spending an adequate amount of time with the child to provide the quality of care the parent/caretaker of the child member anticipates or expects to meet the child's healthcare needs. Member experiences related to quality of care could be related to frustrations with parents/caretakers' perception of a lack of access and availability of needed care or an overall need for quality care improvements. **Recommendation:** HSAG recommends that the Illinois Medicaid and All Kids programs conduct root cause analyses or focus studies to determine why parents/caretakers of child members are potentially perceiving a lack of access to care, timeliness of needed care, and overall quality of care. Once a root cause or probable reasons for lower ratings are identified in each area, the Illinois Medicaid and All Kids programs can determine appropriate interventions, education, and actions to improve performance.

CCC Population

The Illinois statewide program aggregate (i.e., Illinois Medicaid and All Kids combined) CAHPS results for the CCC population are displayed in the table below.

Table 6-6—Statewide Survey CCC Population Aggregate Results

	2021	2022	Trending Results (2021–2022)
Composite Measures			
Getting Needed Care	84.7% ★	78.3% ★	▼
Getting Care Quickly	86.0% ★	84.4% ★	—
How Well Doctors Communicate	95.2% ★★	91.5% ★	▼
Customer Service	85.2% ★	81.1%+ ★+	—
Global Ratings			
Rating of All Health Care	61.6% ★	61.8% ★	—
Rating of Personal Doctor	74.0% ★	70.5% ★	—
Rating of Specialist Seen Most Often	73.5% ★★	64.4% ★	▼
Rating of Health Plan	57.9% ★	52.5% ★	—
CCC Composites and Items			
Access to Specialized Services	60.6% ★	58.2% ★	—
FCC: Personal Doctor Who Knows Child	91.7% ★★	89.5% ★	—
Coordination of Care for Children with Chronic Conditions	78.6% ★★★	73.8% ★	—
Access to Prescription Medicines	89.0% ★	87.2% ★	—
FCC: Getting Needed Information	87.9% ★	87.1% ★	—

▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
— Indicates the 2022 score is not statistically significantly higher or lower than the 2021 score.

Strengths	None of the experience survey results showed a statistically significant improvement from the prior year.
Opportunities for Improvement	**Opportunity:** Experience survey results show a statistically significant decline from last year for *Getting Needed Care*, *How Well Doctors Communicate*, and *Rating of Specialist Seen Most Often*. This indicates that parents/caretakers of child members perceive a lack of access to care, as well as an overall lack of quality of care. **Why the Opportunity Exists:** Lower ratings in the above measures may indicate that parents/caretakers of child members have difficulty obtaining access to the care or treatment their child needs, as well as difficulty scheduling the care their child needs with a provider or at a facility in a timely manner. Additionally, when caring for child members, providers may not be communicating well with the parents/caretakers or spending adequate time with the child to provide the quality of care the parent/caretaker anticipates or expects to meet the child's healthcare needs. **Recommendation:** HSAG recommends that the HealthChoice Illinois health plans conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. The HealthChoice Illinois health plans could consider whether there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve performance related to the care child members need. Additionally, HSAG recommends that HealthChoice Illinois health plans evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill gaps or evaluate why providers may not want to participate with the health plan. **Opportunity:** Experience survey results were below the 25th percentile for every measure, indicating that parents/caretakers of child members may perceive a lack of access to and timeliness of care for their child, as well as an overall lack of quality of care and services from providers and the programs. **Why the Opportunity Exists:** Member experiences related to quality of care could be related to parents/caretakers' frustration resulting from their perception of a lack of access and availability of needed care or an overall need for quality care improvements. Additionally, lower experience scores with customer service and the program overall are likely related to member materials, interactions with program staff, and the level of assistance that was provided when parents/caretakers of child members were in need. **Recommendation:** HSAG recommends that the Illinois Medicaid and All Kids programs conduct root cause analyses or focus studies to determine why

parents/caretakers of child members are potentially perceiving a lack of access to care, timeliness of needed care, and overall quality of care. Once a root cause or probable reasons for lower ratings are identified in each area, the Illinois Medicaid and All Kids programs can determine appropriate interventions, education, and actions to improve performance.

7. Additional EQR Activities

This section presents a description of activities HSAG conducted as optional EQR activities, as allowed for by federal regulations and as requested by HFS.

Section Contents

Quality Rating System

Overview

Federal regulation 42 CFR §438.334 requires the development of a Medicaid managed care quality rating system. While a federal protocol has yet to be released, HFS contracted HSAG to develop a consumer quality comparison guide which shows how HealthChoice Illinois (HealthChoice) health plans compare to one another in key performance areas.

In SFY 2022, HSAG was tasked with developing a report card to evaluate the performance of health plans serving HealthChoice Illinois beneficiaries.

The Cook County guide included an analysis of the health plans that are available to Medicaid beneficiaries in Cook County. The statewide guide included an analysis of the health plans that are available statewide to Medicaid beneficiaries. HFS uses the consumer guides to assess progress on the State's Quality Strategy goals and inform its quality improvement efforts.

Reporting Measures and Categories

Health plan performance was evaluated in six separate reporting categories.[7-1] Each reporting category consisted of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the measures they contain were:

- **Doctors' Communication**: Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate and overall ratings of personal doctors. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access to Care**: Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' access to care and children's and adolescents' access to dentists.
- **Women's Health**: Includes HEDIS measures that assess how often women-specific services are provided (e.g., breast cancer, cervical cancer, and chlamydia screenings, as well as prenatal and postpartum care).

[7-1] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

- **Living With Illness**: Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions, such as diabetes and hypertension.
- **Behavioral Health**: Includes HEDIS measures that assess whether members with behavioral health conditions received appropriate follow-up after hospitalization, emergency department (ED) visit, or high intensity care, as well as measures that assess pharmacotherapy for opioid use disorder and the initiation and engagement of alcohol and other drug (AOD) dependence treatment. In addition, this category includes a HEDIS measure that assesses if children and adolescents using antipsychotic prescriptions receive appropriate metabolic testing.
- **Keeping Kids Healthy**: Includes HEDIS measures that assess how often preventive services are provided (e.g., child and adolescent immunizations, well-child visits, and weight assessment and counseling for children/adolescents).

Measures Used in Analysis

HFS, in collaboration with HSAG, chose measures for the report card based on a number of factors, such as measures that best approximate the reporting categories that are useful to consumers; the available data; and nationally recognized, standardized measures of Medicaid and/or managed care. Fifty-three measures were chosen: 11 CAHPS and 42 HEDIS, and their associated weights. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contributed equally to the derivation of the final results.

Comparing Plan/Plan Category Performance to National Benchmarks

HSAG presented measure-level ratings on the selected HEDIS and CAHPS measures based on comparisons to national Medicaid benchmarks. A five-level rating scale was used to report how HEDIS and CAHPS measures compare to the 2021 Quality Compass national Medicaid benchmarks. In addition, HSAG provided category-level trending information for the selected categories (Doctor's Communication, Access to Care, Women's Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy) to indicate whether the health plan's average rating in each category improved, declined, or stayed the same from 2020 to 2021 based on comparisons to national Medicaid benchmarks. HSAG computed six reporting category summary scores for each health plan. HSAG compared each measure to national benchmarks and assigned star ratings for each measure.

Responding to Illinois Legislation

Illinois Public Act 099-0725 sets forth requirements for the Medicaid quality rating system. HSAG and HFS worked together to tailor the consumer guide to meet the requirements of the legislation.

Evaluation of Quality Strategy

On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, launching HealthChoice Illinois; therefore, HFS published a fully revised and restructured Quality Strategy in 2018. However, due to additional program changes, such as incorporating Special Needs Children 1915(b) waiver (SNC) populations in HealthChoice Illinois and the statewide expansion of the Managed Long Term Services and Supports 1915(b) waiver (MLTSS), HFS worked throughout SFY 2020 to revise its Quality Strategy. HFS' *Comprehensive Medical Programs Quality Strategy (Quality Strategy)* was published in March 2021 at: https://www2.illinois.gov/hfs/info/reports/Pages/default.aspx.

Regulations at 42 CFR §438.340(c)(2), (c)(2)(i), and (c)(2)(ii) require states to review and update their quality strategy as needed, but no less than every three years. A state's review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years.

In SFY 2023, HSAG will assist HFS with its Quality Strategy evaluation in accordance with CMS' *Quality Strategy Toolkit for States*.[7-2]

[7-2] Centers for Medicare & Medicaid Services. *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf. Accessed on: Feb 22, 2023.

Case Management (CM) Staffing and Training Reviews

Introduction

HSAG is contracted by HFS to conduct a biannual calendar year review of the health plans' compliance with case management staffing and training requirements. The first biannual review of 2022 included an assessment of internal health plan staff members as well as any delegated entities performing case management services.

HSAG reviewed the qualifications and related experience, caseload assignments, general training completion, and waiver-specific training completion for case management staff members serving the HealthChoice Illinois population (including Home- and Community-Based Services (HCBS) 1915[c], MLTSS 1915[b], and SNC 1915[b] waiver services) and the Medicare-Medicaid Alignment Initiative (MMAI) population, including HCBS 1915(c) waiver services.

HSAG analyzed contractually required elements of case management staffing and training, which were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance. Health plans were also required to provide remediation responses related to findings from the CY 2021 biannual staffing and training reviews.

The first biannual review of 2022 included health plan data for staff members with hire dates on or before April 1, 2022. HSAG noted that training is completed each calendar year; therefore, training completion is assessed only during the second biannual review, which is to be conducted in the fall.

Findings

HealthChoice Illinois

HSAG analyzed health plan compliance with 11 contractually required elements of case management staffing and training in the HealthChoice Illinois contract. YouthCare Specialty Plan's compliance with

eight contractually required elements of case management staffing was analyzed. The health plan-specific strengths, opportunities for improvement, and recommendations are described below.

Strengths	• Four health plans (Aetna, BCBSIL, CountyCare, and Molina) met all contract requirements related to caseloads. • All five health plans met contract requirements related to HIV and Persons with Brain Injury (BI) waiver caseload limits.
Opportunities for Improvement	**Opportunity:** Meridian did not meet weighted, high-risk, or moderate-risk caseload limits. **Recommendation:** The health plan should identify a plan to reassign caseloads to those case managers not meeting weighted, high-risk, or moderate-risk caseload limits.
	Opportunity: All five health plans had waiver case managers who did not meet qualification/education requirements. **Recommendation:** The health plans should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. Those staff without the appropriate qualifications/education should have those waiver cases reassigned to qualified staff. The health plans should also review their staffing submissions to ensure that specificity regarding qualifications/education which may show compliance with the contract requirements is included in submissions. The health plans may also consider submitting exemption requests to HFS for consideration.
	Opportunity: YouthCare did not meet weighted, moderate-risk, or low-risk caseload limits. **Recommendation:** The health plan should identify a plan to reassign caseloads to those case managers not meeting weighted, low-risk, or moderate-risk caseload limits.

MMAI

HSAG analyzed Medicare-Medicaid Plan (MMP) compliance with 11 contractually required elements of case management staffing and training in the MMAI contract. The health plan-specific strengths, opportunities for improvement, and recommendations are described below.

Strengths	• All five MMPs met all contract requirements related to caseloads. • All five health plans met contract requirements related to HIV and BI waiver caseload limits.

Opportunities for Improvement	**Opportunity:** Four of the five MMPs (BCBSIL, Humana, Meridian, and Molina) had waiver case managers who did not meet qualification/education requirements. **Recommendation:** The health plans should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. Those staff without the appropriate qualifications should have those waiver cases reassigned to qualified staff. The health plans should also review their staffing submission to ensure that specificity regarding qualifications/education that may show compliance with the contract requirements is included in submissions. The health plans may also consider submitting exemption requests to HFS for consideration.
	Opportunity: Meridian had four HIV waiver case managers who did not have the required related experience. **Recommendation:** The health plan should review the experience requirements for the HIV waiver and develop a plan to ensure that only staff meeting requirements are assigned HIV waiver caseloads. Those staff without the appropriate related experience should have those waiver cases reassigned to qualified staff. The health plan should also review its staffing submission to ensure that specificity regarding experience which may show compliance with the contract requirements is included in its submissions.

Remediation

Health plans are required to remediate all findings from the first biannual review, which are to be assessed during the 2022 second biannual review.

Recommendations for HFS

Based on the findings of the staffing analysis across health plans, HSAG identified the following recommendations for HFS:

- HFS should require that Meridian and YouthCare provide a plan to comply with weighted caseload and caseload volume requirements and redistribute cases to ensure the requirement is met.
- HFS should review the qualification/education requirements for the BI, HIV, Persons who are Elderly (ELD), and Persons with Disabilities (PD) waivers to determine if further clarity and guidance related to interpretation of the contract language can be provided to the health plans. HFS may also consider identification of qualification/education requirements not specifically dictated in contract language that HSAG may consider compliant in future assessments.

Critical Incident Monitoring Review

Introduction

To provide feedback and analysis on the health plans' compliance with and critical incident (CI) requirements, HFS requested that HSAG conduct quarterly reviews of CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Ongoing performance is monitored through quarterly record reviews, health plan-specific feedback, and remediation of review findings. The CI review evaluated the health plans' compliance with all CI requirements required by contract, State and federal statutes and regulations, and 1915(b) and 1915(c) waiver conditions.

Methodology

HSAG conducted quarterly record reviews and system effectiveness assessments to determine health plan compliance with the HealthChoice Illinois and MMAI contract measures and MLTSS waiver requirements. Six health plans were included in the FY 2022 review. A detailed description of the sampling methodology and data collection processes is provided in health plan-specific reports, which are available on request. File review elements were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

HSAG reviewed information provided by the health plans to assess system effectiveness. HSAG assessed the following elements:

- CI intake and processing
- CI data reporting
- CI reporting to investigating authorities
- Communication with investigating authorities
- CI risk mitigation and resolution
- Remediation of recommendations from quarterly reviews
- Updated policy and procedure for the Adult Protective Services (APS) Report of Substantiation (ROS) process
- Barriers to utilization of the APS ROS process policy
- Implementation of internal policy and procedure updates
- Internal unable to reach (UTR) process for CIs
- Internal UTR oversight
- Barriers to using the UTR process for enrollees with CIs
- Health plans' use of the APS portal

- Processing of CIs for the MLTSS waiver population

System Effectiveness and File Review Findings

File review and evaluation of the health plans' system effectiveness demonstrated the following strengths, opportunities for improvement, and recommendations:

Strengths	• All six health plans demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority. • All six health plans demonstrated 90 percent or higher performance in assuring the health, safety, and welfare (HSW) of the enrollee after the CI was identified. • All six health plans demonstrated system effectiveness in the ability to identify, address, and seek to prevent instances of abuse, neglect and exploitation (ANE) and unexplained death.
Opportunities for Improvement	**Opportunity**: The six health plans demonstrated different processes to execute the APS ROS process policy. **Why the Opportunity Exists**: The health plans reported that they have not received training on the APS ROS process policy, which has allowed for different interpretations on how best to execute requirements. The health plans also reported inconsistent engagement from APS, which contributes to barriers in fulfilling policy requirements. **Recommendation**: HFS should consider collaborating with APS to provide training for all health plans to ensure uniformity and consistent expectations in executing the requirements of the APS ROS process policy.
	Opportunity: The six health plans do not uniformly report internal CIs, which impacts the aggregate analysis of the health plans' performance. **Why the Opportunity Exists:** All six health plans demonstrated utilization of CI categorizations that were inconsistent with the *HFS Critical Incident Guide* that was updated in April 2022. **Recommendation:** The health plans would benefit from HFS' direction regarding the utilization of categories specified in the *HFS Critical Incident Guide*. HFS should consider having the health plans submit their CI categorization for approval.
	Opportunity: Molina demonstrated opportunity for improvement in contacting enrollees to ensure their HSW prior to closure of the CI. **Why the Opportunity Exists:** The health plan staff members demonstrated inconsistent utilization of their CI closure process, which requires enrollee contact or exhaustion of UTR attempts prior to CI closure.

Recommendation: The health plan should evaluate its current oversight process to identify opportunities for staff training and ensure that the enrollee has been contacted or UTR attempts have been completed prior to closure of the CI.
Opportunity: All six health plans demonstrated an opportunity for improvement in contacting the enrollee or the enrollee's authorized representative, or in documenting why the enrollee is unable to participate in CI follow-up, for enrollees who live in a Supportive Living Program (SLP) or Long-Term Care (LTC) facility. **Why the Opportunity Exists:** Due to COVID-19 visitation restrictions, health plans were unable to conduct face-to-face visits with enrollees who reside in a SLP or LTC facility. This barrier has adversely impacted the health plans' ability to contact enrollees, as most enrollees do not have a direct line and the nursing staff are unable to field the volume of incoming calls. **Recommendation:** The health plans should revise their processes for enrollees who reside in SLP or LTC facilities to include contact attempts to the enrollee or an authorized representative as a requirement prior to closure of the CI. The health plans should also consider documenting why the enrollee is unable to participate in the CI follow-up, such as cognitive or behavioral health conditions.
Opportunity: Aetna, BCBSIL, CountyCare, and Molina demonstrated an opportunity for improvement in following their process for communication with the investigating authority after the initial CI report. **Why the Opportunity Exists:** The health plans do not consistently apply their internal procedures to contact the investigating authority for an update on the status of the CI report prior to closure of the internal CI. **Recommendation:** The health plans should consider revising their processes for communication with the investigating authority to align with the external entity's communication requirements. The health plans should provide training to staff members on their process for conducting follow-up with the investigating authority after an initial CI report has been made.

Health Plan-Specific Results

Findings and recommendations for the health plans and additional details were provided in quarterly reports that are available upon request.

CMS HCBS Waiver Performance Measures Record Reviews

Overview

CMS requires HFS to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to discover successes and opportunities for improvement within the HCBS waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that HSAG conduct quarterly reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver beneficiaries.

This summary of findings for the SFY 2022 HCBS Waivers CMS Performance Measures Record provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for HealthChoice Illinois, including the MLTSS 1915(b) waiver program and the MMAI managed care population. Details about the methodology and detailed results are included in Appendix F1.

An overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements, a review of remediation activities conducted within the required time frames, and a summary of technical assistance (TA) that HSAG provided to the health plans are presented. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

HealthChoice Illinois Record Reviews

Table 7-1 displays the five HealthChoice Illinois health plans reviewed in SFY 2022.

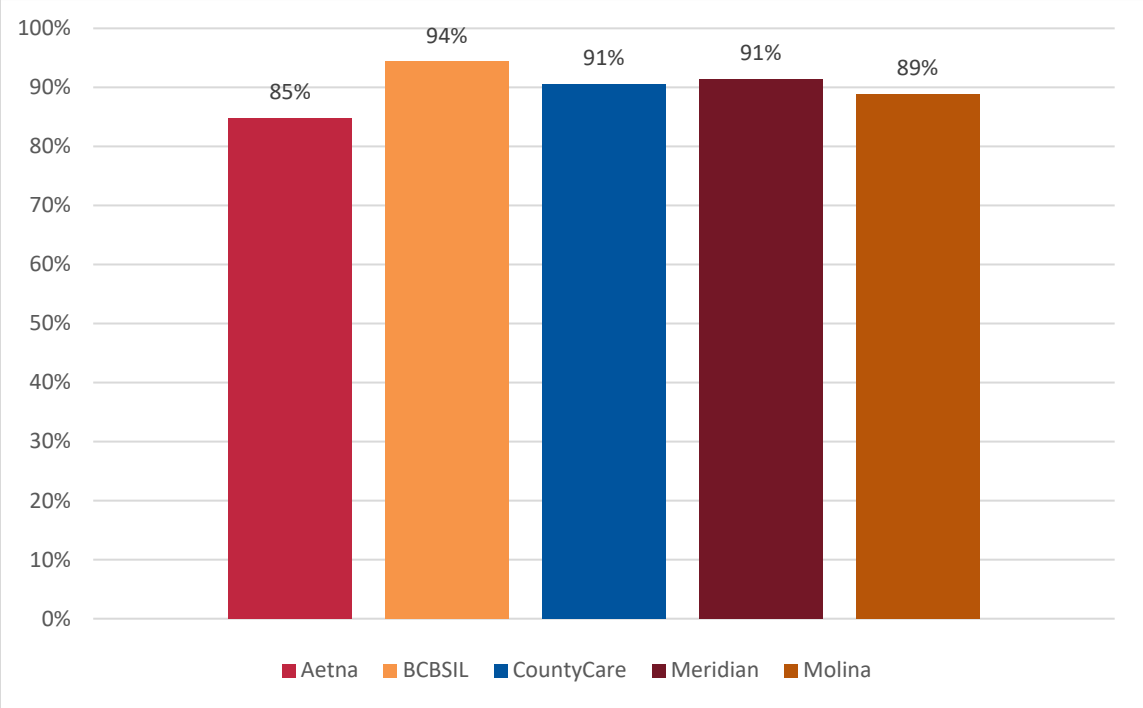
Table 7-1—HealthChoice Illinois Plans Reviewed in SFY 2022

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

During SFY 2022, 1,456 HealthChoice records were reviewed using HSAG's web-based data collection tool, which identified 1,473 HealthChoice findings of noncompliance.

Figure 7-1 displays a computed average of the total performance achieved by each health plan on the 21 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 21 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans. Three of the five health plans averaged greater than 90 percent compliance in SFY 2022. There was a 9-percentage-point difference (85 percent to 94 percent) among health plans.

Figure 7-1—Overall HealthChoice Compliance



SFY 2022 represented the fifth year of review for the HealthChoice population, and several successes were identified as well as opportunities for improvement.

Strengths

- Twelve of the 21 CMS performance measures averaged 90 percent or greater compliance.
- Two performance measures realized statistically significant increases in compliance in SFY 2022 when compared to SFY 2021.
- Three of the five health plans averaged greater than 90 percent compliance.
- Compared to SFY 2021, Molina realized a statistically significant increase in performance for five measures in SFY 2022.
- Three of the five waiver types averaged greater than 90 percent compliance.
- Compared to SFY 2021, the BI waiver realized a statistically significant increase in compliance for two measures in SFY 2022.

Opportunities for Improvement	**Opportunity:** Aetna demonstrated a statistically significant decrease in five performance measures in SFY 2022 when compared to SFY 2021. **Recommendation:** Aetna should focus improvement efforts on measures 35D, D6, D7, D8, and G1.
	Opportunity: Four performance measures demonstrated statistically significant decreases in compliance in SFY 2022 when compared to SFY 2021. **Recommendation:** Health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review.
	Opportunity: Four of the five health plans and all five waivers demonstrated a statistically significant decrease in compliance with Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP [persons in a supportive living program] provider (if applicable) and dates of signatures*, when SFY 2022 was compared to SFY 2021. **Recommendations:** • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete timely service plan updates. • Ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. • Reeducate care managers on appropriate documentation to meet HFS' expectations during the public health emergency (PHE).
	Opportunity: Two of the five health plans and three of the five waivers demonstrated a statistically significant decrease in compliance with Measure D7, *the most recent service plan is in the record and completed in a timely manner*, when SFY 2022 was compared to SFY 2021. **Recommendations:** • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete annual service plan updates. • Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.
	Opportunity: Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 73 percent compliance in SFY 2022.

Recommendation:

- Conduct a root cause analysis to determine opportunities to effect change.
- Conduct a root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

MLTSS Record Reviews

Table 7-2 displays the five MLTSS health plans reviewed in SFY 2022.

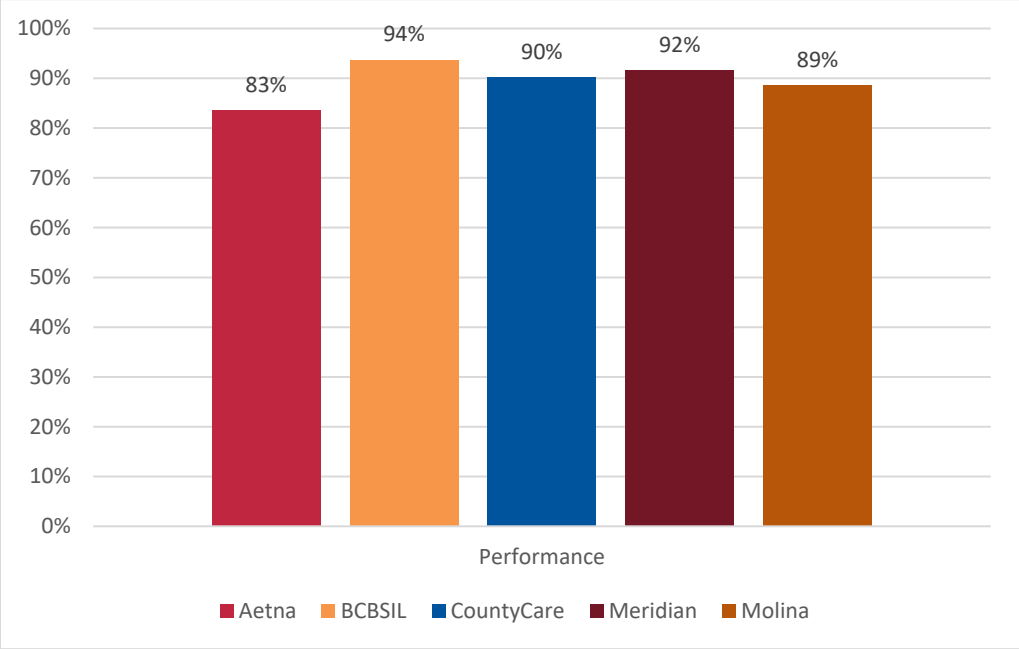
Table 7-2—MLTSS Health Plans Reviewed in SFY 2022

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

During SFY 2022, 1,516 MLTSS records were reviewed using HSAG's web-based data collection tool, which identified 1,697 MLTSS findings of noncompliance.

Figure 7-2 displays a computed average of the total performance achieved by each health plan on the 21 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 21 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans. Three of the five health plans averaged 90 percent or greater compliance in SFY 2022. There was an 11-percentage-point difference (83 percent to 94 percent) among health plans.

Figure 7-2—Overall MLTSS Compliance



Additional EQR Activities

HCBS Waiver Reviews

SFY 2022 represented the fourth year of review for the MLTSS population, and several successes were identified as well as opportunities for improvement.

Strengths	• Twelve of the 21 CMS performance measures averaged 90 percent or greater compliance. • Two performance measures realized statistically significant increases in compliance in SFY 2022 when compared to SFY 2021. • Three of the five health plans averaged greater than 90 percent compliance. • Compared to SFY 2021, Molina realized a statistically significant increase in performance for five measures in SFY 2022. • Three of the five waiver types averaged greater than 90 percent compliance. • Compared to SFY 2021, the BI waiver realized a statistically significant increase in compliance for two measures in SFY 2022.
Opportunities for Improvement	**Opportunity:** Aetna demonstrated a statistically significant decrease in five performance measures in SFY 2022 when compared to SFY 2021. **Recommendation:** Aetna should focus improvement efforts on measures 35D, D6, D7, D8, and G1.
	Opportunity: Four performance measures demonstrated statistically significant decreases in compliance in SFY 2022 when compared to SFY 2021. **Recommendation:** Health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review.
	Opportunity: Four of the five health plans and all five waivers demonstrated a statistically significant decrease in compliance for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP [persons in a supportive living program] provider (if applicable) and dates of signatures*, when SFY 2022 was compared to SFY 2021. **Recommendations:** • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete timely service plan updates. • Ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. • Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

Opportunity: Two of the five health plans and three of the five waivers demonstrated a statistically significant decrease in compliance with Measure D7, *the most recent service plan is in the record and completed in a timely manner*, when SFY 2022 was compared to SFY 2021.

Recommendations:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete annual service plan updates.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

Opportunity: Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 73 percent compliance in SFY 2022.

Recommendation:

- Conduct a root cause analysis to determine opportunities to effect change.
- Conduct a root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

MMAI Record Reviews

Table 7-3 displays the five MMAI health plans reviewed during SFY 2022.

Table 7-3—MMAI Health Plans Reviewed in SFY 2022

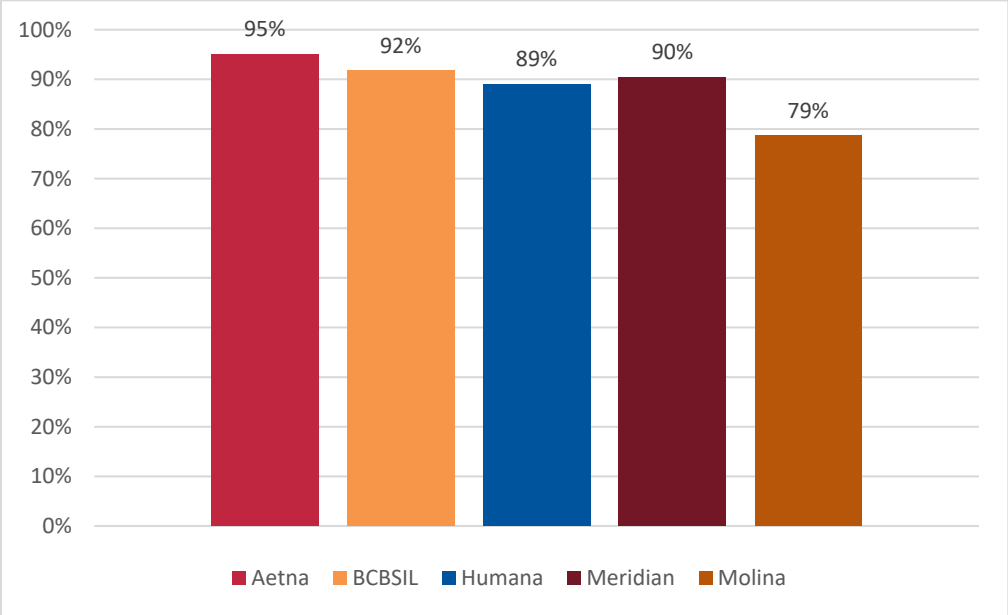
Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
Humana Health Plan, Inc.	Humana
MeridianComplete	Meridian
Molina Healthcare of Illinois	Molina

During SFY 2022, 1,227 MMAI records were reviewed using HSAG's web-based data collection tool, which identified 1,485 findings of noncompliance.

Figure 7-3 displays a computed average of the total performance achieved by each health plan on the 21 CMS waiver performance measures reviewed by HSAG. Each health plan's overall average on the 21 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Three of the five health plans averaged 90 percent or greater compliance in SFY 2022. There was a 16-percentage-point difference (79 percent to 95 percent) among health plans.

Figure 7-3—Overall MMAI Compliance



SFY 2022 represented the eighth year of review for the MMAI population, and several successes were identified as well as opportunities for improvement.

Strengths	• Twelve of the 21 CMS performance measures averaged 90 percent or greater compliance. • Three of the five health plans averaged 90 percent or greater compliance. • Compared to SFY 2021, Humana realized a statistically significant increase in performance for five measures in SFY 2022. • Three of the five waiver types averaged greater than 90 percent compliance. • Compared to SFY 2021, the ELD waiver realized a statistically significant increase in compliance for four measures in SFY 2022.
Opportunities for Improvement	**Opportunity:** BCBSIL demonstrated a statistically significant decrease in eight performance measures in SFY 2022 when compared to SFY 2021. **Recommendation:** BCSBIL should focus efforts on measures 35D and D6 and benefit from implementing the performance measure-specific recommendations provided by HSAG.
	Opportunity: Overall compliance rates on Measure D6, *the case manager made timely contact with the enrollee, or there is valid justification in the record*, averaged 78 percent. **Recommendation:** Conduct a root cause analysis on HIV and BI cases to determine opportunities to effect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads. In addition, health plans should ensure that audit processes for the PD and ELD waivers measure performance against contract (and now waiver) requirements, and that case managers are held accountable to meeting contact standards for enrollees in the PD and ELD waivers.
	Opportunity: Measure D7, *the most recent service plan is in the record and completed in a timely manner,* averaged a 79 percent compliance rate. **Recommendation:** Analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual service plans in a timely manner. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely completion of service plans. Health plans should review COVID-19 PHE processes to ensure that case managers are knowledgeable of documentation requirements related to annual service plan completion.

Opportunity: Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, averaged a compliance rate of 79 percent, and all five health plans and all five waivers demonstrated a statistically significant decrease in compliance.

Recommendation: Analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals and witnessed verbal consent indicating a signature on the service plan.

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

Introduction

As part of its continuous effort to evaluate quality improvement activities of the Illinois Medicaid managed care plans (health plans), HFS contracted HSAG to assess each health plan's FY 2022 Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) annual report.

Methodology

Annually, HFS provides the health plans with a QA/UR/PR report outline, which describes the expectations for the annual report. HSAG reviewed the report outline and the annual QA/UR/PR report requirements in the HealthChoice Illinois and MMAI contracts to develop an assessment tool.

For contractually required elements, the HSAG review team assessed the QA/UR/PR reports for evidence of compliance. HSAG used a two-point scoring methodology. Each requirement was scored as *Met* (the report included the element required) or *Not Met* (the report did not include the element required). HSAG also used a designation of *N/A* if the requirement was not applicable to the health plan; *N/A* findings were not included in the two-point scoring methodology.

HSAG calculated an overall percentage-of-compliance score for each of the annual report elements. HSAG calculated the score by adding the score from each element, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

HSAG also assessed general requirements for the annual report, as identified in HFS' report outline. General requirements were scored *Met* or *Not Met* but were not included in overall scoring. Elements scored as *Not Met* were included in recommendations to inform health plans and HFS of opportunities for improved compliance to HFS' report outline requirements.

HSAG also assessed the overall quality and effectiveness of the health plan's annual report. This qualitative assessment was scored as *Beginning, Effective,* or *Mature* but was not included in overall scoring. Scores of *Beginning* or *Effective* were included in recommendations to inform the health plans and HFS of opportunities for improvement to the health plan's overall processes.

General Requirements

HSAG assessed each health plan's FY 2022 QA/UR/PR report for the following general requirements, which were prescribed by HFS in its annual outline document provided to the health plans:

- Does the report address all populations served by the health plan?
- Did the health plan submit all applicable appendices?

- Is the Executive Summary no more than 10 pages?
- Is the entire report (excluding appendices) no more than 70 pages?
- Does the report cover the correct time period (FY 2022, HEDIS calendar year 2021)?
- Does the report include discussion of the impact of COVID-19 on operations and quality results, including implementation of any community or enrollee initiatives related to COVID-19?
- Does the report include discussion of analysis, initiatives, and opportunities to address health equity, including analysis of geography, disproportionately impacted areas, etc.

Contract Requirements

As shown in Table 7-4, HSAG's assessment of annual QA/UR/PR report contract requirements included 23 elements across HealthChoice and MMAI; some elements were applicable to only one contract.

Table 7-4—QA/UR/PR Contract Requirements

Standard
1. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7; MMAI Three-Way 1/1/18, 2.13.5.1.2*
2. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1; MMAI Three-Way 1/1/18, 2.13.5.1.2.1*
3. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy, including all pillars? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2; MMAI Three-Way 1/1/18, 2.13.5.1.2.2*
4. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6; MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*
5. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3; MMAI Three-Way 1/1/18, 2.13.5.1.2.3*
6. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*
7. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*
8. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5; MMAI Three-Way 1/1/18, 2.13.5.1.2.5*

Standard
9. Does the report include a detailed population profile including demographics and geography-based statistics (disproportionately impacted areas, urban/rural, etc.)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7; MMAI Three-Way 1/1/18, 2.13.5.1.2.7*
10. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8; MMAI Three-Way 1/1/18, 2.13.5.1.2.8*
11. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*
12. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*
13. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*
14. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12; MMAI Three-Way 1/1/18, 2.13.5.1.2.11*
15. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13; MMAI Three-Way 1/1/18, 2.13.5.1.2.12*
16. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14; MMAI Three-Way 1/1/18, 2.13.5.1.2.13*
17. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*
18. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*
19. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17; MMAI Three-Way 1/1/18, 2.13.5.1.2.15*
20. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18; MMAI Three-Way 1/1/18, 2.13.5.1.2.16*
21. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19; MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*
22. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20; MMAI Three-Way 1/1/18, 2.13.5.1.2.18*
23. Does the report include a detailed analysis of Americans with Disabilities Act compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*

Findings and Recommendations

General Requirements

Review of the health plans' annual reports identified that five of six health plans demonstrated full compliance with the general requirements. Aetna failed to include a detailed analysis or summary for its HealthChoice population. The health plan should realign the overall quality process to demonstrate that the health plan has a robust QAPI program inclusive of all populations/programs served.

Contract Requirements

Table 7-5 summarizes the findings related to contract requirements for all health plans.

Table 7-5—Summary Scoring Table for Contract Requirements

Scoring Summary—Contract Elements				
Health Plan	**Number Met**	**Number Not Met**	**Number N/A**	**Performance Score**
Aetna	17	6	0	74% (17/23)
BCBSIL	19	4	0	83% (19/23)
CountyCare	18	2	3	90% (18/20)
Humana	16	3	4	84% (16/19)
Meridian	20	3	0	87% (20/23)
Molina	21	2	0	91% (21/23)

HSAG offered the following overall recommendations to HFS:

1. All six health plans received recommendations to include a detailed analysis of access and utilization of dental services. HFS should consider providing additional detail to the health plans of expectations for reporting on access and utilization of dental services.
2. Four of the six health plans received recommendations to include a detailed analysis of cultural competency. HFS should require the health plans to provide their culturally and linguistically appropriate services (CLAS) analyses and/or substantial analysis of the inclusion of cultural competency plans and programs. HFS may consider use of the CMS document, *A Practical Guide to*

Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities[7-3] as a resource for health plans.

3. To demonstrate achievement in the qualitative analysis section, all health plans may benefit from additional direction from HFS regarding expectations for analysis and reporting. Health plans should be encouraged to consider use of the report outline narrative example, which may provide alternatives to the report structure that may allow for more intuitive analysis.
4. HFS' health plan account managers should follow up with the health plans to provide guidance on findings and expectations to ensure a successful report submission in FY 2022.

Remediation

As directed by HFS, remediation of findings will be expected to be addressed in the health plans' FY 2023 reports.

[7-3] National Committee for Quality Assurance. A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities, December 2016. Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf. Accessed on: Feb 22, 2023.

Mental Health Parity Review

Overview

Certain mental health and substance use disorder parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) apply to the coverage provided to the enrollees of the Medicaid program and Children's Health Insurance Program (CHIP) to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs. In accordance with the MHPAEA and its implementing regulations (including Title 42 of the Code of Federal Regulations [CFR] Parts 438, 440, and 457; and 45 CFR Part 146.136) and Illinois statute 215 ILCS 5/370c.1,[7-4] HFS, and the Illinois Department of Insurance (DOI) complete oversight activities related to compliance to the State and federal parity laws.

To meet Mental Health Parity (MHP) requirements in 42 CFR §438 Subpart K and Illinois statute 215 ILCS 5/370c.1, HFS contracted with HSAG in SFY 2022 to conduct a MHP analysis of all HealthChoice Illinois health plans (health plans). The purpose of the review is to provide meaningful information to HFS, DOI, and the health plans regarding the evaluation of each health plan's processes to ensure compliance with MHPAEA requirements.

For each health plan, HSAG made a determination as to whether the health plan demonstrated how it designs and applies nonquantitative treatment limitations (NQTLs), both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition (MH/SUD) benefits as compared to how it designs and applies NQTLs, as written and in operation, for medical and surgical (M/S) benefits. This report provides a summary of the findings from the 2022 MHP Analysis across all health plans.

Methodology

HSAG collaborated with HFS to define the scope of the MHP review to include applicable federal and State regulations and laws and the requirements set forth in the contract, as they relate to the scope of the review. HSAG developed a protocol and tools in alignment with guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[7-5]

[7-4] Illinois General Assembly. Illinois Compiled Statutes, 215 ILCS 5/370c.1. Available at: https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021500050K370c.1. Accessed on: Feb 22, 2023.

[7-5] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP are available at https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html. Accessed on: Feb 22, 2023.

The MHP analysis consisted of:

- Review of the health plans' MHP Parity Analysis Template and comparative analyses, which were submitted to HFS on July 1, 2021.
- An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes since the July 1, 2021, submission.
- Review of the health plans' utilization management (UM) documents and information.
- Review of the availability of prior authorization (PA) and clinical practice guideline (CPG) information on each health plan's website.
- Analysis of M/S and MH/SUD PA denial data, which are self-reported to HFS.
- File review of adverse benefit determination (ABD) records encompassing both M/S and MH/SUD denials.

Detailed information regarding the methodology is included in the full report.

Results

Overall, HSAG determined that the health plans demonstrated parity between M/S and MH/SUD services. Documentation and implementation of the health plans' processes demonstrated compliance with State and federal MHP requirements and standards.

Each health plan achieved parity overall on the ABD record reviews. The overall average for health plan compliance with scored elements of M/S and MH/SUD ABD records was 85 percent. For both M/S and MH/SUD records, the highest percentage scores were associated with UM policies and procedures, while the lowest percentage scores (including fully noncompliant) were associated with the timeliness and readability of notices of ABD.

Recommendations

Based on the results of the MHP analysis, HSAG offered the following recommendations.

- **Readability**: All six health plans had an opportunity for improvement related to readability levels for denial letters. HSAG recommends that all health plans review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with sixth grade reading levels. HSAG's recommendation may be achieved through revisions the health plans make to processes subsequent to receipt of the HFS readability protocol.
- **Notice sent within required time frame**: All six health plans had an opportunity for improvement related to compliance with timely notifications of ABD. The health plans should ensure and demonstrate that decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).

- **Non-parity between M/S and MH/SUD denial rates**: One health plan, CountyCare, demonstrated non-parity when self-reported denial data were analyzed; however, results are limited to data analysis and do not reflect review of appropriateness of decisions. The health plan should continue its efforts with high-volume MH/SUD providers to reduce overturns (cases that were reversed in the providers' favor once documentation was received) and identify strategies to address provider barriers to submission of clinical documentation during the PA process.
- **Continued assessment of MHP**: HSAG noted that HFS has requested Phase II MHP documentation from the health plans, which includes reporting of M/S and MH/SUD NQTL exclusion criteria, out-of-network coverage standards, and geographic restrictions, which will be reported in June 2022. HFS may also consider the following assessments to inform HFS of MHP:
  - Review of appropriateness of health plan denial decisions.
  - Focused review of M/S and MH/SUD records, subcategorized by outpatient and inpatient services.

Technical Assistance (TA) to HFS and Health Plans

At the State's direction, the EQRO may provide technical guidance to Medicaid agencies and health plans as described at 42 CFR §438.358(d). HSAG has provided a variety of TA to HFS that has led to quality outcomes, including TA in the following areas: PIPs, grievance and appeals process, care management/HealthChoice Illinois programs, CAHPS sampling and development of CAHPS supplemental questions, P4P program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS waiver program requirements, and much more.

HSAG understood the importance of providing ongoing and specific TA to each health plan, as needed, and provided consultation, expertise, suggestions, and advice to assist with decision making and strategic planning. HSAG worked in partnership and collaboration with HFS and health plans to ensure that it delivered effective technical support that facilitated the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG continued to provide technical guidance to the health plans to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective CAPs. In addition, the following TA activities were conducted in SFY 2022.

NCQA Accreditation Tracking

The 2010 federal ACA called for the use of accreditation to ensure quality in the managed healthcare sector. The ACA requires that, beginning in 2014, all health plans offered through state insurance exchanges "…must be accredited with respect to local performance on clinical quality measures … by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans…."[7-6] The NCQA's Health Plan Accreditation is considered the industry's gold standard to provide a current, rigorous, and comprehensive framework for essential quality improvement and measurement. Illinois implemented legislation that requires all HealthChoice Illinois health plans to achieve NCQA

[7-6] H.R. 3590—Patient Protection and Affordable Care Act. Available at: https://www.congress.gov/bill/111th-congress/house-bill/3590/text. Accessed on: Mar 2, 2023.

accreditation. HSAG designed several tools to assist HFS in monitoring plan accreditation status. The NCQA tracking spreadsheet displays each health plan's accreditation eligibility date, accreditation dates, date of final NCQA decision letter and summary report, accreditation expiration date, accreditation status, and NCQA health insurance plan ratings and accreditation star ratings.

HSAG developed the HealthChoice Illinois Managed Care Program NCQA Medicaid Healthcare Maintenance Organization Accreditation status sheet (status sheet), which succinctly displays each health plan's accreditation date and status, along with a description of the NCQA accreditation levels. HFS features this status sheet on its website to make the information public. The most recent version can be accessed at: https://www2.illinois.gov/hfs/info/reports/Pages/default.aspx.

Throughout SFY 2022, HSAG updated the NCQA tracking spreadsheet for HFS' reference periodically and any time there was an update to a health plan's status. HSAG also keeps the status sheet updated through accessing the most recent accreditation information on NCQA's website.

Freedom of Information Act (FOIA) Requests

The FOIA pertains to a person's right of access to federal agency records, except those protected from disclosure by a set of exemptions and special law enforcement exclusions. When a FOIA request is received, HFS often requests HSAG's assistance to provide the necessary information to fulfill the request as required.

Development of Program-Specific Performance Measures

Historically, HSAG has provided key support to assist HFS in developing performance measures that meet the unique demands of Illinois Medicaid programs. HSAG works collaboratively with HFS to identify and develop performance measures specific to each of the programs and the populations they currently serve as part of the care coordination expansion.

HFS, Health Plan, and Stakeholder Training

HFS is aware of the need to stay abreast of federal regulations and healthcare trends and to inform the health plans of any relevant changes. HSAG frequently conducts research and designs trainings to ensure HFS and the health plans are kept up to date. For example, when CMS published the Medicaid and CHIP Managed Care Final Rule requiring states to make a number of changes to the oversight of managed care, HSAG conducted an analysis of the final rule and created an overview for HFS that identified all provisions of the final rule and their effective date. HSAG also conducted training sessions to assist key HFS staff in staying abreast of final rule requirements and timelines. HFS also requests HSAG's assistance in providing training for stakeholders on topics relevant to compliance and quality.

With rapid changes in the patterns of health service needs, scientific and technological developments, and the economic and institutional contexts in which providers of health services are embedded, HFS

and the health plans will need to continue to adapt. HSAG will provide trainings as needed and requested by HFS.

Report and Data Collection Templates

HFS strives to collect meaningful data from the health plans in useful formats. It frequently provides reporting templates to the health plans in an effort to standardize reporting for ease of review and comparison. HFS sometimes contracts HSAG on an ad hoc basis to assist with the development of templates for reporting use. For example, HFS requires health plans to submit an annual QA/UR/PR Annual Report that evaluates the effectiveness of contractor's QA plan and performance. Each reporting year, HSAG completes an evaluation of the health plans and works with HFS to assess the need for any changes to the QA/UR/PR report outline. The updated report template is forwarded to the health plans so they can ensure that their annual submissions contain all the required data and information in a standardized format.

HFS understands that a key to achieving Medicaid delivery system reform is data analytic capacity. HFS seeks to offer support and solutions to health plans in building and strengthening their data analytic capacity and develop common data sets for HFS' use in delivering improved care and driving smarter spending. HSAG has extensive experience in developing standardized data collection tools and processes as required by the analytical task, including accessing and documenting health plan compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements; reporting performance measure results; reporting specific data sets, such as care management outcomes; and additional ad hoc reporting, as required by HFS.

Research

HFS frequently requests HSAG to conduct research on an ad hoc basis to respond to requests for information from stakeholders of the Illinois legislature. Historically, research has been conducted on topics such as care management dashboard reporting, national quality forum measure specifications, recommendations for quality metrics for Children with Special Health Care Needs (CSHCN), addressing social determinants of health, NCQA standards for grievances and appeals, HCBS performance measures and indicators, improving breast cancer screening rates, practices for meeting the behavioral health needs of dually eligible older adults, and many more. HSAG's research efforts sometimes require a simple email response. Other times, reports, presentations, or infographics are developed. In SFY 2022, HSAG assisted HFS with research related to best practices to achieve optimal readability in member documents, resulting in health plan guidance for member materials.

Presentations to the Illinois Legislature and HFS Administration

HFS is sometimes required to make presentations to the Illinois legislature for the purposes of providing education, reporting results, clarifying Medicaid processes, or assisting the legislature in making policy decisions. Likewise, sometimes the HFS director requests presentations on specific topics for internal use. HSAG consults with HFS to clarify the needs for an ad hoc presentation, conducts necessary

research or data analysis, drafts and revises the presentation as necessary, and sometimes delivers the presentation via face-to-face meetings or webinars. Examples of presentations that HSAG has developed for HFS include annual quality results and proposed quality improvement initiatives.

Expansion Map

Given the significant expansion in Illinois, HFS requested HSAG to design a graphical depiction of expansion efforts that could be shared with stakeholders. As a result, HFS and HSAG created the Care Coordination Expansion Map, which demonstrates which health plans are operating across the State of Illinois, and in which programs those health plans participate. HFS used the map to inform stakeholders and legislators of expansion progress, and it was displayed publicly on the HFS website. Throughout SFY 2022, HSAG provided ongoing TA to periodically update the map to reflect up-to-date expansion. HFS provides the most current map on its website, located at https://www2.illinois.gov/hfs/SiteCollectionDocuments/StatewideHealthChoiceIllinoisPlansAugust12021MMAIUpdate.pdf.

Appendix A1. Executive Summary Appendix

EQR Technical Report Requirements

Table A1-1 lists the required and recommended elements for the EQR technical report, per 42 CFR §438.364 and recent CMS technical report feedback received by states. Table A1-1 identifies the page number where the corresponding information that addresses each element is located in the EQR technical report.

Table A1-1—EQR Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30.	NA
2	All eligible Medicaid and CHIP plans are included in the report.	4
3	Required elements are included in the report:	
3a	Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.	7
3b	An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP, and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the healthcare services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	Appendix A3, Sections 2, 4, 5, 6, 7
3c	Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and/or CHIP enrollees.	17-18
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	Appendix A3, Sections 2, 4, 5, 6, 7
3e	Provides state-level recommendations for performance improvement.	15-16; Sections 2, 4, 5, 6, 7
3f	Ensures methodologically appropriate, comparative information about all MCOs.	Sections 2, 3, 4, 5, 6, 7
3g	Assesses the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.	Appendix A2
4	Validation of PIPs: A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	

	Required Elements	Page Number
4a	**Interventions.**	80, 91
4b	• **Objectives.**	83, 95
4c	• **Technical methods of data collection and analysis.**	Appendix C
4d	• **Description of data obtained.**	84, 95-96
4e	• **Conclusions drawn from the data.**	90-94, 101-103, Appendix A3
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
5a	• **Objectives.**	Appendix B; B-2
5b	• **Technical methods of data collection and analysis.**	Appendix B: B-2—B-3
5c	• **Description of data obtained.**	Appendix B: B-4—B7
5d	• **Conclusions drawn from the data.**	30, 32-34, 36-37, 39-40, 48-49, 61-62
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	
6a	• **Objectives.**	72
6b	• **Technical methods of data collection and analysis.**	72-73
6c	• **Description of data obtained.**	72-80
6d	• **Conclusions drawn from the data.**	67-70
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a	• **Objectives.**	Section 7, Appendices D1—D6
7b	• **Technical methods of data collection and analysis.**	Section 7, Appendices D1—D6
7c	• **Description of data obtained.**	Section 7, Appendices D1—D6
7d	• **Conclusions drawn from the data.**	Section 7, Appendices D1—D6

Performance Measure Domains

Table A1-2 shows HSAG's assignment of the HEDIS measurement year (MY) 2021 performance measures HFS prioritized for improvement into the domains of quality, timeliness, and access.

Table A1-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Ambulatory Care—Per 1,000 Member Months—ED Visits—Total and *Outpatient Visits—Total*	NA	NA	NA
Child Health			
Annual Dental Visit—Total			✓
Child and Adolescent Well-Care Visits—Total	✓		✓
Childhood Immunization Status—Combination 3 and *Combination 10*	✓		
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	✓		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits and *Well-Child Visits for Age 15 Months–30 Months—Two or More Visits*	✓		✓
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Maternal Health			
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living With Illness			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0%), HbA1c Poor Control (>9.0%), HbA1c Testing, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		

Performance Measure	Quality	Timeliness	Access
Statin Therapy for People With Diabetes—Received Statin Therapy and *Statin Adherence 80%*	✓		
Adult Behavioral Health			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Ages 18+ and *30-Day Follow-Up—Ages 18+*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64, and *30-Day Follow-Up—Ages 65+*	✓	✓	✓
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 18–64. 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64, and *30-Day Follow-Up—Ages 65+*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64 and *30-Day Follow-Up—Ages 65+*	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 18+ and *Engagement of AOD Treatment—Ages 18+*	✓	✓	✓
Mental Health Utilization—Any Service—Ages 18-64, Any Service—Ages 65+, Inpatient—Ages 18–64, Inpatient—Ages 65+, Intensive Outpatient or Partial Hospitalization—Ages 18–64, Intensive Outpatient or Partial Hospitalization—Ages 65+, Outpatient—Ages 18-64, Outpatient—Ages 65+, ED—Ages 18–64, ED—Ages 65+, Telehealth—Ages 18–64, and *Telehealth—Ages 65+*	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder—Ages 18–64, Ages 65+, and *Total (Ages 16+)*	✓	✓	✓
Child Behavioral Health			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Ages 13–17 and *30-Day Follow-Up—Ages 13–17*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6–17 and *30-Day Follow-Up—Ages 6–17*	✓	✓	✓
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 13–17 and *30-Day Follow-Up—Ages 13–17*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6–17 and *30-Day Follow-Up—Ages 6–17*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 13–17 and *Engagement of AOD Treatment—Ages 13–17*	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Mental Health Utilization—Any Service—Ages 0–12, Any Service—Ages 13–17, Inpatient—Ages 0–12, Inpatient—Ages 13–17, Intensive Outpatient or Partial Hospitalization—Ages 0–12, Intensive Outpatient or Partial Hospitalization—Ages 13–17, Outpatient—Ages 0–12, Outpatient—Ages 13–17, Telehealth—Ages 0–12, and *Telehealth—Ages 13–17*	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total, and *Blood Glucose and Cholesterol Testing—Total*	✓		

NA indicates this measure is a utilization measure and is not assigned to a domain.

Appendix A2. Follow-Up on Prior Year EQR Recommendations

Prior Recommendations

Regulations at §438.364, require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that the plans reported completing in response to HSAG's SFY 2021 recommendations and an assessment of the degree to which each health plan has addressed the recommendations effectively.

Scoring

HSAG worked with HFS to develop a methodology and rating system for the degree to which each health plan addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG will use a three-point rating system. The health plan's response to each EQRO recommendation will be rated as *High*, *Medium,* or *Low* according to the criteria identified below.

High indicates *all* of the following:

- The health plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted ***or*** if performance did not improve, the health plan identified barriers that were specific to the initiative.
- The health plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic indicator:

Medium indicates one or more of the following:

- The health plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the health plan identified barriers that may or may not be specific to the initiative.
- The health plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *medium* is indicated by the following graphic indicator:

Low indicates one or more the following:

- The health plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the health plan did not identify barriers that were specific to the initiative.
- The health plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic indicator:

Health Plan Follow-Up

Please note, content included in this section is presented verbatim as received from the health plans and has not been edited or validated by HSAG.

Aetna Better Health

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Review PIP Module 4 and Module 5 instructions and Rapid-Cycle PIP Reference Guide. • Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. • Consider testing more than one intervention during the duration of the PIP. This will help the health plans address additional identified opportunities for improvement and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project.
Response
a. Describe initiatives implemented based on recommendations: • Reviewed PIP Module 4 and Module 5 instruction and Rapid-Cycle PIP Reference Guide. Used data-driven approach to building new and/or modify existing interventions. Monitored interventions closely for trends identified via more frequent testing.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • Continued member and provider engagement barriers related to the public health emergency.
d. Identify strategy for continued improvement or overcoming identified barriers: • Increased virtual member and provider engagement and telemedicine where possible.
HSAG Assessment

Recommendation
HSAG recommended the following: • Have all analytical staff working on the PIP review the Rapid Cycle PIP Reference Guide section that outlines the baseline and rolling 12-month SMART Aim measure methodology.
Response
a. Describe initiatives implemented based on recommendations: • Analytic staff trained on the elements of Rapid Cycle PIP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Staff understand the methodology to support baseline and rolling 12-month reporting.
c. Identify any barriers to implementing initiatives: • None
d. Identify strategy for continued improvement or overcoming identified barriers: • Include methodology requirements as part of annual refresher training of existing staff and incorporation

into new staff onboarding.

HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members ages 65 with opioid use disorder are not receiving or adhering to pharmacotherapy treatment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.

Response

a. Describe initiatives implemented based on recommendations:

- Conducted root cause analysis to determine why members ages 65+ with opioid use disorder are not received or adhered to pharmacotherapy treatment. Increased case management for high-risk members

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- n/a, too early

c. Identify any barriers to implementing initiatives:

- Member education retention and adherence

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continued member education and increased care management for high-risk members

HSAG Assessment

Recommendation

HSAG recommended the following for *Follow-Up After Hospitalization for Mental Illness*:

- Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions.
- Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:

- Conducted root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness. Increased care coordination and streamlined processes for gap closure via telemedicine.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Gap closures increased via telemedicine.

c. Identify any barriers to implementing initiatives:
- Members unable to reach post discharge.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Embedded discharge planners to coordinate after care.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, work with members to increase the use of telehealth services, when appropriate

Response

a. Describe initiatives implemented based on recommendations:
- Conducted root cause analysis to determine why members are not consistently accessing preventive and ambulatory services. Implemented provider education on telemedicine and member outreach for preventive service reminders.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A, too early due to reduced utilization during Covid

c. Identify any barriers to implementing initiatives:
- Member reluctance to use and/or access to telemedicine

d. Identify strategy for continued improvement or overcoming identified barriers:
- Member and provider education on telemedicine. Continued telemedicine utilization monitoring.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

• Conducted root cause analysis to determine why female members are not receiving timely screenings for breast and cervical cancer. Implemented and/or enhanced interventions to improve members' access.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A, too early due to reduced utilization during COVID-19
c. Identify any barriers to implementing initiatives: • Ongoing Public Health Emergency
d. Identify strategy for continued improvement or overcoming identified barriers: • Member education on available benefit coverage, transportation, and provider partnerships for access to care.
HSAG Assessment

Recommendation
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not receiving timely screenings for diabetes and if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance.
Response
a. Describe initiatives implemented based on recommendations: • Conducted root cause analysis to determine barriers to members receiving timely screenings for diabetes and identify barriers to care for members with high blood pressure. Implemented member engagement strategies to overcome these barriers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A, too early due to reduced utilization during COVID-19.
c. Identify any barriers to implementing initiatives: • Member reluctance to use and/or access to remote patient monitoring.
d. Identify strategy for continued improvement or overcoming identified barriers: • Increased provider/community partnerships for remote patient monitoring abilities.
HSAG Assessment

3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy
Recommendation
HSAG recommended the following to improve the accuracy of provider directories: • Follow the contract requirements and internal processes to verify the accuracy of the online provider directory.

- Conduct telephone surveys to validate the information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys.
- Conduct outreach to their providers to ensure they collect updated information on all service indicators. Provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.

Response

a. Describe initiatives implemented based on recommendations:

- HC partnered with AArete Consulting for a review of current directory review practices as well as root cause analysis into key drivers for directory inaccuracy. Another aspect of that partnership focused on adjusting the roster intake process to improve upfront analysis of IAMHP formatted rosters for all relevant fields and increased automation of the subsequent review to the health plan provider data systems
- HC Provider experience representatives were trained in the use of the upfront roster review macros as well as instructed to circle back with providers where data was only partially populated on roster submissions for non-essential data elements that still improve the directory experience such as website and service indicators
- HC Monthly cross-functional directory touchpoint meetings occurred to receive input from downstream areas such as medical management and Quality to receive input on any challenges or issues they're encountering with provider demographic/directory data to identify, track, and remediate those concerns internally
- MMAI administered a provider appointment availability and incorporated questions to verify accuracy of the provider directory. A total of 545 providers were surveyed to ensure accuracy and compliance, the following information was assessed to determine accuracy of what the health plan displays on its website:
    - Accuracy of office locations and phone numbers
    - Accuracy of hospital affiliations
    - Accuracy of accepting new patients
    - Awareness of physician office staff of physician's participation in the organization's network
- MMAI Provider Relations Liaisons incorporated verification of provider demographic information during ad-hoc and routine engagement. This information is being captured and updated in the health plan's system to provide accurate provider and location details throughout all systems and the provider website.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The health plan continues to see improvements in the number of providers that are utilizing the IAMHP roster format, as opposed to other methods of submitting updates, as well as the percentage of the "non-required" fields that are being populated
- The additional up-front roster reviews from provider experience reps, and the semi-automation of that process, has helped to reduce back and forth with providers due to data inaccuracies/incompleteness allowing for quicker TATs and reduced chances of "stale" data remaining on the directory as a result
- Through both the directory audit review process as well as the directory touchpoint meetings the health plan was able to focus on the data elements that were the key drivers in external deficiencies as well as those causing issues with internal teams. That focus helped ensure resources were focused on those elements most essential to the member experience and those impacting operational efficiency
- In comparison to CY2020, MMAI saw an improvement of 12.9% in the accuracy of provider phone numbers. In addition, MMAI also experienced an increase of 24.9% in the acceptance of new patient

status.

- The MMAI annual provider directory accuracy survey is scheduled to be completed CY2022 and will be used to determine any improvements from the prior year. Aetna MMAI partners with a third-party vendor to conduct the survey, which will then be used for analysis and to determine if the results meet the health plan's standards.

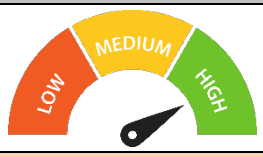
c. Identify any barriers to implementing initiatives:

- Providers either not populating or inserting default values for demographic information not essential for provider loads. E.g. website, service indicators, detailed ADA fields. The health plan followed up with providers in cases where the IAMHP format was either partially populated or there looked to be default Y/N values listed for every attribute and every provider, but there's also a need to balance loading/updating those provider records in a timely manner which resulted in cases where providers were loaded but without every attribute/data element present
- The timeliness and consistency with which providers send over updated roster information when changes occur still varies from group to group. The health plan pushes for monthly rosters where possible and at least quarterly, but there are still instances where that cadence isn't met, and necessary updates are subsequently identified via other channels such as internal reviews or complaints
- The MMAI team has not identified any barriers at this time to administer the survey to verify accuracy or to obtain provider feedback during any engagement where demographic information is being requested

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continue to stress to providers the need for populating all elements of the provider roster including provider website, email, and service indicators that historically have been more hit or miss.
- Create additional avenues for provider communications to the plan around demographic changes or issues. Availity is being leveraged for certain self-service demographic reporting for providers already with the plan looking to expand upon that moving forward
- Conduct more routine external facing audit calls to assess accuracy from the perspective members would experience when reaching out to provider offices

HSAG Assessment



Recommendation

HSAG recommended the following for provider network time/distance standards:

- Examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers.
- Notify HFS within five business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis.
- Work with contracted providers (i.e., dental and pharmacy) to ensure vendor provider data are accurate and complete.

Response

a. Describe initiatives implemented based on recommendations:

- The health plan will continue to conduct ongoing monitoring/maintenance of the data that is received from network providers via the IAMHP roster template(s). Provider experience will continue to review

the information received from the providers and request any corrections or confirmation of accuracy of the age range of the members they render services.

- In the efforts to cure the network gaps in oral surgery in the rural counties of Region 1, 2, and 3 (Northwestern, Central, and Southern Counties) and the network gaps in psychologists in the urban counties in Region 1 and 2, consists of the following tasks: (1) network development will continue to build upon the vendor's dental network for oral surgeons; (2) network development will continue to use Quest Cloud reporting in order to identify any new practice(s) for oral surgeons and psychologists located in the mentioned counties with network gaps and (3) the health plan will also continue to pursue these specialties that are located in the contiguous state(s) and negotiate direct agreements (4) we will also continue to educate and collect updated rosters from essential Medicaid providers: Rural Health Clinics (RHC), Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FQHC), and local health departments (LHD) in order to capture additional specialists that would cure either specialty gap.
- The health plan is aware that it is imperative to have accurate provider data in order to effectively support and service our members. Therefore, the health plan will continue to have monthly meetings with the vendors and list this as an ongoing agenda item for the account managers to continue to request, update, and load the information from the rosters proficiently.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The plan has successfully cured the psychologist gap in region 1 (northwestern)

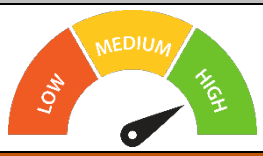
c. Identify any barriers to implementing initiatives:

- There is a limited subset of oral surgeons in the area and of that subset, some are not willing to accept Medicaid members to their book of business, are not registered with HFS which makes them ineligible to participate with the health plan or are looking for astronomical rates. Another barrier the health plan faces are the largely rural counties in region 1, 2 and 3; therefore, oral surgeons are not physically located in all rural counties.

d. Identify strategy for continued improvement or overcoming identified barriers:

- The health plan will continue to evaluate the network for oral surgeons and psychologists in the regions that reflect network gaps. In a case where travel time or distance is a barrier, the health plan works with local providers to coordinate transportation or other types of intermediate intervention such as telehealth for behavioral health services in order to ensure accessibility to all sectors of the state. Other tools used to overcome the identified barriers include single case agreement requests and out of network authorizations

HSAG Assessment



4. Prior Year Recommendation from the EQR Technical Report for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct root cause analyses or focus studies to determine why adult members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

- Determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

- The Network team conducted a DIA analysis, and concluded there are multiple opportunities to enhance adequacy, specifically in the of specialties of dermatology, licensed clinical professional counselor, Oral Surgery and Psychologist, where an adequacy rate below 1% exists for DIA in Regions 1, 2 and 3. We will continue our ongoing efforts to identify behavioral health and dental providers in those areas and will be initiating efforts for increasing dermatologists who accept Medicaid within our network. In addition, several activities were initiated to address the recommendations, including: Performed SWOT and Fishbone analysis to address member low awareness of PCP assignment and changes, which led to installing PCP awareness SWAT Team to identify potential solutions; assessed member onboarding process (including reviewing Welcome package) for PCP messaging; facilitated PCP engagement feedback discussions during committee and monthly Quality Provider Liaison meetings, as well as incorporating CAHPS best practices in monthly QPL meetings (e.g., building trusting relationships between PCP and members); leveraging member newsletter to reinforce and encourage PCP engagement; initiated assessment for installing clinic days and/or block scheduling with high volume providers; raised awareness in internal departmental cross-functional workgroups (e.g., discussions on how Case Management, Member Services, and Quality Management can impact ease of making provider appointments through care planning process or how Member Services respond to member commentary about our calling or texting campaigns); initiated exploration of leveraging market research consultants to help inform additional strategies and solutions; use of off-cycle (i.e., pre-CAHPS) survey for further investigation of low rated areas; implemented a Quality Management Member Services Call Calibration to listen monthly for opportunities that impact member access to and perception of care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- An off-cycle survey was initiated at the end of 2021, but a low response rate (0.3%), in addition to recognition that the survey may have been too lengthy for members, necessitated a review and overhaul of strategies and goals. A comprehensive CAHPS improvement workplan that highlighted the responses above was developed to impact the recommendations and guide the health plan toward overall increases in member ratings of their perception of care and health plan services. This work to build the foundation to address access to care and other aspects of members' experience and health outcomes began in CY 2022 Q1. The impact on performance outcomes based on the CAHPS workplan are expected to be fully realized over multiple years (e.g., 2023 CAHPS survey, improved off-cycle surveys, health plan ratings, etc.), and feedback and other data collected and analyzed from the activities are expected to continuously inform and guide the health plan's improvement strategies and actions. However, internal processes of incorporating data from activities like the Member Services Call Calibration improved interdepartmental collaboration, which led to call script enhancements including ensuring that service representatives were confirming the assigned PCP while member was on the phone. In addition, changes made in improving Member Services processes through 2021 (including staff systems trainings and stabilization of resources) resulted in markedly improved Customer Service ratings in 2022 (90.12% in 2022 vs. 82.97% in 2021). Furthermore, 2022 CAHPS Survey results for Getting Needed Care improved in 2022 (79.47% vs 78.91% in 2021), as well as the rating for Getting Care Quickly (79.85% in 2022 vs 78.23% in 2021). Lastly, a vast majority of adults in the survey indicated that they received the care they needed right away, which improved year-over-year (84.17% in 2022 vs. 77% in 2021).

c. Identify any barriers to implementing initiatives:

- COVID-19 fears and restrictions may have impacted member engagement efforts during the time period. For example, provider practices may have been hesitant to allow Aetna staff on-site during the PHE.

Insufficient and/or inaccurate data on member demographics (addresses, missing phone numbers, race/ethnicity not captured, etc.), may have impacted ability to outreach to members in a timely manner or stifled efforts to accurately pinpoint areas of need (e.g., heatmap generation to identify gaps in care by populations may have been inaccurate).

d. Identify strategy for continued improvement or overcoming identified barriers:

- Aetna will continue to leverage data and insights from member engagement sources such as the Member Advisory Committee, improved off-cycle survey process, market research project (to better understand members' needs and expectations, and drive a more engaging experience and satisfaction with the plan) and the 2023 CAHPS Survey. In addition, the heal plan will concurrently work on enhancing internal processes that strengthen interdepartmental collaboration and improved data and reporting analysis. These strategies should help Aetna to continuously inform and guide its goals and actions to address issues related to access to care.

HSAG Assessment

Recommendation

HSAG recommended the following for child CAHPS:

- Conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care child members need..
- Evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill gaps or evaluate why providers may not want to participate with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

- The Network team conducted a DIA analysis, and concluded there are multiple opportunities to enhance adequacy, specifically in the of specialties of dermatology, licensed clinical professional counselor, Oral Surgery and Psychologist, where an adequacy rate below 1% exists for DIA in Regions 1, 2 and 3. We will continue our ongoing efforts to identify behavioral health and dental providers in those areas and will be initiating efforts for increasing dermatologists who accept Medicaid within our network. In addition, several activities were initiated to address the recommendations, including: Performed SWOT and Fishbone analysis to address member low awareness of PCP assignment and changes, which led to installing PCP awareness SWAT Team to identify potential solutions; assessed member onboarding process (including reviewing Welcome package) for PCP messaging; facilitated PCP engagement feedback discussions during committee and monthly Quality Provider Liaison meetings, as well as incorporating CAHPS best practices in monthly QPL meetings (e.g., building trusting relationships between PCP and members); leveraging member newsletter to reinforce and encourage PCP engagement; initiated assessment for installing clinic days and/or block scheduling with high volume providers; raised awareness in internal departmental cross-functional workgroups (e.g., discussions on how Case Management, Member Services, and Quality Management can impact ease of making provider appointments through care planning process or how Member Services respond to member commentary

about our calling or texting campaigns); initiated exploration of leveraging market research consultants to help inform additional strategies and solutions; use of off-cycle (i.e., pre-CAHPS) survey for further investigation of low rated areas; implemented a Quality Management Member Services Call Calibration to listen monthly for opportunities that impact member access to and perception of care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- An off-cycle survey was initiated at the end of 2021, but a low response rate (0.3%), in addition to recognition that the survey may have been too lengthy for members, necessitated a review and overhaul of strategies and goals. A comprehensive CAHPS improvement workplan that highlighted the responses above was developed to impact the recommendations and guide the health plan toward overall increases in member ratings of their perception of care and health plan services. This work to build the foundation to address access to care and other aspects of members' experience and health outcomes began in CY 2022 Q1. The impact on performance outcomes based on the CAHPS workplan are expected to be fully realized over multiple years (e.g., 2023 CAHPS survey, improved off-cycle surveys, health plan ratings, etc.), and feedback and other data collected and analyzed from the activities are expected to continuously inform and guide the health plan's improvement strategies and actions. However, internal processes of incorporating data from activities like the Member Services Call Calibration improved interdepartmental collaboration, which led to call script enhancements including ensuring that service representatives were confirming the assigned PCP while member was on the phone. In addition, changes made in improving Member Services processes through 2021 (including staff systems trainings and stabilization of resources) resulted in markedly improved Customer Service ratings in 2022 (90.12% in 2022 vs. 82.97% in 2021). Furthermore, 2022 CAHPS Survey results for Getting Needed Care improved in 2022 (79.47% vs 78.91% in 2021), as well as the rating for Getting Care Quickly (79.85% in 2022 vs 78.23% in 2021). Lastly, a vast majority of adults in the survey indicated that they received the care they needed right away, which improved year-over-year (84.17% in 2022 vs. 77% in 2021).

c. Identify any barriers to implementing initiatives:

- COVID-19 fears and restrictions may have impacted member engagement efforts during the time period. For example, provider practices may have been hesitant to allow ABH IL staff on-site during the PHE. Insufficient and/or inaccurate data on member demographics (addresses, missing phone numbers, race/ethnicity not captured, etc.), may have impacted ability to outreach to members in a timely manner or stifled efforts to accurately pinpoint areas of need (e.g., heatmap generation to identify gaps in care by populations may have been inaccurate).

d. Identify strategy for continued improvement or overcoming identified barriers:

- HC will continue to leverage data and insights from member engagement sources such as the Member Advisory Committee, improved off-cycle survey process, market research project (to better understand members' needs and expectations, and drive a more engaging experience and satisfaction with the plan) and the 2023 CAHPS Survey. In addition, the heal plan will concurrently work on enhancing internal processes that strengthen interdepartmental collaboration and improved data and reporting analysis. These strategies should help HC to continuously inform and guide its goals and actions to address issues related to access to care.

HSAG Assessment

5. Prior Year Recommendation from the EQR Technical Report for Critical Incident Monitoring:
Recommendation
HSAG recommended the following: • Consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.
Response
a. Describe initiatives implemented based on recommendations: • During the time of the prior report, COVID restrictions were in place and the health plan was not able to conduct face to face visits to members who resided in a nursing home or SLP. During that time, if members were unable to be reached for health risk assessments, care planning, and service planning, the health plan followed its internal Unable to Reach processes in efforts to identify additional contact information for each member using all the different internal systems. The health plan worked diligently to partner with nursing home and SLP contacts in order to reach members telephonically and/or engage their representatives. Outreach was also conducted to a member's power of attorney or guardian(s)s if the health plan's HIPAA validation protocol was verified. In the beginning of SFY2023, those visits have resumed, and representatives of our Care Management team are now able to engage in person. • Aetna workflow includes specific language to address speaking to authorized rep in NF or SLP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • None
d. Identify strategy for continued improvement or overcoming identified barriers: • Ongoing staff training to ensure all efforts are incorporated into outreach.
HSAG Assessment

Recommendation
HSAG recommended the following: • Consider merging internal CI processes to ensure consistent process application, valid data capture and categorization of CIs, and identification and utilization of best practices between lines of business. • Consider conducting a strengths, weaknesses, opportunities, and threats (SWOT) analysis. • Revise provider agreements and conduct provider training on identification and reporting of ANE/CIs.
Response
a. Describe initiatives implemented based on recommendations: • Internal processes for MMAI and HCI/MLTSS have been merged with only slight differences as appropriate currently • Critical Incident Training has been embedded in both our new provider orientation and ongoing provider education. Within our website, we have also included training related to the process for reporting critical incidents https://www.aetnabetterhealth.com/illinois-medicaid/providers/report-abuse-neglect-

exploitation.html

- Within our provider agreements, we have a section in references to critical incidents and providers obligation to cooperate with training within Section 2.13(f)
- Company's obligation to provide orientation, education, and training for Provider/Subcontractor as set forth in the State Contract, including without limitation (i) training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and (ii) education on the application of required clinical guidelines. [Medicaid Contract 5.10, Attachment XI]

- Fraud, Waste, and Abuse education is included in IL MMAI Provider Handbook. The information includes training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and reporting process.
  - Within the MMAI website we have also included the CMS Fraud, Waste and Abuse Training https://www.aetnabetterhealth.com/illinois/providers/resources/tools

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Per FY2021 Q4 Critical Incident Monitoring Review HSAG did not identify any further recommendations related to system effectiveness. The HealthChoice and MMAI plans have been able to consistently follow the same CI processes and have regular communication around any changes or updates to ensure continued consistency around processes.

c. Identify any barriers to implementing initiatives:

- High volume of CIs (approximately 200/month for HCI/MLTSS)
- No barriers identified for MMAI

d. Identify strategy for continued improvement or overcoming identified barriers:

- Strategizing to enhance management of large volume including SWOT analysis to develop new model for tracking and trending

HSAG Assessment

6. Prior Year Recommendation from the EQR Technical Report for HCBS Waiver Performance Measures:

Recommendation

HSAG recommended the following for Measure 4A, *overdue service plan was completed within 30 days of expected renewal*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans.
- Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

Response

a. Describe initiatives implemented based on recommendations:

- In late 2020, the HC waiver team began utilizing a standard Outreach Report to capture, track, and

validate assessments/outreach/care planning. The staff can access the Outreach Report at all times.

- This report is used as an early warning system to indicate when CP/SP is due and/or overdue
- The HC Waiver team has a dedicated trainer, hired in Q3 of 2019 as a new position to better support continuous improvement. The trainer works with team members upon initial hire and at multiple training sessions throughout the year.
- The HC management team works closely with the trainer to ensure that workflows and processes for all measures are up to date with the health plan standards, as well as best practices.
- In Q4 2020, the HC trainer conducted retrainings specific to this metric.
- MMAI team had retraining addressing service planning the weeks of 6/21/21, 1/3/22, 7/18/22 for all staff in team meetings.
- The MMAI team implemented a tool referred to as the dashboard, which is fully accessible at all times to staff. It was introduced to the department in February 2020 and is monitored regularly by leadership and reviewed with staff a minimum of once a month. Service plans should at minimum align with the annual InterRAI and interRAIs are tracked on the dashboard to prompt staff to complete outreaches early and timely along with the service plan. Workflows prompt staff to check the last service plan date to address during member contacts

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- There was little improvement in this metric early in the reporting period, however, the metric was discontinued in Q4 of 2021.

c. Identify any barriers to implementing initiatives:

- None

d. Identify strategy for continued improvement or overcoming identified barriers:

- N/A
    - This metric has been discontinued

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations.
- Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Response

a. Describe initiatives implemented based on recommendations:

- Enhanced training developed for staff to improve process timeframes and knowledge

- Retrained all team members regarding timely completion and completion for multiple PAs (all training completed April 2021)
- Added metric to supervisor monthly reviews of files for 1:1 supervision
- Updated internal staff audits to encompass this measure more clearly

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- This metric performed significantly throughout the SFY. During Q1 it was at 0% and was up to 50% at the end of the SFY (MLTSS) and the score doubled from Q1 to Q4 of SFY for HC.
- The MMAI team has seen little improvement (0%, 67% and 33% respectively for the last three audits)

c. Identify any barriers to implementing initiatives:

- Manual reporting processes and limited capacity to identify when there are multiple PAs needing an evaluation

d. Identify strategy for continued improvement or overcoming identified barriers:

- Enhance reporting to include early warning system to identify 60 day timeline prior to due date

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 20C, *a PA evaluation was completed annually*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations.
- Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Response

a. Describe initiatives implemented based on recommendations:

- Enhanced training developed for staff to improve process timeframes and knowledge
- HC team retrained all team members regarding timely completion and completion for multiple PAs (all training completed April 2021)
- MMAI team retrained all team members regarding timely completion and completion for multiple PAs (all training completed June 2021)
- Added metric to supervisor monthly reviews of files for 1:1 supervision

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For MLTSS the performance throughout the fiscal year went up from 79% to 84% and for HC, we saw smaller improvements as the measure went from 81% to 82% during the fiscal year.
- MMAI team saw improvement from Q4 2021 to Q4 2022 of 87% to 93%

c. Identify any barriers to implementing initiatives:

- Manual reporting processes and limited capacity to identify when there are multiple PAs needing an

evaluation

d. Identify strategy for continued improvement or overcoming identified barriers:
- Enhance reporting to include early warning system to identify 60 day timeline prior to the due date

HSAG Assessment

Recommendation

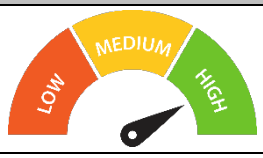
HSAG recommended the following for Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- Conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

Response

a. Describe initiatives implemented based on recommendations:
- During Q4 of 2020, prior to transition from CNC to ABH, the following remediations were put into place by the HC team to specifically address the HIV and BI outreaches:
    - The entire Waiver team is now utilizing a standard Outreach Report to capture, track, and validate assessments/outreach. The Outreach Report is accessible to staff at all times.
    - The dedicated waiver trainer works with team members upon initial hire and at multiple training sessions throughout the year
- Post cutover to ABH, the HC team put several measures into place to address 36D for all populations:
    - Development of automated CM dashboard
    - Realignment of staffing model using Aetna staffing analysis tool
    - Dedicated audit team for LTSS population
- The MMAI team implemented a tool referred to as the dashboard, which is fully accessible at all times to staff. It was introduced to the department in February 2020 and is monitored regularly by leadership and reviewed with staff a minimum of once a month to evaluate compliance
- MMAI workflow was updated to include a visit event to ensure TBI mbrs are contacted for monthly visits

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- For FY 2021, there was improvement for the HCI population from 81%-84% as well as for MLTSS as it

improved from 85% to 88%. • MMAI continues to maintain 90% or above in this measure
c. Identify any barriers to implementing initiatives: • Workforce challenges • Public Health Emergency • Manual reporting
d. Identify strategy for continued improvement or overcoming identified barriers: • Creative recruiting and retention to decrease attrition and increase workforce • Offering overtime to LTSS staff to cover additional cases
HSAG Assessment


Blue Cross Blue Shield of Illinois

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Review PIP Module 4 and Module 5 instructions and Rapid-Cycle PIP Reference Guide. • Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. • Consider testing more than one intervention during the duration of the PIP. This will help the health plans address additional identified opportunities for improvement and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project.
Response
a. Describe initiatives implemented based on recommendations: • Three intervention testing cycles were initially set at a sample size of 3 members per week for 12 weeks, each cycle. Intervention testing cycle 2 was shortened to 10 weeks after receiving Health Services Advisory Group (HSAG) recommendation. Intervention testing cycle 3 duration was shortened to 4 weeks, increasing the sample size to 12 members per week, in anticipation for implementation. • Based on the results of Cycle 1 intervention testing, the Same-day Notification of Member Admission intervention was adapted. The 1-week post discharge outreach intervention process step was added in Cycle 2 intervention testing: 1 (one) business week post discharge, Health Care Services Corporation (HCSC) Care Coordinator will outreach intervention test members who did not answer the outreach while inpatient and intervention test members who answered the outreach during inpatient, but do not have a 30- day post discharge appointment. HCSC Care Coordinators will educate regarding importance of 30-day post discharge appointments, telehealth, and safety precautions that member can take at in-person provider appointments. HCSC Care Coordinators will also assess for telehealth access, and transportation to the scheduled appointment is arranged if needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The shorter intervention testing period allowed quicker data gathering to support the effectiveness of the adapted Same-day Notification of Member Admission intervention. At the conclusion of Cycle 3 intervention testing, the adapted Same-day Notification of Member Admission intervention was adopted into implementation. • The adaptation of the same-day notification system intervention step to include a 1-week post discharge outreach in Cycle 2 intervention testing phase, resulted in 52% of answered 1 week post discharge outreach, and 67% of those members that answered the 1-week post discharge outreach were successful, meaning that member has a 30-day appointment scheduled. The 1-week post discharge intervention process step resulted in a 61% increase in successful outreach compared to just having the inpatient outreach. In comparison to Cycle 1 intervention testing's successful member outreach, Cycle 2 intervention testing yielded a 9% increase in successful member outreach.
c. Identify any barriers to implementing initiatives: • Prior to the intervention testing phase, Re-organization in Christ Hospital resulted in: • Delay in intervention testing commencement due to waiting for Christ Advocate to respond to meeting requests to discuss the deployment of the Same-day Notification intervention. Intervention testing was planned to start on 6th February 2020 but was not able to start until March 3, 2020.

- Loss of point of contact that was part of the planning of the Same-Day Notification system. New point of contact was unaware of initiative and felt that the Daily Census that Care Coordination receives should suffice as a Same-day notification of members admitted. This also resulted in the lack of collaboration support between Christ Case Managers and HCSC Care Coordinators.

COVID-19 Barriers:

- Christ Advocate placed all non-essential projects on hold, and any attempts of building a strong collaboration with Christ Advocate Case Managers is no longer their priority.
- Christ Advocate Case managers were no longer allowed on unit floors, and were outreaching patients telephonically, encountering the same barriers that HCSC Care Coordinators encounter such as being "unable to reach" (UTR). Christ case managers have also not been returning HCSC Care Coordinator's calls. Having Christ Advocate Case Managers working telephonically versus outreaching members face- to-face lessens opportunities of education re-enforcement regarding the importance of having a 30-day post discharge appointment and appropriate introduction of the HCSC Care Coordinator's role in their discharge planning.
- Members refusing appointment set-ups due to fears of contracting COVID-19 and members who had appointments did not attend due to these fears.
- Media reports regarding fraudulent phone calls regarding COVID-19 relief lead to more UTR.
- Provider offices being closed, having limited appointments, or only seeing patients with emergent issues resulted in being unable to schedule 30-day post discharge appointments.
- Provider offices are having long hold times or not returning voicemails made by HCSC Care Coordinators and members, causing members not to schedule appointments and difficulty with verifying member appointments.
- Staffing shortage within the HCSC Care Coordination Department limited the care coordination assignment and outreach capabilities, and prioritized outreach to High-Risk members. Non-High-risk members were not assigned care coordinators unless the member themselves contact HCSC Care Coordination.

d. Identify strategy for continued improvement or overcoming identified barriers:

- To overcome barriers related to the loss of collaboration with Advocate Christ Hospital Case Managers and UTR members, HCSC Care Coordinators continued outreach efforts utilizing Christ resources such as contacting floor nurses to assist in connecting the member with the care coordinator, utilizing resources such as Guiding Care Coordination documentation platform, Google, White Pages, Smart UM, and ECM systems (Enterprise Contact Management) to obtain members updated and accurate contact information for outreach and UTR members are sent outreach letters by HCSC Care Coordination in addition to phone outreach.
- To address barriers of members fears of contracting COVID-19 during appointments, HCSC Care Coordinators incorporated assessing for telehealth access and telehealth education to their discharge planning.
- To overcome barriers related to provider office communications and appointment scheduling, HCSC Care Coordinators continued to make multiple provider outreach to facilitate member appointment scheduling. Administrative claims and FACETs were utilized to verify member appointments.
- The Same-day Notification of Member Admission Intervention was adopted to be implemented to all Blue Cross Community Health Plan (BCCHP) members 18 years of age and older, admitted to Christ Advocate Hospital, with a goal of a monthly minimum of 90 members, with consideration that actual eligible member admissions may be lower than targeted minimum per month; to increase the likelihood of achieving the SMART Aim goal.

HSAG Assessment

Recommendation
HSAG recommended the following: • *Follow-Up After Hospitalization for Mental Illness PIP*: Follow the rolling 12-month SMART Aim methodology documented in Module 1 throughout the duration of the PIP.
Response
a. Describe initiatives implemented based on recommendations: • The Rapid Cycle PIP for Follow-Up Post Hospitalization for Mental Illness was designed to target high volume, low performing facilities to improve their 30-day Follow-up after Hospitalization (FUH) rates through collaboration to identify the challenges of discharge planning and member follow-up. A baseline rate of 33.4% was identified using the number of members, ages 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who maintained their 30-day FUH appointment following discharge from Hartgrove Hospital. The goal of 43.4% by 12/31/2021 was selected, as a 10-percentage point increase above the baseline would impact a meaningful number of members during the measurement period. The final submitted rate of 20.3%, was below the 33.4% • Initiatives include a targeted facility care-management program, alongside the established transition of care program, has been implemented to improve collaboration with facilities and improve member care post-discharge plans.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improved collaboration with facilities around member discharge planning to maintain community tenure.
c. Identify any barriers to implementing initiatives: • Timely notification and engaging with facility social work team to assess member needs.
d. Identify strategy for continued improvement or overcoming identified barriers: • Monitor performance and internally evaluate for areas for continued improvement and collaboration with facility provider.
HSAG Assessment

Recommendation
HSAG recommended the following: • *Transitions of Care—Patient Engagement After Inpatient Discharge PIP*: Rather than randomly selecting member, using all members would produce faster intervention testing results, allowing the health plan to revise the intervention quickly and test other interventions.
Response
a. Describe initiatives implemented based on recommendations: • The Implementation phase of the PIP increased its sample size to include all Blue Cross Community Health

Plan (BCCHP) members 18 years of age and older who are admitted to into Christ Advocate Hospital with a monthly minimum of 90 members, with consideration that actual eligible member admissions may be lower than the targeted minimum per month. The monthly minimum of member sample of 90 was based on the calculated average of eligible members from the administrative claims data starting January 2018 up to the latest data of June 2020, with a 95% confidence level, and a 5% margin of error.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- In the Implementation phase of the PIP, 86% of the members who answered the inpatient outreach, or 1-week post discharge outreach had a 30-day post discharge appointment scheduled. 88% of the Implementation phase members who had a 30-day post discharge appointment scheduled, attended their provider appointments. Only 34% of members who did not answer the Health Care Services Corporation (HCSC) Care Coordinator's outreach but scheduled their own 30-day post discharge appointment, and successfully attended.
- The Same-day Notification intervention prevented the continued steep decline in the 12-month rolling percentage. Prior to the intervention starting, the 12-month rolling compliance percentage had a maximum decrease of 6% between the pre-intervention months of July 2019 to February 2020, whereas the intervention months of March 2020 to December 2020 only had a 2% 12-month rolling compliance percentage decrease within the intervention months. The decline in the 12-month rolling compliance percentage during the pre-intervention months of July 2019 to February 2020 has a slope of decline equal to -0.0079, whereas the intervention months of March 2020 to December 2020's 12-month rolling compliance percentage has a slope of incline equal to 0.0002.

c. Identify any barriers to implementing initiatives:

COVID 19:

- Christ Advocate placed all non-essential projects on hold, and any attempts of building a strong collaboration with Christ Advocate Case Managers is no longer their priority.
- Christ Advocate Case managers were no longer allowed on unit floors, and were outreaching patients telephonically, encountering the same barriers that HCSC Care Coordinators encounter such as being "unable to reach" (UTR). Christ case managers have also not been returning HCSC Care Coordinator's calls. Having Christ Advocate Case Managers working telephonically versus outreaching members face-to-face lessens opportunities of education re- enforcement regarding the importance of having a 30-day post discharge appointment and appropriate introduction of the HCSC Care Coordinator's role in their discharge planning.
- Members refusing appointment set-ups due to fears of contracting COVID-19 and members who had appointments did not attend due to these fears
- Media reports regarding fraudulent phone calls regarding COVID-19 relief lead to more UTR
- Provider offices being closed, having limited appointments, or only seeing patients with emergent issues resulted in being unable to schedule 30-day post discharge appointments
- Provider offices are having long hold times or not returning voicemails made by HCSC Care Coordinators and members, causing members not to schedule appointments and difficulty with verifying member appointments

Other:

- Staffing shortage within the HCSC Care Coordination Department limited the care coordination assignment and outreach capabilities, and prioritized outreach to High-Risk members. Non-High-risk members were not assigned Care Coordinators unless the member themselves contact HCSC Care Coordination
- Low census, having less than 90 eligible members per month. The Health Effectiveness Data and Information Set (HEDIS) Transition of Care (TRC) specification regarding readmission or direct transfer

identified Christ Advocate Hospital admissions or eligible members who are actually not admitted at Christ Advocate Hospital during the PIP, hence the eligible member indicated in the administrative claims data as being admitted in Christ Advocate Hospital during the month was not

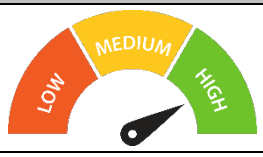
indicated in the same-day notification system received by HCSC Care Coordination daily from Christ Advocate Hospital

- Members needed to be taken out of the sample due to the following factors: members passing away, transferring out of Christ Advocate Hospital, re-admission to a new facility, termed out of BCCHP, and members still admitted beyond the PIP measurement period of December 31, 2020.

d. Identify strategy for continued improvement or overcoming identified barriers:

- HCSC is continuing to improve health outcomes of members to ensure appropriate and timely member engagement though these initiatives:
    - Daily collaboration with HCSC Utilization Management department to follow-up on high-risk members from admission through discharge
    - Improvement in Guiding Care application to alert Care Coordinators on admission, transfers, and discharge based on real-time data
    - Admission Discharge Transfer System (ADT) implemented in other hospitals beyond Christ Advocate Hospital, which provides daily admission data of members admitted to the participating hospitals.
    - Blue Cross Blue Shield Remote Member Monitoring (RMM) Program partnership with hospitals to ensure members with a diagnosis of Congestive Heart Failure (CHF) are engaged while inpatient.
    - Partnership with a Business Enterprise Program (BEP) vendor to provide RMM to members with asthma, diabetes, hypertension, congestive heart failure, and chronic obstructive pulmonary disease
    - Integrated Care Program (ICP) Pilot: ICP members are assigned care coordinators and bi- weekly rounds are conducted to ensure appropriate discharge planning.
- To overcome barriers related to the loss of collaboration with Advocate Christ Hospital Case Managers and UTR members, HCSC Care Coordinators continued outreach efforts utilizing Christ resources such as contacting floor nurses to assist in connecting the member with the care coordinator, utilizing resources such as Guiding Care Coordination documentation platform, Google, White Pages, Smart UM, and ECM systems (Enterprise Contact Management) to obtain members updated and accurate contact information for outreach and UTR members are sent outreach letters by HSCS Care Coordination in addition to phone outreach.
- To address barriers of members fears of contracting COVID-19 during appointments, HCSC Care Coordinators incorporated assessing for telehealth access and telehealth education to their discharge planning.
- To overcome barriers related to provider office communications and appointment scheduling, HCSC Care Coordinators continued to make multiple provider outreach to facilitate member appointment scheduling. Administrative claims and FACETs were utilized to verify member appointments
- To overcome barriers related to staffing shortage in HCSC Care Coordination, HCSC is actively hiring care coordinators to ensure member needs are met.

HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members ages 65 with opioid use disorder are not receiving or adhering to pharmacotherapy treatment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.
Response
a. Describe initiatives implemented based on recommendations: • Root cause analysis shows this population is more likely to experience chronic pain based on their age and therefore more likely to be prescribed opioids. This age group can be difficult to reach and tends to be less receptive to telehealth appointments and with the pandemic they were also hesitant to get out in the community. As a result, the members may have deprioritized treatment. Additionally, this membership has a small denominator which makes it more difficult to make significant improvements. • Provider education was offered concerning the importance of staying on Medication Assisted Treatment (MAT) following an opioid diagnosis. This education was aimed at both prescribers and providers who would be appropriate to encourage medication compliance. A video for members was created educating on the importance of medication compliance as a part of continued treatment for a behavioral health diagnosis. In order to improve appointment availability to those who received medication assisted treatment (MAT), reserved appointments were created for BCBSIL members to ease access and encourage attendance. Care Coordination partnered with the Provider Network Consultant team to remove barriers at the provider level and educate on ways to better support the over 65 population. Notifications are in place in our medical management system alerting care coordinators if members have an opioid prescription and receive suboxone.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • It is expected that the results from the 2022 trainings and the member video will be seen in late Q4 2022 or Q1 2023.
c. Identify any barriers to implementing initiatives: • No barriers were identified in providing the education; however Blue Cross Blue Shield of Illinois (BCBSIL) is unable to impact implementation of the knowledge provided. Overall, prescribers may be less likely to continue to prescribe MAT in the 65 and over population due to the increased risk of side effects and negative impact on co-morbid medical conditions.
d. Identify strategy for continued improvement or overcoming identified barriers: • Blue Cross Blue Shield of Illinois (BCBSIL) elicits feedback from providers about the educational trainings with a focus on how useful the information was and how providers plan to use this information in their day-to-day practices. BCBSIL will use this feedback to tailor future interventions to be more effective. BCBSIL is in the process of creating a tip sheet for providers as enduring materials that they can reference. At the member level, BCBSIL provides support and education about member benefits and services available and how to access them.
HSAG Assessment


Recommendation
HSAG recommended the following for *Follow-Up After Hospitalization for Mental Illness*: • Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions. • Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. • Evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.
Response
a. Describe initiatives implemented based on recommendations: Based on recommendations provided, a Reserved Appointment Initiative was implemented to address the timely appointment shortage, which was identified as an issue due to the COVID-10 pandemic. In partnership with Network, BH Quality Improvement and BH Clinical Operations identified facilities to partner with to reserve appointments. BH Care Coordination worked with provider partners to select days/times for BCBS members. Additionally, BH Care Coordination scheduled appointments for members upon discharge or diagnosis. Several other initiatives serve to enhance communication and the relationship between hospitals and Blue Cross Blue Shield Illinois: • The facility partnership allows representatives from select hospitals to meet with varies teams at BCBSIL to discuss progress and how to remove barriers to ensure successful discharges. • Additionally, the Transition of Care (TOC) team outreaches facilities and members prior to discharge to engage in discharge planning and the implementation of the Admission, Transfer & Data Portal through Collective Medical Technologies allows Care Coordination staff to access real-time data which makes outreach to members more efficient and offers admission information such as member status, diagnosis, disposition, and the most up to date contact information. • A video targeting member was created and distributed explaining the importance of follow-up care for mental illness after hospitalization. • Telehealth grants were awarded in 2020 to offset the cost of adding a telehealth component this has led to an increase in the availability of these appointments. This has increased availability for members who were uncomfortable with in person appointments throughout SFY2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Blue Cross Blue Shield of Illinois has shown an improvement in FUH (Follow Up After Hospitalization) HEDIS measure for both the 7- and 30-day measure from the previous year. In August 2021 the Total follow-up within 7 and 30 days was 22.89% and 41.73% percent respectively whereas August 2022 shows Total follow-up within 7 and 30 days to be 28.93% and 47.04% respectively.
c. Identify any barriers to implementing initiatives: • Barriers included identifying partners in the community who had the ability to provide timely appointments on a scheduled basis around highest need. • The Public Health Emergency that remains in effect through at least 10/2022 is impacting the Care Coordination team's ability to return to facilities in person, as well as the degree of willingness by the facility to allow Care Coordination staff into the building. • Some members may be hesitant to use telehealth due to lack of the proper technology, limited resources,

and unfamiliarity or distrust with the platform.

d. Identify strategy for continued improvement or overcoming identified barriers:

- To improve the efficacy of the reserved appointment initiative there has been an increased focus on improving visibility of the available appointments. This includes outreaching high-volume facilities, providers in need of behavioral health resources for our members, and internal staff who help secure follow-up appointments.
- To address the barriers of Care Coordination being unable to return to the facilities in person, ongoing education is being provided about the benefits available to members and how to better access them.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

Breast Cancer Screening (BCS)- Based on the root cause analysis conducted to determine why female members are not receiving timely screenings for breast cancer, it was determined that the primary barrier to timely screenings was access to care during the COVID-19 pandemic. According to the National Institutes of Health, this barrier has been recognized nationwide. Additionally, while working with low-performing provider groups within our network, the same access issue has been identified as a barrier as well. While members are now starting to feel more comfortable going to their Providers and scheduling their mammograms, facilities are backlogged with appointments and are also dealing with staff shortages. To address this access barrier, BCBSIL:

- Partnered with the Clinical Practice Consultant team to provide in-network medical groups with patient level care gap reports. Providers are asked to outreach non-compliant members in an effort to make appointments and close care gaps. Further analysis of the care gap reports will be evaluated to determine if there are any socioeconomic factors associated with the non-compliant population.
- Partnered with Healthmine, a health reward and engagement company, to help target member engagement for BCS.
- Partnered with HealConnect, to launch a text messaging campaign to help target member engagement for members who have not completed their mammogram
- Partnered with Canary Telehealth to conduct a call outreach campaign to non-compliant African American female members in an effort to schedule preventative screenings to reduce the total amount of BCS care gaps.

Cervical Cancer Screening (CCS)-Based on the root cause analysis conducted to determine why female members are not receiving timely screenings for cervical cancer, we believe that this may be attributed to the guidelines for cervical cancer screening having increased in complexity over time, which results in a greater likelihood for missing or incomplete self-reported information about the screening tests women have

received. Additionally, there could be instances in which members are new to the plan who may have already received a screening with a different provider, but that information may not be relayed to the new provider. To address these barriers, BCBSIL:

- Partnered with the Clinical Practice Consultant team to provide in-network medical groups with patient level care gap reports. Providers are asked to outreach non-compliant members in an effort to make appointments and close care gaps. Further analysis of the care gap reports will be evaluated to determine if there are any socioeconomic factors associated with the care gap population.
- Partnered with Canary Telehealth to conduct a call outreach campaign to non-compliant Hispanic female members in an effort to schedule preventative screenings to reduce the total amount of CCS care gaps.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- By utilizing the HealthMine partnership, members have become more engaged with this platform since its launch in early 2021. Particularly for BCS, there has been a 37% increase in members completing their BCS health screenings since December 2021.
- By partnering with Canary Telehealth, BCBSIL was able to help schedule a total of 276 appointments for our members in the BCS and CCS population.

c. Identify any barriers to implementing initiatives:

- Cost-effective strategies to collaborate with vendors
- The lack of mobile mammography services in the disproportionately impacted area (DIA) zip codes restricts the opportunities to perform services for members who are in need of mammograms
- Timeliness to complete breast cancer screenings due to the backlog of appointments due to the ongoing COVID-19 pandemic.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Based on the barriers identified related to BCS and CCS, we are currently working with low performing provider groups to increase measure compliance and to increase the member outreach for these two measures
- BCBSIL is currently completing an analysis on member specific populations based on race, ethnicity, and DIA zip codes to identify the non-compliance rates within these categories and determine the most appropriate interventions based on the data findings.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance related to this measure.

Response

a. Describe initiatives implemented based on recommendations:

- Based on the root cause analysis conducted, it was determined that one of the barriers was low health literacy specifically amongst the African American members. To address this barrier, BCBSIL has implemented multiple initiatives including:

- Provide nutritional counseling and education through care coordination programs
- Increasing the regular monitoring of blood pressure through member engagement
- Improving the understanding around the importance of regular blood pressure monitoring
- We also partnered with Wellth app for the Medication adherence program for members with chronic conditions including high blood pressure. Members receive daily reminders, behavior reinforcements and can earn up to $300 for demonstrating care plan adherence over the course of their 12-month Wellth program.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Please see below the Wellth App Pre and Post Intervention Rates (11/29/2021 Data)

	TARGET 1			TARGET 2						
	Num	Den	Rate	Num	Den	Rate	Rate Change	Z score	Two Tailed P-value	Statistical Signific
CBP	28	616	4.55%	119	664	17.92%	13.38%	15.93812	0.000	Significantly Highe
	CONTROL 1			CONTROL 2						
	Num	Den	Rate	Num	Den	Rate	Rate Change	Z score	Two Tailed P-value	Statistical Signific
CBP	9	546	1.65%	102	616	16.56%	14.91%	27.36282	0.000	Significantly Highe
	CONTROL 1			TARGET 1						
	Num	Den	Rate	Num	Den	Rate	Rate Change	Z score	Two Tailed P-value	Statistical Signific
CBP	9	546	1.65%	28	616	4.55%	2.90%	5.31673	0.000	Significantly Highe
	CONTROL 2			TARGET 2						
	Num	Den	Rate	Num	Den	Rate	Rate Change	Z score	Two Tailed P-value	Statistical Signific
CBP	102	616	16.56%	119	664	17.92%	1.36%	0.91026	0.363	Not Significantly Different

There was a statistically significant increase in the CBP rates for the control groups based on this intervention.

c. Identify any barriers to implementing initiatives:

- Low enrollment and engagement with the Wellth app were identified as barriers.

d. Identify strategy for continued improvement or overcoming identified barriers:

- We will work with Care Coordination to target members for improving engagement with the Wellth app.
- CBP demonstrated a 13.13% increase from MY 2021 and exceeded the HEDIS 2022 performance goal of 45.45% by 12.21%. Amongst the total number of members with a documented blood pressure readings ≥ 140/90, 43.8% of members are African American men and women, 80% between the ages of 18-64 and 20% are age 65+. Interventions impacting results include a Text Message Outreach. Members will be educated of benefits, provided a BP cuff if member does not have one and education about the importance of medication adherence and disease management, educated on community resources and address SDoH barriers to care. Members will also be educated and encouraged to inform their provider of pilot and blood pressure readings.

HSAG Assessment

3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy
Recommendation
HSAG recommended the following to improve the accuracy of provider directories: • Follow the contract requirements and internal processes to verify the accuracy of the online provider directory. • Conduct telephone surveys to validate the information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys. • Conduct outreach to their providers to ensure they collect updated information on all service indicators. Provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.
Response
a. Describe initiatives implemented based on recommendations: • BCBSIL conducts reviews 25% of its online directory for accuracy. 25% of provider records (PFIN) are chosen randomly. Provider outreach is conducted to validate provider demographic information. Maximum of 3 attempts are made. The staff also researches provider online using a search engine such as google chrome for provider websites to validate the provider demographic details. • In 2022, the IL Provider Performance team conducted a project, which included validation of the city, zip code and county data at each provider office address. In this review, 736,012 locations were reviewed using a vendor SmartyStreets. As a result, 32,660 corrections to either the city, county or zip code were made. An additional 2,361 locations required manual review and correction. Additionally, the Provider Network Consultants used hospital health system websites, google searches, physician profile reviews and telephonic outreach to validate 1,580 providers in 11 downstate counties. This review included all providers in three large health systems, OB/GYN and radiation oncology provider types. As part of the Secret Shop review in 2022, we have added four questions specific to telehealth availability at the provider level. This will allow us to capture additional provider demographic information and display in the online and paper directories.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improved provider demographic information online and paper print directory. Improved accuracy of network adequacy results leading to 31% providers meeting compliance requirements.
c. Identify any barriers to implementing initiatives: • Providers not self-validating and notifying BCBSIL of changes in their provider demographic information.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to validate provider demographic information via various outreach efforts and continue education of provider network on the importance of their self-validation of provider demographic data.
HSAG Assessment

Recommendation
HSAG recommended the following for provider network time/distance standards:

- Examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers.
- Notify HFS within five business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis.
- Work with contracted providers (i.e., dental and pharmacy) to ensure vendor provider data are accurate and complete.

Response

a. Describe initiatives implemented based on recommendations:

- In 2022, the IL Provider Performance team reviewed all providers statewide with a specialty of Family Practice. The effort was to determine the patient age-range the providers would treat. The review includes researching using health system websites, google searches, provider profiles and telephonic outreach. If determined that the provider would treat a patient age "0-99", the provider demographic information was updated to reflect this information, which is useful in the geographic regions of the state where we may not meet the time and distance standards for a pediatric specialty but have coverage with a Family Practice provider.
- P&P was created to include the five business days notification to HFS when a gap is discovered. Process is operationalized moving forward for that notification to HFS. A Quarterly report was developed used in Q3 and Q4 of 2021 and is in use for 2022 to identify provider gaps by county using time/distance standards. All gaps are reviewed and recorded on a tracker and are assigned with an owner who is responsible to do outreach to targeted providers created from Quest Analytics.
- The assigned owner of a gap is expected to discuss progress on closing the gaps each week at their one on one with their manager. Each gap is reviewed as part of a Government Products Monthly Network Adequacy Status Review meeting as well as the Government Products Advisory Board meeting also held monthly. Network Adequacy remediation efforts of gaps from previous quarter are presented and discussed quarterly at a Quality Advisory Committee and presented at a high level at Contract Review Committee Meeting also held Quarterly.
- Vendor liaisons meet with vendors at least once monthly to review open issues, gaps, and data issues. The vendor liaisons are required to be part of the Government Products Monthly Network Adequacy Status Review meeting and are part of gap reviews.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Updated provider demographic information online and paper print directories.

c. Identify any barriers to implementing initiatives:

- Provider's failure to notify BCBSIL of changes in their demographic information.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continue to review reports and work with staff on ways to overcome barriers to closure of gaps.

HSAG Assessment

4. Prior Year Recommendation from the EQR Technical Report for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct root cause analyses or focus studies to determine why adult members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.
- Determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

In a network analysis for the BCCHP network, BCBSIL was adequate in all counties for all specialties except for the following: OB/GYN in Jo Daviess; Endocrinology in Rock Island; and Infectious disease in Vermilion. BCBSIL was inadequate for Hospitals in the following counties of Champaign and Vermilion. In addition, BCBSIL was inadequate for Pharmacy in Grundy.

- Outreached to UnityPoint to close the Rock Island endocrinology gap, as their website indicates they have two endocrinologists that would close this gap but are not included in our current roster. Our Provider Network Consultants have requested an updated roster.
- Outreached to Genesis Health and they are reviewing an all products contract. They have one endocrinologist who would close the gap.
- Based on the Quest target reports, there were no OBGYN's within Jo Daviess County. We are in contract discussions with Medical Associates in Dubuque and SSM Health for Monroe Clinic in Stephenson County to close this gap.

Additionally, pursuing contracting opportunities for improvement via feedback from our Care Coordination interactions with our members.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- BCBSIL has identified providers in Rock Island for the Endocrinology gap and the Vermilion Infectious disease gap. Since 2021, BCBSIL identified a provider in Grundy County and the Pharmacy gap is now closed.

c. Identify any barriers to implementing initiatives:

- BCBSIL has been unable to identify a provider in Jo Daviess County to fill the OB/GYN gap that is willing to sign a contract.
- COVID-19 has remained the major barrier for both Medicaid and MMAI. Members are hesitant to go for in-person visits, affecting both adults and children. Accessibility barriers occurred due to limited office hours or office closures due to COVID-19. Provider offices are experiencing a staff shortage with some offices employing traveling nurses to staff the quality position.

d. Identify strategy for continued improvement or overcoming identified barriers:

- In areas in which our network is deemed adequate we continue to pursue opportunities for improvement via feedback from our Care Coordinators' interactions with our members. If a member prefers a provider or received care in the past by a provider not currently contracted in our network, our Care Coordinator team will refer that information to the Provider Network team to begin recruitment. The Provider Network team will also arrange for a Letter of Agreement with a non-contracted provider to maintain continuity of care for

the member.

Furthermore, based on the CAHPS results analysis conducted, we identified that of the eligible adult members who completed the CAHPS survey, Asian members scored 12.9% lower compared to White members for the response of "Getting Care Quickly" followed by Hispanic at 2.7% lower and African American members at 1.7% lower than White members. For the response of "Getting Needed Care," Asian members scored 25.5% lower than White members followed by African American members at 9.1% lower and Hispanic members at 5.5% lower than White members. A geography analysis revealed members residing in Chicago's South/Southwest region and in the City of Chicago scored lower in both categories of "Getting Care Quickly" and "Getting Needed Care" when compared to Chicago North/Northwest members

Adult CAHPS Results				
CAHPS Survey Response Based on Race	**White**	**African American**	**Hispanic**	**Asian**
Getting Care Quickly *(% Always/Usually)*	80.70%	79.00%	78.00%	67.80%
Getting Needed Care *(% Always/Usually)*	83.30%	74.20%	77.80%	57.80%
CAHPS Survey Response Based on Geography	**City of Chicago***	**Chicago South/Southwest***	**Chicago North/Northwest**	[redacted]
Getting Care Quickly *(% Always/Usually)*	76.90%	74.50%	95.50%	
Getting Needed Care *(% Always/Usually)*	75.10%	76.50%	85.00%	

*Top 10 DIA Zip Codes Chicago South/Southwest for CAHPS: 60425, 60429, 60432, 60433, 60436, 60458, 60438, 60428, 60827 and 60472
*Top 10 DIA Zip Codes for City of Chicago for CAHPS: 60620, 60621, 60624,60619, 60623, 60626, 60628, 60617, 60827 and 60649

We will continue to evaluate Geo-Access along with grievances to assess geographical distribution of PCPs and specialists. Next year, BCBSIL will incorporate the CAHPS interventions based on qualified Disproportionately Impacted Area (DIA) Zip Codes.

HSAG Assessment

Recommendation

HSAG recommended the following for child CAHPS:

- Conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care child members need.
- Evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill

gaps or evaluate why providers may not want to participate with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

- Of the eligible child members who had a completed the CAHPS survey, Asian members scored 24.3% lower compared to African American members for the response of "Getting Care Quickly" followed by White at 3.6% lower and Hispanic members at 3.3% lower than African American members. For the response of "Getting Needed Care," Asian members scored 25.9% lower compared to African American members followed by Hispanic members at 10.2% lower and White members at 3.8% lower than African American members. A geography analysis revealed members residing in the City of Chicago and Chicago North/Northwest side scored lower in both categories of "Getting Needed Care" and "Getting Care Quickly" compared to Chicago South/Southwest side members.

Child CAHPS				
CAHPS Survey Response based on Race	**White**	**African American**	**Hispanic**	**Asian**
Getting Care Quickly (% Always/Usually)	80.70%	84.30%	81.00%	60.00%
Getting Needed Care *(% Always/Usually)*	82.50%	86.30%	76.10%	60.40%
CAHPS Survey Response Based on Geography	**City of Chicago***	**Chicago South/Southwest***	**Chicago North/Northwest**	
Getting Care Quickly (% Always/Usually)	74.50%	87.60%	77.50%	
Getting Needed Care *(% Always/Usually)*	72.10%	82.90%	73.00%	

*Top 10 DIA Zip Codes Chicago South/Southwest for CAHPS: 60425, 60429, 60432, 60433, 60436, 60458, 60438, 60428, 60827 and 6

*Top 10 DIA Zip Codes for City of Chicago for CAHPS: 60620, 60621, 60624,60619, 60623, 60626, 60628, 60617, 60827 and 60

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Interventions pertaining to the CAHPS survey include analyzing the results, comparing them with to previous years and working with our internal partners such as Provider Network, Care Coordination, Appeals & Grievance, Pharmacy and Utilization Management to develop initiatives.

c. Identify any barriers to implementing initiatives:

- COVID-19 has remained the major barrier for both Medicaid and MMAI. Members are hesitant to go for in-person visits, affecting both adults and children. Accessibility barriers occurred due to limited office hours or office closures due to COVID-19. Provider offices are experiencing a staff shortage with some offices employing traveling nurses to staff the quality position.

d. Identify strategy for continued improvement or overcoming identified barriers:

- We will continue to evaluate Geo-Access along with grievances to assess geographical distribution of PCPs and specialists. Next year, BCBSIL will incorporate the CAHPS interventions based on qualified Disproportionately Impacted Area (DIA) Zip Codes.

HSAG Assessment

5. Prior Year Recommendation from the EQR Technical Report for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.

Response

a. Describe initiatives implemented based on recommendations:

- Reviewed and updated care coordination training to include order of outreach to the POA/Guardian or other identified key support people if the member is not able to be reached. Process updates also included appropriate documentation to evidence any barriers to reaching the member, active POA, Guardian or identified ICT participants. Trainings occurred for the updated outreach process for critical incident monitoring in April 2021 with refresher training in September and December 2021.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Documentation now evidences who the care coordinator spoke to and why if it is other than the member.

c. Identify any barriers to implementing initiatives:

- No barriers identified.

d. Identify strategy for continued improvement or overcoming identified barriers:

- The LTC/SLP team maintains regular refresher trainings which include outreach process for monitoring critical incidents. This is part of the standard process and evidenced within clinical documentation.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Consider revising processes for communication with the investigating authority to align with the external entity's communication requirements and provide training to staff members on their process for conducting follow-up with the investigating authority after an initial CI report has been made.

Response

a. Describe initiatives implemented based on recommendations:

- BCBS's process is to follow up with the investigating authority within 15 calendar days which was the timeframe in place prior to the external policy being shared with the MCOs. This 15 -day timeframe was discussed with the former Director of APS who was satisfied with our process since the APS policy indicates within 20 calendar days. All staff were trained on this process in June 2020.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- NA

c. Identify any barriers to implementing initiatives:
- No barriers identified.

d. Identify strategy for continued improvement or overcoming identified barriers:
- The Critical Incident Team provides critical incident training to all new hires and provides annual refresher trainings to all staff. Ad Hoc trainings are also offered for any identified training needs around critical incidents.

HSAG Assessment

6. Prior Year Recommendation from the EQR Technical Report for HCBS Waiver Performance Measures:

Recommendation

HSAG recommended the following for Measure 4A, *overdue service plan was completed within 30 days of expected renewal*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans.
- Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

Response

a. Describe initiatives implemented based on recommendations:
- Performance Measure 4A was retired effective Q1 SFY 2022. Our Internal Auditing Team enhanced its process to include additional focus audits for this measure.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- During SFY 2021 the overall Service plan completion rate was steady with all lines of business averaging 90% or higher.

c. Identify any barriers to implementing initiatives:
- Timely completion of Service Plans left BCBS with a lower rate of applicable members for the audit with Performance Measure 4A.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Quarterly, annually along with induvial continued training for our Care Coordination staff on Service Plan completion.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with

care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Based off the system enhancement implementation of the PA activity code, an oversight process was created. Unit Managers review Care Coordination reports to identify any PA activity. Unit Managers monitor the report for any late activity.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance Measure 12C was added effective Q1 SFY 2021. In SFY 2022, the available data for analysis was small. With all Lines of Business having a count of 17 and under.
c. Identify any barriers to implementing initiatives: • None, with this Performance Measure being introduced during SFY 2021 BCBS welcomed the feedback and guidance from HSAG.
d. Identify strategy for continued improvement or overcoming identified barriers: • Quarterly, annually along with induvial continued training for our Care Coordination staff on timely completion of the PA Evaluation.
HSAG Assessment
N/A; newly implemented and small data set.
Recommendation
HSAG recommended the following for Measure 20C, *a PA evaluation was completed annually*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Our Internal Auditing Team enhanced its process to include additional focus audits for this measure. The LTSS team during the claims process review, using WebCM, will identify any members with multiple PA's. Unit Manager oversight process of the Care Coordination reports to identify upcoming members due for annual completion.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance Measure 20C was added effective Q1 SFY 2021. From Q1 SFY 2022 to Q3 2022 all Lines of Business have showed stable progress with MLTSS and HealthChoice statistically improving by several points.
c. Identify any barriers to implementing initiatives: • None, with this Performance Measure being introduced during SFY 2021 BCBS welcomed the feedback and guidance from HSAG.
d. Identify strategy for continued improvement or overcoming identified barriers:

- Quarterly, annually along with individual continued training for our Care Coordination staff on timely completion of the PA Evaluation.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- Conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

Response

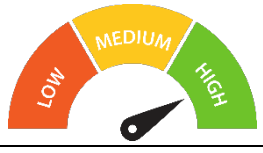
a. Describe initiatives implemented based on recommendations:
   - System enhancement implemented of the required Activity code. Unit Manager oversight process with an in-depth review of the Care Coordination reports on how to identify upcoming contact activities. Unit Managers also monitor the report for any late activity. The Unit Manager will have a one-on-one coaching session with any Care Coordination staff showing signs of low performance within the required activities. Along with additional and continuous oversight and monitoring of the weekly caseload report by Management.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - CY 2022 Q3 closed out with BCBS showing additional improvement with the HIV/TBI waiver population on Performance Measure D6 with an 80% or higher for all Lines of business.

c. Identify any barriers to implementing initiatives:
   - Staffing changes

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Quarterly training for the Care Coordination staffs on this Performance Measure along with use of Valid Justification. Dedicated HIV/TBI annual waiver training for all staff that manage the HIV/TBI population. This training also includes a peer-to-peer question/answer/suggestion/workflow session.

HSAG Assessment



CountyCare

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Review PIP Module 4 and Module 5 instructions and Rapid-Cycle PIP Reference Guide. • Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. • Consider testing more than one intervention during the duration of the PIP. This will help the health plans address additional identified opportunities for improvement and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project.
Response
a. Describe initiatives implemented based on recommendations: • Performance Improvement Workgroups (Pillars 1 and 2) were initiated focused on Adult and Children's Behavioral Health with short-term and long-term interventions planned as part of the work plan based on best practices, evidence-based guidelines, and root cause analysis. • Performance Improvement Workgroup leaders and participants were trained in quality improvement methodology and PDSA cycles implementation (all PIW groups). • CountyCare hired a Behavioral Health Program Manager to focus on performance improvement initiatives specific to these populations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Though the Behavioral Health focused PIP is no longer active, CountyCare continues to track performance on these measures as part of its Pillar 1 & Pillar 2 Performance Improvement Workgroups (BH PIWs). The BH PIWs are responsible for the ongoing implementation and testing of interventions designed to positively impact these metrics. • From MY2019 to MY2020, CountyCare observed a 1.35% improvement in FUH, though the MY2020 rate of 42.15% did not meet the goal target of 50%. • Due to the barriers noted below, CountyCare observed a 1.0% decrease in its rate in MY2021 as compared to MY2020. The final rate of 41.15% in MY2021 still marked a sustained improvement as compared to the MY2019 rate of 40.80%.
c. Identify any barriers to implementing initiatives: • CountyCare experienced frequent staffing turnover in positions key to the work of the Adult and Children's Behavioral Health Performance Improvement Workgroups (Pillars 1 and 2) making it difficult to sustain improvement initiatives without disruption and delays. • CountyCare experienced changes in key systems related to the tracking of BH crises and BH utilization. • Due to the highly confidential nature of Behavioral Health diagnoses, BH diagnoses and care information is often redacted or removed from reporting. CountyCare has experienced barriers with identifying adult BH admissions and is working to analyze utilization data more effectively to allow for timely engagement with members following a BH ED visit or inpatient admission.
d. Identify strategy for continued improvement or overcoming identified barriers: • CountyCare implemented the HealthChoice Illinois ADT platform, Collective Medical Technology, significantly expanding real-time ADT alerts received for its members. Integration of ADT alerts and use

of this data has been prioritized for CMEs and staff responsible for following up with members experiencing a transition of care.

HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members ages 65 with opioid use disorder are not receiving or adhering to pharmacotherapy treatment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.

Response

a. Describe initiatives implemented based on recommendations:
- CountyCare participates in an annual HEDIS audit process which validates significant changes in performance rates or eligible member population.
- Data for the HEDIS Pharmacotherapy for Opioid Use Disorder (POD) measure was provided to CountyCare's pharmacy team who completed further analysis to determine what barriers exist for members while initiating or sustaining substance use treatment for opioid use disorders.
- Performance Improvement Workgroup leaders completed segmentation analysis of P4R measures. Any identified disparities or notable trends as a result of segmentation analysis, were addressed through revision of Performance Improvement Workgroups interventions and/or work plans.
- CountyCare's Pharmacy team works to make MAT treatment options more widely available and provide regular education to providers and CME staff supporting members with substance use disorders.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- CountyCare reported on HEDIS Pharmacotherapy for Opioid Use Disorder (POD) measure for MY2020 and MY2021. Improvements was noted for members 65+ with a rate of 25.81% in MY2020 compared to a rate of 33.04% for this population in MY2021.

c. Identify any barriers to implementing initiatives:
- The ongoing COVID-19 pandemic made it more difficult for members to initiate and adhere to substance use treatment options, such as Medication Assisted Treatment (MAT) and other treatment options since more frequent visits are required during the initiation of treatment for patient safety and quality of care.
- CountyCare's HEDIS Pharmacotherapy for Opioid Use Disorder (POD) measure had a relatively small denominator, potentially skewing performance results and changes in performance year-over-year.
- Members with co-morbid severe mental illness and substance use disorders are often difficult to contact making consistent member engagement challenging.

d. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare will work to continue to expand telehealth options, especially for behavioral health services.
- CountyCare will continue to work to mitigate other consistently identified barriers, like transportation, to minimize obstacles for members.

HSAG Assessment

Recommendation

HSAG recommended the following for *Follow-Up After Hospitalization for Mental Illness*:

- Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions.
- Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:

- Performance Improvement Workgroups (PIWs) were initiated for Pillars 1 & 2 (Adult and Children's Behavioral Health) with short-term and long-term interventions put into work plan based on best practices, evidence-based guidelines, and root cause analysis.
- The PIWs for Pillars 1 & 2 completed a thorough assessment of barriers and root cause analysis related to performance below goal targets.
- CountyCare expanded and promoted BH telehealth services as an alternative option for members, especially with ongoing barriers of COVID-19 pandemic and impacts of social determinants of health.
- CountyCare completed an analysis of BH hospitalizations (adult and child) to determine high volume facilities and revised care management workflow with identified high volume hospitals. CountyCare continues to work to improve workflow for high volume facilities in DIA areas with CME partners.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- From MY2019 to MY2020, CountyCare observed a 1.35% improvement in Follow-up After Hospitalization for Mental Illness, though the MY2020 rate of 42.15% did not meet the goal target of 50%.
- Due to the barriers noted below, CountyCare observed a 1.0% decrease in its rate in MY2021 as compared to MY2020. The final rate of 41.15% in MY2021 still marked a sustained improvement as compared to the MY2019 rate of 40.80%.

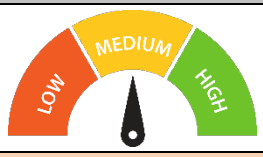
c. Identify any barriers to implementing initiatives:

- Due to the highly confidential nature of Behavioral Health diagnoses, BH diagnoses and care information is often redacted or removed from reporting. CountyCare has experienced barriers with identifying adult BH admissions and is working to analyze utilization data more effectively to allow for timely engagement with members following a BH ED visit or inpatient admission.
- Due to the highly confidential nature of Behavioral Health diagnoses, BH diagnoses and care information is often redacted or removed from reporting. CountyCare has experienced barriers with identifying adult BH admissions and is working to analyze utilization data more effectively to allow for timely engagement with members following a BH ED visit or inpatient admission.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Due to the highly confidential nature of Behavioral Health diagnoses, BH diagnoses and care information is often redacted or removed from reporting. CountyCare has experienced barriers with identifying adult BH admissions and is working to analyze utilization data more effectively to allow for timely engagement with members following a BH ED visit or inpatient admission.
- PIWs for Pillars 1 & 2 will continue to plan and implement interventions aimed at reducing identified disparities and improving overall performance on this measure.
- Discovery – additional telehealth BH services

HSAG Assessment



Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast cancer and chlamydia. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.

Response

a. Describe initiatives implemented based on recommendations:

- CountyCare distributes quarterly care gaps lists and HEDIS performance reports to provider groups and CMEs to facilitate proactive addressing of member care gaps.
- CountyCare developed a breast cancer screening resource guide, published on CountyCare's website, to streamline access for mammography services and to serve as a reference for members.
- CountyCare continuously assesses barriers to accessing routine and preventive care services and works to address barriers as identified.
- In 2021, CountyCare hosted a health fair at Provident Hospital for members residing in DIA zip codes to offer an alternative option for receiving some preventive care services (including breast cancer screening) and is planning another health fair at Provident Hospital in 2022.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- CountyCare's rate for Breast Cancer Screening in MY2020 was 53.50%; a slight decrease in MY2021 was observed with a final rate of 50.89%.
- CountyCare's total rate for Chlamydia Screening in Women in MY2020 was 61.61% and performance on this screening measurement remained fairly consistent with a rate of 61.37% in MY2021.

c. Identify any barriers to implementing initiatives:

- Provider groups continue to juggle many competing priorities as they work to address acute needs of members and work with reduced access/capacity due to staffing shortages and the ongoing impact of COVID-19 pandemic.
- Some CountyCare members experience long wait times for mammography services since there are some regions of Cook County with more limited options for mammography services, though all network adequacy and access standards are met.

d. Identify strategy for continued improvement or overcoming identified barriers:

- CountyCare will continue to provide proactive, regular distribution of care gaps worklists throughout the

year to provider groups and CMEs.

- CountyCare offers member incentives for mammography completion. The member incentive increased in 2022 because of planning that occurred based on results in FY22.
- Text messaging outreach is planned for November to promote the completion of preventive services including breast cancer screening. CountyCare continues to work to be more interactive with education to ensure communications are engaging to target key populations.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why its members are not receiving timely screenings for diabetes and if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

- CountyCare distributes quarterly care gaps lists and HEDIS performance reports to provider groups and CMEs to facilitate proactive addressing of member care gaps.
- CountyCare implemented a self-management program with Canary Telehealth targeting members with asthma, diabetes, hypertension and/or obesity. This program provides support to members offering education on daily health habits and for the management of their condition(s).
- CountyCare offers home blood pressure monitoring devices regularly to members as durable medical equipment to support effective chronic disease management.
- CountyCare continuously assesses barriers to accessing routine and preventive care services and works to address barriers as identified.
- In 2021, CountyCare hosted a health fair at Provident Hospital for members residing in DIA zip codes to offer an alternative option for receiving some preventive care services (including blood pressure and Hemoglobin A1c screening) and is planning another health fair at Provident Hospital in 2022.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For Comprehensive Diabetes Care Hemoglobin A1c Control (< 8.0%), CountyCare's rate of 21.28% in MY2020 improved to 33.54% in MY2021.
- For Comprehensive Diabetes Care Blood Pressure Control (< 140/90), CountyCare's rate of 10.89% in MY2020 improved to 22.23% in MY2021.
- For Controlling Blood Pressure, CountyCare showed a decline in rate of control from MY2019 to MY2020, going from 50.12% in MY2019 to 43.80% in MY2020. This decline is likely due to the impact of the COVID-19 pandemic. In MY2021, CountyCare's rate improved by 1.70% to 45.50%.

c. Identify any barriers to implementing initiatives:

- Provider groups continue to juggle many competing priorities as they work to address acute needs of members and work with reduced access/capacity due to staffing shortages and the ongoing impact of COVID-19 pandemic.
- Members may have a lack of awareness or understanding of steps needed to effectively manage their chronic conditions.

- Members may be more hesitant to access preventive or maintenance care due to the ongoing COVID-19 pandemic.

d. Identify strategy for continued improvement or overcoming identified barriers:

- CountyCare will continue to provide proactive, regular distribution of care gaps worklists throughout the year to provider groups and CMEs to support effective management of chronic conditions.
- CountyCare offers member incentives for Hemoglobin A1c monitoring to support member engagement with self-management of chronic conditions.
- Text messaging outreach is planned for November to promote the completion of preventive services including access to primary care services and the management of diabetes and hypertension. CountyCare continues to work to be more interactive with education to ensure communications are engaging to target key populations.
- Supplemental data – address more proactively

HSAG Assessment

3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy

Recommendation

HSAG recommended the following to improve the accuracy of provider directories:

- Follow the contract requirements and internal processes to verify the accuracy of the online provider directory.
- Conduct telephone surveys to validate the information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys.
- Conduct outreach to their providers to ensure they collect updated information on all service indicators. Provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.

Response

a. Describe initiatives implemented based on recommendations:

- PDM performs multiple Quality Checks throughout process to ensure data aligns accurately with what has been submitted on rosters. We have an application (Roster Management Tool or RMT) which identifies missing required fields, does formatting, and checks for inconsistent data. Our BI tool also performs QA checks and bounces against state file, NPPES. Once data transfers from BI to Aldera there additional QA checks.
- Developed and implemented ongoing FAP reviews. PDM selects 100 random providers each month to perform telephone surveys to ensure demographic data is accurate. We are developing process for PR to do a similar review with regards to appointment wait times and to capture why providers may not be able to meet the standard.
- CCH provider manual requires comprehensive rosters quarterly and our messaging to providers via email, newsletter, online notices all include same messaging. This is also included in PR meeting agendas as a regular item.
- CCH has implemented new QBR sessions with our top groups to review their roster data and CCH PDM

is working with those who put the rosters together to ensure accurate submission and alignment with roster data.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Our annual directory accuracy audit showed significant improvement over last years; most increasing their score by 40+ percentage points and aligning in the 90% range for accuracy.
c. Identify any barriers to implementing initiatives: • Getting accurate roster data. We find that most groups require a lot of education on how to submit data to get outcomes they are expecting.
d. Identify strategy for continued improvement or overcoming identified barriers: • QBR's initiated with our supergroups is proving to be a good format that we will be automating over the next year so we can offer these type of reviews for all groups. CCH PDM will be hosting roster summits to review commonly seen roster issues and allow for questions to be reviewed in a live format.
HSAG Assessment

Recommendation
HSAG recommended the following for provider network time/distance standards: • Examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers. • Notify HFS within five business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis. • Work with contracted providers (i.e., dental and pharmacy) to ensure vendor provider data are accurate and complete.
Response
a. Describe initiatives implemented based on recommendations: • CountyCare has met, and continues to meet, all time and distance standards for each provider type, including BH and non-BH practitioners. CountyCare performs a network adequacy assessment quarterly utilizing Quest Analytics software. Further, as of 9/1/2022, CountyCare added 100+ urgent care facilities to its network and added an urgent care provider which performs in-home services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
d. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment


Recommendation
HSAG recommended the following: • Implement a process to annually evaluate enrollee access to provider time-specific appointments, conduct an annual after-hours survey to evaluate provider compliance with after-hours access for enrollees, develop and implement a process to monitor provider compliance with PCP panel requirements, and implement a process to ensure accurate provider directory information.
Response
a. Describe initiatives implemented based on recommendations: • CountyCare has an established process to evaluate both PCP and specialist open and closed panels on a quarterly basis and this information is then shared with the CountyCare Quality Improvement Committee (QIC) also on a quarterly basis. Open and closed panel data is reviewed against data from previous quarters to identify noteworthy changes although this occurs very infrequently if at all.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CountyCare recently implemented a process/data change to default OB/GYN practitioners as PCPs which should result in an increase to the overall number of open PCP panels.
c. Identify any barriers to implementing initiatives: • N/A
d. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
N/A; new implementation.
4. Prior Year Recommendation from the EQR Technical Report for CAHPS:
Recommendation
HSAG recommended the following for adult CAHPS: • Conduct root cause analyses or focus studies to determine why adult members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need. • Determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.
Response
a. Describe initiatives implemented based on recommendations: • CountyCare implemented a CAHPS Workgroup that includes leaders from key departments. This multi-disciplinary team continues to work on interventions that address the root causes of areas of low performance. • The Network team at CountyCare participates in the CAHPS Workgroup and has worked to fill gaps in specialty care, including contracting with additional urgent care centers to increase access for CountyCare members. • The CAHPS Workgroup analyzes CAHPS results, including population segmentation, to identify areas of low performance and to develop interventions to achieve set goals for improvement. The CAHPS Workgroup initiatives target populations with identified lower performance or response rates.

- CountyCare prioritizes meetings with supergroups and reviews population segmentation analysis and results by supergroup, as well as identified interventions for improvement with categories with low scores/rates.
- CountyCare provides ongoing education to CM teams on CAHPS, educating on CAHPS rates and questions, as well as identified areas for improvement.
- CountyCare meets with the Customer Service team at least annually and educates them on the CAHPS survey, CAHPS rates and questions, as well as identified areas for improvement.
- The Network team completed a survey to assess access standards being upheld/met by provider groups.
- CountyCare met with Cook County Health to identify discuss improvement to access for specialty services (next available appointment timeframe) and PCP engagement to ensure members are able to access care in a timely manner.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The 2022 Adult CAHPS survey results showed improvement in three categories: Customer Service, Coordination of Care, and Rating of Specialist.
- CountyCare did not observe an improvement in the percentile ranking of Getting Needed Care or Rating of Health Care, as both remained at the 10th percentile consistent with the 2021 Adult CAHPS survey.
- Getting Care Quickly performance declined from the 10th percentile in 2021 to <10 percentile in 2022. This may be due to ongoing access challenges related to the COVID-19 pandemic which has been impacted national staffing shortages.

c. Identify any barriers to implementing initiatives:
- Members continue to have inaccurate contact information as an ongoing impact of public health emergency and the COVID-19 pandemic.
- Observed ongoing access issues with providers in the network with routine and urgent PCP appointments due to staffing shortages and the impact of the ongoing pandemic as providers work to address vaccination and acute issues as priorities.
- Members may be more hesitant to access preventive or maintenance care due to the ongoing COVID-19 pandemic.
- CountyCare received reports that some CountyCare members experience long wait times for mammography and colonoscopy services since there are some regions of Cook County with more limited options for these screening services, though all network adequacy and access standards are met.

d. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare will continue to provide ongoing education to care management staff, provider groups, and customer service staff on the CAHPS survey, questions, and performance to foster collaboration on identified opportunities for improvement.
- CountyCare will continue to assess access and availability in its network, mitigating any areas of deficiency.
- CountyCare's CAHPS Workgroup will continue to analyze CAHPS results and develop a comprehensive set of interventions to support optimal performance on the adult CAHPS survey.
- Contract with additional urgent care, communicate
- Survey to go out to members related to member satisfaction related to topics from CAHPS survey
- CountyCare analyzes CAHPS supplemental questions to identify specialty areas of concerns where member-reported access concerns exist; the CAHPS workgroup is responsible for addressing these identified opportunities for improvement.

HSAG Assessment

Recommendation

HSAG recommended the following for child CAHPS:

- Conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care child members need..
- Evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill gaps or evaluate why providers may not want to participate with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

- CountyCare implemented a CAHPS Workgroup that includes leaders from key departments. This multi-disciplinary team continues to work on interventions that address the root causes of areas of low performance.
- The Network team at CountyCare participates in the CAHPS Workgroup and has worked to fill gaps in specialty care, including contracting with additional urgent care centers to increase access for CountyCare members.
- The CAHPS Workgroup analyzes CAHPS results, including population segmentation, to identify areas of low performance and to develop interventions to achieve set goals for improvement. The CAHPS Workgroup initiatives target populations with identified lower performance or response rates.
- CountyCare prioritizes meetings with supergroups and reviews population segmentation analysis and results by supergroup, as well as identified interventions for improvement with categories with low scores/rates.
- CountyCare provides ongoing education to CM teams on CAHPS, educating on CAHPS rates and questions, as well as identified areas for improvement.
- CountyCare meets with the Customer Service team at least annually and educates them on the CAHPS survey, CAHPS rates and questions, as well as identified areas for improvement.
- The Network team completed a survey to assess access standards being upheld/met by provider groups.
- CountyCare met with Cook County Health to identify discuss improvement to access for specialty services (next available appointment timeframe) and PCP engagement to ensure members are able to access care in a timely manner.
- CountyCare analyzes CAHPS supplemental questions to identify specialty areas of concerns where member-reported access concerns exist; the CAHPS workgroup is responsible for addressing these identified opportunities for improvement.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The 2022 Child CAHPS survey results showed improvement in four categories: Getting Needed Care, Customer Service, Rating of Health Care, and Rating of Health Plan.

- In 2022, CountyCare observed improvements in the percentile rankings of Getting Needed Care and Rating of Health Care. Getting Needed Care improved from the <10 percentile in 2021 to the 10th percentile in 2022. Rating of Health Care improved from the 10th percentile in 2021 to the 33rd percentile in 2022.
- Getting Care Quickly performance did not improve in 2022 and remains at <10th percentile. This may be due to ongoing access challenges related to the COVID-19 pandemic which has been impacted national staffing shortages.

c. Identify any barriers to implementing initiatives:
- Members continue to have inaccurate contact information as an ongoing impact of public health emergency and the COVID-19 pandemic.
- Observed ongoing access issues with providers in the network with routine and urgent PCP appointments due to staffing shortages and the impact of the ongoing pandemic as providers work to address vaccination and acute issues as priorities.
- Members may be more hesitant to access preventive or maintenance care due to the ongoing COVID-19 pandemic.

d. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare will continue to provide ongoing education to care management staff, provider groups, and customer service staff on the CAHPS survey, questions, and performance to foster collaboration on identified opportunities for improvement.
- CountyCare will continue to assess access and availability in its network, mitigating any areas of deficiency.
- CountyCare's CAHPS Workgroup will continue to analyze CAHPS results and develop a comprehensive set of interventions to support optimal performance on the child CAHPS survey.

HSAG Assessment

5. Prior Year Recommendation from the EQR Technical Report for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.

Response

a. Describe initiatives implemented based on recommendations:
- CountyCare resumed in-person visits with members in nursing homes and SLP facilities in July 2022 to help overcome the challenges of reaching this population by phone.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- SLP member contacts improved from 76% in Q2 to 82% in July 2022
- Nursing facility member contacts improved from 56% in Q2 to 73% in July 2022

c. Identify any barriers to implementing initiatives:
- Delays by union in union staff returning to field visits

d. Identify strategy for continued improvement or overcoming identified barriers:
- Ongoing negotiations with the union to ensure all care coordinators are routinely seeing facility members

in-person.
- CI refresher training occurs at minimum, annually, with the team.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Revise provider agreements and conduct provider training on identification and reporting of ANE/CIs. Consider revision of processes for communication with the investigating authority to align with the external entity's communication requirements.

Response

a. Describe initiatives implemented based on recommendations:
- Have set up recurring bi-weekly meetings with CMEs to discuss opening CI's.
- Continue to provide training to CME management on outreach expectation to any involved IA. Will conduct on-site training with any CME that requires additional training/outreach from health plan.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- HSW team has seen a continued increase in the amount of CI's reported from all CME's and within the health plan.

c. Identify any barriers to implementing initiatives:
- N/A

d. Identify strategy for continued improvement or overcoming identified barriers:
- HSW team will continue providing training and feedback to CME's/health plan related to the reporting and follow up of ANE.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Consider revising processes for communication with the investigating authority to align with the external entity's communication requirements and provide training to staff members on their process for conducting follow-up with the investigating authority after an initial CI report has been made.

Response

a. Describe initiatives implemented based on recommendations:
- Continue to provide training to CME management on outreach expectation to any involved investigative authority.
- Have begun working on self-paced video that can be accessed for additional training by staff/management that includes information regarding outreach requirements to investigative authorities

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Increased outreach to IA's has been noted in case manager's documentation.

c. Identify any barriers to implementing initiatives:
- Investigative authorities are not always providing updates to Care Coordinators at the time of follow up due either to assigned investigator being unable to be reached, or having had a different Care Coordinators make the initial referral to the IA.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Care Coordinators will continue to make minimum required outreaches to IA in attempt to receive updates.

HSAG Assessment

6. Prior Year Recommendation from the EQR Technical Report for HCBS Waiver Performance Measures:

Recommendation

HSAG recommended the following for Measure 4A, *overdue service plan was completed within 30 days of expected renewal*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans.
- Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

Response

a. Describe initiatives implemented based on recommendations:
- In July 2021, the health plans were notified that Performance Measure 4A was discontinued.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- NA

c. Identify any barriers to implementing initiatives:
- NA

d. Identify strategy for continued improvement or overcoming identified barriers:
- NA

HSAG Assessment

NA

Recommendation

HSAG recommended the following for Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations.

• Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • The health plans were notified that Performance Measure 12C was discontinued effective Q3 FY2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NA
c. Identify any barriers to implementing initiatives: • NA
d. Identify strategy for continued improvement or overcoming identified barriers: • NA
HSAG Assessment
NA
Recommendation
HSAG recommended the following for Measure 20C, *a PA evaluation was completed annually*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Performance measure 20C was a new measure beginning in 2021. Training/re-training was needed with staff around this expectation and new audit item.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance has improved from 75% in 2021 to 83% in 2022 as a result of retraining
c. Identify any barriers to implementing initiatives: • NA
d. Identify strategy for continued improvement or overcoming identified barriers: • Ongoing refreshers and reminders to ensure staff are completing the evaluation on every PA involved in care.
HSAG Assessment

Recommendation
HSAG recommended the following for Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*: • Conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure.

- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

Response

a. Describe initiatives implemented based on recommendations:
- CountyCare performs well for HIV and BI contact metrics averaging in the mid-high 80 percentile and continues to improve achieving 92% for the July 2022 enrollee engagement report.
- CountyCare transitioned to a new care management system, CMIS, on 1/31/2022, which offers better tracking and monitoring mechanisms for care management activity (including contacts) than the prior system.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- TBI – CY2021 averaged 85%; CY2022 thru July is 89%
- HIV – CY2021 averaged 81%; CY2022 thru July is 87%

c. Identify any barriers to implementing initiatives:
- No barriers

d. Identify strategy for continued improvement or overcoming identified barriers:
- A system enhancement was made in September 2022 to highlight on the Care Coordinator's Dashboard which members are due to be contacted each month.
- Hiring additional care coordinators

HSAG Assessment

Humana

1. Prior Year Recommendation from the EQR Technical Report for Network Adequacy
Recommendation
HSAG recommended the following to improve the accuracy of provider directories: • Conduct biannual audits to improve the accuracy of the health plan's provider directory.
Response
a. Describe initiatives implemented based on recommendations: • Humana conducts ongoing review and verification of provider contact and location information that displays in the MMAI directory with the goal of contacting each provider to verify their information a minimum of 2 times per year.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Quality audits Humana has conducted based on sampling indicate that Humana's MMAI directory was 3.6% less accurate in Q1 2022 that it was in Q3 2021, the most recent data available.
c. Identify any barriers to implementing initiatives: • Providers tend to submit incorrect data in their roster updates. The primary error types for the audited fields are; 1) providers listed at locations where they do not regularly work and accept appointments and 2) incorrect phone numbers for appointment scheduling. Due to requirements governing the timely loading of the roster update information once received, Humana is unable to identify the errors until after the data is loaded and displaying in the directory. Generally speaking, providers are resistant to change how they manage their roster data to improve accuracy, shifting the responsibility for directory data accuracy largely to the Plan.
d. Identify strategy for continued improvement or overcoming identified barriers: • Humana will sustain its provider outreach and verification processes to identify as many directory errors as possible for correction. Additionally, Humana has and is collaborating with other health plans in various initiatives to develop industry solutions to improve directory accuracy. Humana is also engaged with CMS to provide input on initiatives CMS has considered and is considering facilitating a solution for the industry.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Critical Incident Monitoring:
Recommendation
HSAG recommended the following: • Consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.
Response
a. Describe initiatives implemented based on recommendations: • After this remediation (2021 Q2) staff training did occur: 1/19/22 - Staff training completed with the IL LTSS team and included a review of the CI process, incidences, and follow up expectations. 1/24/22 - Staff training completed with the LTSS & SLP teams with a focus on working with facilities to evaluate

member formal or informal supports and if they were in place during the critical incident. The HRA reassessment and POC updates were reviewed as well as expectations for follow up and documentation of findings (HSAG Critical Incident Remediation Training 1.24.22).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increased staff knowledge and noted improvement on attempts to contact the authorized representative when we have the information. This has been noted on internal audits.
c. Identify any barriers to implementing initiatives: • One barrier identified was our ability to contact members and/or their authorized representative when a CI occurred. It was difficult if a relationship with the facility was not previously created and when we were unable to complete an HRA and Plan of Care.
d. Identify strategy for continued improvement or overcoming identified barriers: • Escalate non-cooperative Supportive Living Facilities to HFS
HSAG Assessment

Recommendation
HSAG recommended the following: • Consider revising processes for communication with the investigating authority to align with the external entity's communication requirements and provide training to staff members on their process for conducting follow-up with the investigating authority after an initial CI report has been made.
Response
a. Describe initiatives implemented based on recommendations: • After this remediation (2021 Q1) staff training did occur. LTSS team trained 6/9/22. LTSS quality oversight and support for care coordinators was implemented.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Internal audits indicate timely contact with the investigating authorities.
c. Identify any barriers to implementing initiatives: • Care Coordinators reach out to APS but there are times when: 1) APS will not provide information due to client confidentiality; 2) APS caseworkers do not return calls or emails. Difficult to evaluate client status particularly if Unable to Contact. Also, there are times when client seems stable, but we can't get final communication from APS regarding status of investigation. Regarding Nursing Home neglect cases report, we do not always receive a final investigation report.
d. Identify strategy for continued improvement or overcoming identified barriers: • CI training includes reminder to follow up with investigative agency, particularly APS, in 14 days of initial report. Training also includes follow up with APS when ROS reports are received.
HSAG Assessment


Recommendation
HSAG recommended the following: • Identify potential barriers that impact staff, enrollees, and providers in identifying and reporting instances of abuse, neglect, or exploitation. The health plan should reeducate staff, enrollees, and providers on identification of abuse, neglect, and exploitation and the health plan's reporting requirements.
Response
a. Describe initiatives implemented based on recommendations: • Humana staff are trained during their initial onboarding/hiring. Also, staff are retrained/reminded in the umana annual ethics/compliance training completed early fall each year. After this remediation (2021 Q2) staff training did occur: Humana at Home 7/2/21; LTSS 6/9/22; Beacon 9/14/22. Another Critical Incident training was held Wednesday 10/5/22 with LTSS team and Beacon. HAH will have a CI review 11/5/22.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • COVID made it difficult due to suspension of in-person visits
d. Identify strategy for continued improvement or overcoming identified barriers: • Continues education on identification; members asked during care plan review to identify Abuse, Neglect & Exploitation. Face to Face visits are resuming in long term care.
HSAG Assessment

3. Prior Year Recommendation from the EQR Technical Report for HCBS Waiver Performance Measures:
Recommendation
HSAG recommended the following for Measure 4A, *overdue service plan was completed within 30 days of expected renewal*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans. • Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.
Response
a. Describe initiatives implemented based on recommendations: • Additional staff added to Process Improvement Team to increase capacity to audit records to provide quality feedback • Team Leads added to assist Operations Managers in oversight of timely completing contacts, including HRAs and POCs • Provide Operations reporting to aid in oversight of timely service plans

• Training completed with staff on 6/4/2021 & 11/10/21
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There was not noted performance when Humana brought LTSS in house beginning 1/1/21. In fact, there was a decrease in performance until the metric was discontinued.
c. Identify any barriers to implementing initiatives: • Inability to pull reporting to identify when a service plan was uploaded as an attachment.
d. Identify strategy for continued improvement or overcoming identified barriers: • System enhancements to support uploading the service cost maximum and service level plan in the Plan of Care • Reporting to capture both the Service Level Plan and the active authorization for services
HSAG Assessment
NA metric discontinued.
Recommendation
HSAG recommended the following for Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Training completed with staff on 6/4/21 & 11/10/21 • Additional staff added to Process Improvement Team to increase capacity to audit records to provide quality feedback • Team Leads added to assist Operations Managers in oversight of timely completing contacts, including annual assessments
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Humana experienced 6 findings during the Q2 SY21 audit and zero findings Q4 SY22 audit
c. Identify any barriers to implementing initiatives: • The PA evaluation is a stand-alone assessment and not part of the routine HRA or Care Plan review conducted by the Care Coordinators. It is a manual process to add the assessment on an annual basis.
d. Identify strategy for continued improvement or overcoming identified barriers: • A system enhancement to incorporate the PA assessment into the HRA if a member has a DRS waiver. • Daily staff facing reporting identifying if a PA assessment was completed
HSAG Assessment


Recommendation
HSAG recommended the following for Measure 20C, *a PA evaluation was completed annually*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Training completed with staff on 6/4/21 & 11/10/21 • Additional staff added to Process Improvement Team to increase capacity to audit records to provide quality feedback • Team Leads added to assist Operations Managers in oversight of timely completing contacts, including annual assessments
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Our findings during the quarterly record review audit have remained consistent with between 5-8 findings each audit.
c. Identify any barriers to implementing initiatives: • The PA evaluation is a stand-alone assessment and not part of the routine HRA or Care Plan review conducted by the Care Coordinators. It is a manual process to add the assessment on an annual basis.
d. Identify strategy for continued improvement or overcoming identified barriers: • A system enhancement to incorporate the PA assessment into the HRA if a member has a DRS waiver. • Daily staff facing reporting identifying if a PA assessment was completed
HSAG Assessment

Recommendation
HSAG recommended the following for Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*: • Conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. • Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement. • Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30. • Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required. • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion

with care managers/care coordinators to identify opportunities for improvement.

- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

Response

a. Describe initiatives implemented based on recommendations:
   - Training completed with staff on 6/4/21 & 11/10/21
   - Additional staff added to Process Improvement Team to increase capacity to audit records to provide quality feedback
   - Team Leads added to assist Operations Managers in oversight of timely completing contacts, including annual assessments
   - Daily Staff Facing report that is color coded to alert the CC when a contractual contact is due.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Marked improvement on this metric is realized through Humana's internal review of metrics on a monthly basis. The team timely contacts members greater than 95% of the time or has 3 or more valid attempts to contact the member before the call is due.

c. Identify any barriers to implementing initiatives:
   - Member movement between care coordinators has proven to be a barrier to making timely contacts with the member.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Better use of case level tasks and a review of the case after a new care coordinator is assigned will help to alleviate this barrier.

HSAG Assessment

4. Prior Year Recommendation from the EQR Technical Report for Contract Requirements

Recommendation

HSAG recommended the following to improve the Quality Assurance/Utilization Review/Peer Review Report:

- Establish metrics for analysis of its members' utilization of dental services.

Response

a. Describe initiatives implemented based on recommendations:
   - The Plan monitors overall member dental utilization percentage on an annual basis.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - (FY 2022: 28%, FY 2021: 30%; FY 2020 36.4%; 2019 21.9%;).

c. Identify any barriers to implementing initiatives:
   - With the expansion throughout the state, dental access has not appeared to be an issue and dental access complaints are not a major issue.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Continue to monitor annually

HSAG Assessment


Meridian

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Review PIP Module 4 and Module 5 instructions and Rapid-Cycle PIP Reference Guide. • Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. • Consider testing more than one intervention during the duration of the PIP. This will help the health plans address additional identified opportunities for improvement and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project.
Response
a. Describe initiatives implemented based on recommendations: • The initiatives implemented based on the recommendations include: o Continuing to collaborate with relevant departments o Established monthly meetings with Care Coordination and Behavioral Health • Implemented a best practices checklist, created a communication and training plan for the checklist, and generated a daily report of admissions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MMAI exceeded the goal at 50.00% compliance during the intervention testing period in the first few months of testing for members due for Follow-up After Hospitalization for Mental Illness-30 Day. There was an increase to 59.43% among Medicaid members who were discharged from Chicago Behavioral, Riveredge, or Touchette Regional Hospitals in the 6/1/19-12/31/20 timeframe.
c. Identify any barriers to implementing initiatives: • The COVID-19 global pandemic posed a challenge to initiatives as embedded Care Coordinators could no longer conduct face-to-face outreach with members. Decreased member engagement was observed due to uncertainties as a result of the pandemic, including in-person appointments and unfamiliarity with telehealth. Some hospitals were also noted to have been less responsive due to capacity and providers lacking telehealth capabilities.
d. Identify strategy for continued improvement or overcoming identified barriers: • Strategies for continued improvement to overcome identified barriers include: o Additional member-facing talking points and associated contact code to use during post-discharge outreach ▪ These strategies provide a more member-centric and personalized approach to understanding the importance of follow-up care. Strategy to mitigate staffing shortages included adding additional Care Coordinators to the PIP process for continued follow-up telephonically.
HSAG Assessment


Recommendation
HSAG recommended the following: • Review feedback from the previous modules/check-ins and review the final module instructions and Rapid-Cycle PIP Reference Guide before submitting final modules for validation to ensure approved methodology is followed.
Response
a. Describe initiatives implemented based on recommendations: • The plan reviewed feedback from previous modules and check-ins and reviewed the final module instructions and Rapid-Cycle PIP Reference Guide before submitting Module 5 of the PIP. Multiple levels of review with the necessary resources to provide a check of all submitted work.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Module 5 was submitted within the requested timeframe and all the modules passed
c. Identify any barriers to implementing initiatives: • No barriers were noted to implementing initiatives based on the HSAG recommendations.
d. Identify strategy for continued improvement or overcoming identified barriers: • In order to continue improvement, Meridian will continue to partner with relevant internal and external departments and more resources will be created for member, provider, and internal outreach education to reinforce the measure and associated timelines.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members ages 65 with opioid use disorder are not receiving or adhering to pharmacotherapy treatment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.
Response
a. Describe initiatives implemented based on recommendations: • Internal collaboration with Pharmacy Department to conduct medication non-adherence outreach
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Month over month improvement on POD for members 65+ years in 2022
c. Identify any barriers to implementing initiatives: • Members may lack access to appropriate treatment providers • Provider education on opioid use disorder pharmacotherapy treatment options
d. Identify strategy for continued improvement or overcoming identified barriers: • Ongoing internal collaboration between Departments

- Member and provider education on treatment options

HSAG Assessment

Recommendation

HSAG recommended the following for *Follow-Up After Hospitalization for Mental Illness*:

- Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions.
- Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:

- Meridian implemented the Admission, Discharge, and Transfer data feed with Collective Medical Technology to improve timeliness of hospital admission and discharge information in order for Transition of Care (ToC) activities to be readily implemented, including coordination with the hospital, and scheduling the follow up appointment
- Meridian revamped the Find A Provider tool on the Meridian website to include a checkmark if the provider offers telehealth services.
- Meridian provides a one-time incentive to members who complete the 7-day Follow-up after Hospitalization
- Offered behavioral health providers an incentive for every successful FUH visit completed

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian saw a 3% improvement in FUH rate by utilizing provider taxonomy to identify behavioral health providers
- Meridian is still assessing performance improvements from the addition of the ADT feed, Find-a-Provider updates, and member incentive impacts

c. Identify any barriers to implementing initiatives:

- Difficulty reaching members during TOC due to bad telephone numbers.
- Difficulty connecting with hospital staff while members are inpatient.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian is planning to create a webpage focused on behavioral health for members and to include a listing of the behavioral health practices that offer telehealth services to allow for increased member access
- Meridian has identified hospitals to partner with and is working to assign a single care coordinator to a hospital to improve communication and coordination.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast cancer and chlamydia. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.

Response

a. Describe initiatives implemented based on recommendations:

- Breast Cancer Screening
  - Meridian hosted wellness events for members due for a mammogram in Disproportionately Impacted Area (DIA) Zip Codes
    - Partnered with St. Bernard Hospital, University Illinois Chicago, and Southern Illinois Healthcare to host a total of five events
  - Co-hosted a Breast Cancer Awareness walk with SistaStrut and community-facing teams
  - Included Breast Cancer Awareness and self-exam tips in member e-newsletter
  - Provider education and incentive with three target rates
  - Telephonic outreach through third-party vendor
  - SMS text messaging for care gap reminders
  - Included in member incentive program
- Chlamydia Screening in Women
  - Provided care gap reminders at member wellness events targeted towards annual visits
  - Members may lack access to appropriate treatment providers
  - Provider education and incentive with three target rates
  - Women's Health and STI education included in member e-newsletters
  - SMS text messaging for care gap reminders
  - Telephonic outreach through third-party vendor
  - Included in member incentive program

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Overall success rate: 40.9% (36 members attended / 88 members scheduled)
  - Members may lack access to appropriate treatment providers

c. Identify any barriers to implementing initiatives:

- Breast Cancer Screening
  - COVID-19 continues to be a barrier for members going in for appointments
  - Call center having limited capacity to field incoming phone calls
    - Resulted in a hold in outreach and material updates
  - Low success rate for telephonic outreach

- Chlamydia Screening in Women
  - Sensitivity of measure and demographic to utilize historical methods of outreach
  - Call center having limited capacity to field incoming phone calls
    - Resulted in a hold in outreach and material update
  - Low success rate for telephonic outreach
  - COVID-19 continues to be a barrier for members attending appointments

d. Identify strategy for continued improvement or overcoming identified barriers:

- Breast Cancer Screening
  - Increase frequency of member wellness events and continue to target high-volume areas of care gaps in DIA zip codes
  - Work with vendors to optimal timeframes for outreach methods
    - Include in monthly Member and Provider Satisfaction Workgroup to brainstorm additional initiatives
  - Ongoing internal collaboration between departments
- Chlamydia Screening in Women
  - Continue to explore vendor partnerships for home testing kits
  - Work with vendors to optimal timeframes for outreach methods
    - Include in monthly Member and Provider Satisfaction Workgroup to brainstorm additional initiatives
  - Update a checklist mailing to include measure
  - Ongoing internal collaboration between departments

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members are not receiving timely screenings for diabetes and if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

- Comprehensive Diabetes Care (Blood Pressure Control, Diabetic Eye Exam, HbA1c Testing)
  - SMS text messaging for care gap reminders
  - In-home testing for Diabetes Screenings (CDC-DRE, CDC-HbA1c)
  - Member Rewards (CDC-DRE, CDC-HbA1c)
  - Included in member e-newsletter
  - Provider education and incentive with three target rates (CDC-DRE, CDC-HbA1c)
  - Nutrition education emails to encourage healthy eating and lifestyle habits
- Controlling High Blood Pressure (CBP)

- SMS text messaging for care gap reminders
- Educational information included in e-newsletters
- Social media posts

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Programs for in-home testing have not yet launched. Success rates for performance improvement are anticipated by year end

c. Identify any barriers to implementing initiatives:

- COVID-19 continues to be a barrier for members committing to in-home visits
- Members may lack access to appropriate treatment providers
- Delayed pickups or last-minute transportation cancellations by vendor impacted members' ability to successfully complete the appointment

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian will continue to complete the annual availability of practitioners analysis, however in the future additional specialties, outside of oncologists, obstetrics and gynecologists, and behavioral health, could be added to the analysis if Meridian receives increased member feedback on the lack of availability of a specific specialist type
- Include in monthly Member and Provider Satisfaction Workgroup to brainstorm additional initiatives
- Continue to work with transportation vendor MTM to provide reliable and timely transportation to members needing services
    - Meridian is currently participating in a statewide Performance Improvement Plan for Transportation to identify barriers and create approaches to improve the member experience

HSAG Assessment

3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy

Recommendation

HSAG recommended the following to improve the accuracy of provider directories:

- Follow the contract requirements and internal processes to verify the accuracy of the online provider directory.
- Conduct telephone surveys to validate the information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys.
- Conduct outreach to their providers to ensure they collect updated information on all service indicators. Provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.

Response

a. Describe initiatives implemented based on recommendations:

- Website URL address is requested on IAMHP roster template for groups and facilities. This data is being

entered into Meridian database to appear in online directory.

- Online website launched to allow providers to submit updates in a streamlined process for efficient and timely processing.
- External vendor directory audit findings have corrective action taken quarterly.
- Blank phone number are being researched quarterly and updated accordingly

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian directory audit scores have improved 7% (Q3 2021 – Q2 2022)

c. Identify any barriers to implementing initiatives:

- Lack of capacity to put large-scale, impactful resources towards directory accuracy across networks without impacting standard enrollment inventory.
- Provider education on importance of completing IAMHP roster template correctly and fully completing all fields.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Additional staffing and project manager solely dedicated to directory accuracy.
- Root cause analysis of primary factors contributing to directory inaccuracy and implementing preventative process improvements.
- Piloting a new external vendor to routinely audit directory for data accuracy is being launched in Q4 2022.
- Analysis tool implementation in 2023 to improve reconciliation of data received from providers to Meridian system

HSAG Assessment

Recommendation

HSAG recommended the following for provider network time/distance standards:

- Examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers.
- Notify HFS within five business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis.
- Work with contracted providers (i.e., dental and pharmacy) to ensure vendor provider data are accurate and complete.

Response

a. Describe initiatives implemented based on recommendations:

- Network Adequacy had been previously analyzed on a quarterly basis and is now conducted monthly.
    - If Gaps are identified, Meridian develops a plan within 5 days to close the identified gaps.
- Vendor contracts require them to follow Meridian's policies and performance standards regarding provider network adequacy. Vendor access reports are reviewed by Meridian's Compliance department to ensure adherence.
- In addition to the required time and distance standards, adequate access also takes into consideration

Meridian's anticipated membership volume, their expected utilization of services, the number, and types of providers necessary to furnish the Covered Services, the number of Affiliated Providers with closed panels, the geographic location of the Affiliated Providers compared to Meridian members, and access requirements of our members with disabilities

- Ad hoc reports are also run upon identification of any potential significant network change. If gaps are identified, Meridian develops a plan within 5 days to close the identified gaps.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Current GEO access reports demonstrate adequacy per current filing requirements.
- The new contractual relationship with CVS as Meridian's PBM increases access to high quality pharmacies in our network throughout the state.

c. Identify any barriers to implementing initiatives:

- Oral Surgeons are difficult to recruit as very few are willing to accept Medicaid reimbursement

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian will utilize of Single Case Agreements (SCAs)
- Meridian contracted with two Mobile Anesthesia providers to go to dental offices and provide sedation

HSAG Assessment

4. Prior Year Recommendation from the EQR Technical Report for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct root cause analyses or focus studies to determine why adult members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.
- Determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

- Hosted wellness events with providers in disproportionately impacted area (DIA) zip codes
  - Conducted member outreach to members residing in the area of the wellness event
- Meridian completes an annual analysis of the availability of primary care providers, high-volume and high-impact specialty care practitioners, and behavioral health providers. The analysis assesses the availability and proximity of specialists to members residing in both urban and rural areas. Meridian met all of the time and distance standards for specialist proximity to members as well as the ratio of specialists to members. Although all of the goals were met, Meridian will continue to recruit, contract, and credential all available non-par specialists available and continue to monitor for any gaps in practitioner availability.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Meridian partnered with three provider groups and executed five BCS events in 2022
- Meridian associates conducted telephonic outreach to members to extend an invitation to the event and fill the appointment time slots allocated by the provider partner and assist with coordinating transportation if needed for confirmed attendees
- Outcomes - Meridian achieved 36 direct care gap closures

c. Identify any barriers to implementing initiatives:

- Event approval timeframes limited the number of events that could be scheduled as providers did not always have the resources to confirm opportunities sixty or more days in advance. This timeframe was needed in order to receive internal and HFS approval of the event and associated outreach resources
- Delayed pickups or last-minute transportation cancellations with vendor MTM impacted the members' ability to successfully complete the appointment

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian will continue to complete the annual availability of practitioners analysis, however in the future additional specialties, outside of oncologists, obstetrics and gynecologists, and behavioral health, could be added to the analysis if Meridian receives increased member feedback on the lack of availability of a specific specialist type.
- Meridian is currently participating in a statewide Performance Improvement Plan for Transportation to identify barriers and create approaches to improve the member experience

HSAG Assessment

Recommendation

HSAG recommended the following for child CAHPS:

- Conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care child members need..
- Evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill gaps or evaluate why providers may not want to participate with the health plan.

Response

a. Describe initiatives implemented based on recommendations:

- Hosted wellness events with providers in disproportionately impacted area (DIA) zip codes
    - Conducted member outreach to members residing in the area of the wellness event
- Meridian completes an annual analysis of the availability of pediatric primary care providers. The analysis assesses the availability and proximity of pediatricians to members residing in both urban and rural areas. Meridian met all of the time and distance standards for proximity to members as well as the ratio of pediatricians to members. Although all of the goals were met, Meridian will continue to recruit, contract, and credential all available non-par pediatricians available and continue to monitor for any gaps

in availability.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian piloted a Well-Child focused member event with a provider group in Alton, IL in 2022 • Meridian associates conducted telephonic outreach to members to extend an invitation to the event and fill the appointment time slots allocated by the provider partner and assist with coordinating transportation if needed for confirmed attendees • The event resulted in 70 Well-Child care gaps being closed
c. Identify any barriers to implementing initiatives: • Event approval timeframes limited the number of events that could be scheduled as providers did not always have the resources to confirm opportunities sixty or more days in advance. This timeframe was needed in order to receive internal and HFS approval of the event and associated outreach resources • Delayed pickups or last-minute transportation cancellations with vendor MTM impacted the members' ability to successfully complete the appointment • Some members had children or were guardians of children that did have Meridian and some who did not, but wanted to utilize the opportunity to complete appointments for all children at one time
d. Identify strategy for continued improvement or overcoming identified barriers: • Provide tools, resources, and best practices to enhance support for providers to plan/schedule future events • Coordinate in advance with providers to connect parents with appointments if not all children are Meridian members
HSAG Assessment

5. Prior Year Recommendation from the EQR Technical Report for Critical Incident Monitoring:
Recommendation
HSAG recommended the following: • Consider merging internal CI processes to ensure consistent process application, valid data capture and categorization of CIs, and identification and utilization of best practices between lines of business. Also consider conducting a strengths, weaknesses, opportunities, and threats (SWOT) analysis.
Response
a. Describe initiatives implemented based on recommendations: • Meridian conducted a Critical Incident process SWOT analysis on 9/8/2021. After conducting the SWOT analysis, an interdisciplinary Critical Incident workgroup was formed. This workgroup worked over the course of three quarters to align critical incident reporting and follow up in one application across all lines of business. The health plan will be conducting training and rolling out an updated process during SFY 2023.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives:

• Delay in testing proposed system updates
d. Identify strategy for continued improvement or overcoming identified barriers: • Close collaboration with new leadership to review current project status and develop timeline for completion and rollout of training and new process
HSAG Assessment
NA; intervention to be implemented in SFY 2023
Recommendation
HSAG recommended the following: • Consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.
Response
a. Describe initiatives implemented based on recommendations: • The health plan conducts Critical Incident follow up with the member directly or authorized representative. For members who are cognitively impaired, residing in a nursing home, or long-term care facility, the health plan will attempt to contact the member and if the member is unable to reach, staff will attempt to contact a member of the nursing staff to confirm the health, safety, and welfare of the member. All outreach documentation is completed in the member managed system and on the Critical Incident Report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
d. Identify strategy for continued improvement or overcoming identified barriers: • The health plan will review and update applicable job aids and staff resources • This process will be reviewed in an upcoming training session for staff
HSAG Assessment

Recommendation
HSAG recommended the following: • Revise provider agreements and conduct provider training on identification and reporting of CIs.
Response
a. Describe initiatives implemented based on recommendations: • Meridian conducted Critical Incident training with providers on April 21, 2022. Additionally, Meridian Provider Relations provides Critical Incident training monthly to new network providers. On Demand Critical Incident provider resources are also available on the Meridian Provider website.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A

c. Identify any barriers to implementing initiatives:
- N/A

d. Identify strategy for continued improvement or overcoming identified barriers:
- Quality Improvement will work with provider relations to review current provider agreement language and update if needed
- Quality Improvement will review and update applicable provider resources

HSAG Assessment

6. Prior Year Recommendation from the EQR Technical Report for HCBS Waiver Performance Measures:

Recommendation

HSAG recommended the following for Measure 4A, *overdue service plan was completed within 30 days of expected renewal*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans.
- Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

Response

a. Describe initiatives implemented based on recommendations:
- Meridian reviewed internal audit tool and provided refresher training/education to case managers regarding required service level plan update timeframes as part of our HSAG remediation trainings which occur quarterly.
- Meridian provided case managers and leadership internal tools/reports that identify due dates of care coordination activities, including service level plan updates and overdue Service Level Plan's (SLP) for correction.
- Internal audit practices continue to capture overdue Service Level Plans and remediation measures are due by staff within 15 days of receiving the audit. For staff that do not meet internal audit expectations a review occurs with the staff member to discuss opportunity for improvement.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- In the beginning of SFY 2021/2022, Meridian went through a system integration and started capturing audit results again in August of 2021.
- Staff demonstrated opportunities for improvement as the audit scores for Service Level Plans were 85% in August 2021. However, with the implementation of initiatives the scores increased to 98% in June of 2022.
    - Please note: These results only include the cases that were pulled for internal audits and are not reflective of overall SLP compliance rates for all members with an HCBS waiver.

c. Identify any barriers to implementing initiatives:

- Public health emergency (PHE) restrictions in place.
- A system integration requiring retraining for all individuals.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian will continue to review and enhance internal tools available to staff to ensure contractual timeframes are met.
- Refresher training is held at minimum quarterly to review contractual requirements and increased monitoring and remediation of activities relating to internal audit measures.
- Continue to leverage overtime options on an ad hoc basis to assist in staff caseload compliance.
- Staff will continue outreach attempts to engage members with a waiver who are unable to reach (UTR)/non-compliant.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations.
- Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Response

a. Describe initiatives implemented based on recommendations:

- Meridian educated case managers on all required actions when completing PA evaluation, including all PA's the member has on service plan and required timeframes.
- A personal assistant evaluation tracker report has been built to assist staff members in monitoring and tracking personal assistant evaluations for their members.
- Internal audit practices have captured this measure since September 2020. If a PA evaluation was not completed in a timely manner, staff are given 15 days to remediate and complete the evaluation. If a staff member does not meet audit expectations, they meet with their auditor or supervisor to discuss the results and opportunities for improvement.
- Staff have received education regarding timely PA evaluation completion as part of our HSAG remediation training which occurs quarterly.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- During SFY 2021/2022 Meridian underwent a system integration and maintained rates throughout SFY 2021/2022.

c. Identify any barriers to implementing initiatives:

- Public health emergency (PHE) restrictions in place.

- Staff were completing a PA evaluation on only one PA when there were multiple PAs on a members' service plan.
- A system integration requiring retraining for all individuals.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continue to educate staff on how to utilize internal reports available with due dates for PA evaluations, timeframe requirements for completing PA evaluations, and uploading correctly to the system.
- Continue to leverage overtime options on an ad hoc basis to assist in staff caseload compliance.
- Staff will continue attempts to engage waiver members who are UTR/Non-compliant.
- Continued monitoring and tracking of PA evaluations per the PA evaluation report.
- Refresher training is held at minimum quarterly to review contractual requirements and increased monitoring and remediation of activities relating to internal audit measures.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 20C, *a PA evaluation was completed annually*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations.
- Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Response

a. Describe initiatives implemented based on recommendations:

- Meridian educated case managers on all required actions when completing PA evaluation, including all PA's the member has on service plan and required timeframes. Reporting tool available to assist staff in monitoring their caseloads and upcoming due dates to ensure compliance.
- A personal assistant evaluation tracker report has been built to assist staff members in monitoring and tracking personal assistant evaluations for their members.
- Internal audit practices have captured this measure since September 2020. If a PA evaluation was not completed in a timely manner, staff are given 15 days to remediate and complete the evaluation. If a staff member does not meet audit expectations, they meet with their auditor or supervisor to discuss the results and opportunities for improvement.
- Staff have received education regarding timely PA evaluation completion as part of our HSAG remediation training which occurs quarterly.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- During SFY 2021/2022 Meridian underwent a system integration and maintained rates throughout SFY 2021/2022.

c. Identify any barriers to implementing initiatives:

- Identified PHE restrictions allowing exceptions for certain individual providers (such as parent) that are a member's caregiver and cannot complete PA eval on themselves is a barrier present on a low volume.
- In addition, staff were completing PA evaluation on only one PA when there were multiple PAs on a member's service plan.
- A system integration required retraining for all individuals.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continue to educate staff on how to utilize internal reports available with due dates for PA evaluations, timeframe requirements for completing PA evaluations, and uploading correctly to the system.Meridian will continue to increase oversight in areas identified as an opportunity to ensure education and monitoring provides positive impact.
- Continue to leverage overtime options on an ad hoc basis to assist in staff caseload compliance.
- Staff will continue attempts to engage waiver members who are UTR/Non- compliant.
- Refresher training is held at minimum quarterly to review contractual requirements and increased monitoring and remediation of activities relating to internal audit measures.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- Conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

Response

a. Describe initiatives implemented based on recommendations:

- Implemented increased oversight, specifically on HIV and BI caseloads to provide significant training and monitoring of monthly contacts. Increased oversight included monitoring of at least 3 outreach attempts per month and education on appropriate documentation for outreach efforts.
- Reporting tool available to assist staff in monitoring their caseloads and upcoming due dates to ensure compliance.
- All other waiver types and caseloads have continued to review staffing, made enhancements to internal

tools/reports utilized by teams, and implemented unannounced home visits to locate hard to reach members now that Meridian has returned to the field as of April 2022.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- There have been significant improvements noted since implementing the increased oversight and education to BI/HIV caseloads.
- For members with a BI waiver, the percentage of compliant contacts completed to meet contractual timeframes was 66.23% in the beginning of SFY 2021-2022. Through the implementation of the initiatives surrounding this measure, the compliance rate was 97.51% at the end of SFY 2021-2022.
- For members with a HIV/AIDS waiver, the percentage of compliant contacts completed to meet contractual timeframes was 68.80% in the beginning of SFY 2021-2022. Through the implementation of the initiatives surrounding this measure, the compliance rate was 97.42% at the end of SFY 2021-2022.

c. Identify any barriers to implementing initiatives:

- PHE restrictions in place that impact ability to close waivers for members that are unable to reach and not compliant with contact.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian will continue to review caseload sizes and staffing status to ensure caseloads are appropriately staffed to manage required outreach.
- Meridian will continue to increase oversight in areas identified as an opportunity to ensure education and monitoring provides positive impact.
- Continue to leverage overtime options on an ad hoc basis to assist in staff caseload compliance.
- Staff will continue outreach attempts to engage waiver members who are UTR/Non-Compliant.
- Continued monitoring and tracking of BI/HIV timely contacts per our internal reports.

HSAG Assessment

7. Prior Year Recommendation from the EQR Technical Report for Care Coordination/Care Management:

Recommendation

HSAG recommended the following:

- Identify a plan to reassign caseloads to those case managers not meeting caseload limits.
- Review the qualifications/education and related experience requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads.
- Review its staffing submission to ensure that specificity regarding qualifications/education that may show compliance with the contract requirements is included in its submissions.
- Also consider submitting exemption requests to HFS for consideration.

Response

a. Describe initiatives implemented based on recommendations:

- Staff completes the Qualifications Survey upon hire and annually. Results from the survey are then tracked in reporting and case assignments are made based off qualifications and specific population types. Leadership modifies case assignments as needed upon any changes to staffing or staff qualifications.

- Meridian utilizes the Case Weight Report to monitor caseload count and weight by role and team. The report is used to monitor caseload distribution and assess staffing priorities.
- Mismanaged Report is utilized to ensure correct waiver assignments.
- Implementation of updated waiver closure process for members admitting to Long Term Care Facility (LTCF), allowing for waiver closure follow-up and monitoring, ensuring appropriate staff are managing waiver while awaiting waiver closure to process.
- Meridian utilizes assistance of community outreach staff to locate unable to reach (UTR) members. UTR members are monitored but are not considered as part of the caseload count.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Closer monitoring of waiver closure for members who move into an LTCF has allowed for increased compliance of PD and Aging waivers.

c. Identify any barriers to implementing initiatives:

- Staffing changes.
- Members residing in an LTCF but showing as having an active waiver.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Meridian will continue to utilize Case Weight Report to reassign cases to ensure compliance with caseload limits.
- Meridian will continue to utilize Mismanaged Report to identify staff holding inappropriate waiver members, allowing for correct reassignment.

HSAG Assessment

Molina

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Review PIP Module 4 and Module 5 instructions and Rapid-Cycle PIP Reference Guide. • Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. • Consider testing more than one intervention during the duration of the PIP. This will help the health plans address additional identified opportunities for improvement and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project.
Response
a. Describe initiatives implemented based on recommendations: • The previous PIP topics have ended, and new PIPs have been introduced. • Molina has implemented interventions for the current Prenatal PIP, such as Bump Boxes and outbound calling, that are easier to track and monitor.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • NA – previous PIP/QIPs were retired, and new PIP/QIPs are in place
c. Identify any barriers to implementing initiatives: • COVID proved to be a significant barrier in implementing and tracking interventions during the previous PIP/QIPs
d. Identify strategy for continued improvement or overcoming identified barriers: • Identifying interventions that can be more easily tracked and monitored
HSAG Assessment
NA; new interventions implemented.
Recommendation
HSAG recommended the following: • Review the final module instructions and Rapid-Cycle PIP Reference Guide prior to completing the final module for validation.
Response
a. Describe initiatives implemented based on recommendations: • The Quality Team was restructured to integrate interventions into all roles on the Quality Improvement Team.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Processes have been put into place to improve timeliness of deliverables and visibility with leadership prior to submission.
c. Identify any barriers to implementing initiatives: • No barriers identified
d. Identify strategy for continued improvement or overcoming identified barriers: • N/A

HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members ages 65 with opioid use disorder are not receiving or adhering to pharmacotherapy treatment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.

Response

a. Describe initiatives implemented based on recommendations:

- Regular member education on medication options and ongoing assistance with scheduling treatment and where needed setting up transportation to the provider to limit barrier to care.
- Monitor substance use disorder and opioid use disorder diagnoses as well as pharmacy utilization for opioid prescription fulfillment. To limit the number of script fills and number of prescribing providers

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The POD 65+ blended rate has not shown any improvement. The rate decreased from MY2020 to MY2021 by 2.12 percentage points (MY2021 4.55 – MY 2020 6.67).
- The measure denominator increased in MY2021, but overall remained low. In MY2021 the denominator was 44 (reportable) and 15 in MY2020 (non-reportable). Because there is such a low denominator, there is higher likelihood for rate volatility.

c. Identify any barriers to implementing initiatives:

- Low denominator in this age group for the measure – 44 in MY2021
- Many treatment clinics have a waitlist that can be up to 2-3 weeks causing members to have to call daily, which can result in discouragement, and disengagement from treatment
- Members not utilizing the transportation benefit to receive services

d. Identify strategy for continued improvement or overcoming identified barriers:

- Monthly reporting to monitor substance use and opioid use diagnosis as well as pharmacy utilization for opioid prescription fulfillment to limit the number of script fills and number of prescribing physicians.
- Member education on medication options, assistance with scheduling treatment and assisting with transportation to provider to limit barrier to care.

HSAG Assessment

Recommendation

HSAG recommended the following for *Follow-Up After Hospitalization for Mental Illness*:

- Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not

accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions.

- Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:

- Care Connections Follow-up Program – Care Connections makes outreach to members to perform a telehealth follow-up visit within 30 days for members discharged from the hospital with a mental health diagnosis. (MMP and HealthChoice IL)
- Partnership with In-Home Medical Group (IHMG) – IHMG is conducting outreach to members to perform a telehealth follow-up visit within 30 days for members discharged from the hospital with a mental health diagnosis. (HealthChoice IL)
- Admissions, Discharges and Transfers (ADT) Platform – Molina has launched the ADT platform which provides a dashboard of members that have been admitted as Inpatient or in the Emergency Department. These dashboards provide nearly real-time notification to Molina of admission of members.
- Provider Behavioral Health Bonus Program – Incentivize providers who meet FUH 7 and FUH 30 goals.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Direct scheduling members to telehealth has shown a year-to-date impact of 1.59% increase of the FUH 7 rate and a 4.07% increase of the FUH 30 rate

c. Identify any barriers to implementing initiatives:

- This population is difficult to reach and engage
- Post-discharge appointment availability – some providers only providing walk-in hours at clinic
- Providers that will only accept scheduling directly from members, not from the case manager
- Intake screening requirements prior to appointment scheduling is also a barrier and causes member disengagement

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continued direct outreach with Care Connections and IHMG to members to schedule telehealth visits
- Continue to incentivize providers to who meet FUH 7 and FUH 30 goals.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, work with its members to increase the use of telehealth services, when appropriate.

Response
a. Describe initiatives implemented based on recommendations: • Molina Day Wellness Exams. Molina partners with in-network providers to set aside appointment times for patients. Molina Quality Interventions staff outreach members and schedule appointments and transportation to the event. • Direct Outreach. Molina Quality Interventions staff outreach members and schedule appointments and transportation to annual well visits. • Office Availability. After office closures/limited appointments due to COVID-19 shutdowns, there was an increase in appointment availability at providers. MHIL was able to offer a greater amount of appointment slots for scheduling and offer Molina Days to fill appointments. • Member Incentive. Members who had not seen a PCP in the previous 12 months were eligible to receive a gift card incentive after completing their well visit before December 31, 2021. Gift cards were mailed directly to eligible members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Annual Well Visit measure saw measurable improvements as a result of the Molina Day intervention and direct outreach for appointment scheduling by MHIL staff. Molina Days supported an impact of almost 0.1% and the direct outreach resulted in an impact of approximately 0.8%. It is important to note that this measure has a large denominator of over 150,000 members and combined, these interventions account for about 1,500 appointments YTD.
c. Identify any barriers to implementing initiatives: • Members who were new to managed care in 2021 may not have been fully aware of the benefits available to them. These members may have also had knowledge deficits on locating providers and how to utilize Molina's online provider directory. This could lead to gaps in care and missed preventative visits. • Members in the targeted population are likely to be healthier overall (i.e., no chronic conditions, younger population, etc.) and are less likely to go to the doctor for a wellness visit. • The reminder phone call intervention is likely to be less impactful on the younger demographic since that population is less likely to answer a phone call.
d. Identify strategy for continued improvement or overcoming identified barriers: • Annual Wellness Reminder Text Messages. During CY 2022 Q4, reminder text messages to members who are still in need of an annual wellness exam for the year are targeted with a reminder to schedule an exam with their PCP before December 31. • Provider Performance Reporting. Molina Quality staff provides performance scorecards at least quarterly to provider groups and on a monthly basis provides groups with member-level care gap information to show gap closure opportunities. • Provider Education. Molina Quality staff provides regular education to providers on priority measures including a measure overview, updates to the technical specifications and coding requirements, and open discussion with provider groups on barriers they are experiencing getting patients in for needed care followed by collaboration strategies to alleviate those barriers with Molina Quality staff support. • In Home Assessments. Molina's nurse practitioners conduct in-home exams and/or telehealth visits for members who are missing their annual wellness visit. • On Hold Messaging. Molina utilizes on-hold messaging to convey the importance of various types of preventive care. Molina sets 3-4 messages to rotate at a time, and rotates messages quarterly based on seasonal needs.

- HEDIS Alerts. Molina's internal systems are equipped with alerts configured for each member so that when staff pulls up the member's account in both the inbound/outbound call system and case management system, they are alerted to all missing care gaps for the member.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast cancer and chlamydia. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.

Response

a. Describe initiatives implemented based on recommendations:

- Mammogram Molina Day Events. Molina's Quality staff partners with high volume provider groups to set aside blocks of appointment times which Molina staff can outreach members to schedule appointments for. At the event members will receive Molina goody bags, refreshments, and an incentive gift card reward. Year to date data show that there has been over a 1% positive impact on rates for Breast Cancer Screenings completed by members who were scheduled as a part of a Molina Day event. Currently, about 15% of these compliant members live in DIA zip codes.
- Direct Outreach. Molina Quality Interventions staff outreach members and schedule appointments and transportation to mammogram appointments. During these phone calls, Molina staff also educate members on additional benefits as well as gift card reward for completing their preventative screening. Year to date data show that there has been almost a 1% positive impact on rates for wellness visits completed by members who were scheduled via direct outreach by Molina staff. More than 50% of these members live in DIA zip codes. It is likely that members who utilized the direct scheduling services for well visits were also motivated to obtain other preventative services such as Breast Cancer and Chlamydia screenings.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Both rates for breast cancer and chlamydia screenings were down from MY2019 to MY2020 due to results of the COVID-19 pandemic. Breast cancer screening rates dropped slightly from 49.52% in MY2019 to 49.45% in MY2021. Although the current rate for MY2022 of 47.47% has not yet trended upward, there is still time left in the measurement year to achieve that goal. Chlamydia screenings have improved since MY2019. The final rate in MY2019 was 58.06% which decreased to 56.1% in MY2020. The current rate for MY2022 is already trending upward and is at 56.38%.
- Timely screenings for breast cancer and chlamydia correlate with members receiving their annual wellness exams. The AAP measure saw decreases amid COVID which correlate with the BCS and CHL measures. From MY2019 to MY2020, AAP dropped from 75.35% to 71.91%. Currently, the AAP rate is at 71.06% with time left in the measurement year. With members increasingly obtaining their wellness screenings, it is likely that they are also meeting their needs for additional preventative care and timely screenings.

c. Identify any barriers to implementing initiatives:

- The younger members in this targeted population are likely to be healthier overall (i.e., no chronic

conditions) and are less likely to seek preventative care such as annual check-ups, and screening for chlamydia.

d. Identify strategy for continued improvement or overcoming identified barriers:

-

HSAG Assessment

3. Prior Year Recommendation from the EQR Technical Report for Network Adequacy

Recommendation

HSAG recommended the following to improve the accuracy of provider directories:

- Follow the contract requirements and internal processes to verify the accuracy of the online provider directory.
- Conduct telephone surveys to validate the information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys.
- Conduct outreach to their providers to ensure they collect updated information on all service indicators. Provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.

Response

a. Describe initiatives implemented based on recommendations:

- Applied a secret shopper initiative targeting Primary Care Providers (PCP) to confirm name, phone number, location, accepting new member and timing of appointments

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Currently validating findings to determine if any gaps are identified

c. Identify any barriers to implementing initiatives:

- Staff at medical offices understanding their relationship with Molina and groups submitting over accurate information

d. Identify strategy for continued improvement or overcoming identified barriers:

- When gaps are identified with the group conduct outreach and education

HSAG Assessment

Recommendation

HSAG recommended the following for provider network time/distance standards:

- Examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers.

- Notify HFS within five business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis.
- Work with contracted providers (i.e., dental and pharmacy) to ensure vendor provider data are accurate and complete.

Response

a. Describe initiatives implemented based on recommendations:

- With regards to dental provider data accuracy, Molina performs a quarterly sampling audit of the dental delegate data that consists of verifying data against the provider's website, the dental delegate's POD, and what is provided on the roster from the dental delegate. Any discrepancies found are submitted to the delegate as well with a request for a verification of any other discrepancies found in their review of the data that Molina sends.
- Per MHIL's Provider Network Policy PM-PP0010, when material gaps are identified within five (5) business days, develop and implement a recruitment strategy to fill the gaps and immediately thereafter submit any request for proposed strategy timelines as requested.
- Molina has identified a potential discrepancy that is causing an understatement of the available providers for the Pediatric Allergy & Immunology and Pediatric Rehabilitation Therapy. There is a manual review of provider records and reporting structure taking place to verify that the correct data is being sent.
- Molina has contracted with Oral Surgeons to the extent that Oral Surgeons are willing to contract within the state of Illinois. With many of these providers residing in Cook County, it has proven to be difficult to fill the network in all regions.
- Molina and our PBM (CVS/Caremark) have conducted a GeoAccess evaluation for Region 1 and 2. Our findings document that 100% of members in this region have access to pharmacies as required by the access standard. Molina uses the CVS National Pharmacy Network which includes ALL eligible pharmacies (not sanctioned or excluded from participating with Medicaid). GeoAccess reports conducted by Molina/CVS are available upon request.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The number of providers identified in the quarterly dental audit has decreased throughout 2021 as a result of increased review being consistently applied to the vendor's data.

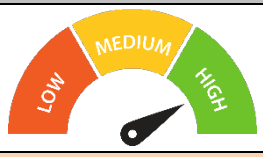
c. Identify any barriers to implementing initiatives:

- There are few Oral Surgeons to contract with outside of Cook County.

d. Identify strategy for continued improvement or overcoming identified barriers:

- MHIL will continue to outreach to Oral Surgeons as they become active in IMPACT.
- Molina, together with CVS/Caremark, does ongoing monitoring by performing GeoAcess evaluation of the pharmacy network for all regions at least annually or sooner if needed.

HSAG Assessment



Recommendation

HSAG recommended the following for monitoring enrollee access to providers:

- Implement processes and develop/submit policies to demonstrate compliance with access and availability

monitoring requirements, including time and distance standards, appointment availability and after-hours access, PCP panel capacity, and open and closed panels.

- Revise policy to include 24/7 coverage requirements for primary care and specialty providers.

Response

a. Describe initiatives implemented based on recommendations:

- Policy PN-PP-010 outlines the procedure that is implemented to monitor the network for adequacy- MHIL shall analyze the geographic distribution of the Provider Network on a quarterly basis. MHIL shall also monitor other network adequacy indicators, such as Member and Provider complaints related to access; call center requests from Members, Providers, advocates, and external organizations for help with access; and the percentage of completely open primary care Provider panels versus the percentage open only to existing patients. MHIL shall generate geographic distribution tables and maps to plot Member and Network Provider locations by ZIP code and analyze the information, considering the prevalent modes of transportation available to Members, Members' ability to travel, and Members' ability to be in an office setting. When material gaps in MHIL's Provider Network are identified, MHIL shall, within five (5) business days, develop and implement a recruitment strategy to fill the gaps and immediately thereafter submit any request for proposed strategy timelines as requested.
- Policy PN-PP-010 outlines internal standards for monitoring appointment availability and afterhours access - Network and Quality will confirm any additional internal standards for access and availability are being trended and met, including Member Services: Member grievances related to PCP and specialty access and availability. Provider Education: Members' needs and preferences, including language, cultural, ethnic, geographic, and special needs. This includes reporting on the language line utilization. Network Management: Ad Hoc requests. Any additional access and availability issues that may arise. Monitoring Activities for Network Access and Availability - Providers or contracting counties identified as non-compliant are referred to appropriate resources to correct the deficiencies of any standards not met. Responsible resource must acknowledge and gaps and complete a corrective action plan regarding how to correct the deficiency. Network Management and Operations assess and contract with additional Providers to ensure networkadequacy, if warranted. Network Management and Operations add new Providers to maintain ratio and timely access standards as necessary based on governing regulatory agency requirements.
- Policy PN-PP-010 identifies the process in which an analysis is conducted on PCP panels - Analysis of PCPs with Open Panels: The Director of Provider Network Management will utilize the supplied reports to complete the PCP Practice Locations Accepting New Members to Membership Ratios grid in the MHIL Practitioner Availability Template for each line of business. To execute this process, the following steps will be adhered to: From the QNXT report, populate the number of PCP Practice Locations by county. From the QNXT report, the number of PCP Providers Accepting New Members populate. Calculate the percentage of PCP Providers with Open Panels by dividing the number of PCP Practice Service Locations for each county by the number of PCP Providers Accepting New Members. Ensure that the percentage of PCP Providers with Open Panels is > 5%.
- Implemented a sharepoint ticketing process for reporting of specialties that are not available, escalated member grievances for appointment issues, and identified issues by enrollees with provider office.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The implementation of the Sharepoint Network gap process has allowed enrollee issues to be resolved immediately to avoid disruption in member care. Members can get into appointments sooner with the intervention of their case manager and the provider network manager working with the provider. It allows member grievances to be addressed and resolved in a timely manner.

c. Identify any barriers to implementing initiatives:
- N/A

d. Identify strategy for continued improvement or overcoming identified barriers:
- Based on the identified needs of enrollees for certain specialists not available in the state, we will work to identify those specialists in other states and the availability to make sure that the enrollee is able to be seen.
- Meet with providers to ensure that they are aware of the availability requirements to continue to meet the need of the enrollee

HSAG Assessment

Recommendation

HSAG recommended the following:

- Conduct root cause analyses to determine the reason for the high number of discrepancies in the Provider Specialty indicators and collaborate with the provider offices to ensure the correct information is received from the providers and updated within the provider directory and provider data file layout submissions.

Response

a. Describe initiatives implemented based on recommendations:
- Will initiate a compare of a Provider's taxonomy in the system to the State's Provider enrollment file

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Currently validating data to determine if any gaps are identified

c. Identify any barriers to implementing initiatives:
- State's Provider enrollment file containing accurate and up to date information

d. Identify strategy for continued improvement or overcoming identified barriers:
- Create a monthly Provider's taxonomy comparison to ensure the correct taxonomy is updated in the system

HSAG Assessment

NA; Implementations in progress.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct root cause analyses or focus studies to determine why adult members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.
- Determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.

Response
a. Describe initiatives implemented based on recommendations: • Member education on available service such as transportation, what to expect at their doctor appointment and expectation of appointment availability with providers • CAHPS TIP sheet in provider portal that includes provider requirements for appointment availability as well as tips to avoid member abrasion • Direct member outreach to schedule members with care gaps into appointments and arrange transportation if needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Getting Needed Care composite rate improved from 83.3% in 2021 to 85.1% in 2022. • The Getting Quality Care composite rate did not improve. The rate declined from 80.4% to 77.9% in 2022. • The rate for Getting Needed Care for Black or African American members improved from 79.7% to 85.7%, although it still is lower than the rates for White members.
c. Identify any barriers to implementing initiatives: • Low response rates to CAHPS surveys. The response rate in 2022 was 11.6%, which is only slightly lower than CAHPS vendor SPH's national response rate of 12.2%. Low denominators can cause rates to vary widely. • Black or African American members rates for both composites are lower than rates for White members, but improvement was shown in the Getting Needed Care rate in 2022. • CAHPS reporting does not provide analysis by location making it difficult to determine if results are related to provider shortage in a specific area.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued member education on appointment expectations and services available to assist member • Continued direct member outreach to schedule members into needed appointments and arrange transportation when needed.
HSAG Assessment

Recommendation
HSAG recommended the following for child CAHPS: • Conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. Consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care child members need. • Evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill gaps or evaluate why providers may not want to participate with the health plan.

Response
a. Describe initiatives implemented based on recommendations: • Member education on available service such as transportation, what to expect at their doctor appointment and expectation of appointment availability with providers • CAHPS TIP sheet in provider portal that includes provider requirements for appointment availability as well as tips to avoid member abrasion • Direct member outreach to schedule members with care gaps into appointments and arrange transportation if needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The 2022 Getting Care Quickly composite rate improved by 4.2 percentage points to 87.9%. • The Getting Needed Care composite rate declined slightly from 84.7% in 2021 to 83.9% in 2022. • The 2022 Getting Needed Care rate was higher for African American members than for White members at 86.4% and 87.7% respectively.
c. Identify any barriers to implementing initiatives: • Low response rates for CAHPS Survey. The 2022 response rate was 10.6% which was slightly above the CAHPS vendor SPH's average response rate of 10.2%. Low denominators can cause rates to vary widely. • CAHPS reporting does not provide analysis by location making it difficult to determine if results are related to provider shortage in a specific area.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued member education on appointment expectations and services available to assist member • Continued direct member outreach to schedule members into needed appointments and arrange transportation when needed.
HSAG Assessment

5. Prior Year Recommendation from the EQR Technical Report for Critical Incident Monitoring:
Recommendation
HSAG recommended the following: • Consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.
Response
a. Describe initiatives implemented based on recommendations: • Molina has reviewed our internal critical incident processes and reinforced their implementation through case management training which took place 9/29/2022
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • No Barriers

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue with internal auditing to ensure outreach is attempted and barriers are documented.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Consider revising their processes for communication with the investigating authority to align with the external entity's communication requirements.
- Provide training to staff members on their process for conducting follow-up with the investigating authority after an initial CI report has been made.

Response

a. Describe initiatives implemented based on recommendations:
- Staff will follow the Critical Incident Process which has outreach requirements. Training was held on 1/27/22 as a re-education of the process.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

c. Identify any barriers to implementing initiatives:
- No Barriers

d. Identify strategy for continued improvement or overcoming identified barriers:
- Molina will Continue with internal auditing to ensure critical incident process is followed and reports of any barriers be escalated.

HSAG Assessment

6. Prior Year Recommendation from the EQR Technical Report for HCBS Waiver Performance Measures:

Recommendation

HSAG recommended the following for Measure 4A, *overdue service plan was completed within 30 days of expected renewal*:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans.
- Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

Response
a. Describe initiatives implemented based on recommendations: • Audit Program Implemented Q2 2020 • QA Program implemented Q4 2021 serving as remediation program for staff not meeting performance expectations • Report enhancements implemented Q1 2022 • Training enhancements implemented Q1 2022 • Breakout sessions conducted routinely with this being 1 area of focus • Focused audits conducted with this being 1 area of focus
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance in timely service planning has improved significantly with recent internal audits scores sustained in mid-high 90% since 2021.
c. Identify any barriers to implementing initiatives: • Staff stability given high turnover rates with the "Great Resignation" in Q4 2021 through Q1 2022
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued and disciplined outcome monitoring and accountability throughout the organization
HSAG Assessment

Recommendation
HSAG recommended the following for Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Audit Program Implemented Q2 2020 • QA Program implemented Q4 2021 serving as remediation program for staff not meeting performance expectations • Report enhancements implemented Q1 2022 • Training enhancements implemented Q1 2022 • Breakout sessions conducted routinely with this being 1 area of focus • Focused audits conducted with this being 1 area of focus

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance related to timely completion of PA Eval has improved significantly with internal audit scores improving since 2021 and now sustained around 95%
c. Identify any barriers to implementing initiatives: • Staff stability given high turnover rates with the "Great Resignation" in Q4 2021 through Q1 2022
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued and disciplined outcome monitoring and accountability throughout the organization
HSAG Assessment

Recommendation
HSAG recommended the following for Measure 20C, *a PA evaluation was completed annually*: • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. • Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Response
a. Describe initiatives implemented based on recommendations: • Audit Program Implemented Q2 2020 • QA Program implemented Q4 2021 serving as remediation program for staff not meeting performance expectations • Report enhancements implemented Q1 2022 • Training enhancements implemented Q1 2022 • Breakout sessions conducted routinely with this being 1 area of focus • Focused audits conducted with this being 1 area of focus
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance related to timely completion of PA Eval has improved significantly with internal audit scores improving since 2021 and now sustained around 95%
c. Identify any barriers to implementing initiatives: • Staff stability given high turnover rates with the "Great Resignation" in Q4 2021 through Q1 2022
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued disciplined outcome monitoring and accountability throughout the organization

HSAG Assessment

Recommendation
HSAG recommended the following for Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*: • Conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. • Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement. • Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30. • Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required. • Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. • Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.
Response
a. Describe initiatives implemented based on recommendations: • Audit Program Implemented Q2 2020 • QA Program implemented Q4 2021 serving as remediation program for staff not meeting performance expectations • Report enhancements implemented Q1 2022 • Training enhancements implemented Q1 2022 • Breakout sessions conducted routinely with this being 1 area of focus • Focused audits conducted with this being 1 area of focus • Teams reorganized to match skill sets • SLP reorganized under LTC leadership • HIV/TBI SMEs developed one per region with caseloads of 30 or less
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance with timely contact has improved consistently since 2020 across all waiver types with results currently at/near 90%
c. Identify any barriers to implementing initiatives: • Staff stability given high turnover rates with the “Great Resignation” in Q4 2021 through Q1 2022
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued disciplined outcome monitoring and accountability throughout the organization

HSAG Assessment


Appendix A3. Health Plan-Specific Conclusions

Introduction

This section summarizes an assessment of each health plan's strengths and opportunities for improvement for the quality, timeliness, and accessibility of healthcare services furnished to Medicaid beneficiaries and recommendations for improving the quality of healthcare services furnished by each health plan, as required by 42 CFR §438.364.

Methodology

42 CFR §438.364 also requires a description of how the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of the care furnished by each health plan.

EQR activities typically measure program performance through quantitative data (i.e., data are numeric and consist of frequency counts, percentages, or other statistics) that provide evidence of outcomes and help assess a health plan's or a program's progress toward its stated goals. While data demonstrate what is occurring, these data do not necessarily indicate what caused the occurrence.

The EQRO is tasked with drawing conclusions from the data for an overall assessment that distinguishes successful efforts from ineffective activities and services and to provide recommendations for improving results. HSAG analyzes the quantitative results obtained from each EQR activity for each health plan to identify strengths and opportunities for improvement for providing healthcare timeliness, access, and quality across activities. HSAG then identifies whether common themes or patterns exist across the data and conducts a qualitative analysis to draw conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each health plan independently and the overall statewide Medicaid managed care program.

Health Plan-Specific Conclusions

Aetna Better Health

Strengths Related to Quality	
+	Demonstrated an increase in performance for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.
+	Demonstrated an increase of more than 10 percentage points for the *Controlling High Blood Pressure* measure.
+	Continued to meet or exceed the 50th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator and improved to meet or exceed the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed* measure indicators.
+	In the Child Behavioral Health domain, ranked at or above the 75th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* indicator. Additionally, demonstrated an increase of more than 5 percentage points for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total* measure indicators.
+	Achieved a *Reportable* designation for all PMV activities.
+	Designed methodologically sound PIPs and QIPs and achieved all validation criteria for Steps 1 through 6 (PIP Design) for QIPs and for the *Improving Transportation Services* PIP.
+	Child member experience survey results were at or between the 75th percentile and 89th percentiles for *Getting Needed Care.*
+	Demonstrated compliance with staffing contract requirements related to caseload limits, including those for specific waiver types.
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the health, safety, and welfare (HSW) of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.
+	Performed at or above 90 percent for MMAI in demonstrating compliance to CMS HCBS performance measures, as identified by the quarterly record reviews.
Strengths Related to Quality, Access, and Timeliness	
+	Ranked at or above the 50th percentile for the *Child and Adolescent Well-Care Visits* measure.
+	Ranked at or above the 90th percentile for the *Immunizations for Adolescents—Combination 1* measure.

Health Plan-Specific Conclusions

Strengths Related to Quality, Access, and Timeliness	
+	In the Child Behavioral Health domain, demonstrated an increase of more than 5 percentage points for the *Follow-Up After Hospitalization for Mental Illness* indicators. Additionally, ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7 Day Follow-Up and 30-Day Follow-Up* indicators.
+	In the Adult Behavioral Health domain, ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day—Ages 18—64* indicator.
+	Demonstrated an increase in performance for the *Annual Dental Visit* measure.
+	Contracted with a sufficient number of required provider types within each service region for HealthChoice and MMAI and was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions for MLTSS.

Opportunities and Recommendations	
−	**Opportunity:** Rates decreased for *Adults' Access to Preventive/Ambulatory Health Services—Total.* This measure continued to rank below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
−	**Opportunity:** Demonstrated a decrease in performance for the *Well-Child Visits in the First 30 Months of Life—Six or More Visits* and ranked below the 50th percentile. Additionally, the health plan continued to rank below the 25th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* indicator. This performance indicates that children are not receiving well-care visits. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving the recommended well-child visits. Consider whether there are disparities within the population that contribute to lower performance in a particular race or ethnicity, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to well-child visits.
−	**Opportunity:** Demonstrated a decline in performance and ranked below the 25th percentile for the *Childhood Immunization Status—Combination 3* and the *Childhood Immunization Status—Combination 10* measure indicators, suggesting that children are not receiving these immunizations, which are a critical aspect of preventable care for children. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving all recommended vaccines. Consider whether there are disparities within populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also consider whether a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, implement appropriate interventions to improve the performance related to these measures.

Opportunities and Recommendations	
–	**Opportunity:** *Breast Cancer Screening* rates decreased more than 5 percentage points in MY 2021 and ranked below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast cancer. Consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.
–	**Opportunity:** In the Adult Behavioral Health domain, demonstrated low performance for *Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions. Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
–	**Opportunity:** In an access and availability survey with specialty provider types, HSAG was unable to reach almost 41.4 percent of sampled cases and was only able to obtain an appointment date with 13.2 percent of the sampled locations. **Recommendations:** Work with HFS to obtain the case-level survey data files and address provider data deficiencies identified during the survey calls. Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate standards into educational materials.
–	**Opportunity:** Results of the time and distance study demonstrated that the provider network for Pharmacy and Oral Surgery—Adult and Pediatric did not meet the time/distance standards in all regions. **Recommendations:** Collaborate with HFS to continue to monitor the status of time/distance standards for all provider categories, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.
–	**Opportunity:** Adult member experience survey results for *Getting Needed Care* and *Getting Care Quickly* were below the 50th percentile, and below the 25th percentile for *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan*. **Recommendations:** Conduct root cause analyses or focus studies that include health plan enrollees to address results of adult CAHPS experience surveys.

Health Plan-Specific Conclusions

Opportunities and Recommendations	
–	**Opportunity:** Child member experience survey results for *Getting Care Quickly, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan* were below the 25th percentile, and below the 50th percentile for *Rating of Specialist Seen Most Often*. **Recommendations:** Conduct root cause analyses or focus studies that include health plan enrollees to address results of child CAHPS experience surveys.
–	**Opportunity:** Results of the staffing review demonstrated that the health plan had waiver case managers who did not meet qualification/education requirements. **Recommendations:** The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads and that specificity regarding qualifications/education which may show compliance with contract requirements is included in staffing analysis submissions.

Blue Cross Blue Shield of Illinois

Strengths Related to Quality	
+	Demonstrated an increase in performance and ranked at or between the 50th and 74th percentiles for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.
+	Increased more than 10 percentage points and ranked at or between the 50th and 74th percentiles for the *Controlling High Blood Pressure* measure.
+	Met or exceeded the 75th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator and ranked at or above the 90th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator. Additionally, the health plan ranked at or above the 50th percentile for two additional *Comprehensive Diabetes Care* measure indicators.
+	In the Child Behavioral Health domain, ranked at or above the 90th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* indicator and at or above the 75th percentile for the *Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* indicators.
+	Achieved a *Reportable* designation for all PMV activities.
+	Designed methodologically sound PIPs and QIPs and achieved all validation criteria for Steps 1 through 6 (PIP Design) for all PIPs/QIPs.
+	Adult member experience survey results were at or above the 75th percentile for *Customer Service* and were at or between the 75th and 89th percentiles for *Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan.*
+	Demonstrated compliance with staffing contract requirements related to caseload limits, including those for specific waiver types.
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the HSW of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.
+	Performed at or above 90 percent for HealthChoice, MLTSS, and MMAI in demonstrating compliance to CMS HCBS performance measures, as identified by the quarterly record reviews.

Strengths Related to Quality, Access, and Timeliness	
+	Continued to perform at or above the 75th percentile for the *Ambulatory Care—Outpatient Visits—Total* measure.
+	In the Child Behavioral Health domain, ranked at or above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day* and *30-Day Follow-Up* indicators.

Health Plan-Specific Conclusions

Strengths Related to Quality, Access, and Timeliness	
+	Demonstrated an increase in performance of more than 10 percentage points for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits* measure.
+	Ranked at or above the 90th percentile for the *Immunizations for Adolescents—Combination 1* measure.
+	Demonstrated an increase in performance for the *Prenatal and Postpartum Care—Postpartum Care* indicator, ranking at or between the 75th and 89th percentiles.
+	In the Child Behavioral Health domain, demonstrated an increase of more than 5 percentage points for both *Follow-Up After Hospitalization for Mental Illness* indicators and met or exceeded the 50th percentile for the *30-Day Follow-Up* indicator.
+	Ranked at or above the 50th percentile for the *Child and Adolescent Well-Care Visits* measure.
+	In the Child Behavioral Health domain, the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 13–17* indicator demonstrated an increase of more than 5 percentage points and met or exceeded the 50th percentile.
+	Contracted with a sufficient number of required provider types within each service region for HealthChoice and MMAI and was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions for MLTSS.

Opportunities and Recommendations	
−	**Opportunity:** Rates decreased for *Adults' Access to Preventive/Ambulatory Health Services—Total.* This measure continued to rank below the 50th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
−	**Opportunity:** Performance for the *Annual Dental Visit* measure showed a decline of more than 15 percentage points from the prior MY and ranked at or between the 25th and 49th percentiles, suggesting child members are not receiving regular dental visits. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving regular dental visits. Upon identification of a root cause, BCBSIL should implement appropriate interventions to improve performance.
−	**Opportunity:** Although BCBSIL demonstrated an increase in performance of more than 10 percentage points for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits*, its ranking was at or between the 25th and 49th percentiles. Additionally, the health plan ranked below the 25th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* indicator. This performance indicates that a majority of children are not receiving well-care visits.

Opportunities and Recommendations	
	Recommendations: Conduct a root cause analysis or focus study to determine why its child members are not receiving the recommended well-child visits. Consider whether there are disparities within the population that contribute to lower performance in a particular race or ethnicity, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to well-child visits.
−	**Opportunity:** Demonstrated a decline in performance and ranked below the 25th percentile for the *Childhood Immunization Status—Combination 3* and the *Childhood Immunization Status—Combination 10* measure indicators, suggesting that children are not receiving these immunizations, which are a critical aspect of preventable care for children. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving all recommended vaccines. Consider whether there are disparities within populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also consider whether a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.
−	**Opportunity:** *Breast Cancer Screening* rates decreased in MY 2021 and ranked below the 50th percentile. **Recommendations:** Conduct a root cause analysis or focused study to determine why female members are not receiving timely screenings for breast cancer. Consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.
−	**Opportunity:** In the Adult Behavioral Health domain, demonstrated low performance for *Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions. Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
−	**Opportunity:** In an access and availability survey with specialty provider types, HSAG was unable to reach almost 32.6 percent of sampled cases and was only able to obtain an appointment date with 21.9 percent of the sampled locations. **Recommendations:** Work with HFS to obtain the case-level survey data files and address provider data deficiencies identified during the survey calls. Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate standards into educational materials.

Health Plan-Specific Conclusions

Opportunities and Recommendations	
–	**Opportunity:** Child member experience survey results for *Getting Needed Care, Getting Care Quickly,* and *Rating of All Health Care* were below the 25th percentile, and below the 50th percentile for *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. **Recommendations:** Conduct root cause analyses or focus studies that include health plan enrollees to address results of child CAHPS experience surveys.
–	**Opportunity:** Adult member experience survey results for *Getting Care Quickly* and *Rating of All Health Care* were below the 50th percentile. **Recommendations:** Conduct a root cause analysis or focus study to identify strategies for improvement for adult CAHPS experience surveys.
–	**Opportunity:** Results of the time and distance study demonstrated that the provider network for Pharmacy and Oral Surgery—Adult and Pediatric, Allergy and Immunology—Adult and Pediatric, and Neurosurgery—Adult and Pediatric did not meet the time/distance standards in all regions. **Recommendations:** Collaborate with HFS to continue to monitor the status of time/distance standards for all provider categories, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.
–	**Opportunity:** Results of the staffing review demonstrated that the health plan had waiver case managers who did not meet qualification/education requirements. **Recommendations:** The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads and that specificity regarding qualifications/education which may show compliance with contract requirements is included in staffing analysis submissions.

CountyCare Health Plan

Strengths Related to Quality	
+	Demonstrated an increase in performance and ranked at or between the 75th and 89th percentiles for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.
+	Continued to meet or exceed the 75th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator and the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator.
+	In the Child Behavioral Health domain, ranked at or above the 90th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* indicator.
+	Achieved a *Reportable* designation for all PMV activities.
+	Designed a methodologically sound PIP and achieved all validation criteria for Steps 1 through 6 (PIP Design).
+	Adult member experience survey results were at or above the 75th percentile for *Customer Service*.
+	Child member experience survey results were at or above the 90th percentile for *Customer Service* and at or between the 75th and 89th percentiles for *Rating of Health Plan*.
+	Demonstrated compliance with staffing contract requirements related to caseload limits, including those for specific waiver types.
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the HSW of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.
+	Performed at or above 90 percent for HealthChoice and MLTSS in demonstrating compliance to CMS HCBS performance measures, as identified by the quarterly record reviews.

Strengths Related to Quality, Access, and Timeliness	
+	Ranked at or above the 75th percentile for the *Child and Adolescent Well-Care Visits* measure.
+	Ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 1* measure.
+	Demonstrated an increase in performance for the *Annual Dental Visit* measure and ranked at or above the 50th percentile.
+	Consistent performance for the *Prenatal and Postpartum Care—Postpartum Care* indicator, ranking at or between the 75th and 89th percentiles.

Health Plan-Specific Conclusions

Strengths Related to Quality, Access, and Timeliness	
+	Contracted with a sufficient number of required provider types within each service region for HealthChoice and was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions for MLTSS.
+	In the Child Behavioral Health domain, ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* indicator.

Opportunities and Recommendations	
−	**Opportunity:** Rates decreased for *Adults' Access to Preventive/Ambulatory Health Services—Total,* falling to rank below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
−	**Opportunity:** Demonstrated a decrease in performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits* and ranked below the 50th percentile. Additionally, the health plan ranked below the 25th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* indicator. This performance indicates that children are not receiving well-care visits. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving the recommended well-child visits. Consider whether there are disparities within the population that contribute to lower performance in a particular race or ethnicity, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to well-child visits.
−	**Opportunity:** Demonstrated a decline in performance for the *Childhood Immunization Status—Combination 3* and the *Childhood Immunization Status—Combination 10* measure indicators, suggesting that children are not receiving these immunizations, which are a critical aspect of preventable care for children. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving all recommended vaccines. Consider whether there are disparities within populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also consider whether a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, implement appropriate interventions to improve the performance related to these measures.
−	**Opportunity:** *Breast Cancer Screening* rates decreased in MY 2021 and ranked below the 50th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast cancer. Consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.

Opportunities and Recommendations	
–	**Opportunity:** Demonstrated a decrease in performance of more than 10 percentage points for the *HbA1c Poor Control (>9.0%)* indicator. **Recommendations:** Conduct a root cause analysis or focus study to determine why diabetic members' blood sugar levels were not properly controlled. Consider whether there are disparities within its population that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.
–	**Opportunity:** In the Adult Behavioral Health domain, demonstrated low performance for *Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions. Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
–	**Opportunity:** In an access and availability survey with specialty provider types, HSAG was unable to reach almost 34.5 percent of sampled cases and was only able to obtain an appointment date with 13.2 percent of the sampled locations. **Recommendations:** Work with HFS to obtain the case-level survey data files and address provider data deficiencies identified during the survey calls. Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate standards into educational materials.
–	**Opportunity:** Adult member experience survey results for *Getting Needed Care* and *Getting Care Quickly* were below the 50th percentile, and *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan* were below the 25th percentile. **Recommendations:** Conduct root cause analyses or focus studies to determine why members perceive a lack of quality of care from their personal doctors, as well as an overall lack of quality of the care and services they receive.
–	**Opportunity:** Child member experience survey results for *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Rating of Specialist Seen Most Often* were below the 25th percentile, and below the 50th percentile for *Rating of All Health Care,* and *Rating of Personal Doctor*.
	Recommendations: Conduct root cause analyses or focus studies that include health plan enrollees to address results of child CAHPS experience surveys.
–	**Opportunity:** Results of the staffing review demonstrated that the health plan had waiver case managers who did not meet qualification/education requirements.
	Recommendations: The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads and that specificity regarding qualifications/education which may show compliance with contract requirements is included in staffing analysis submissions.

Humana Gold Plan Integrated

Strengths Related to Quality	
+	Designed a methodologically sound QIP and achieved all validation criteria for Steps 1 through 6 (QIP Design).
+	Demonstrated compliance with staffing contract requirements related to caseload limits, including those for specific waiver types.
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the HSW of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Strengths Related to Quality, Access, and Timeliness	
+	Contracted with a sufficient number of required provider types within each service region for MMAI.

Opportunities and Recommendations	
−	**Opportunity:** Results of the staffing review demonstrated that the health plan had waiver case managers who did not meet qualification/education requirements.
	Recommendations: The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads and that specificity regarding qualifications/education which may show compliance with contract requirements is included in staffing analysis submissions.

MeridianHealth

Strengths Related to Quality	
+	Continued to meet or exceed the 50th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator and improved to meet or exceed the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator.
+	In the Child Behavioral Health domain, ranked at or above the 75th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* indicator.
+	Designed methodologically sound PIPs and QIPs and achieved all validation criteria for Steps 1 through 6 (PIP Design) for all PIPs/QIPs.
+	Adult member experience survey results were at or above the 90th percentile for *How Well Doctors Communicate*.
+	Demonstrated compliance with staffing contract requirements related to waiver caseload limits.
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the HSW of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.
+	Performed at or above 90 percent for HealthChoice, MLTSS, and MMAI in demonstrating compliance to CMS HCBS performance measures, as identified by the quarterly record reviews.

Strengths Related to Quality, Access, and Timeliness	
+	Ranked at or above the 50th percentile for the *Child and Adolescent Well-Care Visits* measure.
+	Ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 1* measure.
+	Demonstrated an increase in performance for the *Annual Dental Visit* measure and ranked at or above the 50th percentile.
+	Demonstrated an increase in performance for the *Prenatal and Postpartum Care—Postpartum Care* indicator, ranking at or between the 75th and 89th percentiles.
+	In the Child Behavioral Health domain, ranked at or above the 50th percentile for the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day and 30-Day Follow-Up* indicators and at or above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* indicator.
+	Contracted with a sufficient number of required provider types within each service region for HealthChoice and MMAI and was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions for MLTSS.

Opportunities and Recommendations	
−	**Opportunity:** Rates decreased for *Adults' Access to Preventive/Ambulatory Health Services—Total.* This measure continued to rank below the 50th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
−	**Opportunity:** Demonstrated a decrease in performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits* and ranked below the 50th percentile. Additionally, the health plan ranked below the 25th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* indicator. This performance indicates that children are not receiving well-care visits. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving the recommended well-child visits. Consider whether there are disparities within the population that contribute to lower performance in a particular race or ethnicity, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to well-child visits.
−	**Opportunity:** Demonstrated a decline in performance and ranked below the 25th percentile for the *Childhood Immunization Status—Combination 3* and the *Childhood Immunization Status—Combination 10* measure indicators, suggesting that children are not receiving these immunizations, which are a critical aspect of preventable care for children. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving all recommended vaccines. Consider whether there are disparities within populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also consider whether a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, implement appropriate interventions to improve the performance related to these measures.
−	**Opportunity:** *Breast Cancer Screening* rates decreased more than 5 percentage points in MY 2021 and ranked below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast cancer. Consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.
−	**Opportunity:** Performance for the *Cervical Cancer Screening* measure showed a decline of more than 10 percentage points from the prior MY and ranked below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for cervical cancer. Consider whether there are disparities within its population that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.

Opportunities and Recommendations	
–	**Opportunity:** In the Adult Behavioral Health domain, demonstrated low performance for *Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions. Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
–	**Opportunity:** In an access and availability survey with specialty provider types, HSAG was unable to reach almost 35.1 percent of sampled cases and was only able to obtain an appointment date with 14.8 percent of the sampled locations. **Recommendations:** Work with HFS to obtain the case-level survey data files and address provider data deficiencies identified during the survey calls. Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate standards into educational materials.
–	**Opportunity:** Results of the time and distance study demonstrated that the provider network for Pharmacy and Oral Surgery—Adult and Pediatric did not meet the time/distance standards in all regions. **Recommendations:** Collaborate with HFS to continue to monitor the status of time/distance standards for all provider categories, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.
–	**Opportunity:** Adult member experience survey results for *Getting Needed Care, Getting Care Quickly, Rating of All Health Care*, and *Rating of Specialist Seen Most Often* were below the 50th percentile. **Recommendations:** Conduct root cause analyses or focus studies to determine why members perceive a lack of quality of care from their specialists, as well as an overall lack of quality of the care and services they receive.
–	**Opportunity:** Results of the staffing review demonstrated that Meridian did not meet weighted, high-risk, or moderate-risk caseload limits, and had waiver case managers who did not meet qualification/education/related experience requirements. **Recommendations:** The health plan should identify a plan to reassign caseloads to those case managers not meeting weighted, high-risk, or moderate-risk caseload limits. The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads and that specificity regarding qualifications/education/related experience which may show compliance with contract requirements is included in staffing analysis submissions.

Opportunities and Recommendations	
−	**Opportunity:** Child member experience survey results for *Getting Needed Care, Rating of All Health Care, Rating of Specialist Seen Most Often,* and *Rating of Health Plan* were below the 25th percentile, and below the 50th percentile for *Getting Care Quickly, How Well Doctors Communicate,* and *Rating of Personal Doctor*. **Recommendations:** Conduct root cause analyses or focus studies that include health plan enrollees to address results of child CAHPS experience surveys.

Molina Healthcare of Illinois

Strengths Related to Quality	
+	Demonstrated an increase in performance and ranked at or between the 50th and 74th percentiles for two of three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.
+	Increased more than 5 percentage points and ranked at or between the 50th and 74th percentiles for the *Controlling High Blood Pressure* measure.
+	Continued to meet or exceed the 50th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator and ranked at or above the 75th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator.
+	Ranked at or above the 75th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* indicator.
+	Achieved a *Reportable* designation for all PMV activities.
+	Designed methodologically sound PIPs and QIPs and achieved all validation criteria for Steps 1 through 6 (PIP Design) for all PIPs/QIPs.
+	Demonstrated compliance with staffing contract requirements related to caseload limits, including those for specific waiver types.
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the HSW of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Strengths Related to Quality, Access, and Timeliness	
+	Demonstrated a significant increase for the *Ambulatory Care—Outpatient Visits—Total* measure.
+	Ranked at or above the 50th percentile for the *Child and Adolescent Well-Care Visits* measure.
+	Demonstrated an increase in performance for the *Annual Dental Visit* measure and ranked at or above the 75th percentile.
+	Demonstrated an increase in performance for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator and an increase of more than 5 percentage points for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, ranking at or between the 75th and 89th percentiles for both measures.
+	In the Child Behavioral Health domain, demonstrated an increase of more than 5 percentage and ranked above the 50th percentile for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 13–17* indicator.

Strengths Related to Quality, Access, and Timeliness	
+	In the Child Behavioral Health domain, ranked above the 75th percentile for the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day and 30-Day Follow-Up* indicators and at or above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day and 30-Day Follow-Up* indicators.
+	Contracted with a sufficient number of required provider types within each service region for HealthChoice and MMAI and was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions for MLTSS.

Opportunities and Recommendations	
−	**Opportunity:** Rates decreased for *Adults' Access to Preventive/Ambulatory Health Services—Total.* This measure continued to rank below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
−	**Opportunity:** Demonstrated a decrease in performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits* and ranked below the 25th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* indicator. This performance indicates that children are not receiving well-care visits. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving the recommended well-child visits. Consider whether there are disparities within the population that contribute to lower performance in a particular race or ethnicity, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to well-child visits.
−	**Opportunity:** Ranked below the 25th percentile for the *Childhood Immunization Status—Combination 3* and the *Childhood Immunization Status—Combination 10* measure indicators, suggesting that children are not receiving these immunizations, which are a critical aspect of preventable care for children. **Recommendations:** Conduct a root cause analysis or focus study to determine why its child members are not receiving all recommended vaccines. Consider whether there are disparities within populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also consider whether a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, implement appropriate interventions to improve the performance related to these measures.

Opportunities and Recommendations	
–	**Opportunity:** Adult member experience survey results for *Getting Care Quickly, Rating of All Health Care, Rating of Specialist Seen Most Often,* and *Rating of Health Plan* were below the 50th percentile. **Recommendations:** Conduct root cause analyses or focus studies to determine why members perceive a lack of quality of care from their specialists, as well as an overall lack of quality of the care and services they receive.
–	**Opportunity:** *Breast Cancer Screening* rates decreased in MY 2021 and ranked below the 25th percentile. **Recommendations:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast cancer. Consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve performance.
–	**Opportunity:** In the Adult Behavioral Health domain, demonstrated low performance for *Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions. Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
–	**Opportunity:** In an access and availability survey with specialty provider types, HSAG was unable to reach almost 38.9 percent of sampled cases and was only able to obtain an appointment date with 12.9 percent of the sampled locations. **Recommendations:** Work with HFS to obtain the case-level survey data files and address provider data deficiencies identified during the survey calls. Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate standards into educational materials.
–	**Opportunity:** Results of the time and distance study demonstrated that the provider network for Pharmacy and Oral Surgery—Adult and Pediatric and Allergy and Immunology—Pediatric did not meet the time/distance standards in all regions. **Recommendations:** Collaborate with HFS to continue to monitor the status of time/distance standards for all provider categories, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.

Health Plan-Specific Conclusions

Opportunities and Recommendations	
–	**Opportunity:** Adult member experience survey results for *Getting Care Quickly, Rating of All Health Care, Rating of Specialist Seen Most Often,* and *Rating of Health Plan* were below the 50th percentile. **Recommendations:** Conduct root cause analyses or focus studies to determine why members perceive a lack of quality of care from their specialists, as well as an overall lack of quality of the care and services they receive.
–	**Opportunity:** Child member experience survey results for *Rating of All Health Care* and *Rating of Health Plan* were below the 25th percentile, and below the 50th percentile for *Getting Needed Care, How Well Doctors Communicate,* and *Rating of Specialist Seen Most Often*. **Recommendations:** Conduct root cause analyses or focus studies that include health plan enrollees to address results of child CAHPS experience surveys.
–	**Opportunity:** Results of the staffing review demonstrated that the health plan had waiver case managers who did not meet qualification/education requirements. **Recommendations:** The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads and that specificity regarding qualifications/education which may show compliance with contract requirements is included in staffing analysis submissions.

YouthCare Specialty Plan

Strengths Related to Quality	
+	As a subset population of MeridianHealth, designed a methodologically sound PIP and achieved all validation criteria for Steps 1 through 6 (PIP Design).
+	Demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority; assuring the HSW of the enrollee after the CI was identified; and demonstrating system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Strengths Related to Quality, Access, and Timeliness	
+	Contracted with a sufficient number of required provider types within each service region for HealthChoice.

Opportunities and Recommendations	
−	**Opportunity:** In an access and availability survey with specialty provider types, HSAG was unable to reach 38.4 percent of sampled cases and was only able to obtain an appointment date with 10.8 percent of the sampled locations. **Recommendations:** Work with HFS to obtain the case-level survey data files and address provider data deficiencies identified during the survey calls. Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate standards into educational materials.
−	**Opportunity:** Results of the time and distance study demonstrated that the provider network for Pharmacy and Oral Surgery—Adult and Pediatric did not meet the time/distance standards in all regions. **Recommendations:** Collaborate with HFS to continue to monitor the status of time/distance standards for all provider categories, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.
−	**Opportunity:** Results of the staffing review demonstrated that YouthCare did not meet weighted, moderate-risk, or low-risk caseload limits, and had waiver case managers who did not meet qualification/education requirements.
	Recommendations: The health plan should identify a plan to reassign caseloads to those case managers not meeting weighted, high-risk, or moderate-risk caseload limits.

Appendix B. 2021–2022 PMV Methodology & Audit Results

NCQA HEDIS Compliance Audit

Objectives

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

A key element of improving healthcare services is the ability to provide easily understood, comparable information on the performance of the health plans. 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 health plans 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. HFS requires the health plans to monitor and evaluate the quality of care using HEDIS performance measures. The health plans must establish methods to determine if the administrative data are accurate for each measure. In addition, the health plans are required by contract to track and monitor each performance measure and applicable performance goal on an ongoing basis, and to implement a quality improvement initiative addressing compliance until the health plans meet the performance goal.

NCQA licenses organizations and certifies selected employees of licensed organizations to conduct HEDIS Compliance Audits using NCQA's standardized audit methodology. The NCQA HEDIS Compliance Audit indicates the extent to which health plans 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 system practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, and analytic file production.

Technical Methods of Data Collection and Analysis

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's MY 2021 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 2021, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, which outlines the accepted approach for auditors to use when conducting an Information Systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a health plan. All of HSAG's lead auditors were Certified HEDIS Compliance Auditors (CHCAs). The audit involved three phases: *Audit Validation Activities*, *Audit Review Activities*, and *Follow-Up and Reporting Activities*. The following provides a summary of HSAG's activities with the health plans, as applicable, within each of the validation phases:

Audit Validation Phase (October 2021 through May 2022)

- Forwarded HEDIS MY 2021 Record of Administration, Data Management, and Processes (Roadmap) to health plans upon release from NCQA.
- Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled virtual audit review dates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS audit processes, and ensure that health plans were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards and provided the information system standard tracking report which listed outstanding items and areas that required additional clarification.
- Conducted validation for all supplemental data sources (SDS) intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation (MRRV) to ensure the integrity of medical record review (MRR) processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Phase (January 2022 Through April 2022)

- Conducted virtual audit reviews to assess health plans' capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2022 Through July 2022)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final information system standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS MY 2020 Audit Means and Percentiles. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained

Through the methodology, HSAG obtained a number of different information sources to conduct the performance measure validation according to NCQA's established HEDIS deadlines. These included:

- HEDIS Roadmap.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors.

HSAG also obtained information through interaction, discussion, and formal interviews with key health plan staff members as well as through observing system demonstrations and data processing.

A specific set of performance measures was selected by HFS for validation by HSAG based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. The measures selected by HFS for validation by HSAG through the NCQA HEDIS Compliance Audits are listed in the table below. For measures that had administrative (admin) and hybrid specifications, HFS allowed the health plans to choose the data collection methodology (i.e., admin or hybrid) that worked best for its health plan.

Table B-1—HEDIS MY 2021 Measures Selected by HFS for HSAG's Validation

	Performance Measure Name	Acronym	Methodology
1	*Breast Cancer Screening*	*BCS*	Admin
2	*Childhood Immunization Status*	*CIS*	Admin, Hybrid
3	*Comprehensive Diabetes Care*	*CDC*	Admin, Hybrid
4	*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	*FUA*	Admin
5	*Follow-Up After Emergency Department Visit for Mental Illness*	*FUM*	Admin
6	*Follow-Up After High-Intensity Care for Substance Use Disorder*	*FUI*	Admin
7	*Immunizations for Adolescents*	*IMA*	Admin, Hybrid
8	*Pharmacotherapy for Opioid Use Disorder*	*POD*	Admin
9	*Prenatal and Postpartum Care*	*PPC*	Admin, Hybrid

HSAG used several different methods and information sources to conduct the audits, including:

- Teleconference calls with health plan personnel and vendor representatives, as necessary.
- Detailed review of each health plan's completed responses to the HEDIS MY 2021 Roadmap, published by NCQA as Appendix 2 to NCQA's *HEDIS Measurement Year 2021, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, and updated information communicated by NCQA to the audit team directly.
- Virtual audit meetings with the health plans, which included staff interviews, live system and procedure demonstrations, documentation review and requests for additional information, primary source verification (PSV) for a selection of measures, computer database and file structure review, and discussion and feedback sessions.
- If the hybrid method was used, an abstraction of a sample of medical records selected by the auditors was compared to the results of the health plan's review determinations for the same records.
- If nonstandard supplemental data were used, PSV was conducted on a sample of records, which involved review of proof-of-service (POS) documentation for each selected case.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates submitted by the health plans.
- A variety of interviews with individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, the IS director, the quality management director, the enrollment and provider data manager, medical records staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that calculated HEDIS MY 2021 (and earlier) performance measure data may also have been interviewed and asked to provide documentation of their work.

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the NCQA categories listed below in Table B-2.

Table B-2—Performance Measure Audit Results and Definitions

Rate/Result	Definition
R	*Reportable.* A reportable rate was submitted for the measure.
NR	*Not Reported*. The health plan chose not to report the measure.
*NA**	*Small Denominator.* The health plan followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate. a. For Effectiveness of Care (EOC) and EOC-like measures, when the denominator is < 30. b. For utilization measures that count member months, when the denominator is < 360 member months. c. For all risk-adjusted utilization measures, when the denominator is < 150. d. For electronic clinical data systems measures, when the denominator is < 30.
*NB***	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The health plan chose not to report the measure.

Rate/Result	Definition
*NQ***	*Not Required.* The health plan was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The health plan chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

* NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered *Reportable* (R); however, the denominator is too small to report.

** Benefits are assessed at the global level, not the service level.

*** NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

For measures reported as percentages, NCQA has defined "significant bias" as an error that causes 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.)

For some measures, more than one rate is required for HEDIS reporting (e.g., *Childhood Immunization Status* and *Prenatal and Postpartum Care*). It is possible that the health plan prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the health plan would receive a *Reportable (R)* result for the measure as a whole, but significantly biased rates within the measure would receive a *Biased Rate (BR)* result, where appropriate.

Upon completion of the audit, HSAG submitted a final audit report to HFS and each health plan that included a completed and signed final audit statement.

For the MRRV portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the health plan, including data collection instruments/tools, accuracy of data collection, vendor oversight, and the method used for combining MRR data with administrative data; and (2) complete MRRV, which involves the validation of the health plan's abstraction accuracy for a sample of cases across the NCQA-designated measure groups and a comparison of HSAG's validation results to the health plan's abstraction results.

HSAG reviewed the processes in place at each health plan for MRR performance for all measures reported using the hybrid method. HSAG reviewed data collection tools against the measure specifications to verify that all key HEDIS clinical data elements were captured. Feedback was provided to each health plan if the data collection tools appeared to be missing necessary data elements.

HSAG completed the MRRV process and over-read sample records across the appropriate measure groups and compared the results to each health plan's findings for the same medical records. This process provided an assessment of actual reviewer accuracy. HSAG randomly selected 16 cases from the MRR numerator positives as identified by each health plan. If fewer than 16 medical records were found to meet numerator compliance, all records were reviewed or additional records from another measure within the same group were added to equal 16 cases. If an abstraction discrepancy was noted, only critical errors were considered errors. A critical error is defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa). If one critical error was noted, HSAG was required to retest a second sample of 16 records that did not

include the original sampled records. If the second sample was free of errors, the measure and measure group passed. If one or more errors were detected, the measure and measure group did not pass validation and could not be reported until all errors were corrected and reviewed by the auditor. If there was not enough time to correct all errors, the health plan was not allowed to report the measure via the hybrid methodology.

In addition to validating numerator positive cases, HSAG also validated the accuracy of exclusion cases. This task was accomplished by sampling exclusions across all measures to determine the appropriateness of the exclusion. If HSAG deemed that an exclusion was not in alignment with NCQA's specifications, the health plan was required to keep the case in the denominator.

HSAG completed the MRRV component of the audit and provided an assessment of each health plan's medical record abstraction accuracy.

Health Plan-Specific Findings for HealthChoice Illinois Health Plans

NCQA HEDIS Compliance Audit Results for Aetna

HSAG conducted a MY 2021 NCQA HEDIS Compliance Audit of Aetna's data collection and reporting processes for its HealthChoice Illinois population. HSAG determined Aetna was fully compliant with all HEDIS Information System (IS) standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased and all performance measures under the scope of the audit received an *R* designation.

Table B-3—Aetna MY 2021 NCQA HEDIS Compliance Audit Results

Information Systems Capabilities Assessment						
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**MRR Processes**	**Supplemental Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

The rationale for determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

Aetna processed claims during MY 2021 using the QNXT system. Approximately 92 percent of claims were received electronically. Change Healthcare was the vendor used for paper claim scanning and electronic claim transmissions. There were no vendor performance issues in 2021.

Claims audits included Monthly Validation, High Dollar Audit Review, and Random Audit Review. Claims for the random audit were randomly selected from the entire population of claims processed. The 2 percent random claim selection volume was based on the prior day's production of the individual analyst. Overall internal audit scores for 2021 were greater than 98 percent for all categories.

Electronic claims transmissions had requirements in place to ensure Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance. The electronic claims also went through several business rule validations including field edits, member eligibility, provider eligibility, authorization, benefits, and pricing. The claims were then loaded to QNXT.

The majority of providers under capitated payment arrangements were part of primary care practices. Encounters submitted by capitated providers were processed in QNXT in the same way claims were processed. The providers were required by the State to submit all encounters to Aetna.

Aetna claims processing vendors included March Vision, DentaQuest, and CVS. Aetna monitored vendor performance during MY 2021, and no CAPs were necessary.

Aetna was fully compliant with IS Standard 1.0 for medical services data.

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

Aetna received 837 enrollment files from the State, processed them through the Enrollment Central application, and then loaded the files to QNXT. When files completed processing, an automated email was generated indicating the time and total records processed, as well as error and exception messages that needed to be reviewed by enrollment staff and updated manually. There were no issues or delays receiving the State files during MY 2021.

Aetna membership increased by approximately 25,000 members during 2021. Aetna confirmed the increase was due to State redeterminations enabling members to maintain eligibility, and an increase in eligible members due to COVID-19 pandemic-related unemployment.

Race and ethnicity data were provided in the State 834 files in a single field. The categories did not match the HEDIS reporting categories in all cases. Aetna developed a crosswalk to address values that did not have a direct match.

Aetna was fully compliant with IS Standard 2.0 for enrollment data.

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

Aetna housed provider data in the QNXT system for claims processing. There were no changes to Aetna's provider data processes. The State was responsible for credentialing all providers. The State continued to mandate that providers use a standard roster template.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) were determined by the State and identified in the State provider data rosters that were submitted to Aetna. This information was loaded to all systems.

No issues were identified with Aetna's provider data processes. Aetna was fully compliant with IS Standard 3.0 for practitioner data.

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

Aetna's national team and local health plan staff were responsible for MRR. The national team conducted training, initial interrater reliability (IRR) testing, and ongoing over-read validation. The IRR testing was completed following training, with 95 percent accuracy required to work on a measure. The national team also monitored progress and provided weekly reports to the health plan that showed whether the weekly completion goals were met.

Aetna maintained the same team to work on the project, with two new full-time staff added. Aetna had several providers that allowed remote electronic medical record (EMR) access. The remainder of the

charts were requested via fax. Aetna did not conduct any MRRs on-site with providers during the MY. One hundred percent of compliant charts were overread, with the goal of also overreading 100 percent of the noncompliant chases.

The auditor required Aetna to undergo convenience sample validation for the *CDC—Blood Pressure Control (<140/90 mm Hg)* measure since this was new to the scope of the audit. All convenience sample records passed the validation process with no errors identified.

Aetna passed the final MRRV for the *PPC—Postpartum Care*, *CDC—Eye Exam (Retinal) Performed*, *CDC—HbA1c Control (<8.0 %)*, and *CIS—Combination 10*, *IMA—Combination 1* measures, and all medical record exclusions.

Aetna was fully compliant with IS Standard 4.0 for MRR processes.

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

Aetna used 16 supplemental data sources for HEDIS MY 2021 reporting. The auditor determined 13 of the sources to be standard supplemental data, and the remaining three were determined to be nonstandard supplemental data.

The standard data sources included Athena Continuity of Care Document (CCD) files, Quest and LabCorp lab results, State immunizations and historical claims, and several direct EMR data feeds.

Aetna had processes in place to validate all supplemental data files. Prior to loading any data, each data source undergoes scrutiny by Aetna's Data Governance Committee. As part of this process, the file layout is examined, and a sample file is tested.

The auditor conducted primary source verification (PSV) of the Athena CCD data during the previous year's audit, and all cases passed the validation process. Since there were no changes to the data collection processes from the prior year or the measures for which the data source was being used, the auditor designated this as a standard database for HEDIS MY 2021 and PSV was not required.

Centene provided all historical IlliniCare supplemental data to Aetna, and these data were included in Aetna's HEDIS MY 2021 performance measure rates.

Aetna used three data sources that the auditor determined to be nonstandard supplemental data: HealPros, MXOtech IL, and the Year-Round Medical Record Review Tool.

Aetna developed a supplemental database from MXOtech data. MXOtech is a health information exchange (HIE) in Illinois that is providing clinical data from approximately 45 provider groups. The provider groups sending data are located throughout the State. The first files were sent in November 2021. The file for HEDIS MY 2021 only includes one provider group. Additional data were received for 2021 but the data were not internally validated and formatted in time to be included in the PSV selection on March 1, 2022. The auditor determined this data source to be nonstandard supplemental data; therefore, PSV was required. The auditor selected a sample of cases according to NCQA's guidelines.

All cases passed the validation process, and the database was approved to use for HEDIS MY 2021 reporting.

Aetna developed a new supplemental database from HealPros data. HealPros performs eye exams, HbA1c tests, and microalbumin tests at members' homes. HealPros sends the test data to Aetna in an MS Excel spreadsheet and a text file. HealPros provides standard current procedural terminology (CPT) codes and the numeric result. Files were sent to Aetna starting in November 2021. This data source was determined to be nonstandard supplemental data. The auditor selected a sample of cases for PSV. All cases passed the validation process, and the database was approved to use for HEDIS MY 2021 reporting.

The Year-Round Medical Record Review Tool was populated from internally conducted MRRs. There were no changes to the measures collected in this database. QuickBase was used for data collection. A 100 percent over-read was conducted. The auditor determined this source to be nonstandard data. The auditor selected a sample of cases for PSV. All cases passed the validation process, and the database was approved to use for HEDIS MY 2021 reporting.

All 13 standard supplemental data sources and three nonstandard data sources were approved to use for HEDIS MY 2021 reporting. Aetna was fully compliant with IS Standard 5.0 for supplemental data.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Aetna continued to use Inovalon's Quality Spectrum Insight-XL (QSI-XL) HEDIS Certified Measures[B-1] software for reporting HEDIS MY 2021 performance measure rates. The software is vendor hosted. The initial load was in January 2022, and additional loads took place in February, March, and April 2022.

Aetna ensured that all data were transferred to the vendor and were properly formatted by verifying the data loaded into QSI-XL completely. This task was performed by analyzing the data that were placed on the secure file transfer protocol (SFTP) site to the landing zone in QSI-XL and checking the total rows with the exported files document that was updated each month.

Aetna provided the Quality Assurance Testing plan for Aetna's Medicaid analytical and reporting data warehouse, ASDB, in addition to the reconciliation documents. Aetna also provided the Provider Specialty Mapping document with its Roadmap submission. The auditor reviewed the mapping and made recommendations for changes, which were incorporated.

Aetna was fully compliant with IS Standard 6.0 for data preproduction processing.

[B-1] HEDIS Certified Measures[SM] is a service mark of the NCQA.

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

Aetna continued to contract with Inovalon to generate its HEDIS performance measure rates. Inovalon's QSI-XL software achieved NCQA Measure Certification for all measures[SM,B-2] under the scope of the audit. The auditor confirmed the certified version was used to produce the preliminary and final rates.

Aetna provided the HEDIS Data Load Documents for the January 2022 load. No significant issues for Illinois Medicaid were identified.

The auditor reviewed four queries during the virtual audit.

For the first query, the auditor selected five compliant cases each from QSI-XL for the *BCS*, *PPC—Timeliness of Prenatal Care*, and *FUM* measures. For all cases, Aetna demonstrated the POS in either QNXT or the data warehouse, and no discrepancies were noted.

For the second query, Aetna provided the pharmacy claim counts by month for 2021. The auditor reviewed the data with Aetna during the virtual audit. The pharmacy claim counts increased throughout the year as expected due to membership growth.

For the third query, Aetna provided race and ethnicity data for its current Illinois Medicaid membership.

For the fourth query, Aetna provided membership per month for MY 2021 which confirmed the membership increase during the year.

The auditor reviewed preliminary administrative rates during the virtual audit and identified no issues. The auditor did not identify any measures at risk at the time of the virtual audit.

The auditor conducted final rate review, providing trending with the prior years if available as well as national benchmarks for each of the rates reported by Aetna. As part of the final rate review process, the auditor reviewed and signed off on the IDSS Tier 2 Warnings for Aetna's submission. The auditor confirmed by reviewing the IDSS warnings that the certified version of the HEDIS measure reporting software was used to produce each measure rate. All final rates were determined to be reportable for MY 2021 reporting.

Aetna was fully compliant with IS Standard 7.0 for data integration and reporting.

[B-2] NCQA Measure Certification[SM] is a service mark of the NCQA.

NCQA HEDIS Compliance Audit Results for BCBSIL

HSAG conducted a MY 2021 NCQA HEDIS Compliance Audit of BCBSIL's data collection and reporting processes for its HealthChoice Illinois population. HSAG determined BCBSIL was fully compliant with all HEDIS IS standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased and all performance measures under the scope of the audit received an *R* designation.

Table B-4—BCBSIL MY 2021 NCQA HEDIS Compliance Audit Results

Information Systems Capabilities Assessment						
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**MRR Processes**	**Supplemental Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

The rationale for determining full compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

BCBSIL continued to use Cognizant as a third-party administrator to process medical services data. Cognizant used Facets to process claims. Throughout MY 2021, Cognizant received approximately 90 percent of claims in standard 837 format with the remaining 10 percent being received on paper. Cognizant only accepted standard claims forms, diagnosis codes, and procedure codes. Cognizant converted paper claims to 837 format using scanning and optical character recognition (OCR) technology. All 837 files received through the clearinghouse and via Cognizant's scanning process were loaded into Facets through the applications translator. Standard validations and business rules were applied.

For 2021, approximately 99.0 percent of clean claims were adjudicated within 29 days, exceeding Cognizant's established service level agreement with BCBSIL. Cognizant's Quality Team conducted audits on a random sample of claims to monitor processor proficiency and accuracy. BCBSIL met with Cognizant at least weekly to discuss operations and targeted audit results. The audits assessed timeliness, compliance with State processing requirements, potential fraud and abuse, technical accuracy, and financial accuracy. Approximately 3 percent to 4 percent of claims were audited, and Cognizant also conducted focused audits based on identified trends. Error trends identified through these internal audits were discussed with the claims teams, and additional training was conducted as needed. In addition, BCBSIL conducted annual delegation audits of Cognizant. No corrective actions were requested of Cognizant related to medical services data processing during MY 2021. BCBSIL

reimbursed providers on a fee-for-service (FFS) basis for all services which was confirmed during the virtual audit review.

During the virtual audit review, Cognizant provided a system walk-through to demonstrate the ability of the Facets system to capture data elements required to support HEDIS reporting. The walk-through confirmed that Facets had processes to validate procedure codes, diagnosis codes, eligibility, and provider affiliation. The capture of rendering provider identifiers was also confirmed.

BCBSIL had a very close relationship (financial stake) with its pharmacy benefit manager (PBM), Prime Therapeutics. Oversight included weekly and biweekly meetings between BCBSIL and Prime Therapeutics. Reports and dashboards presenting performance on key performance indicators of operational and quality metrics were reviewed during the meetings. No corrective actions were requested of Prime Therapeutics related to its data in MY 2021.

Davis Vision was the vendor contracted with BCBSIL for vision claims processing. BCBSIL held monthly Joint Operational Committee meetings with Davis Vision wherein claims delegation was monitored and performance was discussed. BCBSIL identified a 2021 CAP for Davis Vision as a result of the BCBSIL annual delegation audit. The corrective actions related to HEDIS MY 2021 reporting included an action item to obtain the rendering physician National Provider Identifier (NPI) to ensure appropriate scope of practice for opticians, plus an action item for Davis Vision to update its record retention requirements to meet HIPAA requirements. Additional corrective action items required of Davis Vision were operational, and BCBSIL demonstrated appropriate oversight and documentation of CAPs.

All BCBSIL vendor contracts included performance guarantees.

During the virtual audit, BCBSIL demonstrated sample reports it used to monitor and track both Prime Therapeutics and Davis Vision performance. Cognizant processed all behavioral health claims, and no processes differed for these claims in comparison to those Cognizant used for processing medical services claims.

BCBSIL was fully compliant with IS Standard 1.0 for medical services data.

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

BCBSIL membership increased from 2020 to 2021. Monthly membership counts also increased throughout 2021 with the highest membership of the year in December. This was attributed to the State's redetermination freeze for Medicaid eligibility, and BCBSIL indicated that additional individuals were potentially becoming eligible for Medicaid as a result of having 1115 waiver eligibility. BCBSIL further indicated it has a high auto-assignment rate which contributes to additional enrollment increases.

BCBSIL continued to use Cognizant to process enrollment data. Cognizant continued using the Facets system for enrollment data. BCBSIL received daily enrollment files with additions, terminations, and primary care provider (PCP) information. Monthly 834 audit files were also received from the State and were reconciled to the information received in the daily files and then loaded into Facets via its enrollment processing system application. Even with the increases in membership throughout MY 2021,

Cognizant did not experience any issues with meeting its internal timeliness standard to process enrollment files within 24 hours of receipt. Most records loaded from the State files without any issues, and Facets included checks and balances so any records that were not able to be processed would automatically route to a queue for manual intervention. Examples of records requiring manual intervention were member name changes, phone number mismatches, or other demographic data that required a staff member to research. These were required to be worked within 24 hours, and managers reviewed the queues within 24 to 72 hours to ensure timeliness was maintained. If discrepancies could not be resolved internally, Cognizant enrollment staff members would access an HFS-maintained website where member information could be identified within the State's source data. If unable to resolve by researching through the HFS site, Cognizant routed these issues through BCBSIL staff members who outreached directly to HFS to resolve. Cognizant indicated approximately 5 percent of enrollment records required manual research throughout MY 2021.

The Cognizant Quality Team monitored the accuracy of the enrollment data, and Cognizant demonstrated Facets enrollment screens and the process for editing enrollment data live during the virtual audit. All data elements required to support HEDIS and the HFS reporting were present in the Facets system. Member eligibility history was present and long-term care identifiers were confirmed during the demonstration.

BCBSIL was fully compliant with IS Standard 2.0 for enrollment data.

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

BCBSIL maintained practitioner data in Premier Provider and Facets. Credentialing and contracting data were maintained in the Premier Provider system. BCBSIL did not conduct credentialing since it received provider data on the HFS IMPACT file, which included the provider information as verified through the State's credentialing process. The HFS IMPACT file included all provider specialty data and served as confirmation of the provider's Medicaid enrollment.

To initiate enrollment in BCBSIL, providers completed online applications that initiated the provider enrollment process within the BCBSIL network. Upon receipt of a provider application, BCBSIL reviewed the IMPACT file. After confirming the provider information matched between the application and IMPACT files, BCBSIL would then export and transfer the information on daily provider files to Cognizant via an SFTP site. If BCBSIL identified any provider data mismatches, it notified the provider of the mismatch (e.g., specialty requested on provider application does not match the IMPACT file specialty), so the provider could either correct the information on the application or contact HFS to resolve the data discrepancy within the IMPACT file. Cognizant loaded the BCBSIL provider files in Premier Provider and Facets after conducting its own file verification checks. Weekly reports were produced within Premier Provider and Facets and reviewed to ensure matching between the two systems. The reports compared the full set of practitioner data in each system.

During the virtual audit review, system demonstrations were conducted for both the Premier Provider and Facets provider systems. A PCP and non-PCP record were demonstrated within both systems and configuration of FQHC providers was discussed and demonstrated as well. The system allowed for the

listing of individual practitioners affiliated with FQHCs per the demonstrations. All data elements, including specialty and active contract segments, matched between the two systems.

BCBSIL was fully compliant with IS Standard 3.0 for practitioner data.

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

BCBSIL continued to conduct its own chart abstraction and worked with Episource for a portion of its chart retrieval. Episource retrieved charts for providers with 1,000 members or less assigned, and BCBSIL retrieved charts wherein provider groups have provided direct EMR access or the groups have more than 1,000 assigned members. Episource documented its chart chase status in a database, and BCBSIL has access to the same database to maintain oversight of the progress of the project. Provider chart chase logic was reviewed and determined to be sound. While BCBSIL used an OCR vendor for converting scanned medical records to searchable data in MY 2020, it discontinued that process for MY 2021 and is testing internal OCR technology to use for large medical records, which should increase efficiency by providing searchable text options. BCBSIL continued to use internal staff to conduct quality assurance and had no changes in this process from prior years. Staff members were sufficiently qualified and trained on the HEDIS technical specifications and the use of Inovalon's Quality Spectrum Hybrid Reporter (QSHR) abstraction tool for the measures under review.

BCBSIL used the QSHR MRR dashboard for monitoring completion rates, including a comparison of the current year's completion rates to the prior year for the same timeframe. BCBSIL conducted appropriate post-training assessment of staff and required a 95 percent score for staff to begin working on the project. Ongoing over-reads of records were also conducted, with retraining to occur if an issue was identified. The BCBSIL staff members who conducted the abstraction were temporary staff members; however, BCBSIL uses the same temporary staff each year for the project, and its internal employees in its Quality Department continued to conduct the over-reads. Since *IMA—Combination 2* and *CDC—Blood Pressure Control (<140/90 mm Hg)* were two hybrid measures in the scope of the HFS audit which were not recently selected for MRRV, the auditor requested convenience sample validation for both measures. All cases submitted for convenience sample review successfully passed the validation process.

BCBSIL passed the final MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics & Maternity—*CDC–BP Control*
- Group D: Immunizations & Other Screenings—*IMA—Combo 2*
- Group F: All Medical Record Exclusions

BCBSIL was fully compliant with IS Standard 4.0 for MRR processes.

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

BCBSIL submitted documentation for nine standard supplemental data sources for MY 2021 reporting: Advocate Lab, Advocate Physician Partners, Quest Diagnostics (Quest), I-CARE Illinois Immunization Registry, Swedish Physician Partners, Lawndale Christian Health Center, LabCorp, Northwest

Community Health, and Boncura Lab Data (Boncura), as well as four nonstandard sources: MSOGL-Ravenswood Physician Associates, Epic Payer Platform, Diameter Health-labclaim, and Diameter Health-medclaim.

BCBSIL received laboratory data routinely in a standard format. Lab data were loaded into the BCBSIL Enterprise Data Warehouse (EDW). Boncura lab data were received in a standard proprietary file layout which has been used by the provider group for many years and therefore has remained stable without changes. Boncura data require mapping the lab test name to a standard code.

Both standard and nonstandard sources underwent extensive testing, and error reports were transmitted to alert the submitting entity of any errors for immediate correction. An example of an error report was reviewed during the virtual audit review which showed how data problems (missing mandatory data, invalid values as defined by line number, data in the wrong format, etc.) were flagged. BCBSIL fully deployed its updated file layout for new vendors providing supplemental data in MY 2021, which was discussed previously as initially implemented in MY 2020. The updated file layout has more fields that allow for prompt onboarding of new vendors/trading partners for supplemental data in the future, while ensuring continual use of a standard file layout.

Epic Payer Platform was reviewed live with BCBSIL and Epic staff members to demonstrate how the PDFs are generated, as PDFs were provided for PSV of this nonstandard supplemental data source. Through this demonstration, BCBSIL and Epic showed the Epic source system and the BCBSIL Epic Payer Platform system as the auditor compared each to the fields and data within the PSV PDFs. The auditor observed that the PDFs were an exact replica of the Epic Payer Platform system, which in turn, was an exact replica of the same fields that were identified within the Epic source system. This source passed PSV with a 100 percent match of all cases reviewed.

Additionally, Diameter Health-medclaim and Diameter Health-labclaim both passed PSV after clarifications were provided to identify the following:

- The auditor approved the Diameter Health-medclaim supplemental data source based on the resubmitted data file and subsequent PSV as all 50 cases passed PSV. Diameter Health indicated that the issue of a mismatch in service dates was due to its system defaulting to dates of service in a full encompassing encounter which could result in pulling from a different date of service from the individual encounter. Diameter Health now defaults first to the individual performing provider at the encounter or procedure level, with the encompassing encounter provider being the last resort only after implementing multiple matching logic processes.
- The auditor approved the Diameter Health-labclaim supplemental data source after clarifying a date-time stamp mismatch that resulted in some lab dates of service displaying in the data file as a day prior to the actual date as denoted in the POS record. After evaluating impact to the *PPC* and *CDC* measures, it was determined that the impact was negligible, and the auditor recommended that BCBSIL work with Diameter Health to resolve this issue by deploying a correction to prevent the date-time stamps that are missing the actual time from defaulting to the date prior.

MSOGL-Ravenswood passed PSV, with 100 percent case matches to the data file; no issues were identified.

BCBSIL provided a demonstration of the supplemental data in EDW. The demonstration included discussion about data validation and visual inspection to confirm required data fields. A file review log was used to track all reviewed files.

The auditor approved all nine standard and four nonstandard supplemental data sources for MY 2021 reporting. BCBSIL was fully compliant with IS Standard 5.0 for supplemental data.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

BCBSIL had a sound process for updating and monitoring the accuracy and completeness of the HEDIS data repository. Standard data sources including enrollment, provider, claims, pharmacy, and supplemental data were updated monthly. Routine data checks, including record counts and data integrity checks, were performed and documented. BCBSIL's quality process also included monthly calculation and reporting of HEDIS measures to support internal quality improvement activities and to provide ongoing monitoring and rate trending of the production of HEDIS performance measure calculations.

The BCBSIL data quality review (DQR) process included a mechanism to identify any practitioner specialty data mapping issues requiring review. During the virtual audit review, BCBSIL provided a demonstration of the process for data extraction from the EDW to the Inovalon One QSI-XL software and the validation process. The most recent DQR and the provider specialty mapping were reviewed. No issues were identified during the walk-through or DQR review.

BCBSIL was fully compliant with IS Standard 6.0 for data preproduction processing.

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

BCBSIL used Inovalon One QSI-XL software to generate its performance measure rates. BCBSIL had a sound process for monitoring data integrity and the accuracy of calculations. BCBSIL conducted parallel calculation and reporting processes that provided monthly updated reporting and the annual production for HEDIS reporting. During the virtual audit review, PSV was conducted for five members in each of the following measures: *FUI* and *POD*. For each member, enrollment, administrative, and practitioner data in the QSI-XL repository and source systems were reviewed to confirm compliance with measure specifications and system concordance. All five members for each of the selected measures were found to be compliant with the measure specification requirements. Additionally, BCBSIL demonstrated sufficient monitoring of vendor performance and included evaluation of vendor performance in its oversight processes.

BCBSIL was fully compliant with IS Standard 7.0 for data integration and reporting.

NCQA HEDIS Compliance Audit Results for CountyCare

HSAG conducted a MY 2021 NCQA HEDIS Compliance Audit of CountyCare's data collection and reporting processes for its HealthChoice Illinois population. HSAG determined CountyCare was fully compliant with all HEDIS IS standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased and all performance measures under the scope of the audit received an *R* designation.

Table B-5—CountyCare MY 2021 NCQA HEDIS Compliance Audit Results

Information Systems Capabilities Assessment						
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**MRR Processes**	**Supplemental Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

The rationale for determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

CountyCare continued to delegate most health plan operations to Evolent during MY 2021, including claims processing. Evolent used Aldera as its claims transactional system. For MY 2021, approximately 97.5 percent of claims were received electronically in the standard 837 format. The remaining 2.5 percent of claims were received as paper claims, scanned, and converted to the standard 837 format for loading. Approximately 85 percent of CountyCare's claims auto-adjudicate with the remaining 15 percent pending to a workflow queue to resolve the issue (authorization, coordination of benefits, member eligibility issue, etc.). Other claims may be manually moved to a claims queue for manual processing based on certain remark codes that are added to the claim when an issue needs to be resolved (explanation of benefits required, out-of-network services, etc.).

Evolent only accepted standard claims forms, diagnosis codes, and procedure codes. Electronic claims files were loaded into the Aldera system and industry-standard edits were applied. Evolent had appropriate edits in place at the clearinghouse level for formatting as well as member validation, procedure code edit checks, and required field checks within the Aldera system. CountyCare conducted weekly meetings with Evolent and Evolent provided daily reports to CountyCare for oversight. Evolent described a detailed internal audit process. A dedicated team at Evolent conducted claims audits of a random standard sized sample of claims per each adjudicator. This team was separate from the claims processing team to avoid conflicts of interest. Any issues were discussed with the claims processor and additional training was completed at an employee level, as well as at a team level if trends were

identified. Results were included in the employee's monthly and annual reviews. Evolent conducted both concurrent and retrospective audits and also conducted additional audits (configuration audits for end-to-end claim process, high dollar claims, targeted provider claims, CountyCare-identified specific issues, etc.). CountyCare conducted biweekly oversight meetings. The percentage of clean claims adjudicated within 30 days was determined to be about 98 percent on average, throughout MY 2021.

CountyCare primarily reimbursed providers through a FFS delivery system, with approximately 7.2 percent of providers reimbursed through a capitation model. CountyCare indicated that it increased capitated arrangements in MY 2021 as it had added additional FQHCs which were reimbursed on a capitated basis. All providers were required to submit claims for all services. CountyCare closely monitored received claims and compared the claims with capitation payments. Evolent provided a system demonstration during the virtual audit that showed how original claims were compared with data in the Aldera system and that all HEDIS-related fields were traced through into the Aldera system.

CountyCare contracted with MedImpact as a PBM through the entire MY. MedImpact provided daily encounter files along with monthly reconciliation files. CountyCare contracted with Avesis to process routine vision claims throughout MY 2021. Pharmacy and vision encounter files were received by Evolent and loaded into the data warehouse. Routine validation reports were produced during the process of being loaded into the warehouse.

CountyCare was fully compliant with IS Standard 1.0 for medical services data.

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

CountyCare experienced an increase in membership from MY 2020 to MY 2021 which CountyCare attributed to the COVID-19 pandemic. There were HFS freezes on membership disenrollments and redeterminations; and, similar to the MY 2020 situation, CountyCare speculated that additional individuals were gaining Medicaid eligibility likely due to income impact of the COVID-19 pandemic.

CountyCare delegated enrollment processing to Evolent. Daily and weekly 834 files were received through an automated process and loaded into Aldera. Daily and weekly files contained member additions, terminations, and changes. The 834 files provided by HFS were clean with a very low volume of rows that were rejected during the load process. The most common reason for rows being rejected included overlapping segments, date of birth inconsistencies, and name inconsistencies. CountyCare initially reviewed any discrepancies and contacted HFS if needed to assist with resolution. Evolent provided a demonstration of the Aldera enrollment system during the virtual audit. All HEDIS-relevant data elements were observed in the system, including the capture of historical enrollment spans and long-term care flags.

CountyCare was fully compliant with IS Standard 2.0 for enrollment data.

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

Provider credentialing was centralized with HFS and therefore did not occur at the CountyCare-level. CountyCare received the HFS provider IMPACT files and conducted validation of provider data, comparing the IMPACT and provider roster files which CountyCare received directly from providers at

the initiation of the contracting process. After conducting initial validation of provider data and resolving any data discrepancies between the rosters and the IMPACT files, CountyCare submitted daily provider files to Evolent which were then loaded into the Aldera system. In addition, Evolent routinely identified providers who submitted claims for CountyCare members but were not included in the files provided by CountyCare. These providers were researched through the State provider database and entered into the Aldera system based on the HFS database provider information. Aldera housed all provider data elements including provider specialty. CountyCare demonstrated its process for verifying and processing provider data prior to submission to Evolent, and Evolent provided a demonstration of the Aldera system. No issues were identified with CountyCare's provider data capture, transfer, and entry processes.

CountyCare was fully compliant with IS Standard 3.0 for practitioner data.

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

In MY 2021, for the second year, CountyCare contracted with KDJ Consultants (KDJ) as its medical record vendor. HSAG reviewed and approved the KDJ hybrid abstraction tools and participated in a live demonstration of the MRR application to determine compliance with the HEDIS technical specifications. The MRR system used for clinical documentation was Health and Recovery Plan (HARP). Vital Data Technologies' (VDT's) Affinitē system was used to capture nonclinical chart details.

KDJ completed all chart chases and input the data into VDT's system. CountyCare conducted close oversight of KDJ's chart chase progress and abstraction, along with weekly oversight meetings to ensure complete and accurate data collection.

During the virtual audit review, HSAG reviewed a sample report from KDJ which was generated from HARP. Staff turnover for KDJ was discussed during the virtual audit and KDJ confirmed their staff averages about seven years of experience for HEDIS MRR, with very little turnover. KDJ described its training process which includes webinars for measure updates it offers prior to December. KDJ also has self-learning modules specific to clients so KDJ had a module customized for the CountyCare HEDIS project. These learning modules are reviewed and updated annually to accommodate measure changes and any client-specific requests. Annually, CountyCare delegates overreads of specific measures to Evolent. For MY 2021, Evolent conducted over-reads of 100 percent of compliant records for all hybrid measures in the scope of the HFS audit and a random sample of about 5 percent of noncompliant records. Evolent documented its findings in the VDT system, Affinitē. For oversight, CountyCare conducted over-reads of a sample of 10 percent of Evolent's compliant over-reads. CountyCare met weekly with Evolent and KDJ to discuss over-read results as well as errors. The weekly meetings were also used to discuss and resolve any of the over-reads wherein a disagreement was identified with the KDJ abstractions.

For real-time issue resolution with both KDJ and Evolent, CountyCare has an ongoing communication log and also maintains access to a secure messaging function. KDJ provides a weekly report showing any identified abstraction errors and their resolutions, and KDJ discusses errors at the weekly meeting. If a nurse is continuously identified for making errors, KDJ follows its policy for training or assignment to

another measure. Evolent and CountyCare staff who conduct over-reads are enrolled in KDJ's training and learning platform for consistency; therefore, all assigned staff complete the same training as the KDJ staff members. CountyCare's internal staff also undergo their own MRR training. CountyCare staff who conduct over-reads are full-time staff. Evolent involves contracted staff to assist with over-reads and strives for consistency with these individuals as Evolent has used the same temporary staff for three years. CountyCare owns the MRR accountability and is responsible for documenting final approval in Affinitē, the VDT system.

Since *IMA—Combination 2* and *CDC—HbA1c Poor Control (>9.0%)* were two hybrid measures in the scope of the HFS audit which were not recently selected for MRRV, the auditor requested convenience sample validation for both measures. All convenience sample records passed the validation process.

CountyCare passed the final MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics & Maternity—*PPC—Postpartum Care*
- Group D: Immunizations & Other Screenings—*CIS—HepB*

CountyCare was fully compliant with IS Standard 4.0 for MRR processes.

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

HSAG reviewed CountyCare's supplemental data sources during the virtual audit. HFS provided State sources directly to CountyCare once the State records the member as enrolled in CountyCare. Data were procured from the labs based on CountyCare's contracts with the labs. EMR data were procured directly from the applicable providers. State immunizations (IMMS) data and Care Coordination historical claims data were sent monthly during MY 2021 from HFS. VDT conducted its own quality checks in batch form so that whenever data were submitted, the VDT data quality checks were also run. CountyCare provided process overviews describing data procurement, warehousing, and validations. The following eight data sources were reviewed and determined to be standard supplemental data:

1. Care Coordination Claims Data (CCCD)
2. Medstar
3. IMMS Registry
4. LabCorp
5. Lawndale Christian Health Center
6. Quest
7. Stroger
8. MHN (Medical Home Network) and CCH (Cook County Health) EMRs

Canary Telehealth was the only nonstandard supplemental data source reviewed for MY 2021 HEDIS reporting. PSV was conducted according to NCQA guidelines, and all cases passed the validation process. All nine supplemental data sources were approved to use for MY 2021 HEDIS reporting. CountyCare was fully compliant with IS Standard 5.0 for supplemental data.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Evolent built monthly data warehouses from the Aldera tables, including claims, enrollment, and provider data. VDT loaded the text files into the repository and conducted validations which included repository to source record count reconciliation, integrity checks, and field level validations. Validations were documented through the data quality reports which Evolent provided to CountyCare for review. The data quality reports documented validation results that included detailed information at the file and field level. Evolent did not accept nonstandard coding schemes; therefore, no crosswalks were used or reviewed. CountyCare demonstrated live its oversight of the MedImpact and Guardian Avesis data and sample reports showing data compared to prior submissions. CountyCare used these reports to identify outliers or significant changes. No data quality issues were identified with Guardian Avesis or MedImpact for MY 2021. While no data quality or completeness issues were identified, CountyCare has put stopgaps in place to ensure timeliness of data processing. CountyCare conducted monthly joint operation committee (JOC) meetings with all delegated entities to review reports and metrics, share operational updates and improvement efforts, address grievances, and any other topics. The JOC then reported quarterly to CountyCare's Vendor Oversight Committee, which includes a cross-functional team from all areas of delegation, as well as the CEO and compliance. Predelegation audits, annual audits, data/performance outliers, and CAP oversight was performed by this committee. No corrective actions were in place for any delegated entities. Claims delegates, including MedImpact, Guardian Avesis, and Evolent, were required to complete Sarbanes-Oxley Act (SOX) audits. Evolent had more frequent meetings because of the high volume of work it performed on behalf of CountyCare (e.g., biweekly or more often as needed, based on the specific work stream and scope with the SMEs at CountyCare).

Inbound and outbound data quality reports and flat files from the data warehouse were demonstrated during Evolent's virtual audit. Evolent was able to track the data sources at the file level in its data quality reports. CountyCare also monitored report cards to evaluate year-over-year and month-over-month rate increases and decreases for the prior reporting period. This ensured that CountyCare could promptly probe into unexpected rate changes to identify the root cause, addressing appropriately based on whether the anomaly is a data issue or a reflection of actual member utilization.

CountyCare was fully compliant with IS Standard 6.0 for data preproduction processing.

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

CountyCare continued its relationship with VDT for HEDIS MY 2021 performance measure production. All HEDIS measures within the scope of the audit were included in VDT's measure certification. The VDT Affinitē Quality tool was demonstrated live. VDT also demonstrated its Affinitē Quality Data Flow Diagram, walking through the steps it takes upon data file intake prior to ingesting the data and how it identifies and communicates errors back to CountyCare and Evolent. VDT conducted three stages of validation and demonstrated examples of these stages as it drilled down further into potential issues with each subsequent stage. The first stage was the summary of evaluating potential issues. During this stage, VDT identified a summary count of warnings and errors, as well as information-only messages

that may need some additional research. At the next stage, VDT identified the summary counts related to each specific file's unique information-only messages, warnings, and errors. At the final stage, VDT identified the details associated with each information-only message, warning, and error, then determined next steps working with CountyCare and Evolent regarding how to resolve the items, based on these details.

During the virtual audit, PSV was conducted for five members in each of the following measures: *FUM* and *POD*. Enrollment, administrative, and practitioner data in the source systems were reviewed for each member to confirm compliance with measure specifications and system concordance. All five members reviewed for *FUM* were found to be compliant with the measure specification requirements. All five members reviewed for *POD* were determined to be fully compliant with the measure specifications, based on auditor review of member enrollment data as well as medical and pharmacy claims details as provided by CountyCare.

CountyCare was fully compliant with IS Standard 7.0 for data integration and reporting.

NCQA HEDIS Compliance Audit Results for Meridian

HSAG conducted a MY 2021 NCQA HEDIS Compliance Audit of Meridian's data collection and reporting processes for its HealthChoice Illinois population. HSAG determined Meridian was fully compliant with all HEDIS IS standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased and all performance measures under the scope of the audit received an *R* designation.

Table B-6—Meridian MY 2021 NCQA HEDIS Compliance Audit Results

Information Systems Capabilities Assessment						
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**MRR Processes**	**Supplemental Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

The rationale for determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

From January 1, 2021, through June 30, 2021, Meridian continued to use the internally developed Managed Care System (MCS) for claims and encounter data processing. There were no major upgrades to the system since the previous year's review. MCS was able to capture primary and secondary coding with the appropriate specificity.

Meridian does not accept nonstandard claims, nor does it allow non-standard claim forms. The auditor verified through virtual audit demonstrations, that non-standard codes and claim forms were rejected back to the submitter when received. Meridian conducted audits of its claims receipts during the MY, which resulted in 98.3 percent accuracy of all claims adjudicated.

Claims that failed to auto-adjudicate were usually those with attached medical records. Meridian also maintained an average of two days to process all clean claims.

Meridian had no vendors, other than electronic claims clearinghouses involved with its claims process. Clearinghouses were required to maintain HIPAA-compliant edit checks prior to supplying the electronic claims to Meridian. Ninety-five percent of all claims were processed electronically.

Meridian's MCS system met all requirements for capturing HEDIS relevant information.

From July 1, 2021, through December 31, 2021, Meridian used the AMISYS Advance claim system to capture all claims. The audit team verified that the AMISYS Advance system appropriately captured the required fields used to produce all HEDIS measures under the scope of the review. AMISYS Advance captured the claim receipt date, primary and secondary procedure codes, and unique member and provider identifiers.

Meridian continued to receive encounters from its vendor, Envolve HealthCare, Inc. (Envolve). Envolve was Centene's vendor for vision and behavioral health services. Vendor data from Envolve were used to calculate some of the measures under review. Envolve was wholly owned and operated by Centene, Meridian's parent company. Encounters were received regularly from Envolve, and data were captured in Meridian's enterprise data warehouse. Encounter data were captured in the same manner as traditional medical claims, through standard 837 transactions. All encounters were subjected to the same pre-processing edits as direct billed claims, which required valid standard coding, valid membership, and provider information.

Meridian conducted routine audits of claims and encounter data weekly. Meridian also met with the vision and behavioral health vendors to discuss issues and transactional processes. Meridian continually assessed the data completeness of external encounters through trending reports and regular oversight meetings.

Meridian's audits included a 0.5 percent random sample of adjudicated claims, which were reviewed for financial accuracy. In addition, production standards were monitored daily and monthly by claims operations management to ensure compliance with standards.

HSAG did not have any concerns with Meridian's medical services data processes or either system used to process claims in MY 2021. Meridian was fully compliant with IS Standard 1.0 for medical services data.

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

From January 1, 2021, through June 30, 2021, Meridian continued to use the internally developed MCS for enrollment processing. Meridian relied on HFS to supply accurate information in the monthly enrollment files. No manual steps or vendors were involved with the enrollment process. Meridian received an enrollment file daily from HFS, which was loaded into its MCS claims/encounter processing system. This file contained all enrollment information required for Medicaid. Monthly, Meridian also verified enrollment using the State's full roster. The full roster provides Meridian with additions, changes, or deletions that were previously reported on the daily files.

Meridian's MCS system contained all applicable fields relevant for HEDIS reporting. MCS maintained a unique identifier for each member and captured the Illinois Medicaid HealthChoice identifiers.

HSAG conducted specific enrollment verification reviews that examined enrollment by month during the virtual audit. The review identified July 1, 2021, as the date when Harmony Health Plan of Illinois, Inc. (Harmony) members were acquired by Meridian. HSAG did not have any concerns with the data review or with Meridian's enrollment data processes.

From July 1, 2021, through December 31, 2021, Meridian's enrollment processes were transferred to Centene corporate processes. Meridian still relied on HFS for delivery and accuracy of the 834 enrollment files daily/monthly, and there were no manual steps in enrollment processing. Meridian captured enrollment information in the Centene Unified Member View system (UMV), which sits atop AMISYS Advance. As with the MCS system, UMV was able to capture all necessary fields for HEDIS processing. UMV was also able to capture race and ethnicity fields that were submitted using direct methodology from the State 834 files. UMV used the state-assigned Medicaid identifier and was able to capture family member identifiers using the family link field in AMISYS Advance and UMV.

All historical enrollment data were captured in Centene's data warehouse.

HSAG did not have any concerns with Meridian's systems for processing enrollment files. Meridian was fully compliant with IS Standard 2.0 for enrollment data.

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

From January 1, 2021, through June 30, 2021, Meridian maintained provider records in the MCS system. The provider specialty mappings for FQHCs were mapped to PCPs and approved by the auditor for HEDIS MY 2021 reporting. FQHCs were allowed to provide both primary care and mental health services to Medicaid members in the State of Illinois. Meridian staff indicated that servicing provider identifiers were also captured on FQHC claims and therefore provider specialties would be linked to the servicing provider on the claim; otherwise the FQHC PCP provider type would be used.

Beginning July 1, 2021, all provider data were housed in Portico, Centene's provider system.

Provider files were first loaded into Centene's Portico system where the provider began to undergo the credentialing process. Once the provider was credentialed, the provider information was loaded into AMISYS. Centene had a process in place for validating provider information daily to ensure both systems contained identical demographic information. Specialties were validated in Portico and then matched with AMISYS. The two systems were linked by the unique provider identification number. No significant changes were made to the systems during the MY, other than provider maintenance.

HSAG selected a random PCP and a facility to review during the virtual audit review. Centene was able to demonstrate that the provider specialty matched all systems for both professional and facility providers. The auditor had no concerns upon inspection of the data as the data from both systems matched.

AMISYS maintained all relevant information required for performance measure reporting. Both Portico and AMISYS contained unique identifiers and captured identical information as expected. HSAG conducted PSV of the AMISYS system during the measure drill-down session to identify any potential issues across providers and hospital systems. HSAG also reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. HSAG found Centene to be compliant with the credentialing and assignment of individual provider specialties and hospital accreditation.

HSAG had no concerns with Meridian's ability to capture HEDIS relevant provider data in any system.

Meridian was fully compliant with IS Standard 3.0 for practitioner data.

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

HSAG reviewed Meridian's IS 4.0 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements in HEDIS MY 2021. The auditor verified that Meridian sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples for measures with expected exclusions. Provider chase logic was reviewed and determined appropriate across hybrid measures.

Meridian continued to work with Change Healthcare to conduct abstractions and chases for HEDIS MY 2021. Since Meridian did not have any issues with the final MRRV in the previous year and there were no changes to its MRR process, HSAG did not require Meridian to undergo convenience sample validation.

Change Healthcare continued to conduct IRR for all staff and required all staff to maintain a 95 percent accuracy level to continue working on the project. IRR scores for both training and final results were uploaded to HSAG's SFTP site for verification.

Change Healthcare overread 100 percent of all abstracted records for the first two weeks of reviews and then 90 percent after that. Additionally, Change Healthcare overread 100 percent of all non-compliant records throughout the entire MRR process.

HSAG reviewed and approved Change Healthcare's hybrid abstraction tools to ensure all fields, edits, and drop-down boxes were accurate against NCQA's current technical specifications.

HSAG selected the following measures for the final MRRV: *CDC—Blood Pressure <140/90*, *CDC—HbA1c Poor Control (>9.0%)*, *CIS—Combo 3*, and all hybrid exclusions. Meridian passed MRRV without any critical errors.

Meridian was fully compliant with IS Standard 4.0 for MRR processes.

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

Meridian submitted several supplemental databases in the HEDIS Roadmap that were not relevant to the measures under review. The following supplemental databases were reviewed and approved to use for HEDIS MY 2021 reporting:

1. QCAT—Nonstandard: Required POS verification and passed without any issues. Health plan staff uploaded medical records to the HEDIS User Interface (HUI) application for members with open gaps. Centene corporate conducted medical record validation over-reads to ensure accuracy. Clinical staff trained to collect, enter, and overread data perform these activities frequently.
2. CCCD (I-Care)—Standard: This source has historically been used for supplemental data and is provided to the plan by the State. The data contained in the database are historical claims that were used for the *CIS* measure. The auditor and Meridian discovered the database was missing from the Roadmap prior to March 1, 2022, but corporate provided the updated Roadmap on March 2, 2022, which was allowed by the auditor since this has traditionally always been in previous years' Roadmaps and it was discussed prior to March 1, 2022.

3. Provider Group Data Sources (EMR)—Standard: EMR data were received from several health centers: Lawndale Christian Health Center, Centegra, Eerie, Northshore University Health System, Ravenswood Physician Associates, Rockford, and Access Community Health Network. Providers use the Meridian file format to submit EMR data regularly. Meridian conducted sampling and reviewed POS documents to verify record accuracy. All data submissions were submitted via secure email or SFTP. POS documentation was collected for records that were a part of the internal audit.
4. HL7 Labs—Standard: Previously approved lab database that captures lab results from LabCorp, Quest Diagnostics, Medical Diagnostic Labs (MDL) Bioreference, Clinical Pathology Labs (CPL), and AccuRef Diatherix Labs. Claim counts for each lab vendor were reviewed and tracked each month to ensure files are received, loading properly, and volume remains consistent.

All standard and nonstandard supplemental data sources listed above were approved to use for HEDIS MY 2021 reporting.

HSAG reviewed the final supplemental data impact report and confirmed that only approved sources were used. HSAG also reviewed the IDSS and verified numerator hits from supplemental data. No issues were detected.

Meridian was fully compliant with IS Standard 5.0 for supplemental data.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Meridian continued to use Inovalon's Quality Spectrum Insight XL (QSI XL) HEDIS Certified Measures for HEDIS MY 2021 reporting.

Data loads were completed semimonthly, with the first data load on the fifth day of the month and the second load on the 20th day of the month. Meridian continued to use an extract, transform, load (ETL) process to extract the data from the enterprise data warehouse. The data were staged in SQL server and mapped to the Inovalon QSI XL file formats for ingestion into the HEDIS Certified Measures software platform. Multiple validations occurred for each data load and for each file to ensure record load attempts and record load acceptance were within reasonable limits. Record rejections were reviewed to ensure systemic issues were not present with the data. HSAG reviewed data quality processes and reviews to ensure no issues were prevalent.

Meridian provided medical claims, Electronic Clinical Data System (ECDS) data, and encounters for three and a half years, pharmacy claims for two and a half years, lab claims for two years, vision claims for two years, mental health claims for two years, and dental Claims for one year to Inovalon. For members with at least one day of enrollment in the current or prior MY, Meridian loaded at least three and a half years of enrollment data.

HSAG did not find any materially biased issues with Meridian's data transfers and record consolidations.

Meridian was fully compliant with IS Standard 6.0 for data preproduction processing.

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

Meridian continued to use Inovalon's QSI XL tool for measure production in HEDIS MY 2021. Inovalon maintained that there were no changes to its operational processes or technology used for data integration or reporting and its QSI XL software did not endure any significant changes. Inovalon QSI XL contains HEDIS Certified Measures and undergoes certification annually. Inovalon passed certification for all measures under the scope of the audit for HEDIS MY 2021.

Hospice events for members were identified through claims using the Hospice Value Set or through MRR when applicable. Meridian and Inovalon staff performed data quality checks and field level profiling. The loaded input files were run through QSI XL's data module which verified the quality and reasonableness of the data submitted. Data quality reports were reviewed by Meridian staff to ensure data errors were corrected and final submissions were accurate. This profiling exercise occurred during each data load and ensured the reasonableness, format, and data consistency were accurate.

Final rates were compared to the previous two years' rates for validation and impact. HSAG determined that there were no significant issues when compared to the previous two years. Some measures were still recovering from the impact of COVID-19, and rate fluctuations greater than 5 percent were expected for office type measures. HSAG reviewed all measures under the scope of the audit, and all measures were determined to be reportable.

HSAG did not have any concerns with Inovalon's data integration and reporting process. Meridian was fully compliant with IS standard 7.0 for data integration and reporting.

NCQA HEDIS Compliance Audit Results for Molina

HSAG conducted a MY 2021 NCQA HEDIS Compliance Audit of Molina's data collection and reporting processes for its HealthChoice Illinois population. HSAG determined Molina was fully compliant with all HEDIS IS standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased and all performance measures under the scope of the audit received an *R* designation.

Table B-7—Molina MY 2021 NCQA HEDIS Compliance Audit Results

Information Systems Capabilities Assessment						
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**MRR Processes**	**Supplemental Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

The rationale for determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

During MY 2021, Molina continued to use QNXT, an industry-standard claims adjudication system, to process FFS claims. The QNXT system captured standard procedure and diagnosis codes appropriately and was able to capture primary and secondary codes billed on a claim. Molina used a small amount of nonstandard Z-codes for prenatal and postpartum care. These codes were reviewed and approved during the virtual audit, and the fill code set was submitted as part of Roadmap Section 1.

HSAG verified that QNXT had appropriate claim edits to reject claims using invalid procedure and diagnosis codes. Additional edits were in place to reject claims if they were missing critical information, such as patient and provider identifiers, dates of service, and missing or null fields.

Encounter data were submitted from several vendors and capitated providers for MY 2021. Molina confirmed that there was no impact on claims processing due to COVID-19 during the MY.

All encounter data were directly loaded into the corporate Operational Data Store (ODS) for use with HEDIS data integration. The ODS encounter data were in a standard 837 format. Molina had sufficient processes in place to capture and validate encounter data submissions. Molina validated data submissions against financial reports with the State to ensure reporting accuracy.

Molina continued to use Change Healthcare for both paper and electronic claims submissions. Paper claims were scanned in-house by Molina's claims mailroom where they were date stamped, batched, and

scanned in batches of 100 sheets of paper. The claims were then electronically sent to Molina's Utah location, where the OCR process was completed. The images were returned within two business days of the receipt date via a SFTP site and were uploaded daily by Molina's Information Technology (IT) department. All other claims, that were not initially directed to the centralized Claims Post Office (PO) Box in Long Beach, California were delivered to Molina's Claims Department's Mailroom, where they were immediately batched and sent to Change Healthcare daily for scanning/imaging. In addition, any claims received from other departments within Molina were routed to the claims mailroom daily, where they were prepped and submitted to Change Healthcare for OCR processing.

Molina was fully compliant with IS Standard 1.0 for medical services data.

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

Molina continued to utilize the daily and monthly files provided by the State's 834 transactions. The electronic files were captured in QNXT. There were no changes to this process from the previous year. Pre-processing of eligibility files was performed in the Molina Eligibility Gateway (MEG) module. With the exception of newborns, all records were loaded into QNXT.

All enrollment data were processed in the QNXT system. QNXT had appropriate fields to capture all vital information required for claims processing and HEDIS reporting. QNXT allowed for several identification numbers for families to be linked together. Molina received daily files from the State and reconciled those records with the final monthly file. The amount of time to process enrollment files was less than three days. There were no concerns with the enrollment process following HSAG's review.

All downstream vendors received daily and monthly enrollment files after being processed in the QNXT system. This ensured that all vendors had the most current member information for processing claims/services.

There were no concerns with Molina's enrollment data process for HEDIS MY 2021. Molina was fully compliant with IS Standard 2.0 for enrollment data.

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

There were no changes to Molina's provider processing systems during MY 2021. HSAG reviewed the provider mapping documents included in the Roadmap and found no issues during the virtual audit review.

Molina maintained all providers in the QNXT system and contracted with individual doctors and physician groups; data exchanged between all entities were complete and accurate. All required fields for HEDIS processing were present. QNXT could capture multiple identification numbers. A unique identifier links the records with multiple identification numbers together. There were no issues encountered with this practice of maintaining multiple identifiers.

Monthly, Molina audited the provider data in QNXT to ensure the completion of specialties, license type, and professional degree. This internal audit included a review of provider locations and ZIP Codes. Molina used several delegated entities to process provider information. The delegated entities were

monitored on an annual basis and no significant issues were found. Delegated entities audited were within 95 percent accuracy thresholds for MY 2021.

Molina was fully compliant with IS Standard 3.0 for practitioner data.

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

Molina sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. HSAG reviewed and approved the sample sizes prior to the virtual audit. Molina did not reduce any samples for hybrid measures and did not need approval from NCQA for any sample increases.

Medical record pursuit and data collection were conducted by Molina staff using ClaimSphere Clinical+. ClaimSphere Clinical+ was the HEDIS Software used for data entry, chart collection, data annotation, and chart storage. HSAG reviewed and approved the ClaimSphere hybrid tools. Provider chase logic was reviewed and determined to be appropriate across the hybrid measures. Reviewer qualifications, training, and oversight were appropriate. IRR for training and final abstraction was submitted to HSAG before final approval of the hybrid abstraction, and no concerns were identified.

A convenience sample was not required since Molina successfully passed all validation in the previous year's review and there were no significant changes to its processes from the prior year.

HSAG selected the following measures for the final MRRV: *CDC—Blood Pressure <140/90*, *CDC—HbA1c Poor Control (>9.0%)*, and *CDC—Eye Exam (Retinal) Performed*. Molina passed MRRV without any critical errors.

Molina was fully compliant with IS standard 4.0 for MRR processes.

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

Molina submitted 26 relevant supplemental data sources for review for the Illinois measures under review; however, two were withdrawn as it was determined they did not impact any measures under the scope of the audit. Three sources were determined to be nonstandard. The remaining 21 databases, which included lab results, prior year's audited medical records, EHRs, historical claims from the State, and immunization registries were considered standard data.

PSV was conducted for the three nonstandard supplemental data sources, Pilot Medical Record Review (PMRR), Care Connections, and Provider Registry. HSAG selected a sample of cases for each nonstandard supplemental data source and reviewed POS documentation provided by Molina. Molina successfully passed PSV for each data source and used the data to supplement its rates for several Health Choice Illinois measures.

All 21 standard and three nonstandard supplemental data sources were reviewed and approved to use for HEDIS MY 2021 reporting.

HSAG reviewed the final impact reports for measures and determined that Molina only used databases that were approved by the auditor. HSAG also verified measure impacts against the IDSS for accuracy; no issues were detected.

Molina was fully compliant with IS Standard 5.0 for supplemental data.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Molina continued to contract with Cognizant TriZetto and used the vendor's ClaimSphere HEDIS Certified Measures software for generating its HEDIS MY 2021 performance measure rates.

Data transfers and mappings were managed appropriately as demonstrated during the virtual audit. Molina monitored data transfers by matching data loads to its data extracts from ODS into the ClaimSphere system. Data that fell out were quickly identified to ensure critical errors were corrected. During the virtual audit, the data transfer and consolidation examination did not reveal any issues. HSAG conducted PSV for the *CDC—Eye Exam (Retinal) Performed* and *FUM* measures and did not encounter any issues.

Molina included all paid, denied, and pended claims in its extract process for the MY data loads.

HSAG reviewed all provider type and specialty mapping documents as part of the query process and had no concerns with PCP mapping or the specialties required for HEDIS reporting. Molina followed NCQA guidelines for assigning PCP status to FQHCs and RHCs.

All nonstandard codes were mapped appropriately for a select number of prenatal and postpartum Z-codes.

Molina monitored all data loads to ClaimSphere to ensure data were accepted. Any rejected data records were examined to determine if there were global issues. Molina reported that there were no concerns or global issues with data transfers during the MY.

Molina was fully compliant with IS Standard 6.0 for data preproduction processing.

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

Molina continued to use ClaimSphere, an NCQA HEDIS Certified Measures software product. Molina corporate staff were responsible for the management and conversion of the ClaimSphere product. Corporate processes were reviewed during the virtual audit and were sufficient for HEDIS MY 2021 reporting. Molina's staff were proficient in data warehousing and demonstrated, during the virtual audit, that record counts and volumes were monitored.

Molina met with ClaimSphere team members regularly to discuss file loading and processing. Molina indicated that the change to the new platform in 2020 resulted in a fresh perspective on data and resulted in streamlined processes.

Molina continued to monitor provider submissions and tracked the volume for each submission over time. Trending volumes were compared to expected per member per month (PMPM) counts to determine if data were missing.

Molina regularly monitors the TriZetto ClaimSphere audit control reports to validate the number of records and size of the files to ensure they match the source system before processing the data load. The ETL process is designed with an audit table to gather all record counts for each file loaded. Queries are employed to perform reconciliation checks and balances for both post and pre-load processes. Queries verify naming conventions, the number of records read, the number of records loaded, and the number of records rejected.

Molina and ClaimSphere also performed data quality checks and field-level profiling. The loaded input files were run through ClaimSphere's data profiling module to check the quality and reasonableness of the data submitted in each field in each file. The profiling tool checked the reasonableness, format, range, consistency, and null data fields to ensure there were no concerns.

Final rate review was conducted and three-year trending was reviewed as well as national benchmark comparisons. There were no significant issues with the rates, and all rates were determined to be reportable.

Molina was fully compliant with IS Standard 7.0 data integration and reporting.

MMAI IL 3.6 PMV Methodology

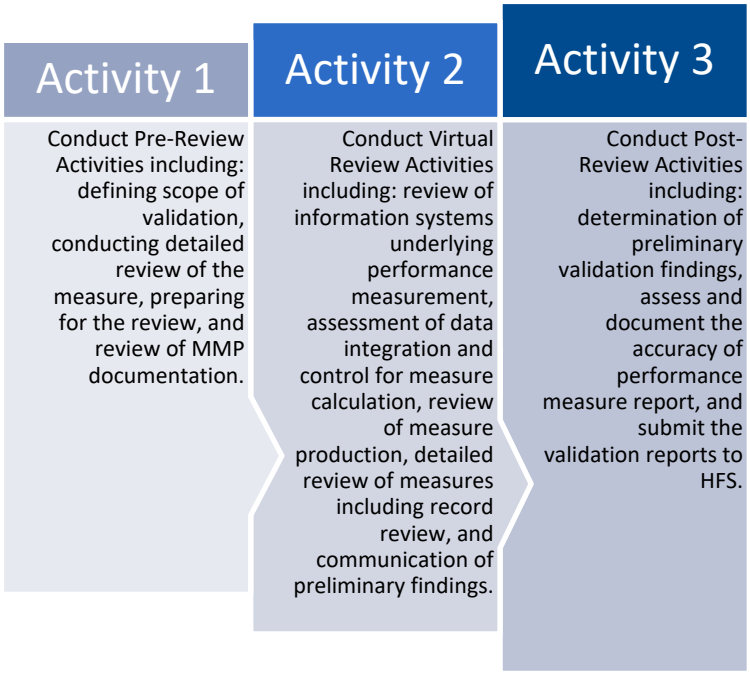
Background

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures. HFS selected one measure for validation for the MMAI program: *IL Measure 3.6: Movement of Members within Service Populations*.

Methodology

HSAG validated the data collection and reporting processes used by the MMPs to report the quality withhold performance measure data for Demonstration Year 6 (January 1, 2020, through December 31, 2020) in accordance with CMS' Protocol 2 cited earlier in this report. Figure B-1 presents the protocol activities conducted.

Figure B-1—Protocol 2 Activities



CMS provided the specifications and supplemental guidance[B-3,B-4] that MMPs were required to use for reporting the performance measures, and which HSAG utilized to define the scope of the validation and complete a detailed review of measure IL 3.6.

The following list describes the types of documentation and data collected and how HSAG conducted analysis of data:

- **Information Systems Capabilities Assessment Tool (ISCAT)—**MMPs were required to complete and submit an abbreviated ISCAT. An ISCAT is a systems assessment tool that allows the organization to provide step-by-step details on its information systems, processes used for collecting and processing data, and processes used for performance measure reporting. The ISCAT was shortened to include questions related to IL 3.6 processes only. Upon receipt by HSAG, the ISCAT underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Primary Source Verification—**HSAG selected a sample of enrollees reported for each element in IL 3.6 and confirmed that the information from the primary source matched the information used for calculation of the performance measure. HSAG also reviewed the processes by which the MMP inputted, confirmed entry, and identified errors in its systems.
- **Supporting Documentation**—MMPs submitted documentation to HSAG that provided additional information to complete the validation process, including file layouts, system flow diagrams, data collection process descriptions, performance measure production, and IL 3.6 enrollee-specific data files. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up.

The PMV review of the MMP's reported data consisted of remote validation and post-validation activities focusing on enrollment and eligibility processes, long-term care category assignment, and performance measure production. HSAG conducted a webinar review with each MMP between August 30, 2021 and September 10, 2021. The webinar review included:

- Discussion of discrepancies between data submitted to the Financial Alignment Initiative Data Collection System (FAI DCS) and data submitted for the PMV, if applicable.
- Review of source code and performance measure production for IL 3.6.
- Evaluation of processes to categorize enrollees into long-term care (LTC) assignment, including enrollment and eligibility processing, state LTC rate cell codes, and claims and authorization processing.
- Enrollee-level record review of the documentation to support data submission for IL 3.6. MMPs submitted enrollee-level data files to HSAG, from which a random sample was drawn for review.

B-3 Department of Health and Human Services, Centers for Medicare & Medicaid Services. Memorandum. Revised Illinois-Specific Reporting Requirements and Value Sets Workbook. Available at: https://www.cms.gov/files/document/ilreportingrequirementsmemo03102021.pdf. Accessed on: Jan 30, 2023.

B-4 Department of Health and Human Services, Centers for Medicare & Medicaid Services. Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Illinois Specific Reporting Requirements; Version: Feb 26, 2021. Available at: https://www.cms.gov/files/document/ilreportingrequirements02262021.pdf. Accessed on: Jan 30, 2023.

The MMPs navigated access through their claims and/or case management system (and through the system of its delegated entity, when applicable). Record review findings were captured by HSAG for analysis. HSAG used the NCQA methodology[B-5] for the file reviews for IL Measure 3.6, referred to as the "8 and 30" file sampling procedure. There was a review of an initial sample of eight files, then review of an additional sample of 22 files if any of the original eight failed the review (a maximum total of 30 records) for each element.

Validation Finding

The validation finding is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined as *NO*. Consequently, it is possible that an error for a single audit element may result in a designation of *Do Not Report* (DNR) because the impact of the error materially biased the reported performance measure. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and, thus the measure is *Reportable* (R).

Table B-8 presents the PMV findings HSAG used for its review of Measure IL 3.6.

Table B-8—Performance Measure Validation Finding

Designation	Description
R = Reportable	Measure was compliant with state specifications
DNR = Do not report	Rate was materially biased and should not be reported
NA = Not applicable	The MMP was not required to report the measure
NR = Not reported	Measure was not reported because the MMP did not offer the required benefit

Table B-9 displays HSAG's validation finding for all MMPs.

Table B-9—Validation Findings for All MMPs

MMAI IL 3.6 Validation Finding				
Aetna	**BCBSIL**	**Humana**	**Meridian**	**Molina**
Reportable	Reportable	Reportable	Reportable	Reportable

[B-5] National Committee for Quality Assurance (NCQA). An Explanation of the "8 and 30" File Sampling Procedure Used by NCQA During Accreditation Survey Visits; May 1, 2001. Available at: https://www.ncqa.org/wp-content/uploads/2018/07/20180110_830_Procedure.pdf. Accessed on: Jan 30, 2023.

Appendix C. PIP/QIP Methodology

Objective

As part of the State's Quality Strategy, each health plan is required to conduct PIPs/QIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the BBA, HSAG, as the State's EQRO, validated the PIPs/QIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG used CMS' publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* (CMS Protocol 1), October 2019.[D-1] Additionally, HSAG's PIP/QIP process facilitates frequent communication with the health plans. HSAG provides detailed validation feedback and provides technical assistance and webinar trainings for further guidance.

HFS requires its health plans to conduct PIPs/QIPs annually and include clinical and nonclinical focused PIPs/QIPs. The new topics initiated and submitted for validation were:

- *Improving Timeliness of Prenatal Care*
- *Improving Transportation Services*

[C-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on Jan 13, 2022

Approach to PIP/QIP Validation

To assess and validate PIP/QIPs, HSAG used a standardized scoring methodology to rate a PIP/QIP's compliance with each of the nine steps listed in the CMS Protocol 1. With HFS' input and approval, HSAG developed a PIP/QIP Validation Tool to ensure uniform assessment of the PIP/QIP. This tool is used to evaluate each PIP/QIP for the following nine CMS protocol steps:

Table C-1—CMS Protocol 1 Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP/QIP Topic
2	Review the PIP/QIP Aim Statement
3	Review the Identified PIP/QIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP/QIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

PIP Validation Scoring

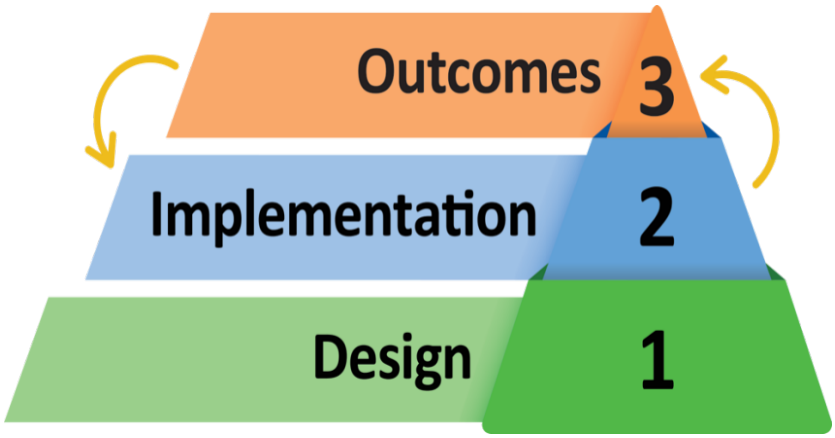
Each required step is evaluated on one or more elements. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP/QIP process as critical elements. For a PIP/QIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP/QIP of *Not Met*. The health plan would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a *Validation Feedback* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP/QIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gives the PIP/QIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Figure C-1 illustrates the three stages of the PIP/QIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage (Steps 1

through 6) establishes the methodological framework for the PIP/QIP. The steps in this section include development of the PIP/QIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP/QIP design is necessary.

Figure C-1—PIP Stages



Once the health plan establishes its design, the PIP/QIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the health plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, the health plan should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

Appendix D1. Validation of Network Adequacy Methodologies

This section describes the methodologies used in the activities HSAG conducted to validate and monitor the health plans' network adequacy during the preceding state fiscal year.

Network Adequacy Validation (NAV) Methodology

Network Data Submission Process

HSAG worked extensively with HFS to develop and standardize the Provider Layout File (PFL) template for submitting provider network data. HFS and HSAG also developed the Provider Network Data Submission Instruction Manual and Data Dictionary (HSAG PFL manual), which included guidance and detailed instructions to the health plans for completing and submitting the PFL template. For example, the HSAG PFL manual included a data directory for all provider types required for reporting and submission to ensure the accuracy and consistency of network provider data across the health plans. The HSAG PFL manual includes the sections below.

- Section 1—Introduction describes the purpose of this manual and its organization as well as an overview of the PFL.
- Section 2—Provider File Layout Instruction provides detailed guidance on properly completing the PFL, including the file naming conventions, provider type specifications and definitions, and a description of the data submission elements needed to complete each field of the PFL.
- Section 3—Submission Process describes the procedure MCOs will use to submit their PFL on a quarterly basis.
- Appendix A—Data Dictionary defines all provider types required for submission.
- Appendix B—Home and Community Based Services (HCBS) Waiver Definitions defines HCBS service types required for submission.
- Appendix C—Provider File Layout Excel workbook template.
- Appendix D—Frequently Asked Questions (FAQs)
- Appendix E—Manual Update History
- Appendix F—List of Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Appendix G—Illinois Department of Public Health (IDPH) Hospital Directory

Health plans were required to upload their provider network data files to a secure HSAG file transfer protocol site. These files include PCPs, adult and pediatric providers, behavioral health (BH) providers, dental providers, hospitals, facilities, pharmacies, HCBS, MLTSS providers, FQHCs, CMHCs, RHCs, nursing facilities, supportive living facilities, exceptional care providers, and transportation providers within each managed care service area including out-of-state providers in contiguous counties.

HFS requires all health plans to follow the guidance and instructions within the HSAG PFL manual to ensure and maintain the integrity of the provider network data across all health plans. HSAG uses the provider network data submissions for network validation analysis and monitors health plan compliance with network adequacy requirements. Health plans are informed of HSAG's findings to respond and address any potential network findings identified during NAV review. Based on the ongoing feedback

between HSAG/HFS and the health plans, HFS has the capability to monitor health plan progress toward the remediation of network findings.

Data Validation Process

Following the receipt of the health plans' provider network data, HSAG conducted a validation process that included:

- Review of the accuracy and completeness of required data fields.
- Identification of duplicate data.
- Verification of provider contract status.
- Categorization of providers to the correct provider group.
- Verification of open and closed panel status.
- Comparison of the number of data records between the prior and current data submissions.
- Verification of provider types.

After completion of HSAG's validation checks, the health plan provider data was loaded to a secure MS Access database containing programmed queries that generated network reports. As an additional validation check, the data generated by the source programming code was validated against the health plan data files to verify the accuracy of the network reports.

HSAG produced health plan-specific and comparative network reports to identify the number of provider types within each county statewide. These reports also included contracted providers within specific out-of-state counties neighboring the service regions.

Reporting and Communication

During the provider network validation reviews in SFY 2022, HSAG maintained ongoing communication with the health plans and HFS regarding any findings and recommendations identified during HSAG's analysis of the health plans' provider networks. HSAG monitored and reported to HFS the health plans' compliance towards establishing an adequate provider network. Network gaps were communicated to HFS, and health plans were required to respond to all identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps.

Monitoring Network Adequacy for HealthChoice Illinois (HCI)

HSAG collaborated with HFS to develop biannual provider network capacity reports to ensure compliance with HFS' specifications. The HCI provider network capacity reports included:

- Hospital Analysis Report—hospitals listed by name and region to show contracted hospitals across the health plans.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.
- Quarterly MLTSS Summary—review of 16 MLTSS service categories across 102 Illinois counties to determine the overall percentage of counties with contracted MLTSS providers. Review also included detail by health plan, county, and provider category.

Monitoring Network Adequacy for Medicare-Medicaid Alignment Initiative (MMAI)

HSAG collaborated with HFS to develop biannual provider network capacity reports to ensure compliance with HFS' specifications. The MMAI provider network capacity reports included:

- Hospital Analysis Report—hospitals listed by name and region to show contracted hospitals across the health plans.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.
- Long Term Services and Supports (LTSS) Provider Summary—review of 16 LTSS service categories across 102 Illinois counties to determine the overall percentage of counties with contracted LTSS providers. Review also included detail by health plan, county, and provider category.
- Behavioral Health Network Review—detailed review of BH providers across 102 Illinois counties to determine the overall percentage of counties with contracted BH providers. Review also included detail by health plan and county.

Appendix D2. Network Adequacy Regional Comparison

IL2022 HealthChoice IL (HCI) Provider Network - Contracted Providers
Provider Network for Region 1 - Northwest Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare*
Enrollment as of March 1, 2022	86,580	42,528	131,359	71,205	3,767

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	2,028	684	1,904	1,042	1,828
Primary Care Providers (Pediatric)	1,526	593	1,450	1,148	1,215
Mid-Level Practitioners (Adult)	1,121	653	50	1,331	53
Mid-Level Practitioners (Pediatric)	1,130	553	0**	1,297	0**
Adult Specialty Providers	2,135	1,628	2,170	1,847	1,789
Pediatric Specialists	1,171	510	1,849	1,334	1,254
Gynecology, OB/GYN	204	101	267	218	198
Dentists (Adult)	454	316	453	253	451
Dentists (Pediatric)	461	299	455	249	423
Behavioral Health Providers (Adult)	542	564	719	696	616
Behavioral Health Providers (Pediatric)	474	102	443	314	433
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	161	203	293	270	235
Skilled Nursing Facilities	108	120	128	122	109
Supportive Living Facilities	24	23	24	24	23
Pharmacies	202	202	247	273	250
Other Facilities	457	204	764	418	616

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	28	22	34	31	26

IL2022 HealthChoice IL (HCI) Provider Network - Contracted Providers
Provider Network for Region 2 - Central Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare*
Enrollment as of March 1, 2022	64,682	45,896	109,857	65,731	3,912

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	2,298	730	2,096	1,315	1,922
Primary Care Providers (Pediatric)	1,839	640	1,649	1,428	1,412
Mid-Level Practitioners (Adult)	863	963	40	1,391	37
Mid-Level Practitioners (Pediatric)	818	827	0**	1,348	0**
Adult Specialty Providers	2,462	2,195	1,993	2,262	1,763
Pediatric Specialists	1,428	765	1,674	1,540	1,185
Gynecology, OB/GYN	231	110	248	237	244
Dentists (Adult)	260	182	209	178	205
Dentists (Pediatric)	257	175	209	170	196
Behavioral Health Providers (Adult)	522	571	740	794	616
Behavioral Health Providers (Pediatric)	330	99	428	322	314
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	219	346	430	379	349
Skilled Nursing Facilities	113	117	126	130	118
Supportive Living Facilities	28	32	25	33	29
Pharmacies	213	221	255	274	256
Other Facilities	246	244	691	516	466

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	36	29	32	34	29

IL2022 HealthChoice IL (HCI) Provider Network - Contracted Providers
Provider Network for Region 3 - Southern Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare*
Enrollment as of March 1, 2022	60,180	35,450	110,804	60,000	3,893

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,479	603	1,346	923	1,206
Primary Care Providers (Pediatric)	1,342	590	1,080	1,015	902
Mid-Level Practitioners (Adult)	465	632	22	754	24
Mid-Level Practitioners (Pediatric)	433	527	0**	721	0**
Adult Specialty Providers	1,683	1,505	1,275	1,419	1,270
Pediatric Specialists	1,044	542	1,071	973	879
Gynecology, OB/GYN	151	86	160	149	143
Dentists (Adult)	170	117	106	82	101
Dentists (Pediatric)	170	100	108	83	100
Behavioral Health Providers (Adult)	264	276	312	352	334
Behavioral Health Providers (Pediatric)	211	61	202	158	202
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	225	315	375	328	331
Skilled Nursing Facilities	87	97	112	91	97
Supportive Living Facilities	23	28	21	27	25
Pharmacies	199	200	204	238	204
Other Facilities	183	273	484	524	359

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	34	34	34	36	31

IL2022 HealthChoice IL (HCI) Provider Network - Contracted Providers
Region 4-Cook & Region 5-Collar Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna Cook & Collars		BCBS Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars		YouthCare Cook & Collars*		CountyCare Cook & Collars	
Enrollment as of March 1, 2022	122,933	77,871	329,154	212,002	309,371	202,649	95,230	31,216	6,114	2,755	419,577	N/A

Health Plan	Aetna Cook & Collars		BCBS Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars		YouthCare Cook & Collars		CountyCare Cook & Collars	
Practitioners (# of unique NPIs)*												
Primary Care Providers (Adult)	4,485	1,681	2,674	1,396	5,499	2,928	2,077	763	4,684	2,463	3,825	N/A
Primary Care Providers (Pediatric)	3,379	1,374	2,065	1,200	3,943	2,058	2,490	932	2,966	1,562	2,757	N/A
Mid-Level Practitioners (Adult)	2,858	1,077	3,783	2,016	176	43	2,138	1,044	178	49	4,465	N/A
Mid-Level Practitioners (Pediatric)	2,662	969	3,174	1,623	0**	0**	2,178	1,048	0**	0**	2,961	N/A
Adult Specialty Providers	6,782	2,238	8,678	4,646	7,348	3,987	3,871	1,425	7,115	3,363	7,346	N/A
Pediatric Specialists	4,254	1,375	4,039	2,079	6,259	3,235	2,841	1,015	5,136	2,428	3,470	N/A
Gynecology, OB/GYN	802	274	625	358	918	490	539	211	959	470	875	N/A
Dentists (Adult)	1,648	1,002	1,408	874	1,417	967	810	421	1,400	953	783	N/A
Dentists (Pediatric)	1,662	1,009	1,322	827	1,410	977	805	421	1,349	903	106	N/A
Behavioral Health Providers (Adult)	1,941	782	2,160	1,242	2,433	1,249	1,980	922	2,384	1,100	2,723	N/A
Behavioral Health Providers (Pediatric)	1,405	655	407	332	1,600	897	974	371	1,462	726	1,639	N/A
Facilities (# of locations)*												
CMHC/FQHC/RHC/BHC/SUPR	501	236	611	303	936	410	838	312	659	286	734	N/A
Skilled Nursing Facilities	188	93	203	112	220	109	175	94	206	107	230	N/A
Supportive Living Facilities	34	26	30	23	32	29	30	24	31	26	36	N/A
Pharmacies	586	371	659	411	796	530	828	531	793	524	790	N/A
Other Facilities	855	360	693	375	1,335	863	812	463	1,210	666	1,271	N/A

Health Plan	Aetna		BCBS		Meridian		Molina		YouthCare		CountyCare	
Hospitals (# of locations)*												
Hospitals	55	12	57	26	58	27	49	14	63	22	53	N/A

Summary Notes

*Enrollment for YouthCare was as of January 2022. Per HFS, the enrollment file obtained from HFS for March 2022 was not complete for YouthCare. As of June 2022, HFS is in the process of updating the enrollment file to include the latest enrollment.

*Provider counts were based on a unique count of NPIs for practitioners and count of provider locations for Facilities & Hospitals. All providers included in the summary above were reported by the health plans as Medicaid Contracted.

**The mid-level specialties (nurse practitioner, physician assistant) reported by Meridian and YouthCare were listed as "Yes" for the PCP column which are reflected in the adult/pediatric PCP categories above. Nurse Midwife providers were included in the adult mid-level practitioner category above.

PCP Specialties

• Adult – Family Practice, General Practice, Internal Medicine, Nurse Practitioner, Physician Assistant
• Pediatric – Pediatric Medicine, Pediatric Nurse Practitioner, Pediatric Physician Assistant
• PCP providers were reported by the health plans as "Yes" for the PCP (Y/N) column.

Mid-Level Practitioners

• Adult – Nurse Practitioner, Physician Assistant, Nurse Midwife
• Pediatric – Pediatric Nurse Practitioner, Pediatric Physician Assistant
• The count for the mid-level category above does not include Nurse Practitioners and Physician Assistants reported as "Yes" for the PCP (Y/N) column.

Behavioral Health Specialties

• Adult – Alcohol and Substance Abuse Rehab. Services, Licensed Professional/Licensed Clinical Counselor, Psychiatrist, Psychologist, Social Worker, Other Behavioral Health Services
• Pediatric – Pediatric Psychiatrist, Pediatric Psychologist, Mental Health Counselor, Qualified Mental Health Professional, Licensed Practitioner of the Healing Arts

Region 1 Contiguous Counties
Iowa and Wisconsin Counties
Contracted Provider Network

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	462	58	619	214	535
Primary Care Providers (Pediatric)	372	54	417	250	256
Mid-Level Practitioners (Adult)	209	74	9	238	16
Mid-Level Practitioners (Pediatric)	205	61	0	235	0
Adult Specialty Providers	442	254	625	521	533
Pediatric Specialists	207	96	485	370	320
Gynecology, OB/GYN	35	17	76	41	72
Dentists (Adult)	47	33	17	14	18
Dentists (Pediatric)	50	34	17	15	17
Behavioral Health Providers (Adult)	52	28	165	91	164
Behavioral Health Providers (Pediatric)	61	2	116	62	96
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	8	6	53	10	50
Skilled Nursing Facilities	0	0	0	0	1
Supportive Living Facilities	0	0	0	0	0
Pharmacies	54	24	2	89	1
Other Facilities	106	27	179	83	126

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	5	3	7	11	8

*Contiguous counties included: Lee-IA, Des Moines--IA, Louisa-IA, Muscatine-IA, Scott-IA, Clinton-IA, Jackson-IA, Dubuque-IA, Grant-WI, Lafayette-WI, Green-WI, Rock-WI, Walworth-WI.

Provider Network for Region 3 Contiguous Counties
Missouri, Kentucky, Indiana Counties
Contracted Providers

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,031	140	1,633	446	1,491
Primary Care Providers (Pediatric)	1,039	165	1,590	505	1,202
Mid-Level Practitioners (Adult)	975	409	18	1,040	11
Mid-Level Practitioners (Pediatric)	979	380	0	1,061	0
Adult Specialty Providers	2,858	722	2,669	2,270	2,650
Pediatric Specialists	2,092	328	2,306	1,791	1,940
Gynecology, OB/GYN	273	78	267	232	258
Dentists (Adult)	36	6	26	30	26
Dentists (Pediatric)	38	9	31	31	31
Behavioral Health Providers (Adult)	278	120	318	259	294
Behavioral Health Providers (Pediatric)	211	3	231	202	200
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	4	2	28	3	20
Skilled Nursing Facilities	1	0	4	0	3
Supportive Living Facilities	0	0	0	0	1
Pharmacies	68	15	6	138	0
Other Facilities	118	70	318	218	287

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	19	10	18	23	20

*Contiguous counties included: St. Charles-MO, St. Louis City-MO, St. Louis-MO, Jefferson-MO, Ste. Genevieve-MO, Perry-MO, Cape Girardeau-MO, Scott-MO, Union-KY, Crittenden-KY, Livingston-KY, McCracken-KY, Ballard-KY, Sullivan-IN, Knox-IN, Gibson-IN, Posey-IN.

IL2022 HealthChoice IL (HCI) - Contracted Providers Percent of Counties Reported with New Provider Types/Specialties Health Plan Provider Data Submitted on May 13, 2022						
	Aetna	**BCBS**	**Meridian**	**Molina**	**YouthCare**	**CountyCare**
New Provider Specialties	*Overall Percent of Counties Reflected with Medicaid Contracted Providers*					*Cook Only*
Audiology	32%	31%	43%	41%	42%	100%
Pediatric Audiology	32%	31%	43%	41%	30%	100%
VP-CST*	0%	0%	0%	0%	0%	0%
Pediatric VP-CST*	0%	0%	0%	0%	0%	0%
BHC*	0%	0%	10%	0%	11%	100%
SUPR*	6%	49%	63%	74%	72%	100%
SMHRF*	3%	0%	4%	0%	4%	100%
DPP*	0%	0%	15%	0%	12%	100%
DSMES*	0%	0%	25%	0%	19%	100%

Notes

•As of May 2022, health plans began reporting the provider types/specialties above. HSAG will continue to monitor the reporting of new providers.

• Provider specialties above reported as "Yes" for Medicaid Contracted.

***Legend for new provider types:**

• VP-CST - Violence Prevention Community Support Team
• BHC - Behavioral Health Clinic
• SUPR - Substance Use Prevention and Recovery
• SMHRF - Specialized Mental Health Rehabilitation Centers
• DPP - Diabetes Prevention Provider
• DSMES - Diabetes Self-Management Education and Support

Appendix D3. MLTSS Network Monitoring

IL2022 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
Statewide and Cook Only Health Plans - Network Summary
Health Plan Network Data as of 5/13/2022

Number of Counties Identified with one or more contracted MLTSS Provider by Health Plan

Health Plan	Aetna		BCBSIL		Meridian		Molina		CountyCare - Cook Only	
Overall Network	Overall*	Two or More Providers**	Overall*	Two or More Providers**	Overall*	Two or More Providers**	Overall*	Two or More Providers**	Overall*	Two or More Providers**
LTSS Provider Categories	*Number of Counties*		*Number of Counties*		*Number of Counties*		*Number of Counties*		*Number of Counties*	
Adult Day Services	101	91	102	102	102	102	64	37	1	1
Adult Day Services Transportation	100	78	102	102	102	88	59	39	1	1
Day Habilitation	92	48	102	102	102	84	73	35	1	1
Environmental Accessibility	96	51	102	102	102	102	102	102	1	1
Home Delivered Meals	94	63	102	102	86	59	102	62	1	1
Home Health Aide	102	100	102	102	102	102	102	102	1	1
Homemaker Services	102	101	102	102	99	92	102	95	1	1
Nursing Intermittent	102	98	102	102	102	102	102	102	1	1
Nursing Skilled	102	101	102	102	102	102	102	102	1	1
Occupational Therapy	100	95	102	102	102	102	102	102	1	1
Personal Emergency Response System	102	102	102	102	101	42	102	102	1	1
Physical Therapy	100	96	102	102	102	102	102	102	1	1
Pre-Vocational Services	101	86	102	102	83	63	102	102	1	1
Respite Care Services	102	102	102	102	102	102	102	102	1	1
Specialized Medical Equipment	102	99	102	102	102	88	102	102	1	1
Speech Therapy	100	94	102	102	102	102	102	102	1	1
Overall percentage of counties with one or more contracted MLTSS provider* **	**98%**	**86%**	**100%**	**100%**	**98%**	**88%**	**93%**	**85%**	**100%**	**100%**

HSAG Notes:

• Table above reflects the total counties reported with contracted MLTSS providers for Medicaid (HCI). Refer to the statewide health plan-specific tabs for a detailed summary by county and MLTSS provider category. Note, the report above does not take into account time/distance between enrollees and providers.

**Overall* indicates the total number of counties identified with at least one contracted provider.

**Indicates the total number of counties identified with two or more contracted providers.

***The health plan percentage was calculated by the sum of all MLTSS service category combinations across the counties reported with Medicaid Contracted Providers over the total 16 MLTSS service category combinations across all 102 counties for each plan (1,632).

IL2022 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
Statewide & Cook Only Health Plans
Provider Network Data submitted on 5/13/2022

Health Plan	Number of Counties with one or more Contracted MLTSS Provider by Service Category and Health Plan															
	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Aetna																
Counties with 2 or more Providers	91	78	48	51	63	100	101	98	101	102	86	102	99	95	96	94
Counties with 1 Provider	10	22	44	45	31	2	1	4	1	-	15	-	3	5	4	6
Counties with no provider	1	2	10	6	8	-	-	-	-	-	1	-	-	2	2	2
Number of Counties by Region Reported with no Medicaid Contracted Providers																
Region 1-Northwest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	1	1	3	2	3	-	-	-	-	-	-	-	-	-	-	-
Region 3-Southern	-	1	7	4	5	-	-	-	-	-	1	-	-	2	2	2
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BCBSIL																
Counties with 2 or more Providers	102	102	102	102	102	102	102	102	102	102	102	102	102	102	102	102
Counties with 1 Provider	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Counties with no provider	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of Counties by Region Reported with no Medicaid Contracted Providers																
Region 1-Northwest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 3-Southern	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meridian																
Counties with 2 or more Providers	102	88	84	102	59	102	92	102	102	42	63	102	88	102	102	102
Counties with 1 Provider	-	14	18	-	27	-	7	-	-	59	20	-	14	-	-	-
Counties with no provider	-	-	-	-	16	-	3	-	-	1	19	-	-	-	-	-
Number of Counties by Region Reported with no Medicaid Contracted Providers																
Region 1-Northwest	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-
Region 3-Southern	-	-	-	-	15	-	2	-	-	-	19	-	-	-	-	-
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Molina																
Counties with 2 or more Providers	37	39	35	102	62	102	95	102	102	102	102	102	102	102	102	102
Counties with 1 Provider	27	20	38	-	40	-	7	-	-	-	-	-	-	-	-	-
Counties with no provider	38	43	29	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of Counties by Region Reported with no Medicaid Contracted Providers																
Region 1-Northwest	3	2	6	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	12	15	14	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 3-Southern	21	25	8	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	2	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-
CountyCare - Cook Only Health Plan*																
Counties with 2 or more Providers	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Counties with 1 Provider	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Counties with no provider	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

HSAG Notes:
• Table above summarizes the number of counties identified with 2 or more providers; number of counties with 1 Provider; and number of counties with no providers by region. Refer to the statewide health plan-specific tabs for a detailed summary by county and MLTSS provider category.
• Green shading indicates that the health plan reported at least one contracted provider for all service counties.

HealthChoice Illinois (HCI)
2022 Statewide Managed Long Term Services and Supports (MLTSS)
Provider Network Data submitted on 5/13/2022

Methodology:

HSAG completed a review of the HCBS/MLTSS network by region and county based on the provider data reported by the health plans.

The analysis in the excel workbook details the following:

• Count of providers was based on the unique count of Tax IDs reported by the health plans as "Yes" for Medicaid (HCI) Contracted within each county/region.

The figures included in this report indicate the following:

• "3+" - three (3) or more contracted providers (shaded green)
• "2" - two (2) contracted providers (shaded green)
•"1" - one (1) contracted provider (shaded yellow/orange)
•"0" - no contracted providers were identified in the health plan network data

Medicaid Model Contract

5.7.1.4 For Providers of each of the Covered Services identified in this section 5.7.1.4 under an HCBS Waiver, Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor's rates, even if one (1) Provider served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception, in writing. These Covered Services include:

5.7.1.4.1 adult day care;
5.7.1.4.2 homecare/in-home services;
5.7.1.4.3 day habilitation;
5.7.1.4.4 supported employment;
5.7.1.4.5 home-delivered meals;
5.7.1.4.6 home health aides;
5.7.1.4.7 nursing services;
5.7.1.4.8 Occupational Therapy;
5.7.1.4.9 Speech Therapy; and
5.7.1.4.10 Physical Therapy.
5.7.1.5 For the following Covered Services that are services under an HCBS

Waiver, the requirements are as follows:

5.7.1.5.1 *environmental accessibility adaptations for the home.* Contractor shall make its best efforts, and document those efforts, to ensure that the work required to meet the need for the Covered Service is satisfactorily completed by a qualified Provider within ninety (90) days after Contractor becomes aware of the need.

5.7.1.5.3 *Personal Emergency Response System.* Contractor shall enter into contracts that meet the requirements of 89 Ill. Admin. Code 240.235 with at least one (1) Provider serving each county within a Contracting Area.

5.8.1.1.8 *LTSS Provider types in which Enrollee travels to Provider* . Contractor shall ensure an Enrollee has access to at least two (2) LTSS Providers within a thirty (30)-mile radius of or thirty (30)-minute
drive from the Enrollee's residence. If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least two (2) LTSS Providers within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

Appendix D4. MMAI Network Monitoring

IL2022 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 1 - Northwest Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Enrollment as of March 1, 2022	2,325	663	2,098	1,729	5,046

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,938	915	194	1,832	1,034
Mid-Level Practitioners (Adult)	996	1,393	196	52	1,282
Adult Specialty Providers	2,163	3,438	583	2,137	1,803
Gynecology, OB/GYN	221	94	54	256	212
Dentists (Adult)	901	282	330	447	277
Behavioral Health Providers (Adult)	247	613	256	651	723
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	69	114	62	241	269
Skilled Nursing Facilities	199	71	330	123	122
Supportive Living Facilities	26	4	14	24	24
Pharmacies	265	201	251	257	273
Other Facilities	205	193	431	721	388

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	21	19	19	28	29

IL2022 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 2 - Central Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Enrollment as of March 1, 2022	1,825	538	1,139	1,181	7,309

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,285	839	174	1,986	1,266
Mid-Level Practitioners (Adult)	541	1,266	181	39	1,330
Adult Specialty Providers	1,447	3,024	498	2,097	2,282
Gynecology, OB/GYN	203	70	70	254	231
Dentists (Adult)	544	177	176	206	209
Behavioral Health Providers (Adult)	369	669	145	625	769
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	82	278	68	311	363
Skilled Nursing Facilities	181	83	454	133	130
Supportive Living Facilities	22	11	25	28	33
Pharmacies	275	221	268	276	274
Other Facilities	189	229	363	628	497

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	23	23	21	31	30

IL2022 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 3 - Southern Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Enrollment as of March 1, 2022	2,437	829	2,566	1,352	3,371

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	904	368	132	926	750
Mid-Level Practitioners (Adult)	317	540	48	18	704
Adult Specialty Providers	1,124	1,377	256	909	1,255
Gynecology, OB/GYN	103	31	26	129	121
Dentists (Adult)	330	85	102	104	89
Behavioral Health Providers (Adult)	137	306	52	233	332
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	68	214	90	283	276
Skilled Nursing Facilities	128	64	336	107	90
Supportive Living Facilities	20	8	23	24	27
Pharmacies	252	200	232	236	238
Other Facilities	164	242	232	380	477

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	11	26	18	22	32

IL2022 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 4-Cook & Region 5-Collar Counties
Health Plan Provider Data Submitted on May 13, 2022

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars		Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
Enrollment as of March 1, 2022	7,320	2,438	14,289	6,422	6,940	4,006	9,948	3,330	816	302

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars		Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
Practitioners (# of unique NPIs)*										
Primary Care Providers (Adult)	5,438	2,630	2,894	1,500	1,083	898	5,797	3,238	1,936	697
Mid-Level Practitioners (Adult)	3,606	1,360	3,757	2,213	433	364	180	48	1,942	939
Adult Specialty Providers	10,411	4,606	9,488	5,915	2,667	2,200	7,740	4,011	3,399	1,246
Gynecology, OB/GYN	1,293	486	654	377	313	268	964	496	497	197
Dentists (Adult)	2,668	1,626	1,358	847	1,378	827	1,412	957	845	450
Behavioral Health Providers (Adult)	2,024	927	2,624	1,394	1,024	707	2,458	1,281	1,812	894
Facilities (# of locations)*										
CMHC/FQHC/RHC/BHC/SUPR	496	227	514	183	264	126	762	326	822	309
Skilled Nursing Facilities	338	148	199	110	388	264	214	113	174	93
Supportive Living Facilities	43	32	35	21	37	28	33	26	30	24
Pharmacies	851	541	659	411	848	543	846	567	828	531
Other Facilities	1,183	568	1,099	659	1,183	1,243	1,319	793	780	433

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars		Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
Hospitals (# of locations)*										
Hospitals	46	22	51	28	53	19	54	23	48	14

Summary Notes

*Provider counts were based on a unique count of NPIs for practitioners and count of provider locations for Facilities & Hospitals. All providers included in the summary above were reported by the health plans as "MMAI Contracted".

**The mid-level specialties (nurse practitioner, physician assistant) reported by Meridian were listed as "Yes" for the PCP column which are reflected in the adult PCP categories above. Nurse Midwife providers were included in mid-level practitioner category above.

PCP Specialties

• Adult – Family Practice, General Practice, Internal Medicine, Nurse Practitioner, Physician Assistant

• PCP provider specialties were reported by the health plans as "Yes" for the PCP (Y/N) column.

Mid-Level Practitioners

• Adult – Nurse Practitioner, Physician Assistant, Nurse Midwife

• The overall count for the mid-level category above does not include Nurse Practitioners and Physician Assistants reported as "Yes" for the PCP (Y/N) column.

Behavioral Health Specialties

• Adult – Alcohol and Substance Abuse Rehab. Services, Licensed Professional/Licensed Clinical Counselor, Psychiatrist, Psychologist, Social Worker, Other Behavioral Health Services

Region 1 Contiguous Counties
Iowa and Wisconsin Counties
Contracted Provider Network

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	782	90	20	315	175
Mid-Level Practitioners (Adult)	290	133	24	6	147
Adult Specialty Providers	1,312	407	75	448	354
Gynecology, OB/GYN	94	23	6	57	29
Dentists (Adult)	79	33	38	17	15
Behavioral Health Providers (Adult)	91	66	12	123	73
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	5	10	0	47	10
Skilled Nursing Facilities	8	0	0	0	0
Supportive Living Facilities	1	0	0	0	0
Pharmacies	130	24	0	488	89
Other Facilities	72	19	192	104	48

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	9	2	1	3	9

*Contiguous counties included: Lee-IA, Des Moines--IA, Louisa-IA, Muscatine-IA, Scott-IA, Clinton-IA, Jackson-IA, Dubuque-IA, Grant-WI, Lafayette-WI, Green-WI, Rock-WI, Walworth-WI.

Region 3 Contiguous Counties
Missouri, Kentucky, Indiana Counties
Contracted Provider Network

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	607	26	6	602	266
Mid-Level Practitioners (Adult)	146	74	23	5	696
Adult Specialty Providers	690	268	91	833	1,656
Gynecology, OB/GYN	50	12	6	76	146
Dentists (Adult)	53	5	8	26	31
Behavioral Health Providers (Adult)	43	11	3	75	104
Facilities (# of locations)*					
CMHC/FQHC/RHC/BHC/SUPR	0	2	0	12	3
Skilled Nursing Facilities	51	0	2	1	0
Supportive Living Facilities	0	0	0	1	0
Pharmacies	165	15	0	530	138
Other Facilities	159	2	133	151	148

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	8	0	2	5	23

*Contiguous counties included: St. Charles-MO, St. Louis City-MO, St. Louis-MO, Jefferson-MO, Ste. Genevieve-MO, Perry-MO, Cape Girardeau-MO, Scott-MO, Union-KY, Crittenden-KY, Livingston-KY, McCracken-KY, Ballard-KY, Sullivan-IN, Knox-IN, Gibson-IN, Posey-IN.

IL2022 Medicare-Medicaid Alignment Initiative (MMAI) - Contracted Providers Percent of Counties Reported with New Provider Types/Specialties Health Plan Provider Data Submitted on May 13, 2022					
	Aetna	**BCBS**	**Humana**	**Meridian**	**Molina**
New Provider Specialties	*Overall Percent of Counties Reflected with MMAI Contracted Providers*				
Audiology	22%	35%	17%	44%	38%
VP-CST	0%	0%	0%	0%	0%
BHC	0%	0%	0%	8%	0%
SUPR	0%	24%	0%	62%	73%
SMHRF	0%	0%	0%	4%	0%
DPP	0%	0%	0%	15%	0%
DSMES	0%	0%	0%	21%	0%

Notes

• As of May 2022, health plans began reporting the provider types/specialties above. HSAG will continue to monitor the reporting of new providers.

• Provider specialties above reported as "Yes" for MMAI Contracted.

***Legend for new provider types:**

• VP-CST - Violence Prevention Community Support Team

• BHC - Behavioral Health Clinic

• SUPR - Substance Use Prevention and Recovery

• SMHRF - Specialized Mental Health Rehabilitation Centers

• DPP - Diabetes Prevention Provider

• DSMES - Diabetes Self-Management Education and Support

Appendix D5. Access and Availability Telephone Survey

State of Illinois
Department of Healthcare & Family Services

State Fiscal Year 2022 Access and Availability Telephone Survey Report

July 2022

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Illinois Department of Healthcare and Family Services (HFS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a telephone survey among provider locations contracted with HealthChoice Illinois managed care plans and specializing in one of five select health specialties:

- Cardiologists
- Pulmonologists
- Allergy and immunologists
- Neurologists
- Licensed professional counselors

Per the managed care plans' contracts with HFS, each managed care plan is required to maintain provider network capacity to ensure that non-symptomatic office visit (i.e., routine, preventive care) appointments are available within 5 weeks.

Specific survey objectives included the following:

- Determine whether specialty locations accept patients enrolled with a Medicaid health plan
- Determine whether specialty locations accept new patients
- Determine appointment availability with the sampled specialty locations for non-urgent services

To address the study objectives described above, HSAG used an HFS-approved methodology (Appendix A) and script (Appendix B) to conduct a non-secret (i.e., "revealed caller") telephone survey of specialty providers' offices to collect information on enrollees' access to providers throughout Illinois. Survey calls sought to determine appointment availability, by specialty category, for non-urgent services for the following health plans:

- Aetna Better Health of Illinois (Aetna)
- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare[1-1]
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare Specialty Plan (YouthCare)

[1-1] Available only in Cook County.

Summary of Access and Availability Survey Conclusions

Results of the 2022 telephone survey of specialty providers indicated an overall response rate of 84.5 percent. While response rates varied slightly by specialty, all specialties had a response rate greater than 80.0 percent. By specialty, response rates ranged from 81.7 percent for cardiology to 88.4 percent for licensed professional counseling.

HSAG found that 13.0 percent of the provider locations had an incorrect address and 21.6 percent did not offer services for the requested specialty. Moreover, 4.3 percent of the locations indicated they did not accept Medicaid, and 3.2 percent did not accept the health plan. Only 1.3 percent of the locations indicated they were not accepting new patients.

Table 1-1 displays the survey call outcomes, including the reasons that calls were excluded from the study, such as locations could not be reached, were not at the sampled location, did not offer services for the sampled specialty, did not accept the health plan or Medicaid, did not accept new patients, and had other limitations. Overall, 14.5 percent of the calls placed to providers indicated having an available appointment, with appointment availability rates ranging from 10.8 percent (YouthCare) to 21.9 percent (BCBSIL).

Table 1-1—Outcome of Survey Calls to Specialty Locations

Outcome	Aetna[1]	BCBSIL[1]	CountyCare[1]	Meridian[1]	Molina[1]	YouthCare[1]	All Health Plans
Location Could Not be Reached	151 (41.4%)	119 (32.6%)	107 (34.5%)	142 (35.1%)	142 (38.9%)	146 (38.4%)	807 (36.8%)
Location Does Not Exist (Incorrect Address)	46 (12.6%)	42 (11.5%)	59 (19.0%)	56 (13.8%)	44 (12.1%)	38 (10.0%)	285 (13.0%)
Location Does Not Offer Specialty Services	73 (20.0%)	57 (15.6%)	56 (18.1%)	105 (25.9%)	97 (26.6%)	84 (22.1%)	472 (21.6%)
Respondent Unable to Answer Questions About Location	9 (2.5%)	13 (3.6%)	4 (1.3%)	7 (1.7%)	8 (2.2%)	7 (1.8%)	48 (2.2%)
Location Not Accepting Medicaid	18 (4.9%)	23 (6.3%)	11 (3.5%)	18 (4.4%)	9 (2.5%)	15 (3.9%)	94 (4.3%)
Location Not Accepting Plan	5 (1.4%)	5 (1.4%)	14 (4.5%)	4 (1.0%)	5 (1.4%)	37 (9.7%)	70 (3.2%)
Location Not Accepting New Patients	5 (1.4%)	8 (2.2%)	5 (1.6%)	4 (1.0%)	3 (0.8%)	3 (0.8%)	28 (1.3%)

Outcome	Aetna[1]	BCBSIL[1]	CountyCare[1]	Meridian[1]	Molina[1]	YouthCare[1]	All Health Plans
Appointment Available[2]	48 (13.2%)	80 (21.9%)	41 (13.2%)	60 (14.8%)	47 (12.9%)	41 (10.8%)	317 (14.5%)
Other Limitation to Scheduling Appointment	10 (2.7%)	18 (4.9%)	13 (4.2%)	9 (2.2%)	10 (2.7%)	9 (2.4%)	69 (3.2%)

[1] The denominator is the total number of contracted provider locations for the health plan.
[2] Appointment availability is limited to survey respondents at the correct location, accepting the provider specialty, accepting Illinois Medicaid, accepting the specified health plan, and accepting new patients.

While survey callers did not specifically ask about scheduling considerations or reasons an appointment may not be offered, the callers were requested to capture additional information offered by survey respondents regarding scheduling considerations that might affect an enrollee's access to care. Since callers identified all applicable scheduling considerations for a survey case, cases may be counted for one or more limitation categories. Among cases offering an appointment, 19.6 percent (n=62) required pre-registration or personal information to schedule, while 17.7 percent (n=56) required eligibility (Medicaid ID) verification. For cases in which an appointment was not offered, 27.8 percent (n=27) required pre-registration or personal information to schedule. Additionally, 29.9 percent (n=29) of the provider offices noted other limitations specific to the location.

Some of the scheduling considerations noted by the survey calls may be part of a provider office's standard medical practice and, therefore, may be valid reasons why a provider would not schedule an appointment until the information is provided. However, to provide an accurate summary of the enrollees' experience scheduling appointments, the top limitations to scheduling appointments among survey calls are displayed in Table 1-2.

Table 1-2—Limitations to Scheduling Appointments

Limitation	Calls With Appointment[1]	Calls Without Appointment[2]
Referral required	75 (23.7%)	29 (29.9%)
Requires pre-registration or personal information	62 (19.6%)	27 (27.8%)
Requires eligibility (Medicaid ID) verification	56 (17.7%)	18 (18.6%)
Must fill out questionnaire first	54 (17.0%)	15 (15.5%)
Requires medical record review	47 (14.8%)	14 (14.4%)
Limits due to coronavirus disease 2019 (COVID-19)	39 (12.3%)	11 (11.3%)
Other limitations	28 (8.8%)	29 (29.9%)
Must have special clinical condition	18 (5.7%)	8 (8.2%)
Schedule/calendar not available	6 (1.9%)	32 (33.0%)

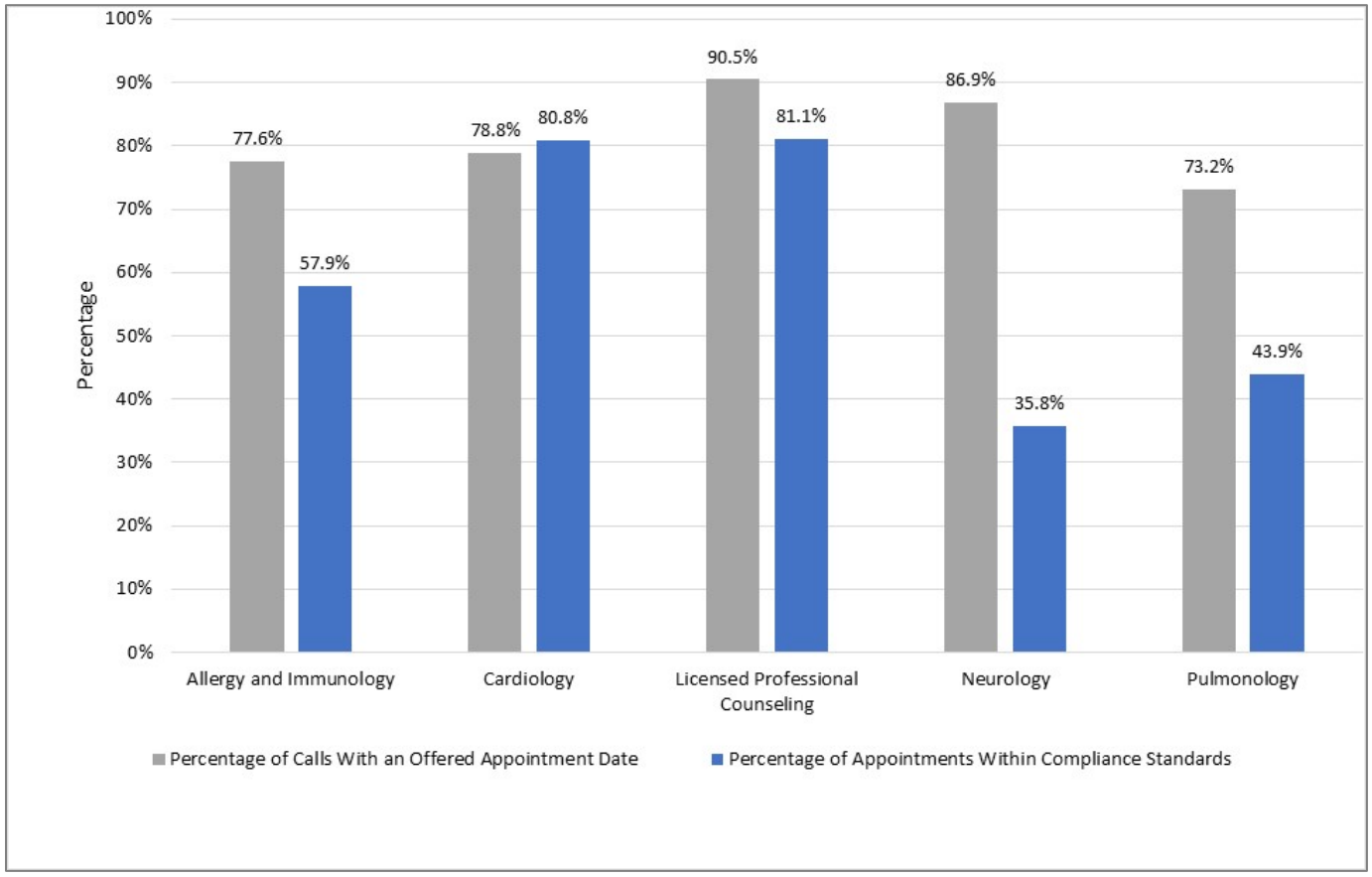
Limitation	Calls With Appointment[1]	Calls Without Appointment[2]
Must be related to an existing patient	4 (1.3%)	1 (1.0%)
Must live in a particular area	3 (0.9%)	0 (0.0%)
Unique age restriction	2 (0.6%)	0 (0.0%)

[1] The denominator is the number of calls with an appointment to contracted provider locations that were able to be reached and the sampled provider was still with the plan and accepting Medicaid.
[2] The denominator is the number of calls without an appointment to contracted provider locations that were able to be reached and the sampled provider was stillwith the plan and accepting Medicaid.

Pulmonology locations offered an appointment for 73.2 percent of the calls. Allergy and immunology locations offered an appointment for 77.6 percent of the calls. While cardiology locations offered an appointment for 78.8 percent of the calls. Neurology offered appointments for 86.9 percent of the calls and licensed professional counseling offered appointments for 90.5 percent of the calls. Despite the limited number of cases with appointment availability, offices that could be reached and that offered appointments for new Medicaid patients were in compliance with the contract standards for 81.1 percent of the offered appointments for licensed professional counseling and 80.8 percent for cardiology appointments. For new Medicaid patients requesting an appointment for allergy and immunology, these offices were in compliance with the contract standards for 57.9 percent of the offered appointments. Pulmonology offices were in compliance with contract standards for 43.9 percent of the offered appointments, while neurology offices were in compliance for 35.8 percent of the offered appointments.

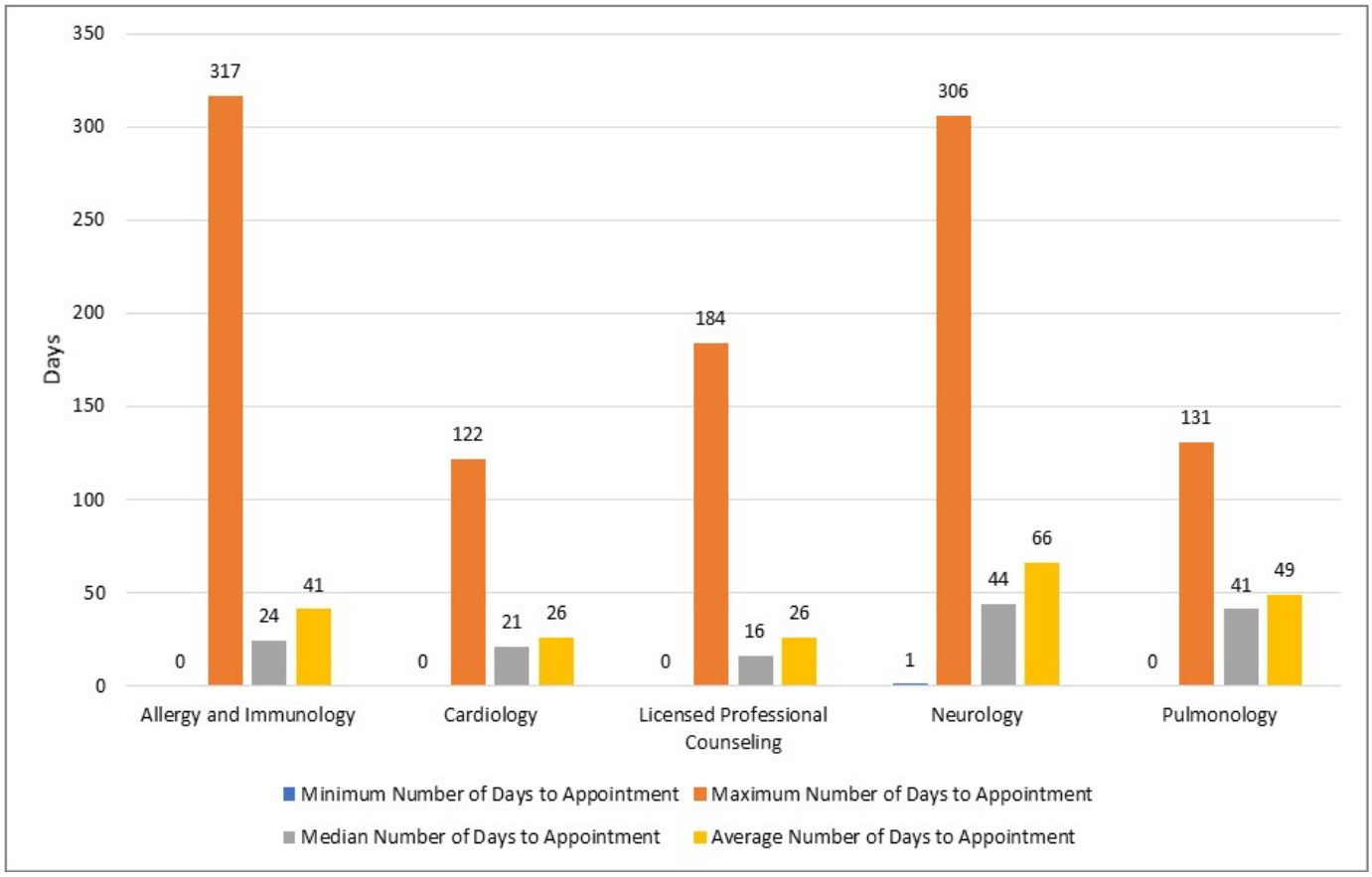
Figure 1-1 displays the characteristics of calls for new patient appointments.

Figure 1-1—Characteristics of New Patient Appointments by Specialty Type



The average time to appointment varied greatly among the specialty categories. The average wait time for an appointment with a licensed professional counselor or a cardiology provider was 26 days, while the average wait time to see a neurology provider was 66 days. Figure 1-2 displays the wait time to schedule an appointment by specialty category.

Figure 1-2—New Patient Appointment Wait Time by Specialty Category



Recommendations

Based on the survey results presented in this report, HSAG identified several opportunities for improvement related to accurate provider information, enrollees' ability to successfully schedule an appointment, and the timeliness of available appointments relative to enrollees' needs. HSAG offers the following recommendations to address potential opportunities to improve access among enrollees covered by HealthChoice Illinois managed care plans:

- HSAG was unable to reach almost 40 percent of sampled cases for each health plan. In addition, key non-response reasons involved call attempts in which the address was incorrect or the office did not provide the requested services.

  - Since the health plans supplied HSAG with the provider data used for this survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls (e.g., disconnected telephone numbers or telephone numbers, addresses, and/or provider specialty information that do not correspond to the sampled provider location).

- HSAG was only able to obtain an appointment date with 14.5 percent of the sampled locations that were accepting the health plan, Medicaid, and new patients. The survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling, Medicaid eligibility verification, requiring a referral, and medical record review. While some barriers pose unique limitations since the caller cannot provide the office personal information, other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments.
  - HFS and the health plans should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment.
  - In coordination with ongoing outreach and network management activities, the health plans should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.
- The overall compliance rate for all specialty categories was 63.1 percent. Appointment availability compliance standards were low, especially in the areas of allergy and immunology (57.9 percent), pulmonology (43.9 percent), and neurology (35.8 percent).
  - The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with specific geographic areas. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
  - HFS should continue to monitor the health plans compliance with existing state standards for appointment availability. Additionally, HFS should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability.

Appendix A. Detailed Findings

Table A-1illustrates the survey response rates by specialty category and health plan. Overall, an 84.5 percent response rate was achieved for this survey.

Table A-1—Response Rate

Specialty Category	Total Number of Cases	Respondents	Response Rate (%)
Allergy and Immunology			
Aetna	73	64	87.7%
BCBSIL	73	67	91.8%
CountyCare	62	49	79.0%
Meridian	81	67	82.7%
Molina	73	63	86.3%
YouthCare	76	65	85.5%
Specialty Total	**438**	**375**	**85.6%**
Cardiology			
Aetna	73	58	79.5%
BCBSIL	73	59	80.8%
CountyCare	62	56	90.3%
Meridian	81	63	77.8%
Molina	73	58	79.5%
YouthCare	76	64	84.2%
Specialty Total	**438**	**358**	**81.7%**
Licensed Professional Counseling			
Aetna	73	61	83.6%
BCBSIL	73	65	89.0%
CountyCare	62	58	93.5%
Meridian	81	76	93.8%
Molina	73	64	87.7%
YouthCare	76	63	82.9%
Specialty Total	**438**	**387**	**88.4%**

Specialty Category	Total Number of Cases	Respondents	Response Rate (%)
Neurology			
Aetna	73	55	75.3%
BCBSIL	73	58	79.5%
CountyCare	62	53	85.5%
Meridian	81	69	85.2%
Molina	73	66	90.4%
YouthCare	76	66	86.8%
Specialty Total	**438**	**367**	**83.8%**
Pulmonology			
Aetna	73	55	75.3%
BCBSIL	73	64	87.7%
CountyCare	62	53	85.5%
Meridian	81	71	87.7%
Molina	73	63	86.3%
YouthCare	76	58	76.3%
Specialty Total	**438**	**364**	**83.1%**
Overall*	**2,190**	**1,851**	**84.5%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Results for non-responsive cases were collected after survey callers attempted to contact each survey case up to two times during standard business hours on different days and times of day. Overall, 339 cases resulted in a non-responsive case across all plans and specialty categories, with 14.3 percent resulting in a call back status. For cases that resulted in a call back, callers left a voicemail message for the office location requesting a return call and did not receive a return call to complete the survey. Table A-2 depicts the non-response reasons by specialty category and health plan.

Table A-2—Non-Response Reasons

Specialty Category	Unable to Complete Survey	Refusal (%)	Ended in Call Back (%)
Allergy and Immunology			
Aetna	9	0.0%	8.2%
BCBSIL	6	4.1%	5.5%
CountyCare	13	1.6%	3.2%
Meridian	14	2.5%	6.2%
Molina	10	4.1%	2.7%
YouthCare	11	1.3%	6.6%
Specialty Total	**63**	**2.3%**	**5.5%**
Cardiology			
Aetna	15	1.4%	13.7%
BCBSIL	14	4.1%	12.3%
CountyCare	6	0.0%	8.1%
Meridian	18	1.2%	9.9%
Molina	15	2.7%	12.3%
YouthCare	12	1.3%	9.2%
Specialty Total	**80**	**1.8%**	**11.0%**
Licensed Professional Counseling			
Aetna	12	1.4%	32.9%
BCBSIL	8	1.4%	35.6%
CountyCare	4	0.0%	38.7%
Meridian	5	1.2%	29.6%
Molina	9	1.4%	28.8%
YouthCare	13	0.0%	26.3%
Specialty Total	**51**	**0.9%**	**31.7%**
Neurology			
Aetna	18	0.0%	17.8%
BCBSIL	15	0.0%	4.1%
CountyCare	9	0.0%	8.1%
Meridian	12	1.2%	16.0%

Specialty Category	Unable to Complete Survey	Refusal (%)	Ended in Call Back (%)
Molina	7	1.4%	24.7%
YouthCare	10	0.0%	18.4%
Specialty Total	**71**	**0.5%**	**15.1%**
Pulmonology			
Aetna	18	0.0%	8.2%
BCBSIL	9	0.0%	6.8%
CountyCare	9	0.0%	6.5%
Meridian	10	1.2%	8.6%
Molina	10	0.0%	8.2%
YouthCare	18	1.3%	10.5%
Specialty Total	**74**	**0.5%**	**8.2%**
Overall*	**339**	**1.2%**	**14.3%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Additional reasons the caller was unable to complete the survey included the following:

- For 472 cases (21.6 percent), the survey respondent indicated that the telephone number connected to a medical facility that did not offer the requested specialty services.
- For 285 cases (13.0 percent), the survey respondent indicated that the address for the sampled location did not exist in their practice's computer system or directory.
- For 181 cases (8.3 percent), the telephone number was disconnected.
- For 75 cases (3.4 percent), the telephone number connected to a non-medical facility.
- For 69 cases (3.2 percent), the caller was placed on hold for longer than 5 minutes.

Table A-3 displays, by specialty category and health plan, the number and percentage of survey respondents reporting that the health plans' provider data reflected the correct location. Overall, 33.8 percent of the contacted locations indicated the caller reached the correct address. The correct location rate ranged from 28.0 percent for pulmonology to 42.4 percent for allergy and immunology. The location rate is limited to survey respondents.

Table A-3—Correct Location

Specialty Category	Respondents[1]	Correct Location	Rate (%)
Allergy and Immunology			
Aetna	64	25	39.1%
BCBSIL	67	37	55.2%
CountyCare	49	22	44.9%
Meridian	67	30	44.8%
Molina	63	15	23.8%
YouthCare	65	30	46.2%
Specialty Total	**375**	**159**	**42.4%**
Cardiology			
Aetna	58	20	34.5%
BCBSIL	59	23	39.0%
CountyCare	56	18	32.1%
Meridian	63	15	23.8%
Molina	58	11	19.0%
YouthCare	64	21	32.8%
Specialty Total	**358**	**108**	**30.2%**
Licensed Professional Counseling			
Aetna	61	22	36.1%
BCBSIL	65	27	41.5%
CountyCare	58	18	31.0%
Meridian	76	31	40.8%
Molina	64	26	40.6%
YouthCare	63	30	47.6%
Specialty Total	**387**	**154**	**39.8%**
Neurology			
Aetna	55	11	20.0%
BCBSIL	58	28	48.3%
CountyCare	53	20	37.7%
Meridian	69	13	18.8%
Molina	66	16	24.2%

Specialty Category	Respondents[1]	Correct Location	Rate (%)
YouthCare	66	15	22.7%
Specialty Total	**367**	**103**	**28.1%**
Pulmonology			
Aetna	55	17	30.9%
BCBSIL	64	32	50.0%
CountyCare	53	10	18.9%
Meridian	71	13	18.3%
Molina	63	14	22.2%
YouthCare	58	16	27.6%
Specialty Total	**364**	**102**	**28.0%**
Overall*	**1,851**	**626**	**33.8%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

[1]Respondents include cases that could be contacted, even if it was determined the address was incorrect, the location did not provide the specialty, or if the interviewee refused or was unable to provide responses to survey questions.

Table A-4 displays, by specialty category and health plan, the number and percentage of cases in which the survey respondent indicated that the sampled location did not offer the requested specialty. Overall, 25.5 percent of the contacted locations did not offer the requested services. The rate of providers not offering the requested specialty ranged from 8.3 percent for licensed professional counseling to 40.1 percent for pulmonology. The specialty rate is limited to survey respondents at the correct location.

Table A-4—Providers Not Offering Specialty

Specialty Category	Respondents[1]	Specialty Not Offered	Rate (%)
Allergy and Immunology			
Aetna	64	20	31.3%
BCBSIL	67	14	20.9%
CountyCare	49	8	16.3%
Meridian	67	19	28.4%
Molina	63	24	38.1%
YouthCare	65	19	29.2%
Specialty Total	**375**	**104**	**27.7%**
Cardiology			
Aetna	58	10	17.2%
BCBSIL	59	11	18.6%
CountyCare	56	12	21.4%
Meridian	63	20	31.7%
Molina	58	20	34.5%
YouthCare	64	17	26.6%
Specialty Total	**358**	**90**	**25.1%**
Licensed Professional Counseling			
Aetna	61	7	11.5%
BCBSIL	65	3	4.6%
CountyCare	58	4	6.9%
Meridian	76	7	9.2%
Molina	64	6	9.4%
YouthCare	63	5	7.9%
Specialty Total	**387**	**32**	**8.3%**

Specialty Category	Respondents[1]	Specialty Not Offered	Rate (%)
Neurology			
Aetna	55	18	32.7%
BCBSIL	58	12	20.7%
CountyCare	53	10	18.9%
Meridian	69	22	31.9%
Molina	66	17	25.8%
YouthCare	66	21	31.8%
Specialty Total	**367**	**100**	**27.2%**
Pulmonology			
Aetna	55	18	32.7%
BCBSIL	64	17	26.6%
CountyCare	53	22	41.5%
Meridian	71	37	52.1%
Molina	63	30	47.6%
YouthCare	58	22	37.9%
Specialty Total	**364**	**146**	**40.1%**
Overall*	**1,851**	**472**	**25.5%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

[1]Respondents include cases that could be contacted, even if it was determined the address was incorrect, the location did not provide the specialty, or if the interviewee refused or was unable to provide responses to survey questions.

Table A-5 displays, by specialty category and plan, the number and percentage of survey respondents serving different populations including adults only, children only, or both adults and children. Overall, 40.8 percent offered appointments for adults only, 6.2 percent offered appointments for children only, and 46.5 percent offered appointments for both adults and children. However, these rates varied greatly by health plan and specialty category. This rate is limited to survey respondents at the correct location and offering the specialty category.

Table A-5—Population Type

Specialty Category	Denom[1]	Adults Only[2]		Children Only[2]		Adults and Children	
		N	Rate (%)	N	Rate (%)	N	Rate (%)
Allergy and Immunology							
Aetna	23	4	17.4%	3	13.0%	15	65.2%
BCBSIL	35	1	2.9%	3	8.6%	29	82.9%
CountyCare	21	4	19.0%	1	4.8%	16	76.2%
Meridian	29	2	6.9%	7	24.1%	19	65.5%
Molina	13	1	7.7%	0	0.0%	12	92.3%
YouthCare	29	0	0.0%	5	17.2%	24	82.8%
Specialty Total	**150**	**12**	**8.0%**	**19**	**12.7%**	**115**	**76.7%**
Cardiology							
Aetna	16	13	81.3%	0	0.0%	3	18.8%
BCBSIL	21	17	81.0%	0	0.0%	4	19.0%
CountyCare	17	13	76.5%	1	5.9%	2	11.8%
Meridian	14	11	78.6%	1	7.1%	2	14.3%
Molina	9	9	100%	0	0.0%	0	0.0%
YouthCare	19	13	68.4%	0	0.0%	5	26.3%
Specialty Total	**96**	**76**	**79.2%**	**2**	**2.1%**	**16**	**16.7%**
Licensed Professional Counseling							
Aetna	20	0	0.0%	1	5.0%	16	80.0%
BCBSIL	24	3	12.5%	1	4.2%	16	66.7%
CountyCare	17	2	11.8%	1	5.9%	11	64.7%
Meridian	29	3	10.3%	1	3.4%	23	79.3%
Molina	25	1	4.0%	1	4.0%	18	72.0%
YouthCare	27	1	3.7%	0	0.0%	20	74.1%

Specialty Category	Denom[1]	Adults Only[2] N	Adults Only[2] Rate (%)	Children Only[2] N	Children Only[2] Rate (%)	Adults and Children N	Adults and Children Rate (%)
Specialty Total	**142**	**10**	**7.0%**	**5**	**3.5%**	**104**	**73.2%**
Neurology							
Aetna	11	8	72.7%	0	0.0%	3	27.3%
BCBSIL	24	19	79.2%	1	4.2%	3	12.5%
CountyCare	19	11	57.9%	1	5.3%	5	26.3%
Meridian	11	6	54.5%	2	18.2%	3	27.3%
Molina	14	9	64.3%	0	0.0%	4	28.6%
YouthCare	15	7	46.7%	1	6.7%	7	46.7%
Specialty Total	**94**	**60**	**63.8%**	**5**	**5.3%**	**25**	**26.6%**
Pulmonology							
Aetna	16	15	93.8%	0	0.0%	1	6.3%
BCBSIL	30	26	86.7%	2	6.7%	1	3.3%
CountyCare	10	7	70.0%	1	10.0%	1	10.0%
Meridian	12	9	75.0%	0	0.0%	2	16.7%
Molina	13	10	76.9%	0	0.0%	2	15.4%
YouthCare	15	11	73.3%	2	13.3%	2	13.3%
Specialty Total	**96**	**78**	**81.3%**	**5**	**5.2%**	**9**	**9.4%**
Overall*	**578**	**236**	**40.8%**	**36**	**6.2%**	**269**	**46.5%**

[1]The denominator includes cases with the correct location and specialty in which the respondent is able to answer questions about the location.
[2]Adults Only may contain respondents serving patients based on unique age restrictions 16 and over; Children Only may contain respondents serving patients based on unique age restrictions 8-18. Some locations indicated unique age restrictions that may cross standard adult only or children only restrictions (e.g., under 21, 12-21).
* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table A-6 displays, by specialty category and health plan, the number and percentage of cases offering telehealth appointments. Overall, 79.9 percent of the sampled locations offered telehealth appointments. The telehealth appointment rate is limited to survey respondents at the correct location for the sampled provider and offering the provider specialty.

Table A-6—Telehealth Appointments

Specialty Category	Denom[1]	Offering Telehealth	Rate (%)[1]
Allergy and Immunology			
Aetna	23	21	91.3%
BCBSIL	35	27	77.1%
CountyCare	21	17	81.0%
Meridian	29	19	65.5%
Molina	13	7	53.8%
YouthCare	29	24	82.8%
Specialty Total	**150**	**115**	**76.7%**
Cardiology			
Aetna	16	12	75.0%
BCBSIL	21	18	85.7%
CountyCare	17	11	64.7%
Meridian	14	7	50.0%
Molina	9	5	55.6%
YouthCare	19	14	73.7%
Specialty Total	**96**	**67**	**69.8%**
Licensed Professional Counseling			
Aetna	20	17	85.0%
BCBSIL	24	23	95.8%
CountyCare	17	17	100%
Meridian	29	28	96.6%
Molina	25	23	92.0%
YouthCare	27	25	92.6%
Specialty Total	**142**	**133**	**93.7%**

Specialty Category	Denom[1]	Offering Telehealth	Rate (%)[1]
Neurology			
Aetna	11	6	54.5%
BCBSIL	24	21	87.5%
CountyCare	19	17	89.5%
Meridian	11	9	81.8%
Molina	14	10	71.4%
YouthCare	15	13	86.7%
Specialty Total	**94**	**76**	**80.9%**
Pulmonology			
Aetna	16	12	75.0%
BCBSIL	30	19	63.3%
CountyCare	10	8	80.0%
Meridian	12	11	91.7%
Molina	13	11	84.6%
YouthCare	15	10	66.7%
Specialty Total	**96**	**71**	**74.0%**
Overall*	**578**	**462**	**79.9%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
[1]The denominator includes cases with the correct location and specialty in which the respondent is able to answer questions about the location.

Table A-7 displays the survey respondents' self-reported telehealth methods and considerations by health plan.

Table A-7—Telehealth Service Delivery Methods and Considerations

Telehealth Method	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Telephone only	35	43	32	31	22	44
Telephone and video or video chat	51	89	63	59	42	74
Patient must travel to a clinic or facility for telehealth appointments	9	13	13	3	4	6
Telehealth limited to specific services or clinical conditions	24	28	12	18	14	27
Telehealth required for a new patient's first appointment	4	2	2	2	1	5

For each specialty category and health plan, Table A-8 displays the number of providers available to see patients and of those, the number accepting new patients. The counts of providers are limited to cases responding to the survey, at the correct location, and offering the specialty category.

Table A-8—Providers Available for Appointments and Accepting New Patients

Specialty Category	Number of Providers Available to See Patients	Number of Offices with Providers Available to See Patients	Number of Providers Accepting New Patients	Number of Offices with Providers Accepting New Patients
Allergy and Immunology				
Aetna	114	23	102	23
BCBSIL	155	35	122	35
CountyCare	84	21	47	20
Meridian	80	28	80	28
Molina	104	13	72	13
YouthCare	77	28	76	27
Specialty Total	**614**	**148**	**499**	**146**
Cardiology				
Aetna	73	16	72	16
BCBSIL	109	20	103	20
CountyCare	165	16	159	15
Meridian	75	13	70	12
Molina	21	9	19	8
YouthCare	75	19	73	18
Specialty Total	**518**	**93**	**496**	**89**
Licensed Professional Counseling				
Aetna	79	16	51	13
BCBSIL	142	19	66	15
CountyCare	83	12	20	7
Meridian	222	22	184	20
Molina	121	22	83	20
YouthCare	113	23	79	22
Specialty Total	**760**	**114**	**483**	**97**

Specialty Category	Number of Providers Available to See Patients	Number of Offices with Providers Available to See Patients	Number of Providers Accepting New Patients	Number of Offices with Providers Accepting New Patients
Neurology				
Aetna	25	10	25	10
BCBSIL	101	23	95	22
CountyCare	215	18	211	18
Meridian	94	11	92	11
Molina	49	14	44	14
YouthCare	115	15	112	15
Specialty Total	**599**	**91**	**579**	**90**
Pulmonology				
Aetna	45	14	43	14
BCBSIL	64	28	52	26
CountyCare	56	10	54	10
Meridian	60	12	59	12
Molina	40	13	40	13
YouthCare	63	14	58	14
Specialty Total	**328**	**91**	**306**	**89**
Overall*	**2,819**	**537**	**2,363**	**511**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table A-9 displays, by specialty category and health plan, the number and percentage of cases accepting Illinois Medicaid. Overall, 83.7 percent of the sampled locations were still contracted with Illinois Medicaid. The rate is limited to survey respondents at the correct location and accepting the specialty category.

Table A-9—Accepting Illinois Medicaid

Specialty Category	Denom[1]	Accepting Medicaid	Rate (%)[1]
Allergy and Immunology			
Aetna	23	20	87.0%
BCBSIL	35	27	77.1%
CountyCare	21	16	76.2%
Meridian	29	22	75.9%
Molina	13	12	92.3%
YouthCare	29	20	69.0%
Specialty Total	**150**	**117**	**78.0%**
Cardiology			
Aetna	16	14	87.5%
BCBSIL	21	19	90.5%
CountyCare	17	15	88.2%
Meridian	14	11	78.6%
Molina	9	8	88.9%
YouthCare	19	17	89.5%
Specialty Total	**96**	**84**	**87.5%**
Licensed Professional Counseling			
Aetna	20	15	75.0%
BCBSIL	24	23	95.8%
CountyCare	17	16	94.1%
Meridian	29	27	93.1%
Molina	25	24	96.0%
YouthCare	27	27	100%
Specialty Total	**142**	**132**	**93.0%**

Specialty Category	Denom[1]	Accepting Medicaid	Rate (%)[1]
Neurology			
Aetna	11	9	81.8%
BCBSIL	24	19	79.2%
CountyCare	19	17	89.5%
Meridian	11	10	90.9%
Molina	14	10	71.4%
YouthCare	15	13	86.7%
Specialty Total	**94**	**78**	**83.0%**
Pulmonology			
Aetna	16	10	62.5%
BCBSIL	30	23	76.7%
CountyCare	10	9	90.0%
Meridian	12	7	58.3%
Molina	13	11	84.6%
YouthCare	15	13	86.7%
Specialty Total	**96**	**73**	**76.0%**
Overall*	**578**	**484**	**83.7%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
[1] The denominator includes cases with the correct location and specialty in which the respondent is able to answer questions about the location.

Table A-10 displays, by specialty category and health plan, the number and percentage of cases accepting the requested health plan. Overall, 85.5 percent of the sampled locations were still contracted with the requested health plan. The rate is limited to survey respondents at the correct location, accepting the specialty category, and accepting Illinois Medicaid.

Table A-10—Accepting Health Plan

Specialty Category	Denom[1]	Accepting Health Plan	Rate (%)[1]
Allergy and Immunology			
Aetna	20	19	95.0%
BCBSIL	27	24	88.9%
CountyCare	16	12	75.0%
Meridian	22	20	90.9%
Molina	12	11	91.7%
YouthCare	20	14	70.0%
Specialty Total	**117**	**100**	**85.5%**
Cardiology			
Aetna	14	14	100%
BCBSIL	19	19	100%
CountyCare	15	11	73.3%
Meridian	11	10	90.9%
Molina	8	7	87.5%
YouthCare	17	7	41.2%
Specialty Total	**84**	**68**	**81.0%**
Licensed Professional Counseling			
Aetna	15	14	93.3%
BCBSIL	23	23	100%
CountyCare	16	15	93.8%
Meridian	27	26	96.3%
Molina	24	24	100%
YouthCare	27	24	88.9%
Specialty Total	**132**	**126**	**95.5%**

Specialty Category	Denom[1]	Accepting Health Plan	Rate (%)[1]
Neurology			
Aetna	9	7	77.8%
BCBSIL	19	18	94.7%
CountyCare	17	13	76.5%
Meridian	10	10	100%
Molina	10	8	80.0%
YouthCare	13	6	46.2%
Specialty Total	**78**	**62**	**79.5%**
Pulmonology			
Aetna	10	9	90.0%
BCBSIL	23	22	95.7%
CountyCare	9	8	88.9%
Meridian	7	7	100%
Molina	11	10	90.9%
YouthCare	13	2	15.4%
Specialty Total	**73**	**58**	**79.5%**
Overall*	**484**	**414**	**85.5%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
[1] The denominator includes cases responding to the survey, at the correct location, accepting the specialty category, and accepting Illinois Medicaid.

Table A-11 displays, by specialty category and health plan, the number and percentage of cases where the location accepts new patients for the specified health plan. Overall, 93.2 percent of the contacted locations were accepting new patients. The new patient acceptance rate is limited to survey respondents at the correct location, accepting the specialty category, accepting Illinois Medicaid, and accepting the specified health plan.

Table A-11—Accepting New Patients

Specialty Category	Denom[1]	Accepting New Patients	Rate (%)[1]
Allergy and Immunology			
Aetna	19	18	94.7%
BCBSIL	24	24	100%
CountyCare	12	11	91.7%
Meridian	20	20	100%
Molina	11	11	100%
YouthCare	14	14	100%
Specialty Total	**100**	**98**	**98.0%**
Cardiology			
Aetna	14	14	100%
BCBSIL	19	18	94.7%
CountyCare	11	11	100%
Meridian	10	10	100%
Molina	7	7	100%
YouthCare	7	6	85.7%
Specialty Total	**68**	**66**	**97.1%**
Licensed Professional Counseling			
Aetna	14	10	71.4%
BCBSIL	23	18	78.3%
CountyCare	15	11	73.3%
Meridian	26	23	88.5%
Molina	24	21	87.5%
YouthCare	24	22	91.7%
Specialty Total	**126**	**105**	**83.3%**

Specialty Category	Denom[1]	Accepting New Patients	Rate (%)[1]
Neurology			
Aetna	7	7	100%
BCBSIL	18	17	94.4%
CountyCare	13	13	100%
Meridian	10	10	100%
Molina	8	8	100%
YouthCare	6	6	100%
Specialty Total	**62**	**61**	**98.4%**
Pulmonology			
Aetna	9	9	100%
BCBSIL	22	21	95.5%
CountyCare	8	8	100%
Meridian	7	6	85.7%
Molina	10	10	100%
YouthCare	2	2	100%
Specialty Total	**58**	**56**	**96.6%**
Overall*	**414**	**386**	**93.2%**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
[1] The denominator includes cases responding to the survey, at the correct location, accepting the specialty category, and accepting the health plan.

Table A-12 displays, by specialty category and health plan, the average and median wait times for new and existing patients for a non-urgent or routine visit. Overall, the average wait time for a new patient appointment was 39 days. Average wait times for a new patient ranged from 25 days for an appointment with a licensed professional counselor to 66 days for an appointment with a neurologist. The average wait time for an existing patient appointment was 23 days. Average wait times for an existing patient ranged from 13 days for an appointment with a licensed professional counselor to 41 days for an appointment with a neurologist. The new patient appointment wait time is limited to survey respondents at the correct location, accepting the provider specialty, accepting the specified health plan, and accepting new patients. The existing patient wait time is limited to survey respondents at the correct location, accepting the provider specialty, and accepting the specified health plan.

Table A-12—Appointment Wait Time

Specialty Category	New Patients			Existing Patients		
	Denom	Average Wait Time (Days)	Median Wait Time (Days)	Denom	Average Wait Time (Days)	Median Wait Time (Days)
Allergy and Immunology						
Aetna	14	42	36	13	28	14
BCBSIL	18	36	20	17	20	11
CountyCare	9	27	14	9	12	7
Meridian	17	44	32	15	21	11
Molina	9	50	21	9	11	7
YouthCare	9	47	41	9	20	14
Specialty Total	**76**	**41**	**24**	**72**	**19**	**11**
Cardiology						
Aetna	12	31	32	10	28	24
BCBSIL	15	17	14	14	13	8
CountyCare	9	24	21	7	29	31
Meridian	8	41	28	8	38	28
Molina	3	38	23	4	32	21
YouthCare	5	13	9	5	13	9
Specialty Total	**52**	**26**	**21**	**48**	**24**	**17**
Licensed Professional Counseling						
Aetna	8	42	11	9	22	7
BCBSIL	16	22	14	20	14	7

Specialty Category	New Patients			Existing Patients		
	Denom	Average Wait Time (Days)	Median Wait Time (Days)	Denom	Average Wait Time (Days)	Median Wait Time (Days)
CountyCare	8	25	18	11	20	7
Meridian	23	28	17	23	10	5
Molina	20	27	23	21	12	10
YouthCare	20	18	14	23	7	7
Specialty Total	**95**	**25**	**16**	**107**	**13**	**7**
Neurology						
Aetna	7	35	21	7	17	14
BCBSIL	13	62	57	12	53	43
CountyCare	11	67	67	10	58	42
Meridian	9	71	84	9	24	9
Molina	7	77	68	7	27	22
YouthCare	6	89	39	5	58	31
Specialty Total	**53**	**66**	**44**	**50**	**41**	**26**
Pulmonology						
Aetna	7	37	14	7	24	14
BCBSIL	18	52	44	16	34	35
CountyCare	4	32	26	4	35	31
Meridian	3	48	46	3	24	32
Molina	8	59	53	8	41	33
YouthCare	1	41	41	1	41	41
Specialty Total	**41**	**48**	**41**	**39**	**33**	**31**
Overall*	**317**	**39**	**24**	**316**	**23**	**13**

* Use caution when interpreting overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across specialty categories. Survey calls were placed by specialty, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table A-13 displays the top limitations to scheduling appointments among survey calls to provider locations who could be reached and accepted the health plan and Medicaid. Among cases in which an appointment was offered, 54.9 percent had no stated limitations, while 23.7 percent required a referral to confirm the appointment date. Additionally, 19.6 percent required pre-registration or personal information prior to confirming an appointment. Among cases unable to offer an appointment, 33.0 percent indicated the schedule/calendar was not available. Additionally, 29.9 percent noted limitations unique to the sampled location or required a referral prior to scheduling, and 27.8 percent required pre-registration or personal information before a date could be provided.

Table A-13—Limitations to Scheduling Appointments

Limitation[1]	Cases Offered an Appointment		Cases Unable to Offer an Appointment	
	Number	Rate[2] (%)	Number	Rate[2] (%)
No limitations noted	174	54.9%	13	13.4%
Referral required	75	23.7%	29	29.9%
Required pre-registration or personal information	62	19.6%	27	27.8%
Required eligibility (Medicaid ID) verification	56	17.7%	18	18.6%
Must fill out a questionnaire first	54	17.0%	15	15.5%
Requires medical record review	47	14.8%	14	14.4%
Limits due to COVID-19	39	12.3%	11	11.3%
Other	28	8.8%	29	29.9%
Must have special clinical condition	18	5.7%	8	8.2%
Schedule/calendar not available	6	1.9%	32	33.0%
Must be related to an existing patient	4	1.3%	1	1.0%
Must live in a particular area	3	0.9%	0	0.0%
Unique age restriction	2	0.6%	0	0.0%

[1] Cases may be counted for more than one limitation.
[2] The denominator includes cases responding to the survey, at the correct location, accepting the specialty category, accepting Illinois Medicaid, and accepting the health plan.

Appendix B. Access and Availability Survey Methodology

Eligible Population

The eligible population included practice locations associated with select specialty providers that were actively enrolled in the HealthChoice Illinois Medicaid Care Program as of February 4, 2022. Out-of-state offices located in contiguous counties in Indiana, Iowa, Kentucky, Missouri, and Wisconsin were included in the study. The specialty provider categories selected for this survey include the following four physical health specialties and one behavioral health specialty:

1. Cardiologists
2. Pulmonologists
3. Allergy and immunologists
4. Neurologists
5. Licensed professional counselors

Data Collection

HSAG received provider data files from the health plans on February 4, 2022. Health plan data included the following minimum data elements for each provider's location: demographic information (e.g., provider name, address, phone number, Medicaid ID), provider specialty (e.g., cardiology), county location, contract status, appropriate provider directory inclusion, and panel information (i.e., open or closed). Upon receipt of the data, HSAG reviewed the address and telephone number information to assess potential duplication and completeness of key data fields.

To minimize duplicated provider records between the health plans, HSAG standardized the providers' address data to align with the United States Postal Service Coding Accuracy Support System (CASS). Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population.

Case Identification Approach

HSAG employed a case identification approach with the aim of minimizing provider burden. HSAG randomly selected survey cases by health plan and specialty category from a de-duplicated list of unique phone numbers along with a single associated unique practice location and specialty. This method minimizes the number of calls a single provider office receives.[B-1] HSAG selected a statistically

[B-1] Unique locations were identified within each Medicaid health plan and specialty category using the telephone number and address.

representative number of provider locations for each health plan based on a 95 percent confidence interval and ±5 percent margin of error.

Telephone Survey Process

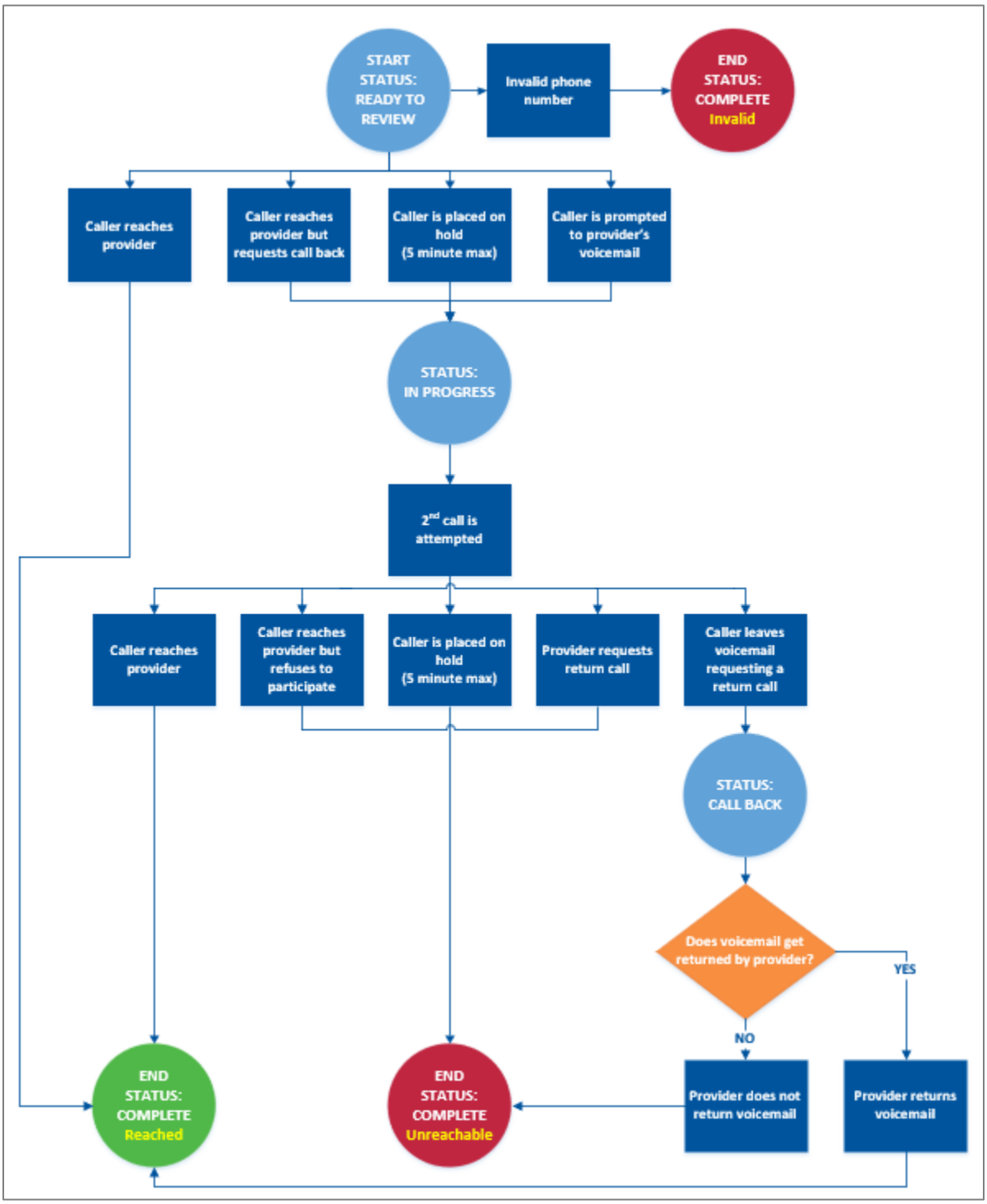
HSAG conducted the survey during March and April 2022. Survey calls requested appointment availability with the sampled health plans for the sampled location. Since HSAG revealed the interviewer's identity to the provider's office, interviewers used the same HFS-approved script (Appendix C) for all specialty categories.

During the survey, callers attempted up to two calls to each sampled case during standard operating hours (i.e., 9:00 a.m.–5:00 p.m. Central Time).[B-2] Interviewers who were put on hold at any point during the call waited on hold for 5 minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the interviewer made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number supplied by the health plan connected to a fax line or a message that the number is no longer in service)
- Telephone number connected to an individual or business unrelated to a medical practice or facility
- Interviewers left a voicemail requesting a return call following the second valid attempt to the location. Office personnel failed to respond within two business days to the voicemail request to complete the survey
- The interviewer was unable to speak with office personnel during either call attempt (e.g., the call was answered by an automated answering service or call center that prevented the interviewer from speaking with office staff or leaving a voicemail)
- The interviewer was placed on an extended hold with additional unsuccessful attempts

[B-2] HSAG did not consider a call attempted when the caller reached an office outside of the office's usual business hours. For example, if the caller reached a recording stating that the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The caller was instructed to attempt to contact the office up to two times outside of the known lunch hour.

The following diagram outlines the survey stop points for this activity.



Survey Indicators

Using data elements identified from the HFS-approved survey script (Appendix C), HSAG classified survey indicators into two domains: provider data accuracy and appointment availability. Provider data accuracy was evaluated by health plan based on survey responses. In general, survey call data that matched the health plan's provider data received a "Yes" response and non-matched information received a "No" response. For data collected on the first available appointment, the average and median wait times were calculated based on call date and earliest appointment date offered by the survey respondent.

HSAG collected the following provider data accuracy information:

- Accuracy of the location's telephone number
- Accuracy of the location's address
- Accuracy of the location's identification as offering services for the designated provider specialty
- Accuracy of the location's affiliation with Illinois Medicaid and the requested health plan

HSAG collected the following access-related information:

- Whether the location served adults, children, or both
- The number of individual practitioners (e.g., allopathic or osteopathic medical practitioners with a Doctor of Medicine or Doctor of Osteopathic Medicine degree) offering services at the location
- Whether the location offered services via telehealth, and if so, the nature of the service delivery modality (e.g., telephone, video chat, asynchronous communications)
- Whether the location accepted new patients
- Number of calendar days until the next available appointment with any practitioner at the sampled location for a new or existing patient with non-urgent or routine issue (i.e., two appointment scenarios: one for a new patient and one for an existing patient)
- Any limitations to accepting new patients or scheduling an appointment (e.g., eligibility verification, medical record review)

Study Limitations

Due to the nature of the survey, the following limitations should be considered when generalizing survey results across specialty providers contracted with the HealthChoice Illinois managed care plans:

- Survey findings were compiled from self-reported responses supplied to HSAG's callers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication. The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).

- Time to the first available appointment was based on appointments requested with the sampled location. Cases were counted as being unable to offer an appointment if the case offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which enrollees are willing to travel to an alternate location.
- Health plans are responsible for ensuring that enrollees have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of the health plans' processes for aiding enrollees who require timely appointments.
- Since this survey required callers to indicate that they were conducting a survey on behalf of HFS, responses may not accurately reflect enrollees' experiences when seeking an appointment. Of note, 1.2 percent of the sampled locations declined to participate in the survey (i.e., refusal). Additionally, 14.3 percent of the locations failed to return survey calls or voicemails (i.e., call back), an outcome that may differ for prospective patients.
- Due to the nature of the survey script, respondents may have ended the caller's conversation without answering all survey elements by transferring the caller to another respondent to collect different survey elements. For example, billing staff may have supplied information on health plan acceptance, then transferred the caller to scheduling staff for appointment availability. As such, HSAG did not collect all survey elements for all respondent cases.

Appendix C. Survey Script

Survey Script

This script guided interviewers in gathering information relevant to obtaining appointment information. The electronic data collection tool controlled skip logic between survey elements and collected the date(s) of the initial and subsequent calls. Interviewers were instructed to leave voicemail messages on the second call attempt. Interviewers were instructed not to schedule appointments, only to ask about appointment availability at the sampled location.

1. Call the office and note the name of the person to whom you are speaking.

   Note: If telephone number is disconnected or does not connect to a medical facility, the survey will end, and the case is considered a non-respondent (i.e., an invalid telephone number).

   If the interviewer reaches a voicemail system on the second call attempt, they will leave a message requesting a return call.

2. "Hello, my name is << Interviewer's First Name>> and I am calling on behalf of the Illinois Department of Healthcare and Family Services to ask about appointment availability for <<specialty category>> at the <<street name>> location. Are you able to answer questions about this location?"

   If yes, move to element #3. If no, ask if there is a better time to call and thank them for their time. If no alternate contact time is offered, the survey will end, and the case is considered a non-respondent (i.e., a refusal).

   If the office indicates that it does not offer the requested specialty at the location noted, the survey will end (i.e., not in the study population).

   If the office indicates that the address is incorrect (i.e., the <<street address, city, state, ZIP code>> is not an address at which patients are seen for <<specialty category>>) and a forwarding telephone number for the sampled address is not available, the survey will end.

3. "Does this location see adults, children, or both for <<specialty category>>?"

   Document the response, including any information offered regarding limitations to patient acceptance.

   If the respondent states that the location does not offer the noted type of select specialty, the survey will end; move to element #13. Otherwise, continue to element #4.

4. "Do any providers at this location offer appointments using telehealth?"

   If yes, move to element #5. If no, move to element #6.

5. "Can you please confirm which of the following methods are available for telehealth?"

Respondent will read the following options and select all that apply: telephone only; telephone and video or video chat; must travel to a clinic or facility for telehealth appointments; telehealth appointments are limited to specific services or clinical conditions; telehealth required as the first appointment for new patients.

6. "How many doctors/providers are available to see patients at the <<street name>> location?"

   If needed, the interviewer will explain that "doctor" refers to allopathic or osteopathic medical practitioners with an M.D. or D.O., and who are licensed to practice medicine in the state in which the sampled case is located.

   Document the response and move to element #7. Responses will be collected verbatim and may be represented as a count or estimation based on day of the week ("e.g., 5, depends on day of the week, usually at least 3").

7. "How many of those doctors are accepting new patients at this location?"

   Document the response, including any information offered regarding limitations to patient acceptance. Responses will be collected verbatim and may be represented as a count or estimation based on day of the week ("e.g., At least 1, but usually 2"). Continue to element #8.

   If the respondent states that the location is not accepting new patients, or that new patient acceptance is contingent on the patient's insurance carrier, the survey will continue to element #8, and appointment availability requests will be limited to the existing patient scenario.

8. "I'm now going to ask about the insurance plans accepted at the <<street name>> location. Can you please confirm that you are accepting Illinois Medicaid?"

   If the respondent indicates that the location accepts patients with the Illinois Medicaid, move to element #9. If the respondent states that no providers at the location accept patients with Illinois Medicaid, confirm that the location will not see any new or existing patients with this insurance and the survey will end.

9. "Can you please confirm that you are accepting <<health plan>>?"

   If the location is sampled for more than one health plan and the respondent indicated in element #9 that the location accepts more than one health plan, the interviewer will ask elements #10-12 once for each health plan.

   If the respondent indicates that the location accepts patients with the requested health plan, move to element #10. If the respondent states that no providers at the location accept patients with the sampled health plan, confirm that the location will not see any new or existing patients with this insurance and the survey will end for the requested health plan; if the location will not see any new or existing patients with any health plan, move to element #13 to end the survey.

10. "Are you accepting new patients with <<health plan>> at this location?"

    If yes, move to element #11. If no, move to element #12.

11. "When is the next available appointment at the <<street name>> location for a non-urgent or routine visit for a new patient with <<health plan>>?"

    Document the appointment date and move to element #12. The interviewer will capture any information offered regarding barriers to scheduling.

12. "When is the next available appointment at the <<street name>> location for a non-urgent issue for an existing patient with <<health plan>>?"

    Document the appointment date and move to element #13. The interviewer will capture any information offered regarding barriers to scheduling.

13. "Those are all of my questions. Thank you for your time and participation in this survey."

Appendix D6. Network Time/ Distance Analysis

Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

SFY 2022 Provider Network Time/Distance Analysis

August 2022

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Executive Summary

Introduction

The Illinois Department of Healthcare and Family Services (HFS) is responsible for the ongoing monitoring and oversight of its contracted HealthChoice Illinois managed care health plans (health plans) that deliver services to Medicaid managed care enrollees. As part of its provider network adequacy monitoring activities, HFS requested its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), conduct a time/distance analysis between enrollees and providers in the health plans' networks. Specifically, the purpose of the state fiscal year (SFY) 2022 Time/Distance Analysis was to evaluate the degree to which health plans comply with network standards outlined in the Illinois Department of Healthcare and Family Services—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

Validation of network adequacy is a mandatory external quality review (EQR) activity, and states must begin conducting this activity, described in the Centers for Medicare & Medicaid Services (CMS) rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol has yet to be released by CMS, time/distance analysis, as conducted in this analysis, aligns with current federal regulations, and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect. The health plans assessed in this analysis include:

- Aetna Better Health of Illinois (Aetna)[1]
- Blue Cross Community Health Plans (BCBSIL)
- CountyCare[2]
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare HealthChoice Illinois (YouthCare)[3]

Overall Statewide Time/Distance Study Findings

The findings from the analysis of the percentage of enrollees residing within the time/distance standards defined by HFS are summarized below. The summary information includes the number of provider categories for which the percentage of enrollees met the time/distance standards for the provider category across all five regions of the state. The summary information also includes the health plans and regions where the time/distance standards were not met for each provider category with deficiencies. Finally, the summary information includes key findings from the analysis of enrollees stratified by age, sex, and residence in Disproportionately Impacted Area (DIA) ZIP Codes.

[1] Formerly IlliniCare Health.

[2] Available only in Cook County.

[3] YouthCare serves Illinois Department of Children & Family Services (DCFS), Youth In Care (YIC) and Former Youth In Care (FYIC) enrollees only.

Health Plan Compliance—Enrollees Residing within Time/Distance Requirements

HSAG validated the time/distance requirements for 16 provider categories within each service region. The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers, of which the contract requires that 100 percent of enrollees have access to providers within the access standard.

- Aetna, Meridian, and YouthCare were compliant with the contract standards for 13 provider categories across all service regions.
- Molina was compliant with the contract standards for 12 provider categories across all service regions.
- BCBSIL was compliant with the contract standards for nine provider categories across all service regions.
- CountyCare was compliant with the contract standards for all 16 provider categories.
- Across Aetna, BCBSIL, Meridian, Molina, and YouthCare, the provider networks for Pharmacy and Oral Surgery—Adult and Pediatric did not meet the time/distance standards in all regions.
- The BCBSIL and Molina provider networks for Allergy and Immunology—Pediatric, and also Adult for BCBSIL, also did not meet the time/distance standards in all regions.
- The BCBSIL Neurosurgery—Adult and Pediatric provider networks did not meet time/distance standards in all regions.

Health Plan Non-Compliance—Provider Categories

Health plans were non-compliant with contract standards for the provider categories in the regions summarized below.

Pharmacy

- BCBSIL: Regions 1, 2, 5
- Aetna: Regions 1, 2, 5
- Meridian: Regions 1, 2, 5
- Molina: Regions 1, 2, 5
- YouthCare: Regions 1, 2

Allergy and Immunology—Adult

- BCBSIL: Regions 1, 2, 3

Allergy and Immunology—Pediatric

- BCBSIL: Regions 1, 2, 3
- Molina: Region 2

Neurosurgery—Adult

- BCBSIL: Region 1

Neurosurgery—Pediatric

- BCBSIL: Region 1

Oral Surgery—Adult

- BCBSIL: Regions 1, 2, 3
- Aetna: Regions 1, 2, 3
- Meridian: Region 3
- Molina: Region 3
- YouthCare: Region 3

Oral Surgery—Pediatric

- BCBSIL: Regions 1, 2, 3
- Aetna: Regions 1, 2, 3
- Meridian: Region 3
- Molina: Region 3
- YouthCare: Region 3

Findings From Stratified Time/Distance Analysis

In addition to assessing the percentage of enrollees residing within the time/distance standards for 16 provider categories and within each service region, HSAG also assessed the results stratified at the enrollee level by urbanicity, age, sex, and whether the enrollee lived in a DIA ZIP Code or not. This section provides a summary of results from these additional analyses.

- Enrollees in urban counties of regions 1, 2, and 5 did not all reside within the 100 percent time/distance standard for Pharmacy, although the urban counties of each of these regions had at least 98.3 percent of enrollees residing within the time/distance standards. All health plans had deficiencies in at least two of these regions.
- The BCBSIL Allergy and Immunology—Adult and Pediatric provider network did not meet the time/distance standards for urban counties in regions 1 and 3. In Region 2, the Allergy and Immunology—Adult provider network did not meet the time/distance standards.
- The Molina Allergy and Immunology—Pediatric provider network did not meet the time/distance standards for either urban or rural counties in Region 2, nor did it meet the standards for rural counties in Region 3.
- The BCBSIL Endocrinology and Neurosurgery—Adult and Pediatric provider networks did not meet the time/distance standards for urban counties in Region 1.
- The Aetna and BCBSIL Oral Surgery—Adult and Pediatric provider networks did not meet the time/distance standards for urban counties in regions 1 and 2, and did not meet the standards for rural counties in regions 2 and 3.

- The Meridian, Molina, and YouthCare Oral Surgery—Adult and Pediatric provider networks did not meet the time/distance standards for rural counties in Region 3, and YouthCare also did not meet the standards for rural counties in Region 2.
- The pattern of results across age and sex stratifications were highly consistent with the results observed for the urbanicity stratification. Pharmacy provider networks exhibited deficiencies across all age groups and all health plans in regions 1, 2, and 5, although enrollees aged 65+ in Region 5 did not experience any deficiencies in access to pharmacies in the Aetna, Meridian, and Molina provider networks.
- When comparing DIA ZIP Codes with non-DIA ZIP Codes, the results indicated that Pharmacy provider networks in DIA ZIP Codes were deficient in Region 5 for Aetna, BCBSIL, Meridian, and Molina. In contrast, the non-DIA ZIP Codes experienced deficiencies in Pharmacy provider networks in regions 1 and 2 across all five health plans.
- The BCBSIL Allergy and Immunology—Adult and Pediatric provider networks did not meet the time/distance standards for either DIA or non-DIA ZIP Codes in Region 3, or for DIA ZIP Codes only in Region 1.
- The Molina Allergy and Immunology—Pediatric provider network did not meet the time/distance standards for either DIA or non-DIA ZIP Codes in Region 2, or for non-DIA ZIP Codes in Region 1.
- The BCBSIL Neurosurgery—Adult and Pediatric provider network did not meet the time/distance standards for either DIA or non-DIA ZIP Codes in Region 1.
- The Aetna and BCBSIL Oral Surgery—Adult and Pediatric provider networks did not meet the time/distance standards for either DIA or non-DIA ZIP Codes in regions 1, 2, or 3.
- The Meridian, Molina, and YouthCare Oral Surgery—Adult and Pediatric provider networks did not meet the time/distance standards for non-DIA ZIP Codes in Region 3; and YouthCare did not meet the standards in Region 2 for its Oral Surgery–Adult provider network.

Recommendations

Based on the results and conclusions presented in this report, HSAG recommends the following for HFS and the health plans to strengthen the HealthChoice Illinois Medicaid managed care provider networks and ensure enrollees' timely access to healthcare services:

- While most health plans are meeting the contract standards for most provider categories, HFS should collaborate with the health plans to continue to monitor the status of time/distance standards for all provider categories.
- HFS should continue to collaborate with those health plans that do not meet the time/distance standards in specific regions, to contract with additional providers if available. Provider categories of concern include Pharmacy, Allergy and Immunology, Neurosurgery, and Oral Surgery.
- HFS should conduct an in-depth review of provider categories for which no health plans met the time/distance standards, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with

providers in the geographic area. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories for which providers may not be available or willing to contract with the health plans.

- As the time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should continue using appointment availability surveys to evaluate providers' availability. HSAG also recommends incorporating encounter data to assess enrollees' utilization of services to identify the active provider network and assess whether access to care among those providers that actually deliver services to enrollees still meet the defined time/distance standards.

Appendix A. Compliance With Time/Distance Standards Findings

Network Accessibility

Geographic network distribution analyses assess whether enrollees in each county are required to travel a reasonable amount of time or distance to reach the nearest provider. HFS has established access standards by provider category for the maximum allowable distance or time an enrollee should be required to travel to receive care (presented in Appendix D, Table D-1). This section presents the percentage of enrollees living within the access standards for each region and for each health plan as well as the percentage of counties per region meeting the contract requirements as defined by the health plan contracts. For Cook County (i.e., Region 4), only results for enrollees living in urban areas are presented since Cook County is classified as urban.

Region 1—Northwestern

Table A-1 displays the enrollment in each plan in Region 1.

Table A-1—Health Plan Enrollments—Region 1

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	87,272	43,509	131,654	71,368	6,797

Table A-2 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 1. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for the Pharmacy provider category, which requires 100 percent of enrollees to have coverage within the access standard.

Table A-2—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 1

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	> 99.9	95.8	99.8	95.8	99.9	95.8	> 99.9	95.8	> 99.9	95.8
Specialists										
Allergy and Immunology—Adult	100.0	100.0	89.7	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	89.9	95.8	100.0	100.0	92.3	87.5	100.0	100.0
Endocrinology—Adult	100.0	100.0	91.3	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	91.4	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	86.7	83.3	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	86.9	79.2	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	81.6	83.3	78.8	79.2	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	83.7	83.3	83.1	79.2	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees with access to providers within provider type-specific time/distance standards and the percentage of Illinois counties where enrollees have access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or when less than 90 percent of counties meet time/distance standards (less than 100 percent for Pharmacy).

Region 2—Central

Table A-3 displays the enrollment in each plan in Region 2.

Table A-3—Health Plan Enrollments—Region 2

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	65,933	46,608	109,312	69,586	6,923

Table A-4 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 2. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in

each county have access to providers within the access standard, except for the Pharmacy provider category, which requires 100 percent of enrollees to have coverage within the access standard.

Table A-4—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 2

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	> 99.9	100.0	100.0	100.0
Hospitals	100.0	100.0	96.8	97.1	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	**99.6**	**88.6**	**99.6**	**88.6**	**99.7**	**88.6**	**99.2**	**91.4**	**99.4**	**94.3**
Specialists										
Allergy and Immunology—Adult	100.0	100.0	90.9	**88.6**	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	92.6	**88.6**	100.0	100.0	**39.4**	**65.7**	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	**78.9**	**82.9**	**60.1**	**77.1**	99.2	100.0	97.4	97.1	92.8	93.3
Oral Surgery—Pediatric	**81.8**	**85.7**	**61.3**	**74.3**	99.2	100.0	98.2	97.1	93.5	94.3

Note: This table presents the percentage of plan enrollees with access to providers within provider type-specific time/distance standards and the percentage of Illinois counties where enrollees have access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or when less than 90 percent of counties meet time/distance standards (less than 100 percent for Pharmacy).

Region 3—Southern

Table A-5 displays the enrollment in each plan in Region 3.

Table A-5—Health Plan Enrollments—Region 3

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	59,639	36,468	111,595	56,441	6,625

Table A-6 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 3. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for the Pharmacy provider category, which requires 100 percent of enrollees to have coverage within the access standard.

Table A-6—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 3

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	99.9	100.0	99.8	100.0	100.0	100.0	99.7	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	**84.8**	**82.4**	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	**86.5**	**82.4**	100.0	100.0	95.1	**76.5**	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	65.7	58.8	69.3	58.8	79.0	52.9	83.8	41.2	78.8	58.8
Oral Surgery—Pediatric	66.0	58.8	69.0	58.8	81.8	52.9	84.5	41.2	76.1	52.9

Note: This table presents the percentage of plan enrollees with access to providers within provider type-specific time/distance standards and the percentage of Illinois counties where enrollees have access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or when less than 90 percent of counties meet time/distance standards (less than 100 percent for Pharmacy).

Region 4—Cook County

Table A-7 displays the enrollment in each plan in Region 4.

Table A-7—Health Plan Enrollments—Region 4

	Aetna	BCBSIL	Meridian	Molina	YouthCare	CountyCare
Enrollment	127,511	335,664	314,719	96,310	9,492	422,085

Table A-8 displays the percentage of enrollees residing within the access standards in Region 4.

Table A-8—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 4

Statewide Health Plans—Region 4						Cook County Only Health Plans—Region 4
Health Plans	Aetna	BCBSIL	Meridian	Molina	YouthCare	CountyCare
Provider Categories	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0

Statewide Health Plans—Region 4						Cook County Only Health Plans—Region 4
Health Plans	**Aetna**	**BCBSIL**	**Meridian**	**Molina**	**YouthCare**	**CountyCare**
Provider Categories	**Enrollees Within Standard (%)**	**Enrollees Within Standard (%)**	**Enrollees Within Standard (%)**	**Enrollees Within Standard (%)**	**Enrollees Within Standard (%)**	**Enrollees Within Standard (%)**
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0
Specialists						
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees with access to providers within provider type-specific time/distance standards in Region 4/Cook County. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.

Region 5—Collar Counties

Table A-9 displays the enrollment in each plan in Region 5.

Table A-9—Health Plan Enrollments—Region 5

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	79,244	213,739	204,011	31,280	4,186

Table A-10 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 5. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in

each county have access to providers within the access standard, except for the Pharmacy provider category, which requires 100 percent of enrollees to have coverage within the access standard.

Table A-10—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 5

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	> 99.9	87.5	99.8	75.0	> 99.9	87.5	> 99.9	87.5	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	> 99.9	100.0	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees with access to providers within provider type-specific time/distance standards and the percentage of Illinois counties where enrollees have access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or when less than 90 percent of counties meet time/distance standards (less than 100 percent for Pharmacy).

Appendix B. Summary of Counties Not Meeting Contract Requirements

For each health plan, Appendix B lists counties that did not meet the contract requirements for each provider category.

Aetna

Pharmacy

- Champaign, DeKalb, Kankakee, McLean, Sangamon, Vermilion

Oral Surgery—Adult

- Adams, Alexander, Franklin, Fulton, Gallatin, Hamilton, Hancock, Hardin, Henderson, Jackson, Johnson, Mason, Massac, McDonough, Peoria, Pope, Pulaski, Saline, Sangamon, Schuyler, Tazewell, Union, White, Williamson

Oral Surgery—Pediatric

- Adams, Alexander, Franklin, Fulton, Gallatin, Hamilton, Hancock, Hardin, Henderson, Jackson, Johnson, Mason, Massac, McDonough, Peoria, Pope, Pulaski, Saline, Sangamon, Tazewell, Union, White, Williamson

BCBSIL

Hospital

- Vermilion

Pharmacy

- Champaign, DeKalb, Kankakee, McLean, Sangamon, Vermilion, Will

Allergy and Immunology—Adult

- Adams, Champaign, Crawford, Edwards, Hancock, Lawrence, Madison, Richland, Rock Island, Vermilion, Wabash

Allergy and Immunology—Pediatric

- Adams, Champaign, Crawford, Edwards, Hancock, Lawrence, Madison, Richland, Rock Island, Vermilion, Wabash

Endocrinology—Adult

- Rock Island

Endocrinology—Pediatric

- Rock Island

Neurosurgery—Adult

- Henry, Jo Daviess, Mercer, Rock Island

Neurosurgery—Pediatric

- Carroll, Henry, Jo Daviess, Mercer, Rock Island

Oral Surgery—Adult

- Adams, Alexander, Franklin, Fulton, Gallatin, Hamilton, Hancock, Hardin, Henderson, Jackson, Johnson, Mason, Massac, McDonough, McLean, Peoria, Pope, Pulaski, Saline, Sangamon, Schuyler, Tazewell, Union, Vermilion, Warren, White, Williamson

Oral Surgery—Pediatric

- Adams, Alexander, Champaign, Franklin, Fulton, Gallatin, Hamilton, Hancock, Hardin, Henderson, Jackson, Johnson, Mason, Massac, McDonough, McLean, Peoria, Pope, Pulaski, Saline, Sangamon, Schuyler, Tazewell, Union, Vermilion, Warren, White, Williamson

Meridian

Pharmacy

- Champaign, DeKalb, Kankakee, McLean, Sangamon, Vermilion

Oral Surgery—Adult

- Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wayne, White, Williamson

Oral Surgery—Pediatric

- Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wayne, White, Williamson

Molina

Pharmacy

- Champaign, DeKalb, Kankakee, McLean, Vermilion

Allergy and Immunology—Pediatric

- Carroll, Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Edwards, Hancock, Jasper, Jo Daviess, Lawrence, Macon, Moultrie, Richland, Rock Island, Sangamon, Shelby, Vermilion, Wabash, Wayne, White

Oral Surgery—Adult

- Adams, Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Lawrence, Massac, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, Williamson

Oral Surgery—Pediatric

- Adams, Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Lawrence, Massac, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, Williamson

YouthCare

Pharmacy

- DeKalb, McLean, Vermilion

Oral Surgery—Adult

- Adams, Alexander, Franklin, Gallatin, Hamilton, Hancock, Hardin, Johnson, Massac, Pope, Pulaski, Saline, Union, Wayne, White, Williamson

Oral Surgery—Pediatric

- Adams, Alexander, Edwards, Franklin, Gallatin, Hamilton, Hancock, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wayne, White, Williamson

Appendix C. Stratified Time/Distance Findings

For each region, Appendix C presents the percentage of enrollees with access within the time/distance standard by the assessed stratifications.

Urbanicity

Table C-1 presents the percentage of enrollees residing within the time/distance standards stratified by urban and rural counties in Region 1.

Table C-1—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 1

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	>99.9%	100.0	99.8	100.0	99.9	100.0	>99.9%	100.0	>99.9%	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	83.8	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	84.0	100.0	100.0	100.0	90.3	96.2	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Endocrinology—Adult	100.0	100.0	86.3	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	86.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	83.7	92.1	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	83.9	92.1	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	70.0	98.2	68.6	96.5	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	73.0	98.4	75.3	96.7	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees in urban and rural areas with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

Table C-2 presents the percentage of enrollees residing within the time/distance standards stratified by urban and rural counties in Region 2.

Table C-2—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 2

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	>99.9%	100.0	100.0	100.0
Hospitals	100.0	100.0	93.3	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Pharmacy	99.3	100.0	99.2	100.0	99.3	100.0	98.8	100.0	98.9	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	89.2	92.5	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	91.3	93.9	100.0	100.0	22.3	80.3	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	73.0	85.4	35.6	83.9	98.4	100.0	99.5	93.2	98.6	85.5
Oral Surgery—Pediatric	76.8	86.9	33.1	86.6	98.4	100.0	99.4	95.3	98.7	87.6

Note: This table presents the percentage of plan enrollees in urban and rural areas with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

Table C-3 presents the percentage of enrollees residing within the time/distance standards stratified by urban and rural counties in Region 3.

Table C-3—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 3

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	99.7	100.0	99.7	100.0	100.0	100.0	99.1	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	**69.8**	93.6	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	**72.0**	94.1	100.0	100.0	100.0	**87.2**	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	**52.6**	100.0	**51.4**	100.0	**60.8**	100.0	**59.5**	100.0	**59.9**
Oral Surgery—Pediatric	100.0	**56.6**	100.0	**52.9**	100.0	**64.1**	100.0	**59.6**	100.0	**61.9**

Note: This table presents the percentage of plan enrollees in urban and rural areas with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

Table C-4 presents the percentage of enrollees residing within the time/distance standards stratified by urban and rural counties in Region 4.

Table C-4—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 4

	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Provider Categories	Urban	Urban	Urban	Urban	Urban	Urban
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0
Specialists						
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees in Region 4/Cook County, which is defined as urban, with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

Table C-5 presents the percentage of enrollees residing within the time/distance standards stratified by urban and rural counties in Region 5.

Table C-5—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 5

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	>99.9%	100.0	99.8	100.0	>99.9%	100.0	>99.9%	100.0	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	>99.9%	100.0	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees in urban and rural areas with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

Age

Table C-6 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee age in Region 1.

Table C-6—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Age Category in Region 1

	Aetna			BCBSIL			Meridian			Molina			YouthCare		
Provider Categories	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
PCPs—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
PCPs—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Behavioral Health Providers—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Behavioral Health Providers—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pediatric Dentist	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pharmacy	>99.9%	>99.9%	99.9	99.9	99.9	98.0	99.9	99.9	99.2	>99.9%	>99.9%	99.9	>99.9%	100.0	NA

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
Specialists															
Allergy and Immunology—Adult	NA	100.0	100.0	NA	89.7	89.7	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology—Pediatric	100.0	NA	NA	89.9	NA	NA	100.0	NA	NA	92.3	NA	NA	100.0	NA	NA
Endocrinology—Adult	NA	100.0	100.0	NA	91.4	90.6	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Endocrinology—Pediatric	100.0	NA	NA	91.4	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Neurosurgery—Adult	NA	100.0	100.0	NA	86.7	86.9	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Neurosurgery—Pediatric	100.0	NA	NA	86.9	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Oral Surgery—Adult	NA	81.6	80.9	NA	78.6	81.6	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Oral Surgery—Pediatric	83.7	NA	NA	83.1	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA

Note: This table presents the percentage of plan enrollees by age group with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and age group or that no one in the age group was enrolled.

Table C-7 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee age in Region 2.

Table C-7—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Age Category in Region 2

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
PCPs—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
PCPs—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Behavioral Health Providers—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA

	Aetna			BCBSIL			Meridian			Molina			YouthCare		
Provider Categories	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
Behavioral Health Providers—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pediatric Dentist	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	>99.9%	NA	NA	100.0	NA	NA
Hospitals	100.0	100.0	100.0	97.4	96.4	95.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pharmacy	99.6	99.6	99.9	99.6	99.6	99.7	99.6	99.7	99.8	99.1	99.2	100.0	99.4	99.2	NA
Specialists															
Allergy and Immunology—Adult	NA	100.0	100.0	NA	91.0	90.1	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology—Pediatric	100.0	NA	NA	92.6	NA	NA	100.0	NA	NA	39.4	NA	NA	100.0	NA	NA
Endocrinology—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Endocrinology—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Neurosurgery—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Neurosurgery—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Oral Surgery—Adult	NA	78.8	81.9	NA	59.8	63.8	NA	99.2	99.6	NA	97.5	94.9	NA	92.8	NA
Oral Surgery—Pediatric	81.8	NA	NA	61.3	NA	NA	99.2	NA	NA	98.2	NA	NA	93.5	NA	NA

Note: This table presents the percentage of plan enrollees by age group with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and age group or that no one in the age group was enrolled.

Table C-8 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee age in Region 3.

Table C-8—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Age Category in Region 3

	Aetna			BCBSIL			Meridian			Molina			YouthCare		
Provider Categories	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
PCPs—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
PCPs—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Behavioral Health Providers—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Behavioral Health Providers—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pediatric Dentist	100.0	NA	NA	99.9	NA	NA	99.8	NA	NA	100.0	NA	NA	99.7	NA	NA
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Specialists															
Allergy and Immunology—Adult	NA	100.0	100.0	NA	84.6	87.5	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology—Pediatric	100.0	NA	NA	86.5	NA	NA	100.0	NA	NA	95.1	NA	NA	100.0	NA	NA
Endocrinology—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Endocrinology—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Neurosurgery—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Neurosurgery—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Oral Surgery—Adult	NA	65.6	69.2	NA	69.1	71.4	NA	79.0	79.5	NA	83.8	84.1	NA	78.8	NA
Oral Surgery—Pediatric	66.0	NA	NA	69.0	NA	NA	81.8	NA	NA	84.5	NA	NA	76.1	NA	NA

Note: This table presents the percentage of plan enrollees by age group with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and age group or that no one in the age group was enrolled.

Table C-9 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee age in Region 4.

Table C-9—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Age Category in Region 4

	Aetna			BCBSIL			CountyCare			Meridian			Molina			YouthCare		
Provider Categories	**<18 Years**	**18–64 Years**	**65+ Years**	**<18 Years**	**18–64 Years**	**65+ Years**	**<18 Years**	**18–64 Years**	**65+ Years**	**<18 Years**	**18–64 Years**	**65+ Years**	**<18 Years**	**18–64 Years**	**65+ Years**	**<18 Years**	**18–64 Years**	**65+ Years**
PCPs—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
PCPs—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Behavioral Health Providers—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Behavioral Health Providers—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pediatric Dentist	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Specialists																		
Allergy and Immunology—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Endocrinology—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Endocrinology—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA

	Aetna			BCBSIL			CountyCare			Meridian			Molina			YouthCare		
Provider Categories	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
Neurosurgery—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Neurosurgery—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Oral Surgery—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Oral Surgery—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA

Note: This table presents the percentage of plan enrollees by age group with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and age group or that no one in the age group was enrolled.

Table C-10 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee age in Region 5.

Table C-10—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Age Category in Region 5

	Aetna			BCBSIL			Meridian			Molina			YouthCare		
Provider Categories	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
PCPs—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
PCPs—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Behavioral Health Providers—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Behavioral Health Providers—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pediatric Dentist	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years	<18 Years	18–64 Years	65+ Years
Hospitals	99.9	99.9	>99.9%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pharmacy	>99.9%	>99.9%	100.0	99.8	99.8	99.9	>99.9%	>99.9%	100.0	>99.9%	>99.9%	100.0	100.0	100.0	NA
Specialists															
Allergy and Immunology—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	>99.9%	NA	NA	100.0	NA	NA
Endocrinology—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Endocrinology—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Neurosurgery—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Neurosurgery—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
Oral Surgery—Adult	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Oral Surgery—Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA

Note: This table presents the percentage of plan enrollees by age group with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and age group or that no one in the age group was enrolled.

Sex

Table C-11 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee sex in Region 1.

Table C-11—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Sex in Region 1

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	>99.9%	>99.9%	99.9	99.8	99.9	99.9	>99.9%	>99.9%	>99.9%	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	89.5	89.8	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	89.9	89.8	100.0	100.0	92.4	92.2	100.0	100.0
Endocrinology—Adult	100.0	100.0	91.2	91.4	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	91.6	91.3	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	86.6	86.9	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	86.8	86.9	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Oral Surgery—Adult	80.5	82.4	77.3	80.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	83.9	83.6	83.3	82.9	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees by sex with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and enrollee sex or that no one of that sex was enrolled.

Table C-12 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee sex in Region 2.

Table C-12—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Sex in Region 2

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	>99.9%	>99.9%	100.0	100.0
Hospitals	100.0	100.0	96.2	97.2	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	99.6	99.7	99.6	99.7	99.6	99.7	99.2	99.2	99.5	99.3
Specialists										
Allergy and Immunology—Adult	100.0	100.0	89.5	92.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	92.6	92.7	100.0	100.0	39.7	39.1	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	77.3	80.2	59.0	60.9	99.2	99.2	97.2	97.5	90.6	95.1
Oral Surgery—Pediatric	81.2	82.3	61.0	61.5	99.1	99.2	98.2	98.2	94.1	92.8

Note: This table presents the percentage of plan enrollees by sex with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and enrollee sex or that no one of that sex was enrolled.

Table C-13 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee sex in Region 3.

Table C-13—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Sex in Region 3

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0
Pediatric Dentist	100.0	100.0	99.9	99.9	99.8	99.8	100.0	100.0	99.7	99.7
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	84.0	85.5	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	86.6	86.5	100.0	100.0	95.1	95.1	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	66.4	65.2	69.1	69.4	78.0	79.6	82.9	84.4	83.5	74.0
Oral Surgery—Pediatric	66.0	66.0	69.4	68.5	81.7	81.9	84.4	84.6	75.7	76.6

Note: This table presents the percentage of plan enrollees by sex with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and enrollee sex or that no one of that sex was enrolled.

Table C-14 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee sex in Region 4.

Table C-14—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Sex in Region 4

	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
Provider Categories	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
Provider Categories	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists												
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees by sex with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and enrollee sex or that no one of that sex was enrolled.

Table C-15 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee sex in Region 5.

Table C-15—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Sex in Region 5

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	99.9	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	>99.9%	>99.9%	99.8	99.8	>99.9%	>99.9%	>99.9%	>99.9%	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	>99.9%	99.9	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees by sex with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. "NA" indicates that the standard is not applicable to the provider type and enrollee sex or that no one of that sex was enrolled.

Disproportionately Impacted Areas

Table C-16 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee residence in DIA ZIP Codes or non-DIA ZIP Codes in Region 1.

Table C-16—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by DIA Status in Region 1

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	>99.9%	100.0	99.8	100.0	99.9	100.0	>99.9%	100.0	>99.9%
Specialists										
Allergy and Immunology—Adult	100.0	100.0	89.0	90.1	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	88.7	90.5	100.0	100.0	95.9	89.5	100.0	100.0
Endocrinology—Adult	100.0	100.0	90.6	91.8	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	90.7	91.9	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	88.9	85.4	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
Neurosurgery—Pediatric	100.0	100.0	88.7	85.9	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	79.6	82.8	78.2	79.1	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	82.2	84.7	82.9	83.3	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees by residence in DIAs with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. DIAs are ZIP Codes identified by the Illinois Department of Commerce & Economic Opportunity. A list of DIA ZIP Codes is accessible at: https://www2.illinois.gov/dceo/SmallBizAssistance/Documents/BIGDIAZIPCodeList_062520.pdf. Accessed on: June 23, 2022.

Table C-17 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee residence in DIA ZIP Codes or non-DIA ZIP Codes in Region 2.

Table C-17—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by DIA Status in Region 2

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	>99.9%	100.0	100.0
Hospitals	100.0	100.0	92.9	98.9	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	99.4	100.0	99.4	100.0	99.5	100.0	98.6	100.0	99.2

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
Specialists										
Allergy and Immunology—Adult	100.0	100.0	90.3	91.3	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	91.4	93.3	100.0	100.0	**20.1**	**53.0**	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	**74.4**	**82.0**	**49.1**	**66.3**	100.0	98.8	100.0	95.5	100.0	**87.6**
Oral Surgery—Pediatric	**78.0**	**84.3**	**49.6**	**67.2**	100.0	98.7	100.0	96.9	100.0	90.3

Note: This table presents the percentage of plan enrollees by residence in DIAs with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. DIAs are ZIP Codes identified by the Illinois Department of Commerce & Economic Opportunity. A list of DIA ZIP Codes is accessible at: https://www2.illinois.gov/dceo/SmallBizAssistance/Documents/BIGDIAZIPCodeList_062520.pdf. Accessed on: June 23, 2022.

Table C-18 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee residence in DIA ZIP Codes or non-DIA ZIP Codes in Region 3.

Table C-18—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by DIA Status in Region 3

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	99.8	100.0	99.8	100.0	100.0	100.0	99.6
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	**88.2**	**83.4**	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	**88.5**	**85.8**	100.0	100.0	99.6	92.5	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	**78.4**	**60.8**	**79.2**	**64.9**	94.6	**71.5**	96.1	**76.7**	95.4	**71.2**

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
Oral Surgery—Pediatric	80.1	60.9	78.9	65.2	95.9	74.8	96.7	77.5	92.6	69.5

Note: This table presents the percentage of plan enrollees by residence in DIAs with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. DIAs are ZIP Codes identified by the Illinois Department of Commerce & Economic Opportunity. A list of DIA ZIP Codes is accessible at: https://www2.illinois.gov/dceo/SmallBizAssistance/Documents/BIGDIAZIPCodeList_062520.pdf. Accessed on: June 23, 2022.

Table C-19 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee residence in DIA ZIP Codes or non-DIA ZIP Codes in Region 4.

Table C-19—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by DIA Status in Region 4

Provider Categories	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists												
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
Provider Categories	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees by residence in DIAs with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. DIAs are ZIP Codes identified by the Illinois Department of Commerce & Economic Opportunity. A list of DIA ZIP Codes is accessible at: https://www2.illinois.gov/dceo/SmallBizAssistance/Documents/BIGDIAZIPCodeList_062520.pdf. Accessed on: June 23, 2022.

Table C-20 presents the percentage of enrollees residing within the time/distance standards stratified by enrollee residence in DIA ZIP Codes or non-DIA ZIP Codes in Region 5.

Table C-20—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by DIA Status in Region 5

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
PCPs—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
PCPs—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code	DIA ZIP Code	Non-DIA ZIP Code
Behavioral Health Providers—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	99.9	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacy	>99.9%	100.0	99.9	99.8	>99.9%	100.0	>99.9%	100.0	100.0	100.0
Specialists										
Allergy and Immunology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	100.0
Endocrinology—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery—Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of plan enrollees by residence in DIAs with access to providers within provider type-specific time/distance standards. Cells are shaded red with a red font when less than 90 percent of a plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards. DIAs are ZIP Codes identified by the Illinois Department of Commerce & Economic Opportunity. A list of DIA ZIP Codes is accessible at: https://www2.illinois.gov/dceo/SmallBizAssistance/Documents/BIGDIAZIPCodeList_062520.pdf. Accessed on: June 23, 2022.

Appendix D. Methodology

Data Sources

HFS and the health plans provided Medicaid enrollee demographic information and provider network files to HSAG for use in the time/distance analyses. The health plans submitted the provider data as part of their regular, ongoing submissions to HSAG. HSAG submitted a detailed data requirements document to HFS requesting its Medicaid enrollee data, including data which met the following criteria:

- Enrollee demographic data as of February 5, 2022.
- Enrollee eligibility and enrollment data including start and end dates for enrollment with the health plan.

Data Processing

HSAG cleaned, processed, and used the data submitted to define unique lists of providers, provider locations, and enrollees for inclusion in the analyses. HSAG standardized and geocoded all Medicaid enrollee and provider addresses using Quest Analytics Suite software. Analyses for pediatric dentists were limited to enrollees younger than 18 years of age, and analyses for adult dentists were limited to enrollees 18 years of age and older. Analyses for obstetrics and gynecology (OB/GYN) providers were limited to female enrollees ages 15 years and older. Analyses for all adult specialist providers were limited to enrollees 18 years of age and older. Analyses for all pediatric specialist providers were limited to enrollees younger than 18 years of age.

Provider offices in the State of Illinois or in contiguous counties were included in the time/distance analyses. All provider office locations associated with a provider were included in the analyses. For example, if a single provider practiced at three locations, each location was considered a unique location for the time/distance analyses.

Table D-1 shows the provider categories included in the time/distance analyses, the enrollee criteria for the time/distance analyses, and the network access standards (i.e., time/distance standards). For each of the access standards presented in Table D-1, the contract requirements state that the health plans must ensure that 90.0 percent of enrollees in each county of the contracting area have access within the stated time or distance standard, except for pharmacy services where 100 percent of the enrollees must have access within the stated time or distance standard. Analyses were conducted by region to illustrate differences by region of the state.

The access standards are defined separately for enrollees living in urban and rural areas. HSAG used the definitions for "urban" and "rural" counties as defined in the Medicaid Model Contract—Attachment II. Using those definitions, Illinois had 19 urban counties and 83 rural counties. Enrollee urbanicity was assigned using the county name associated with the enrollee's residential address included in the provided data. For records without a valid county name, standard county names produced during the geocoding process were used to assign urbanicity. A small portion of the enrollee data could not be geocoded (i.e., < 0.01 percent). These enrollees were excluded from the analyses.

Table D-1—Provider Categories, Enrollee Criteria, and Access Standards

Provider Categories	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Adult Primary Care Provider (PCP)[2]	All adults (on or after 18th birthday) enrolled in a health plan	Access to 2 PCPs within 30 miles or 30 minutes	Access to 1 PCP within 60 miles or 60 minutes
Pediatric PCP[2]	All children (up to 18th birthday) enrolled in a health plan	Access to 2 PCPs within 30 miles or 30 minutes	Access to 1 PCP within 60 miles or 60 minutes
Adult Behavioral Health Provider[3]	All adults (on or after 18th birthday) enrolled in a health plan	Access to 2 behavioral health service providers within 30 miles or 30 minutes	Access to 1 behavioral health service provider within 60 miles or 60 minutes
Pediatric Behavioral Health Provider[3]	All children (up to 18th birthday) enrolled in a health plan	Access to 2 behavioral health service providers within 30 miles or 30 minutes	Access to 1 behavioral health service provider within 60 miles or 60 minutes
OB/GYN Provider[4]	Female adults (on or after 15th birthday) enrolled in a health plan	Access to 2 OB/GYN providers within 30 miles or 30 minutes	Access to 1 OB/GYN provider within 60 miles or 60 minutes
Pediatric Dentist	All children (up to 18th birthday) enrolled in a health plan	Access to 1 pediatric dentist within 30 miles or 30 minutes	Access to 1 pediatric dentist within 60 miles or 60 minutes
Hospital	All enrollees enrolled in a health plan	Access to 1 general or critical access hospital within 30 miles or 30 minutes	Access to 1 general or critical access hospital within 60 miles or 60 minutes
Pharmacy	All enrollees enrolled in a health plan	Access to 1 pharmacy within 15 miles or 15 minutes	Access to 1 pharmacy within 60 miles or 60 minutes
Specialist[5]			
Allergy and Immunology—Adult and Pediatric	All enrollees enrolled in a health plan	Access to 1 specialty services provider within 60 miles or 60 minutes	Access to 1 specialty services provider within 90 miles or 90 minutes
Endocrinology—Adult and Pediatric	All enrollees enrolled in a health plan		
Neurosurgery—Adult and Pediatric	All enrollees enrolled in a health plan		
Oral Surgery—Adult and Pediatric	All enrollees enrolled in a health plan		

[1] For these analyses, "urban" and "rural" are defined by the Medicaid Model Contract 2018-24-001.
[2] Adult PCPs include providers with a specialty of general practice, internal medicine, family medicine, family practice, nurse practitioner, and physician assistant and a PCP flag indicator. Pediatric PCPs include providers with a specialty of pediatric medicine, pediatric physician assistant, and pediatric nurse practitioner and a PCP flag indicator.
[3] Adult behavioral health service providers include providers with a specialty of psychiatry, psychology, alcohol and substance abuse rehab services, licensed professional/licensed clinical, social worker, and other behavioral health services.

Pediatric behavioral health service providers were limited to providers with a specialty of pediatric psychiatry, pediatric psychology, mental health counselor, qualified mental health professional, and licensed practitioner of the healing arts.

[4] OB/GYN providers include providers with a specialty of obstetrics, gynecology, obstetrics/gynecology, or nurse midwife.

Time/Distance Analyses

HSAG used Quest Analytics Suite software to review enrollee and provider addresses to ensure they could be geocoded to the exact geographic locations (i.e., latitude and longitude). Geocoded enrollee and provider addresses were assembled into datasets used to conduct the following three spatial-derived analyses for each health plan for the provider categories listed in Table D-1:

- Percentage of enrollees within predefined access standards
  - A higher percentage of enrollees meeting access standards indicates a better geographic distribution of the health plan's providers relative to the Medicaid enrollees.
- Percentage of counties providing access to a provider within the predefined access standards to at least 90.0 percent of enrollees[D-1]
  - A higher percentage of counties meeting the access standards indicates a better geographic distribution of the health plan's providers relative to the Medicaid enrollees.
- Average travel distances (driving distances in miles) and travel times[D-2] (driving times in minutes) to the nearest three providers
  - A shorter driving distance or travel time indicates greater accessibility to providers since enrollees must travel fewer miles or minutes to access care.
  - Results from the average travel distances and travel times to each provider category are presented by health plan in Appendix A.

Study Limitations

- Time/distance metrics represent a high-level measurement of the similarity of the geographic distribution of providers relative to enrollees. These raw, comparative statistics do not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) at a specific location or how active the provider is in the Medicaid program. It is likely that some providers are contracted to provide services for multiple health plans. As such, time/distance results only highlight

[D-1] For pharmacy providers, the contract requirement states that 100 percent of enrollees must have access within the stated time or distance standard.

[D-2] Average drive time may not mirror driver experience, based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to the distribution of enrollees. HSAG used an average driving speed of 30 miles per hour for calculations in urban counties and 55 miles per hour for calculations in rural counties.

the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations.

- When evaluating the results of these analyses, it is important to note that the reported, average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to enrollees.
- The availability of providers in some counties, specifically rural counties, may be unknown. These study results may assist HFS in determining if provider contracting deficits in certain counties are due to a lack of providers in the county or an inability of the health plans to contract with existing providers.
- When evaluating the results presented in this report, note that provider data supplied by the health plans do not include providers contracted with the health plans under limited use contracts or single case agreements. A larger number of enrollees may have access to providers if health plans contract with selected providers under these limited use agreements versus standard contract agreements.
- County names included in the enrollment data were used to determine enrollees' urbanicity and region. About 2.5 percent of enrollees did not have a valid county name in the data provided by HFS. As such, county names produced by Quest during geocoding were used to assign urbanicity and region to these enrollees.

Appendix E1. Beneficiary Experience With Care Methodology

Member Experience Surveys

Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. Aetna, BCBSIL, CountyCare, Meridian, and Molina were responsible for contracting with a CAHPS vendor to administer the CAHPS surveys on their behalf.[E1-1] Results for all five health plans were forwarded to HSAG for analysis. For the statewide Illinois Medicaid (i.e., children covered under Title XIX) and All Kids (i.e., children covered under Title XXI/CHIP) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS.

The CAHPS results are presented by program type by population. Both the adult and child Medicaid populations were surveyed under HealthChoice Illinois for Aetna, BCBSIL, CountyCare, Meridian, and Molina.[E1-2] Under the Statewide Survey, a statewide sample of child members enrolled in the All Kids and Illinois Medicaid programs were surveyed.[E1-3]

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on the levels of members' experience with their healthcare.

Overview

HFS contracted with five health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Four of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only.

Technical Methods of Data Collection and Analysis

HealthChoice Health Plans

The technical method of data collection was through the administration of the CAHPS 5.1H Adult Medicaid Survey to the adult populations and the CAHPS 5.1H Child Medicaid Survey to the child populations. Aetna, BCBSIL, CountyCare, Meridian, and Molina used a mixed-mode methodology,

E1-1 In 2021 and 2022, the Center for the Study of Services (CSS) administered the CAHPS surveys on behalf of Aetna, and SPH Analytics administered the CAHPS surveys on behalf of BCBSIL, CountyCare, Meridian, and Molina.

E1-2 Aetna Better Health was formerly known as IlliniCare Health Plan.

E1-3 The Illinois statewide program aggregate results presented in this report represent the results of the All Kids and Illinois Medicaid programs combined.

which included both mail and telephone surveys for data collection.[E1-4] Aetna, BCBSIL, CountyCare, and Meridian included the option to complete the surveys in English and Spanish for both the adult and child populations. Molina included the option to complete the surveys in English and Spanish for the child population only.

All Kids and Illinois Medicaid Statewide Survey

The technical method of data collection was through the administration of the CAHPS 5.1 Child Medicaid Survey with the Children with Chronic Conditions (CCC) measurement set to a statewide sample of the child population enrolled in each program. For All Kids and Illinois Medicaid, a sample representing the general child population and a CCC supplemental sample (i.e., a sample of child members who were identified as more likely to have a chronic condition) were selected from each program. All Kids and Illinois Medicaid used a standard mixed-mode methodology for data collection, which included both mail and telephone surveys for data collection, with the option to complete the survey in English and Spanish.

Survey Measures for CAHPS

The survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite measures. The global ratings reflected members' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). For All Kids and Illinois Medicaid, the CAHPS survey also included the CCC measurement set of survey questions, which are categorized into five additional measures of experience. These measures included three CCC composite measures and two CCC individual item measures. The CCC composites and items are sets of questions and individual questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

NCQA requires a minimum of 100 responses on each item to report the measure as a valid CAHPS Survey result; however, for this report, if available, plans'/populations' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

For each of the four global ratings, the percentage of respondents who chose the top experience 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 score). For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," and "Always." For the composite measures (*Getting Needed*

[E1-4] In 2021, Aetna (formerly IlliniCare) and BCBSIL used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.1H Adult Medicaid Survey and CAHPS 5.1H Child Medicaid Survey. This protocol allowed sampled members the option to complete the survey via the Internet.

Care, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), a positive, or top-box response, was defined as a response of "Usually" or "Always." Composite measure scores were calculated by averaging the percentage of positive responses for each item. The percentage of top-box responses was referred to as a global proportion (or top-box score) for the composite measures.

For each of the CCC composites and items for the CCC population, the percentage of respondents who chose a positive response was calculated. CAHPS CCC composite measure/item question response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2) "No" and "Yes." For three of the CCC composite measures/items (*Access to Specialized Services*, *Access to Prescription Medicines*, and *Family-Centered Care* (*FCC): Getting Needed Information*), a positive, or top-box, response was defined as a response of "Usually" or "Always." For two CCC composite measures/items (*FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions*), a positive, or top-box, response was defined as a response of "Yes." CCC composite and item top-box scores were calculated by averaging the percentage of positive responses for each item.

For each CAHPS measure, the resulting 2022 top-box scores were compared to their corresponding 2021 scores to determine whether there were statistically significant differences. Statistically significant differences between the 2022 top-box scores and the 2021 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2022 than 2021 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2022 than 2021 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Additionally, for each CAHPS measure, the resulting 2022 top-box scores were compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data and the resulting 2021 top-box scores were compared to NCQA's 2020 Quality Compass Benchmark and Compare Quality Data.[E1-5, E1-6] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, with one being the lowest possible rating and five being the highest possible rating, using the percentile distributions shown in Table E1-1.

[E1-5] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA. September 2020.

[E1-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA. September 2021.

Table E1-1—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Appendix E2. Beneficiary Experience With Care Detailed Results

Adult CAHPS Medicaid Survey

Response Rates

The 2022 adult Medicaid CAHPS response rates are presented in the tables below for each adult health plan and the statewide aggregate (i.e., all health plans combined).

Table E2-1—2022 Adult Response Rates

Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Aggregate
13.33%	26.68%	13.21%	10.83%	11.58%	15.67%

Adult Health Plan-Specific Findings and Comparisons

The 2021 and 2022 adult Medicaid CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for each adult health plan and the statewide aggregate.

Composite Measures

Table E2-2—2021 and 2022 Adult Health Plan-Specific Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2021	78.9% ★	78.2% ★	91.1% ★	83.0% ★
	2022	79.5% ★	79.8% ★★	93.4% ★★★	90.1% ★★★
BCBSIL	2021	87.9% ★★★★	83.9% ★★★	93.4% ★★	90.7% ★★★
	2022	85.6% ★★★	82.1% ★★	92.3% ★★	91.3% ★★★★
CountyCare	2021	78.9% ★	78.2% ★	90.3% ★	86.3% ★
	2022	80.2% ★	75.3% ★	90.5% ★	91.9%$^{+}$ ★★★★$^{+}$
Meridian	2021	87.1% ★★★★	82.6% ★★	93.1% ★★	88.0% ★★
	2022	83.6% ★★	80.1% ★★	96.0% ★★★★★	86.8%$^{+}$ ★$^{+}$

Experience With Care

Adult CAHPS Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2021	83.3% ★★	80.4% ★★	89.8% ★	88.1%+ ★★+
	2022	85.1% ★★★	77.9% ★	92.9% ★★★	83.7%+ ★+
Statewide Aggregate	2021	83.1% ★★	80.5% ★★	91.6% ★	86.6% ★
	2022	82.3% ★★	78.8% ★	93.8% ★★★	88.2% ★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

For BCBSIL and CountyCare, experience survey results were at or above the 75th percentile for *Customer Service*, which indicates that the members in these health plans perceived better quality of care from their health plan when they needed assistance. Additionally, Meridian's experience survey results were at or above the 90th percentile for *How Well Doctors Communicate,* which indicates that members perceived they were receiving thorough communication from their doctors.

Opportunities for Improvement

Opportunity: Excluding BCBSIL and Molina, experience survey results for *Getting Needed Care* were below the 50th percentile for all health plans, which indicates that these members perceive a lack of access to getting the care they need.

Why the Opportunity Exists: Aetna, CountyCare, and Meridian members may have difficulty obtaining the care, tests, or treatment they need.

Opportunity: Experience survey results show that all health plans were below the 50th percentile for *Getting Care Quickly*, which indicates members perceived a lack of timeliness of care.

Why the Opportunity Exists: Lower ratings for this measure may indicate that members have difficulty scheduling the care they need with a provider or at a facility in a timely manner.

Recommendation: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why their members are not getting timely care, the quality of care they need, or do not have access to care. The health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Global Ratings

Table E2-3—2021 and 2022 Adult Health Plan-Specific Results

Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
Aetna	2021	50.6% ★	66.4% ★★	65.1% ★	49.7% ★
	2022	51.5% ★	63.2% ★	61.9% ★	53.2% ★
BCBSIL	2021	59.9% ★★★	74.5% ★★★★	69.6% ★★	69.7% ★★★★
	2022	58.2% ★★	73.6% ★★★★	75.2% ★★★★	70.3% ★★★★
CountyCare	2021	56.2% ★★	64.2% ★	60.6% ★	59.8% ★★
	2022	52.3% ★	62.7% ★	69.6%+ ★★★+	56.0% ★
Meridian	2021	66.3% ★★★★★	69.5% ★★	76.9% ★★★★★	63.2% ★★★
	2022	56.3% ★★	70.9% ★★★	67.6% ★★	63.8% ★★★
Molina	2021	56.6% ★★	66.1% ★	71.3%+ ★★★+	55.6% ★
	2022	54.9% ★★	71.4% ★★★	68.4%+ ★★+	58.9% ★★
Statewide Aggregate	2021	59.3% ★★★	67.3% ★★	70.0% ★★	58.6% ★★
	2022	54.3% ★	67.7% ★★	67.0% ★★	59.3% ★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths	BCBSIL's experience survey results were at or between the 75th and 89th percentiles for *Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan*, which indicates that BCBSIL members had positive experiences with their personal doctor, specialists, and their health plan overall.
Opportunities for Improvement	**Opportunity:** Experience survey results for BCBSIL, Meridian, and Molina were below the 50th percentile, and Aetna and CountyCare were below the 25th percentile for *Rating of All Health Care,* which indicates a lack of quality of care. **Why the Opportunity Exists:** Health plan members may perceive access and timeliness issues with their providers and the care they need, leading to an overall lower level of experience in how they view the quality of the care they received.
	Opportunity: Experience survey results for Aetna and CountyCare were below the 25th percentile for *Rating of Personal Doctor,* which indicates that members may feel they are not getting quality care from their personal doctors. **Why the Opportunity Exists:** Aetna and CountyCare members may have received poor communication or service from their personal doctor.
	Opportunity: Experience survey results for Meridian and Molina were below the 50th percentile, and Aetna was below the 25th percentile for *Rating of Specialist Seen Most Often,* which indicates that members perceive a lack of quality of care with specialists. **Why the Opportunity Exists:** Aetna, Meridian, and Molina members may feel they are not getting quality care or treatment from the specialists they see most often.
	Opportunity: Experience survey results for Molina were below the 50th percentile, and Aetna and CountyCare were below the 25th percentile for *Rating of Health Plan,* which indicates that members perceive an overall lack of quality of care and service with these health plans. **Why the Opportunity Exists:** Aetna, CountyCare, and Molina members may have felt they received inadequate information, poor communication or service, or a lack of quality of care from their providers or the health plan staff, which led to an overall lower rating of the health plan.
	Recommendations: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why their members perceive a lack of quality of care from their personal doctors and specialists, as well as an overall lack of quality of the care and services they receive. The health plans could consider if there are disparities within their populations that contribute to the lower performances in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Child CAHPS Medicaid Survey

Response Rates

The 2022 child Medicaid CAHPS response rates are presented in the tables below for each child health plan and the statewide aggregate (i.e., all health plans combined).

Table E2-4—2022 Child Response Rates

Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Aggregate
15.53%	9.93%	12.34%	8.26%	10.60%	10.87%

Child Health Plan-Specific Findings and Comparisons

The 2021 and 2022 child Medicaid CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for each child health plan and the statewide aggregate.

Composite Measures

Table E2-5—2021 and 2022 Child Health Plan-Specific Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2021	86.6%+ ★★★+	86.4%+ ★+	97.1% ★★★★	87.0%+ ★+
	2022	89.5%+ ★★★★+	83.3%+ ★+	95.2% ★★★	89.1%+ ★★★+
BCBSIL	2021	76.9% ★	76.0% ★	92.3% ★	86.1% ★
	2022	77.9% ★	78.6% ★	94.4% ★★★	90.2%+ ★★★+
CountyCare	2021	78.9% ★	79.0%+ ★+	91.5% ★	86.7%+ ★+
	2022	79.7%+ ★+	77.3%+ ★+	91.4% ★	96.1%+ ★★★★★+
Meridian	2021	79.0% ★	86.2% ★	91.3% ★	85.8%+ ★+
	2022	74.9%+ ★+	85.0%+ ★★+	93.2% ★★	88.3%+ ★★★+

Experience With Care

Child CAHPS Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2021	84.7% ★★	83.7% ★	93.8% ★	83.9% ★
	2022	83.9% ★★	87.9% ★★★	93.2% ★★	89.1% ★★★
Statewide Aggregate	2021	80.2% ★	82.6% ★	92.6% ★	86.0% ★
	2022	79.4% ★	82.4% ★	93.5% ★★	90.1% ★★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

Experience survey results were at or between the 75th and 89th percentiles for Aetna for *Getting Needed Care*, which indicates that parents/caretakers of child members perceive they have adequate access to getting the care they need. Additionally, CountyCare's experience survey results were at or above the 90th percentile for *Customer Service,* which indicates that parents/caretakers of child members perceived better quality of care from their health plan when they needed assistance.

Opportunities for Improvement

Opportunity: Experience survey results for BCBSIL, CountyCare, and Meridian were below the 25th percentile and Molina was below the 50th percentile for *Getting Needed Care*, which indicates that parents/caretakers of child members may perceive a lack of access to getting the care they need for their child.

Why the Opportunity Exists: Parents/caretakers of child members may have difficulty obtaining the care, tests, or treatment they need.

Opportunity: Experience survey results for Aetna, BCBSIL, and CountyCare were below the 25th percentile, and Meridian was below the 50th percentile for *Getting Care Quickly*, which indicates that parents/caretakers of child members may perceive challenges with a lack of timeliness of care for their child.

Why the Opportunity Exists: Parents/caretakers of child members may have difficulty scheduling the care their child needs with a provider or at a facility in a timely manner.

Opportunity: Experience survey results for CountyCare were below the 25th percentile, and Meridian and Molina were below the 50th percentile for *How Well Doctors Communicate*, which indicates that parents/caretakers of child members do not feel they are understanding or being fully informed when doctors are communicating about their child's care.

Why the Opportunity Exists: When a child member is receiving care, providers may not be communicating well with parents/caretakers or spending adequate time educating or explaining as much as the parent/caretakers expect or need.

Recommendation: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why child members may not have adequate access to or timeliness of care, as well as what may be contributing to a lack of communication with their child's doctor. The health plans could consider whether there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans can then determine what appropriate interventions, education, and actions can be taken to improve performance.

Global Ratings

Table E2-6—2021 and 2022 Child Health Plan-Specific Results

Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
Aetna	2021	67.8% ★	75.8% ★	78.8%+ ★★★★★+	58.1% ★
	2022	65.9% ★	73.0% ★	73.0%+ ★★+	57.1% ★
BCBSIL	2021	76.6% ★★★★	78.2% ★★	68.1%+ ★+	71.6% ★★
	2022	69.5% ★	77.3% ★★	71.8%+ ★★+	72.7% ★★★
CountyCare	2021	70.7% ★★	80.3% ★★★	71.8%+ ★★+	70.6% ★★
	2022	73.0% ★★	77.4% ★★	66.7%+ ★+	77.5% ★★★★
Meridian	2021	75.9% ★★★★	81.5% ★★★★	69.5%+ ★+	71.8% ★★
	2022	65.3% ★	77.7% ★★	60.0%+ ★+	67.9% ★
Molina	2021	72.7% ★★★	79.3% ★★★	79.6%+ ★★★★★+	64.4% ★
	2022	65.6% ★	79.1% ★★★	73.3%+ ★★+	67.7% ★
Statewide Aggregate	2021	73.8% ★★★	79.5% ★★★	71.9% ★★	68.8% ★
	2022	67.6% ★	77.1% ★★	67.1% ★	69.0% ★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths	Experience survey results for CountyCare were at or between the 75th and 89th percentiles for *Rating of Health Plan,* which indicates that parents/caretakers of child members feel they are getting quality health care services.
Opportunities for Improvement	**Opportunity:** Experience survey results for *Rating of All Health Care* were below the 25th percentile for all health plans except CountyCare, which was below the 50th percentile, indicating that parents/caretakers of child members may perceive a lack of quality of care and/or service with these health plans. **Why the Opportunity Exists:** Parents/caretakers of child members may perceive access and timeliness issues with their providers and the care they need, leading to an overall lower level of experience in how they view the quality of the care they received.
	Opportunity: Experience survey results for *Rating of Personal Doctor* were below the 50th percentile for BCBSIL, CountyCare, and Meridian, and Aetna was below the 25th percentile, which indicates that parents/caretakers may feel they are not getting quality care from their child's personal doctor. **Why the Opportunity Exists:** Parents/caretakers of child members may have felt they received poor communication or service from their child's personal doctor.
	Opportunity: Experience survey results for *Rating of Specialist Seen Most Often* were below the 50th percentile for Aetna, BCBSIL, and Molina, and CountyCare and Meridian were both below the 25th percentile, which indicates that parents/caretakers of child members may feel they are not getting quality care from specialists. **Why the Opportunity Exists:** Parents/caretakers of child members may feel they are not getting quality care or treatment from the specialists their child talks to most often.
	Opportunity: Experience survey results for Aetna, Meridian, and Molina were below the 25th percentile for *Rating of Health Plan*, which indicates an overall lack of quality of care. **Why the Opportunity Exists:** Parents/caretakers of child members may have felt they received inadequate information, poor communication or service, and/or a lack of quality of care from their providers or health plan staff. **Recommendation:** HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why parents/caretakers of child members perceive a lack of quality of care from their personal doctors and specialists, as well as an overall lack of quality of care and services. The health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group,

ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Statewide CAHPS Medicaid Survey

Response Rates

The table below presents the 2022 response rates for the general child population and CCC supplemental samples for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate (i.e., All Kids and Illinois Medicaid combined).

Table E2-7—2022 Statewide Survey Response Rates

Program Name	2022 Response Rate
All Kids	21.73%
Illinois Medicaid	13.33%
Illinois Statewide Aggregate	17.51%

General Child Population Findings and Comparisons

The 2021 and 2022 general child populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.[E2-1]

Table E2-8—2021 and 2022 Statewide Survey General Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2021	81.1% ★	81.5% ★	80.5% ★
	2022	78.5% ★	79.1% ★	77.1%+ ★+
Getting Care Quickly	2021	81.5% ★	80.4% ★	83.5% ★
	2022	79.5% ★	79.1% ★	80.1%+ ★+

[E2-1] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
How Well Doctors Communicate	2021	94.2% ★	95.3% ★★	92.6% ★
	2022	93.6% ★★	93.6% ★★	93.5% ★★
Customer Service	2021	86.3% ★	85.8% ★	86.9%+ ★+
	2022	79.2% ★	78.1%+ ★+	80.5%+ ★+
Global Ratings				
Rating of All Health Care	2021	68.4% ★	66.7% ★	71.3% ★★
	2022	66.3% ★	64.7% ★	69.0% ★
Rating of Personal Doctor	2021	76.5% ★★	77.4% ★★	75.0% ★
	2022	74.6% ★	74.2% ★	75.3% ★
Rating of Specialist Seen Most Often	2021	70.6% ★	77.8%+ ★★★★★+	57.8%+ ★+
	2022	64.4% ★	63.9%+ ★+	65.7%+ ★+
Rating of Health Plan	2021	61.8% ★	63.7% ★	58.9% ★
	2022	59.0% ★	56.9% ★	62.3% ★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths	There were no strengths identified for the general child experience survey results for the All Kids program and Illinois Medicaid program.
Opportunities for Improvement	**Opportunity:** General child experience survey results for the All Kids program and Illinois Medicaid program were below the 50th percentile for all measures, which indicates parents/caretakers may not be receiving the access to, timeliness of, and quality of health care services they feel their child needs, such as quality and understanding when doctors communicate with them. **Why the Opportunity Exists:** Parents/caretakers of child members may have difficulty trying to schedule appointments within times they feel are appropriate for the care they are seeking for their child. This could be due to potential patient load or open office hour availability of network providers. Additionally, parents/caretakers may not be able to access providers within a reasonable distance or have limited options to choose from within a specialty. Additionally, parents/caretakers of child members may feel they are not getting the time they need with or appropriate communication from their child's personal doctor, or the adequate materials they require to understand the information presented. **Recommendation:** HSAG recommends that the All Kids and Illinois Medicaid programs conduct root cause analyses or focus studies related to child populations to determine why child members may not be getting timely care, the quality of care they need, or do not have access to care. The programs could consider if there are disparities within their child populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the programs should implement appropriate interventions to improve access and timeliness to care and the quality of care members need. Additionally, HSAG recommends that the programs determine whether there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the program that could be contributing to a lack of network adequacy and access issues.

CCC Child Population Findings and Comparisons

The 2021 and 2022 CCC populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.[E2-2]

Table E2-9—2021 and 2022 Statewide Survey CCC Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2021	84.7% ★	86.4% ★★	82.4% ★
	2022	78.3% ★	79.8% ★	75.4%+ ★+
Getting Care Quickly	2021	86.0% ★	85.5% ★	86.5% ★
	2022	84.4% ★	85.2% ★	83.1%+ ★+
How Well Doctors Communicate	2021	95.2% ★★	95.7% ★★	94.5% ★
	2022	91.5% ★	91.9% ★	90.7% ★
Customer Service	2021	85.2% ★	84.0%+ ★+	86.5%+ ★+
	2022	81.1%+ ★+	84.4%+ ★+	75.0%+ ★+
Global Ratings				
Rating of All Health Care	2021	61.6% ★	64.2% ★	58.0% ★
	2022	61.8% ★	65.2% ★	55.5% ★
Rating of Personal Doctor	2021	74.0% ★	73.7% ★	74.4% ★
	2022	70.5% ★	68.2% ★	75.0% ★

[E2-2] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Rating of Specialist Seen Most Often	2021	73.5% ★★	76.7% ★★★	68.3%+ ★+
	2022	64.4% ★	65.7% ★	61.4%+ ★+
Rating of Health Plan	2021	57.9% ★	60.0% ★	55.1% ★
	2022	52.5% ★	51.3% ★	54.7% ★
CCC Composites and Items				
Access to Specialized Services	2021	60.6% ★	64.3%+ ★+	56.5%+ ★+
	2022	58.2% ★	61.9%+ ★+	52.4%+ ★+
FCC: Personal Doctor Who Knows Child	2021	91.7% ★★	90.0% ★	93.7% ★★★★
	2022	89.5% ★	90.0% ★★	88.7% ★
Coordination of Care for Children with Chronic Conditions	2021	78.6% ★★★	77.9%+ ★★+	79.5%+ ★★★★+
	2022	73.8% ★	74.1%+ ★+	73.3%+ ★+
Access to Prescription Medicines	2021	89.0% ★	91.7% ★★★	85.8% ★
	2022	87.2% ★	88.7% ★	84.4% ★
FCC: Getting Needed Information	2021	87.9% ★	90.3% ★	84.4% ★
	2022	87.1% ★	87.0% ★	87.3% ★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

There were no strengths identified for the CCC experience survey results for the All Kids program and Illinois Medicaid program.

Opportunities for Improvement

Opportunity: CCC experience survey results for the All Kids program and Illinois Medicaid program were below the 25th percentile for all measures except *FCC: Personal Doctor Who Knows Child* for the All Kids program, which was below the 50th percentile. This indicates parents/caretakers may not be receiving the access to, timeliness of, and quality of health care services they feel their child needs, such as quality and understanding when doctors communicate with them. Additionally, parents/caretakers of child members may be experiencing poor timeliness in appointments, poor access to care and services needed for their child with chronic conditions including medical equipment/prescription medicines or treatment, and poor quality of care from customer service staff and their child's personal doctor.

Why the Opportunity Exists: Parents/caretakers of child members may have difficulty trying to schedule appointments with their child's personal doctor or a specialist within times they feel are appropriate for the care they are seeking for their child. This could be due to potential patient load or open office hour availability of network providers. Additionally, there may be a lack of access to providers within a reasonable distance or limited options to choose from within a specialty. Additionally, parents/caretakers of child members may feel they are not getting the time needed with their child's personal doctor or the adequate materials needed to understand the information presented.

Recommendation: HSAG recommends that the All Kids and Illinois Medicaid programs conduct root cause analyses or focus studies related to CCC child populations to determine why CCC child members may not be getting timely care or the quality of care they need, or do not have access to care. The programs could consider whether there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also, the programs could review complaints and grievances to assist in identifying potential problematic providers, facilities, or overall barriers to quality of care, adequate network access, and timely care. Upon identification of a root cause, the programs should implement appropriate interventions to improve access to and timeliness and quality of care that CCC child members need. Additionally, HSAG recommends that the programs determine whether there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the program that could be contributing to a lack of network adequacy and access issues.

Appendix F1. HCBS Record Reviews Methodology and Detailed Results

HealthChoice Illinois

Illinois Department of Healthcare and Family Services

Home- and Community-Based Services (HCBS) Waivers

Centers for Medicare & Medicaid Services (CMS) Performance Measures

Record Review

of

HealthChoice Illinois

Managed Care Plans (MCPs)

Summary of Findings and Recommendations

State Fiscal Year 2022 Report

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to identify opportunities within the Home- and Community-Based Services (HCBS) waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG), conduct on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This State Fiscal Year (SFY) 2022 HCBS Waivers CMS Performance Measures Record Review of HealthChoice Illinois MCPs Summary of Findings and Recommendations Report provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for the HealthChoice Illinois Managed Care Program (HealthChoice), which includes the Managed Long Term Services and Supports (MLTSS) 1915(b) waiver program.

Overview

This report provides an overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

The report includes a summary of trended performance across health plans during SFY 2022 and across review years, and also contains a review of remediation activities conducted within the required time frames and a summary of technical assistance that HSAG provided to the health plans.

For the SFY 2022 review, HFS initially identified 17 CMS waiver performance measures for review. These performances measures were aligned with the state-approved 1915(c) waiver applications. Due to waiver renewals that occurred, the following changes were made to ensure alignment and 19 measures were collected beginning in the third quarter (Q3) SFY 2022:

- Measure 12C, *If the PA [personal assistant] evaluation was not completed annually, it was completed within 60 days of the expected annual date*, was retired.
- Measure A5, *Does the enrollee report the ADS [adult day service] facilitates independent choice while attending ADS?* was added.
- Measure A6-SIGN, *Was the enrollee provided choice of directing services received at the ADS setting?* was added.
- Measure A6-SUPP, *Did the enrollee report he/she feels supported in making decisions to remain independent?* was added.

In addition, evaluation criteria for 36D/D6 were revised to align with contact requirements for enrollees receiving services in the Persons with Disabilities (PD) and Persons who are Elderly (ELD) waivers.

Due to waiver renewals that occurred, the following changes were made to ensure alignment and 21 performance measures were collected beginning Q4 SFY 2022:

- Measure A5-ELD, *Does the enrollee report participation in meaningful activities that help meet their goals/needs?* was added.
- Measure G8, *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?* was added.

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Methodology

HSAG conducted quarterly record reviews to determine health plan compliance to the CMS waiver performance measures and to additional HealthChoice contract measures. During SFY 2022, 1,456 HealthChoice and 1,516 MLTSS records were reviewed using HSAG's web-based data collection tool. As a result, 1,473 HealthChoice and 1,697 MLTSS findings of noncompliance were identified. The SFY 2022 reviews assessed performance during a lookback period of December 1, 2020, through February 28, 2022.

Detailed descriptions of the sampling methodology and data collection processes are provided in Section 2 of this report.

Summary of Findings

Health Plan Participation

Table 1-1 displays the health plans that were reviewed during SFY 2022.

Table 1-1—SFY 2022 HealthChoice and MLTSS Health Plans

HealthChoice Health Plan Name
Aetna Better Health (Aetna)
Blue Cross Blue Shield of Illinois (BCBSIL)
CountyCare
Meridian
Molina Healthcare of Illinois (Molina)

Successes

SFY 2022 represented the fifth year of review for the HealthChoice population, and several successes were identified.

☑ Twelve of the 21 CMS performance measures[1] averaged 90 percent or greater compliance.

☑ Two performance measures realized statistically significant increases in compliance in SFY 2022 when compared to SFY 2021.

☑ Three of the five health plans averaged greater than 90 percent compliance.

☑ Compared to SFY 2021, Molina realized a statistically significant increase in performance for five measures in SFY 2022.

☑ Three of the five waiver types averaged greater than 90 percent compliance.

☑ Compared to SFY 2021, the Persons with Brain Injury (BI) waiver realized a statistically significant increase in compliance for two measures in SFY 2022.

Opportunities for Improvement

Review of SFY 2022 performance identified the following opportunities for improvement:

Aetna demonstrated a statistically significant decrease in five performance measures in SFY 2022 when compared to SFY 2021.

Four performance measures demonstrated statistically significant decreases in compliance in SFY 2022 when compared to SFY 2021.

Four of the five health plans and all five waivers demonstrated a statistically significant decrease in compliance with Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP [persons in a supportive living program] provider (if applicable) and dates of signatures*, when SFY 2022 was compared to SFY 2021. A detailed analysis is provided in Section 3 of this report.

Two of the five health plans and three of the five waivers demonstrated a statistically significant decrease in compliance with Measure D7, *the most recent service plan is in the record and completed in*

[1] A listing of performance measures is available in Appendix A.

a timely manner, when SFY 2022 was compared to SFY 2021. A detailed analysis is provided in Section 3 of this report.

- Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 73 percent compliance in SFY 2022. A detailed analysis is provided in Section 3 of this report.

- Although HFS provided the health plans with guidance regarding documentation expectations for enrollee contacts, service plan updates, and enrollee signatures during the coronavirus disease 2019 (COVID-19) public health emergency (PHE) restrictions, the health plans demonstrated significant decreases in compliance for those measures, as indicated above.

Analysis of SFY 2022 Performance on SFY 2021 Recommendations for Improvement

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG's recommendations following the conclusion of SFY 2021 reviews, efforts to incorporate technical assistance received during on-site reviews, and efforts to integrate HFS guidance into internal processes. Although it is not possible to definitively determine causal relationships, Table 1-2 documents the results of some of the health plan improvement efforts.

Table 1-2—Health Plan Interventions and Results

SFY 2021 Recommendation	SFY 2022 Analysis of Performance
Plan-Specific	
Aetna should focus efforts on measures 4A, 12C, and 39D.	Measure 4A was retired and not collected in SFY 2022. Measure 12C was retired effective Q3 SFY 2022. Aetna achieved a statistically significant increase in performance on Measure 39D/D9 when Q4 was compared to Q1 SFY 2022. Aetna demonstrated stable performance in Measure D9 when SFY 2022 was compared to SFY 2021 (-2 percentage points).
BCBSIL should focus efforts on measures 4A, 12C, and 20C.	Measure 4A was retired and not collected in SFY 2022. Measure 12C was retired effective Q3 SFY 2022. BCBSIL achieved a statistically significant increase in performance on Measure 20C when Q4 was compared to Q1 SFY 2022. BCBSIL realized a 7-percentage-point increase in the rate on Measure 20C when SFY 2022 was compared to SFY 2021.

SFY 2021 Recommendation	SFY 2022 Analysis of Performance
CountyCare should focus efforts on measures 4A, 12C, and 20C.	Measure 4A was retired and not collected in SFY 2022. Measure 12C was retired effective Q3 SFY 2022. CountyCare achieved a statistically significant increase in performance on Measure 20C when SFY 2022 was compared to SFY 2021 (+8 percentage points).
Meridian should focus efforts on measures 4A, 12C, and 20C.	Measure 4A was retired and not collected in SFY 2022. Measure 12C was retired effective Q3 SFY 2022. Meridian demonstrated stable performance in Measure 20C throughout SFY 2022, as well as when SFY 2022 was compared to SFY 2021 (+1 percentage point).
Molina should focus efforts on measures 4A, 12C, and 20C.	Measure 4A was retired and not collected in SFY 2022. Measure 12C was retired effective Q3 SFY 2022. Molina achieved a statistically significant increase in performance on Measure 20C when SFY 2022 was compared to SFY 2021 (+19 percentage points).
Waiver-Specific	
BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.	The rate in Measure 36D, *valid contact with the enrollee at least one time a month*, did not demonstrate a statistically significant difference when comparing Q1 and Q4 FY 2022 or FY 2022 to FY 2021. Focused efforts related to Measure D6 were recommended during FY 2020, FY 2021, and remain as a recommendation for FY 2022.
HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.	The rate for Measure 36D/D6, *valid contact with the enrollee once a month, with a face-to-face contact bimonthly*, did not demonstrate a statistically significant difference when comparing Q1 and Q4 FY 2022 or FY 2022 to FY 2021. Focused efforts related to Measure D6 were recommended during FY 2020, FY 2021, and remain as a recommendation for FY 2022.

SFY 2021 Recommendation	SFY 2022 Analysis of Performance
Performance Measure-Specific	
All health plans should focus improvement efforts on measures 4A, 12C, 20C, and 36D. The health plans may also benefit from implementing the *Performance Measure-Specific* recommendations listed in the FY 2021 annual report.	4A: This measure was retired and not collected in FY 2022. 12C: This measure was retired effective Q3 FY 2022. 20C: This measure achieved a statistically significant increase in improvement through FY 2022 (when Q1 was compared to Q4), as well as year-over-year (when FY 2022 was compared to FY 2021). Two of the five health plans realized a statistically significant increase in performance when Q4 was compared to Q1 FY 2022, and two other health plans realized a statistically significant increase in performance when FY 2022 was compared to FY 2021. 36D/D6: Overall performance averaged 73 percent in FY 2022. Notably, performance statistically significantly decreased when the evaluation criteria for the PD and ELD waivers were aligned with contract language in Q3 FY 2022, requiring evidence of more frequent contact than was previously assessed. There was no statistical difference in performance for the BI and HIV waivers, which averaged compliance of 69 percent and 63 percent in FY 2022, respectively. Focused efforts will continue to remain as recommendations for Measure 36D/D6.

External Quality Review Organization (EQRO) Technical Assistance

To assist the health plans with improvement efforts, HSAG provided ongoing technical assistance throughout SFY 2022. Technical assistance was also provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- How to prepare for quarterly record reviews and remediation validation.
- How to use the HSAG web-based tool to run reports and complete remediation.
- How to complete health, safety, and welfare reports remediation.
- Validation of waiver service provision.
- Timely completion of annual reassessments, care plan, and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.
- Compliance with HFS' guidance regarding SLP documentation expectations.
- Documentation of language required to meet HFS' expectations for enrollee contacts, service plan updates, and enrollee signatures during the COVID-19 PHE restrictions.

In addition, HSAG conducted health plan trainings in July 2021 and January 2022 to provide updates to evaluation criteria and record review expectations.

HFS Policy Guidance

As a result of HFS' efforts for continuous quality improvement for the waiver record reviews and management of waiver enrollees, HFS provided guidance via formal policies to the health plans on the following topics:

- Procedures specific to management of enrollees during the COVID-19 pandemic, including timelines for resuming face-to-face enrollee contacts and expectations for documenting SLP care coordination activities.
- Expectations for conducting a new health risk assessment (HRA) for newly eligible enrollees with a previous HRA.
- CMS' approval of PD and ELD waiver renewals and resulting updated performance measures.

Recommendations

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Recommendations specific to health plans, waivers, and performance measures are identified below.

Health Plan-Specific

Aetna should focus efforts on measures 35D, D6, D7, D8, and G1.

BCSBIL should focus efforts on measures 35D and D6.

CountyCare should focus efforts on measures 35D, D6, D7, and G8.

Meridian should focus efforts on measures 35D and D6.

Molina should focus efforts on measures 35D and D6.

All health plans may benefit from implementing the *Performance Measure-Specific* recommendations listed below.

Waiver-Specific

Brain injury (BI) waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month (Measure D6). Health plans should analyze their staffing to ensure that care managers/care coordinators[2] have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

Human immunodeficiency virus (HIV) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly (Measure D6). Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

Persons with Disabilities (PD) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once every 90 days (Measure D6). Health plans should target efforts for contact to those care managers/care coordinators managing PD caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of PD cases, to identify timely mitigation opportunities.

Persons who are Elderly (ELD) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once every 90 days (Measure D6). Health plans should target efforts for contact to those care managers/care coordinators managing ELD caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of ELD cases, to identify timely mitigation opportunities.

Performance Measure-Specific

All health plans should focus improvement efforts on measures D6, D7, and 35D.

For Measure D6, efforts might include:

- Conduct root cause analysis to determine opportunities to effect change.
- Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.

[2] The terms "case manager(s)" and "care coordinator(s)" are used interchangeably in this report.

- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS' guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

For Measure D7, efforts might include:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete annual service plan updates.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

For Measure 35D, efforts might include:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete timely service plan updates.
- Ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

2. Data Collection and Methodology

Background

The Illinois Department of Healthcare and Family Services (HFS) implemented the Integrated Care Program (ICP) for seniors and adults with disabilities on May 1, 2011. The ICP provides integration of an individual's physical, behavioral, and social needs to improve health outcomes and enhance quality of life by providing individuals the support necessary to live more independently in the community. Management of the HCBS waiver populations was initiated in 2013.

In addition to the ICP, some enrollees received their HCBS waiver services through the Family Health Plan (FHP)/Affordable Care Act (ACA). Voluntary managed care (VMC) was a healthcare option for medical assistance participants in Illinois from 1976 until it was phased out in July 2014 and replaced with FHP/ACA. FHP/ACA is a mandatory program for children and their families as well as ACA adults and includes those who are eligible for HCBS waiver programs.

HFS implemented the MLTSS waiver upon approval from CMS effective July 1, 2016. The MLTSS waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based long-term services and supports who were not enrolled in the State's Medicare-Medicaid Alignment Initiative (MMAI) but were eligible for both Medicare and Medicaid, unless they met the eligibility exclusions. Beginning in July 2016, the MLTSS waiver was implemented in the Greater Chicago service area only and then expanded into additional regions.

Illinois transitioned to an integrated Medicaid program, HealthChoice, on January 1, 2018, which combined the FHP/ACA, ICP, and MLTSS populations into one managed care program and was established statewide for the FHP/ACA and ICP; MLTSS was expanded statewide effective July 1, 2019.

All waiver beneficiaries enrolled in HealthChoice receive care management services. This person-centered, team-based approach supports care coordination across the continuum of care, promoting improved health outcomes, increased beneficiary satisfaction, and improved coordination and integration of benefits.

The program was designed to ensure that beneficiaries receive assistance with clinical and nonclinical needs by assigning an accountable care manager who develops a care plan and service plan with the beneficiary, coordinates frequent personal contact to monitor the beneficiary's progress toward achieving care plan goals, and implements interventions to overcome barriers to care.

To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that HSAG conduct on-site reviews of waiver beneficiary records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

HCBS Waiver Program Implementation and Monitoring

As the EQRO for Illinois, HSAG assisted HFS in assessing the readiness of each health plan to participate in the HCBS waiver program. Prior to receiving HCBS waiver program enrollees, the health plans were required to participate in and pass a readiness review to demonstrate that the health plan was ready to provide services to HCBS waiver enrollees safely and efficiently.

HSAG began on-site record reviews in SFY 2014 to monitor ICP health plan performance on the HCBS waiver performance measures and added FHP/ACA upon waiver service provision inclusion in SFY 2016. MLTSS was included in Q3 SFY 2018.

Waiver Programs and Performance Measures Included in Reviews

Waiver Programs

The following HCBS waiver programs were included in the CMS performance measure record reviews:

- Persons with Disabilities (PD): Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility and can be safely maintained in the home or community-based setting with the services provided in the plan of care. Individuals 60 years of age or older, who began services before age 60, may choose to remain in this waiver.
- Persons with HIV/AIDS (HIV): Persons of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or acquired immune deficiency syndrome (AIDS) and are at risk of placement in a nursing facility.
- Persons with Brain Injury (BI): Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- Persons who are Elderly (ELD): Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are ages 65 and older, and those who are physically disabled, ages 60 through 64.
- Persons in a Supportive Living Program (SLP): Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

Performance Measures

For the SFY2022 review, HFS initially identified 17 CMS waiver performance measures for review. These performances measures were aligned with the state-approved 1915(c) waiver applications for the waiver types listed above. Due to waiver renewals that occurred during the SFY, HFS identified 21 CMS waiver performance measures for review beginning Q4 SFY2022; the following changes were made to ensure alignment:

- Measure A5-ELD, *Does the enrollee report participation in meaningful activities that help meet their goals/needs*? was added.

- Measure G8, *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months*? was added.

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

To collect samples for record review, HSAG selects a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selects a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group will be determined based on the number of eligible members in each waiver program. Once the required sample sizes have been identified, a proportional random sample will be selected based on the distribution of the health plans' populations within each designated waiver program. Each sample is selected to ensure a 95 percent confidence level and 5 percent margin of error at the waiver program level. Additionally, a 10 percent oversample based on the proportional distribution of enrollees across health plans is selected to replace ineligible cases.

This sampling method is designed to ensure that when the samples are combined, there is sufficient statistical power to meet the CMS HCBS reporting requirements. Samples will be selected without resampling, and sample sets will be refreshed for each review using HFS' eligibility file data. Limitations to the sampling methodology include known variables such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g., previously enrolled as MMAI and transferred to MLTSS).

To be included in the sample, a beneficiary must meet the following criteria:

1. Continuously enrolled with the health plan for at least six months as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.
2. At least three months of continuous HCBS waiver coverage during the most recent six months of enrollment as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

Upon receipt of the sample, health plans are expected to review the cases to ensure they meet the above eligibility criteria, notifying HSAG of any cases that should be excluded. Health plans will also notify HSAG of any of the following, who may be excluded from the sample:

- Beneficiaries who have disenrolled from the health plan.
- Beneficiaries who have expired.

- Beneficiaries who have Operating Agency-confirmed waiver case closure.
- Beneficiaries whose current waiver type is different from the waiver type identified on the sample.
- Beneficiaries whose current program (HealthChoice, MLTSS, or MMAI) differs from the program type identified on the sample.
- Beneficiaries in long-term care.

The final sample sizes were calculated based on data extracted in April 2021 and included waiver members enrolled as of April 1, 2021. Table 2-1 and Table 2-2 display the FY 2022 record review sample size by health plan and waiver program for HealthChoice and MLTSS.

Table 2-1—HealthChoice Sample Size, by Health Plan and Waiver Program

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLP
Aetna	4,345	263	68	52	36	68	39
BCBSIL	6,543	407	109	72	52	93	81
CountyCare	4,746	330	71	82	78	74	25
Meridian	6,317	349	100	57	30	101	61
Molina	1,828	107	24	10	14	34	25
Statewide Total	**23,779**	**1,456**	**372**	**273**	**210**	**370**	**231**

Table 2-2—MLTSS Sample Size, by Health Plan and Waiver Program

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLF
Aetna	7,933	302	77	53	27	76	69
BCBSIL	13,225	521	125	73	56	117	150
CountyCare	5,410	212	58	55	36	48	15
Meridian	8,958	356	85	56	45	87	83
Molina	3,545	130	34	12	12	35	37
Statewide Total	**39,071**	**1,521**	**379**	**249**	**176**	**363**	**354**

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this report, including tables and graphs, reflect the quarters in which the health plans were reviewed. The six-month lookback periods during SFY 2022 consisted of the following:

- Quarter 1, SFY 2021: December 1, 2020–May 31, 2021
- Quarter 2, SFY 2021: March 1, 2021–August 31, 2021
- Quarter 3, SFY 2021: June 1, 2021–November 30, 2021
- Quarter 4, SFY 2021: September 1, 2021–February 28, 2022

Web-Based Abstraction Tool and Scoring Methodology

HSAG collaborated with HFS to develop a web-based abstraction tool and reporting database, which included requirements set forth in the HealthChoice contract and the HCBS waivers. The review tool was developed to conduct the review at the individual case level and was modeled after the tool used by the State to monitor the fee-for-service population to ensure waiver enrollees are monitored similarly for similar performance measures. The tool was used to assess compliance with case management activities, including comprehensive assessments, care planning, waiver service planning, beneficiary interaction, and specialized waiver evaluations.

During the on-site review, the HSAG review team reviewed documentation for the selected cases for each review period, consisting of a six-month lookback period from the date of the review. The review team determined evidence of case compliance with each of the HFS-selected scored elements. A score of *Yes*, *No*, or *Not Applicable (N/A)* was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Yes* or *No*. These scores indicated the health plan's compliance with the requirements. HSAG also used a designation of *N/A* if the requirement was not applicable to a record; *N/A* findings were not included in the two-point scoring methodology.

HSAG calculated the score by adding the score from each eligible case and dividing the summed scores by the total number of eligible cases. HSAG aggregated the results across all records by health plan, waiver population, and performance measure.

Interrater Reliability (IRR)

To ensure accuracy of the reviews, HSAG conducted IRR on all review team members. The IRR reviews were conducted by the HSAG senior project manager for 10 percent of all records completed by each individual reviewer via over-read of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95 percent was required, with the reviewer completing retraining if required. Reviews were completed across all waivers, program types, and health plans to ensure continued compliance to the 95 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent.

Remediation Actions and Tracking

As a result of the on-site reviews, HSAG identified noncompliant performance and contract measures. HSAG's web-based abstraction tool and reporting database included a remediation tracking function which detailed the findings of noncompliance related to waiver performance measures and HealthChoice contract requirements. Health plans and HFS had access to their respective reports and the remediation tracking database via the HSAG Web portal.

HSAG notified HFS of the online availability of each health plan's report of findings within 30 days of each review. Once approved by the State, the report of findings was forwarded to each health plan to complete remediation actions. Remediation actions were defined in the HealthChoice contract and were specific to each CMS waiver performance measure and contract finding. The remediation tracking database tracked the date the health plan was notified of findings, the date the health plan reported the remediation action was completed, and the number of days from notification of the finding until the remediation action was completed.

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of enrollees was maintained. HSAG completed remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans. The results of the remediation validation reviews are reported in Section 3 of this report.

3. HealthChoice Overall Summary of Record Review Findings for SFY 2022

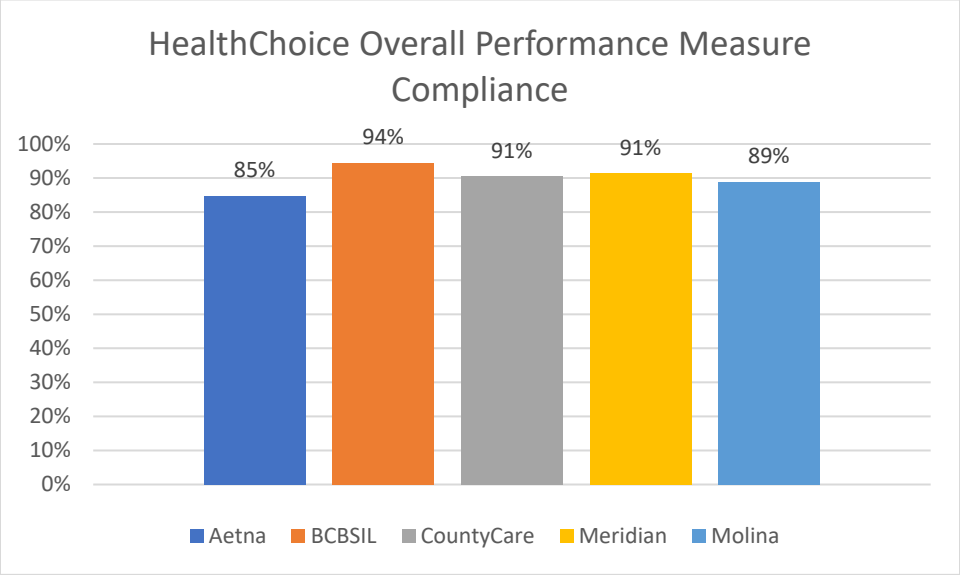
Overall Performance

Overall Health Plan Performance and Comparisons

Five health plans were reviewed during SFY 2022. Figure 3-1 displays a computed average of the total performance achieved by each health plan on the 21 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 21 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Three of the five health plans averaged greater than 90 percent compliance in SFY 2022. There was a 9-percentage-point difference (85 percent to 94 percent) among health plans.

Figure 3-1—Overall Compliance



Statistical significance testing was also performed to compare each health plan's average overall compliance against all other health plans, and the following differences were identified:

- BCBSIL performed at a statistically significantly higher rate than all other health plans.
- Aetna performed at a statistically significantly lower rate than all other health plans.
- Molina performed at a statistically significantly lower rate than BCBSIL, CountyCare, and Meridian.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2022. Comparisons for overall performance from SFY 2021 to SFY 2022 were not completed, as the total number of performance measures reviewed was different in each FY. Health plan-specific performance on all performance measures by quarter is included in Appendix C. Individual health plan performance analyses identified the following for measures that were in place at the end of SFY 2022.

Aetna

Analysis identified that Aetna achieved a compliance rate of 90 percent or greater in nine of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Aetna achieved a statistically significant increase in three performance measures and demonstrated a statistically significant decrease in one measure. When SFY 2022 performance was compared to SFY 2021 performance, Aetna demonstrated a statistically significant decrease in five measures.

Analysis identified that Aetna's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 65 percent compliance rate. Aetna also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with a 67 percent compliance rate; and Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 74 percent compliance rate.

BCBSIL

Analysis identified that BCBSIL achieved a compliance rate of 90 percent or greater in 14 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, BCBSIL achieved a statistically significant increase in five performance measures. When SFY 2022 performance was compared to SFY 2021 performance, BCBSIL achieved a statistically significant increase in one measure and demonstrated a statistically significant decrease in one measure.

Analysis identified that BCBSIL's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, and Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, both with an 89 percent compliance rate.

CountyCare

Analysis identified that CountyCare achieved a compliance rate of 90 percent or greater in 11 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, CountyCare demonstrated a statistically significant decrease in three performance measures. When SFY 2022 performance was compared to SFY 2021 performance, CountyCare achieved a statistically significant increase in one performance measure and demonstrated a statistically significant decrease in two measures.

Analysis identified that CountyCare's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, and Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, both with a 72 percent compliance rate.

Meridian

Analysis identified that Meridian achieved a 90 percent or greater compliance rate in 13 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Meridian demonstrated a statistically significant decrease in two performance measures. When SFY 2022 performance was compared to SFY 2021 performance, Meridian achieved a statistically significant increase in one measure and demonstrated a statistically significant decrease in two measures.

Analysis identified that Meridian's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 58 percent compliance rate. Meridian also had opportunity for improvement in Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with an 87 percent compliance rate.

Molina

Analysis identified that Molina achieved a 90 percent or greater compliance rate in 10 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Molina demonstrated a statistically significant decrease in one performance measure. When SFY 2022 performance was compared to SFY 2021 performance, Molina achieved a statistically significant increase in five measures.

Analysis identified that Molina's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 77 percent compliance rate. Meridian also had opportunity for improvement in

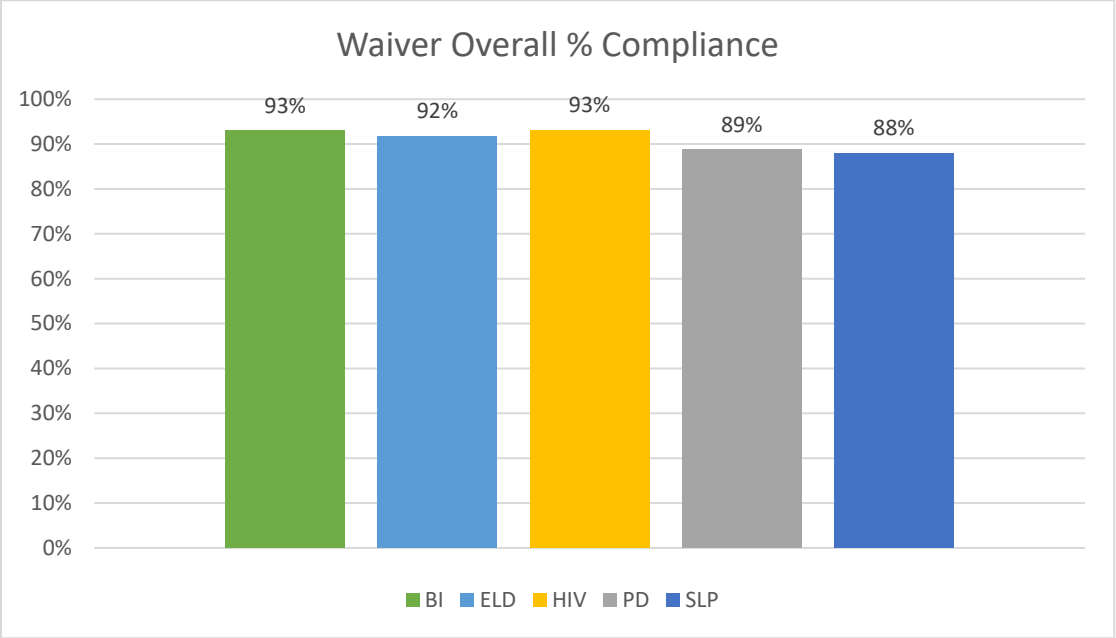
Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 78 percent compliance rate.

Performance by Waiver Type

Comparisons were also analyzed by waiver type, to determine differences and improvement opportunities that may be waiver-specific as opposed to health plan-specific. Appendix D displays waiver compliance per performance measure by quarter.

As Figure 3-2 displays, three of the five waiver types averaged 90 percent or greater overall compliance in SFY 2022.

Figure 3-2—Overall Compliance Across Waiver Types



Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver type's overall compliance from Q1 2022 to Q4 SFY 2022. Comparisons for overall performance from SFY 2021 to SFY 2022 were not completed, as the total number of performance measures reviewed was different in each FY. Individual waiver performance analyses identified the following for measures that were in place at the end of SFY 2022.

BI Waiver

Fourteen performance measures were assessed for the BI waiver. Analysis identified that the BI waiver achieved a 90 percent or greater compliance rate in 10 of the 14 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the BI waiver achieved a statistically significant increase in two performance measures. When SFY 2022 performance was compared to SFY 2021 performance, the BI waiver achieved a statistically significant increase in two performance measures and demonstrated a statistically significant decrease in one performance measure.

Analysis identified that the greatest opportunity for improvement for the BI waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 69 percent compliance rate.

ELD Waiver

Twenty performance measures were assessed for the ELD waiver. Analysis identified that the ELD waiver achieved a 90 percent or greater compliance rate in 10 of the 20 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the ELD waiver demonstrated a statistically significant decrease in two performance measures. When SFY 2022 performance was compared to SFY 2021 performance, the ELD waiver demonstrated a statistically significant decrease in two performance measures.

Analysis identified that the greatest opportunity for improvement for the ELD waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 76 percent compliance rate. The ELD waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with a 77 percent compliance rate.

HIV Waiver

Fourteen performance measures were assessed for the HIV waiver. Analysis identified that the HIV waiver achieved a 90 percent or greater compliance rate in 11 of the 14 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the HIV waiver demonstrated a statistically significant decrease in one measure. When SFY 2022 performance was compared to SFY 2021 performance, the HIV waiver achieved a statistically significant increase in one measure and demonstrated a statistically significant decrease in two measures.

Analysis identified that the greatest opportunity for improvement for the HIV waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 63 percent compliance rate. The HIV waiver also had opportunity for improvement in Measure 35D, *the most recent service plan includes signature of enrollee (or*

representative), Case Manager, and SLP provider (if applicable) and dates of signatures, with an 89 percent compliance rate.

PD Waiver

Seventeen performance measures were assessed for the PD waiver. Analysis identified that the PD waiver achieved a 90 percent or greater compliance rate in nine of the 17 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the PD waiver achieved a statistically significant increase in two measures and demonstrated a statistically significant decrease in one measure. When SFY 2022 performance was compared to SFY 2021 performance, the PD waiver achieved a statistically significant increase in one measure and demonstrated a statistically significant decrease in two measures.

Analysis identified that the greatest opportunity for improvement for the PD waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 77 percent compliance rate. The PD waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with an 80 percent compliance rate.

SLP Waiver

Ten performance measures were assessed for the SLP waiver. Analysis identified that the SLP waiver achieved a 90 percent or greater compliance rate in six of the 10 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the SLP waiver demonstrated a statistically significant decrease in two performance measures. When SFY 2022 performance was compared to SFY 2021 performance, the SLP waiver demonstrated a statistically significant decrease in two performance measures.

Analysis identified that the greatest opportunity for improvement for the SLP waiver related to Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 59 percent compliance rate. The SLP waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with an 81 percent compliance rate.

Performance was analyzed for the subset of SLP waiver members enrolled in the dementia care program. Results are shown in Table 3-1.

Table 3-1—SLP Dementia Care: Compliance With CMS Performance Measures

Measure	Measure Text	FY2019	FY2020	FY2021	FY2022
4A	*Overdue service plan was completed within 30 days of expected renewal.*	33% (1/3)	NA (0/0)	NA (0/0)	*
31D	*The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)	100% (28/28)	95% (77/81)
32D	*The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)	96% (27/28)	95% (77/81)
33D	*The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)	100% (28/28)	93% (75/81)
35D	*The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	92% (12/13)	73% (16/22)	100% (28/28)	41% (33/81)
37D	*The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	77% (10/13)	77% (17/22)	100% (28/28)	91% (74/81)
38D	*The service plan was updated when the enrollee needs changed.*	0% (0/1)	NA (0/0)	100% (3/3)	100% (2/2)
39D	*Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	92% (12/13)	100% (19/19)	100% 28/28)	97% (76/78)
41D	*The enrollee has been given the opportunity to participate in choosing types of services and providers.*	92% (12/13)	59% (13/22)	96% (27/28)	90% (73/81)
42G	*The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	92% (12/13)	55% (12/22)	93% (26/28)	89% (72/81)
DC1[1]	*Does the service plan include the need for delayed egress as a safety intervention?*				84% (42/50)

** Measure retired; not collected*

[1] New measure effective FY2022

Performance by Measure

Comparisons were also analyzed by performance measure. Trending analysis graphs are included in Appendix B.

Table 3-2—Analysis of CMS Performance Measure Compliance

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
20C *A PA evaluation was completed annually.*	This measure achieved a statistically significant increase from Q1 to Q4. Aetna and BCBSIL achieved a statistically significant increase from Q1 to Q4. The BI waiver achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, CountyCare and Molina achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, the HIV waiver achieved a statistically significant increase in SFY 2022.
31D/D1 *The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.*	This measure demonstrated stable performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Aetna demonstrated a statistically significant decrease in SFY 2022.
32D/D2 *The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).*	This measure demonstrated stable performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Molina achieved a statistically significant increase in SFY 2022.
33D/D3 *The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.*	This measure demonstrated stable performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Molina achieved a statistically significant increase in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
34D *(ELD waiver)* *The enrollee reported he/she received the services he/she needed when he/she needed them.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
35D *The most recent service plan includes signature of enrollee (or representative), case manager, and SLP provider (if applicable) and dates of signatures.*	This measure demonstrated a statistically significant decrease from Q1 to Q4. Compared to Q1, Aetna, CountyCare, Meridian, and Molina demonstrated a statistically significant rate decrease in Q4. Compared to Q1, the ELD, HIV, PD, and SLP waivers demonstrated a statistically significant rate decrease in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna, BCBSIL, CountyCare, and Meridian demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, all five waivers demonstrated a statistically significant decrease in SFY 2022.
36D/D6 *PD and ELD waiver—The case manager made contact every 90 days with the enrollee, or there is valid justification in the record.* *HIV waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.* *BI waiver—The case manager made valid contact with the enrollee at least once a month, or valid justification is documented in the enrollee's record.*	The evaluation criteria for this measure were revised in Q3 for the PD and ELD waivers to align contact requirements with contract language; therefore, statistical analysis could not be conducted for the SFY. Rates for all health plans significantly decreased after the evaluation criteria revision, indicating that the health plans were less successful in meeting 90-day time frames for PD and ELD waiver enrollees (previously assessed as annual contact).	Due to evaluation criteria changes in Q3 SFY 2022, historic data were not comparable and statistical analysis could not be completed.
37D/D7 *The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	This measure demonstrated a statistically significant decrease from Q1 to Q4. Compared to Q1, CountyCare and Meridian demonstrated a statistically significant rate decrease in this measure in Q4. Compared to Q1, the ELD and SLP waivers demonstrated a statistically	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna and CountyCare demonstrated a statistically significant rate decrease in this measure in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
	significant rate decrease in this measure in Q4.	Compared to SFY 2021, the ELD, HIV, and PD waivers demonstrated a statistically significant rate decrease in this measure in SFY 2022.
38D/D8 *The care/service plan was updated when the enrollee needs changed or upon enrollee request.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna demonstrated a statistically significant rate decrease in this measure in SFY 2022.
39D/D9 *Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.*	This measure achieved a statistically significant increase from Q1 to Q4. Compared to Q1, Aetna achieved a statistically significant rate increase in Q4. Compared to Q1, the BI and PD waivers realized a statistically significant rate increase in Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, BCBSIL achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, Meridian demonstrated a statistically significant rate decrease in this measure in SFY 2022. Compared to SFY 2021, the BI waiver realized a statistically significant rate increase in this measure in SFY 2022.
40D *(ELD waiver)* *The enrollee reported he/she received all services listed in the plan of care.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
41D/D10 *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	This measure demonstrated stable performance from Q1 to Q4. BCBSIL realized a statistically significant rate increase from Q1 to Q4. The ELD waiver realized a statistically significant rate increase from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Molina achieved a statistically significant rate increase in this measure in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
42G/G1 *The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	This measure demonstrated stable performance from Q1 to Q4. Compared to Q1, CountyCare demonstrated a statistically significant rate decrease in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna demonstrated a statistically significant decrease in this measure in SFY 2022. Compared to SFY 2021, the SLP waiver demonstrated a statistically significant decrease in this measure in SFY 2022.
44C *The enrollee reported satisfaction with his/her PA.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Meridian achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, the PD waiver achieved a statistically significant rate increase in this measure in SFY 2022.
44G/G7 *(ELD waiver)* *The enrollee reported he/she was being treated well by direct support staff.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
49G/D4 *(ELD, BI, HIV, and PD waivers)* *The most recent service plan includes a backup plan that includes the name of the backup.*	This measure achieved a statistically significant increase from Q1 to Q4. Aetna realized a statistically significant rate increase in performance from Q1 to Q4. Compared to Q1, the PD waiver realized a statistically significant rate increase in performance in Q4.	Compared to SFY 2021, this measure achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, Molina achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, the BI waiver realized a statistically significant rate increase in this measure in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
A5 *(ELD and PD waivers)* *Does the enrollee report the ADS facilitates independent choice while attending ADS?*	There were no cases eligible for this measure during FY2022.	Not applicable; new measure effective FY2022.
A5-ELD *(ELD waiver)* *Does the enrollee report participation in meaningful activities that help meet their goals/needs?*	New measure effective Q4 FY2022.	Not applicable; new measure effective FY2022.
A6-SIGN *(ELD and PD waivers)* *Was the enrollee provided choice of directing services received at the ADS setting?*	There were no cases eligible for this measure during FY2022.	Not applicable; new measure effective FY2022.
A6-SUPP *(ELD and PD waivers)* *Did the enrollee report he/she feels supported in making decisions to remain independent?*	There were no cases eligible for this measure during FY2022.	Not applicable; new measure effective FY2022.
G8 *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?*	New measure effective Q4 FY2022.	Not applicable; new measure effective FY2022.

Analysis of Lowest-Scoring Measures

The health plans had the greatest opportunities for improvement related to the following performance measures:

- Measure D6, *the case manager made timely contact with the enrollee, or there is valid justification in the record*, which averaged a 73 percent compliance rate.
- Measure D7, *the most recent service plan is in the record and completed in a timely manner*, which averaged an 84 percent compliance rate.
- Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, which averaged a compliance rate of 82 percent.

Measure D6

Overall compliance rates on Measure D6 averaged 73 percent. In Q3 FY2022, evaluation criteria for this measure for the PD and ELD waivers were aligned with contract language, requiring enrollee contact

every 90 days; historic performance for the PD and ELD waivers measured enrollee contact once annually. When compliance with contact every 90 days was compared to annual contact, the health plans performed worse, indicating that the health plans were less successful in contacting the enrollee every 90 days than annually.

Each waiver type has a different requirement for contact, ranging from once a month to annually. A health plan may be more successful maintaining annual contact rather than monthly contact; as a result, performance in D6 can be significantly different across waivers. The greater frequency of contact for the BI and HIV waivers may result in lower performance.

Health plans should conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads. In addition, health plans should ensure that audit processes for the PD and ELD waivers measure performance against contract (and now waiver) requirements, and that case managers are held accountable to meeting contact standards for enrollees in the PD and ELD waivers.

Measure D7

Measure D7 collects information related to the health plan's success in completing annual service plan documentation in a timely manner.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual service plans in a timely manner. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely completion of service plans. Health plans should review COVID-19 PHE processes to ensure that case managers are knowledgeable of documentation requirements related to annual service plan completion.

Measure 35D

Measure 35D collects information related to the health plan's success in obtaining the enrollee's signature on the most recent service plan. In calendar year (CY) 2020, HFS provided guidance to the health plans regarding obtaining verbal consent on service plan renewals due to restrictions from the COVID-19 PHE, including requirements for documentation of witnessed verbal consent. As COVID-19 restrictions have not been lifted, the HCBS record reviews evaluate the health plans' success in documenting witnessed verbal consent for those enrollees unable to be visited at home.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals and witnessed verbal consent indicating a signature on the service plan.

Remediation and Remediation Validation

Remediation

As a result of the on-site reviews, HSAG identified noncompliant performance measures. The health plans received their individualized report of findings subsequent to each on-site record review and were required to remediate the noncompliant findings and implement performance improvement strategies to improve the quality of care management/care coordination activities for the waiver enrollees.

Remediation actions were defined in the HealthChoice contract and were specific to each CMS waiver performance measure. The time frame for remediation of findings was 60 days, except for two measures, G1 and D4, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. HSAG monitored compliance with timely remediation of these findings through review of completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2022, all health plans demonstrated full compliance with completion of remediation action documentation for all noncompliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semiannually to determine if health plans had appropriately completed remediation actions. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed. Table 3-3 indicates the number of cases reviewed per health plan for HealthChoice, and Table 3-4 indicates the number of cases reviewed per health plan for MLTSS.

Table 3-3—Health Plan Remediation Validation Review Totals: HealthChoice

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Aetna	12/12	11/12
BCBSIL	13/13	6/6
CountyCare	18/18	18/18
Meridian	11/11	13/13
Molina	10/10	9/9

Table 3-4—Health Plan Remediation Validation Review Totals: MLTSS

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Aetna	12/12	12/13

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	9/9	12/12
CountyCare	14/14	14/14
Meridian	13/13	9/10
Molina	12/12	7/7

All health plans received their remediation sample 10 days prior to on-site remediation validation review and were responsible for ensuring all necessary remediation documentation was available during the on-site review. Remediation validation included review of each record in the sample and supporting documentation, to ensure the action taken and completion date documented in the remediation tracking database were consistent with the information in the health plan's care management record and/or staff training records.

Overall remediation validation among the five HealthChoice health plan cases averaged 99 percent. Four of the five health plans demonstrated 100 percent compliance with remediation validation. Aetna did not achieve 100 percent compliance; noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Overall remediation validation among the five MLTSS health plans with remediation validation cases averaged 99 percent. Three of the five health plans achieved 100 percent compliance with remediation validation. Aetna and Meridian did not achieve 100 percent compliance; noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2023 and will include review of any records that were found to be not fully remediated during the SFY 2022 reviews.

Appendix A. CMS Performance Measures Description

Table A-1 provides a description of each CMS performance measure, including the identification of waiver-specific measures. Due to HFS performance measure numbering alignment across waivers, measure numbers are listed with their CY 2022 measure number for historic tracking.

Table A-1—CMS Waiver Performance Measure Descriptions

Historic Measure #	Measure # CY 2022	Measure Description
20C	**20C**	A PA evaluation was completed annually. Captured for only enrollees with PA service
31D	**D1**	The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.
32D	**D2**	The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).
33D	**D3**	The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.
34D	**34D**	The enrollee reported he/she received the services he/she needed when he/she needed them. ELD waiver only
35D	**35D**	The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.
36D	**D6**	PD and ELD waivers—The case manager made valid contact with the enrollee every 90 days, or valid justification is documented in the enrollee's record.
		HIV waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.
		BI waiver—The case manager made valid contact with the enrollee at least one time a month, or valid justification is documented in the enrollee's record.
37D	**D7**	The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
38D	**D8**	The service plan was updated when the enrollee needs changed or upon enrollee request.
39D	**D9**	Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.
40D	**40D**	The enrollee reported he/she received all services listed in the plan of care. ELD waiver only

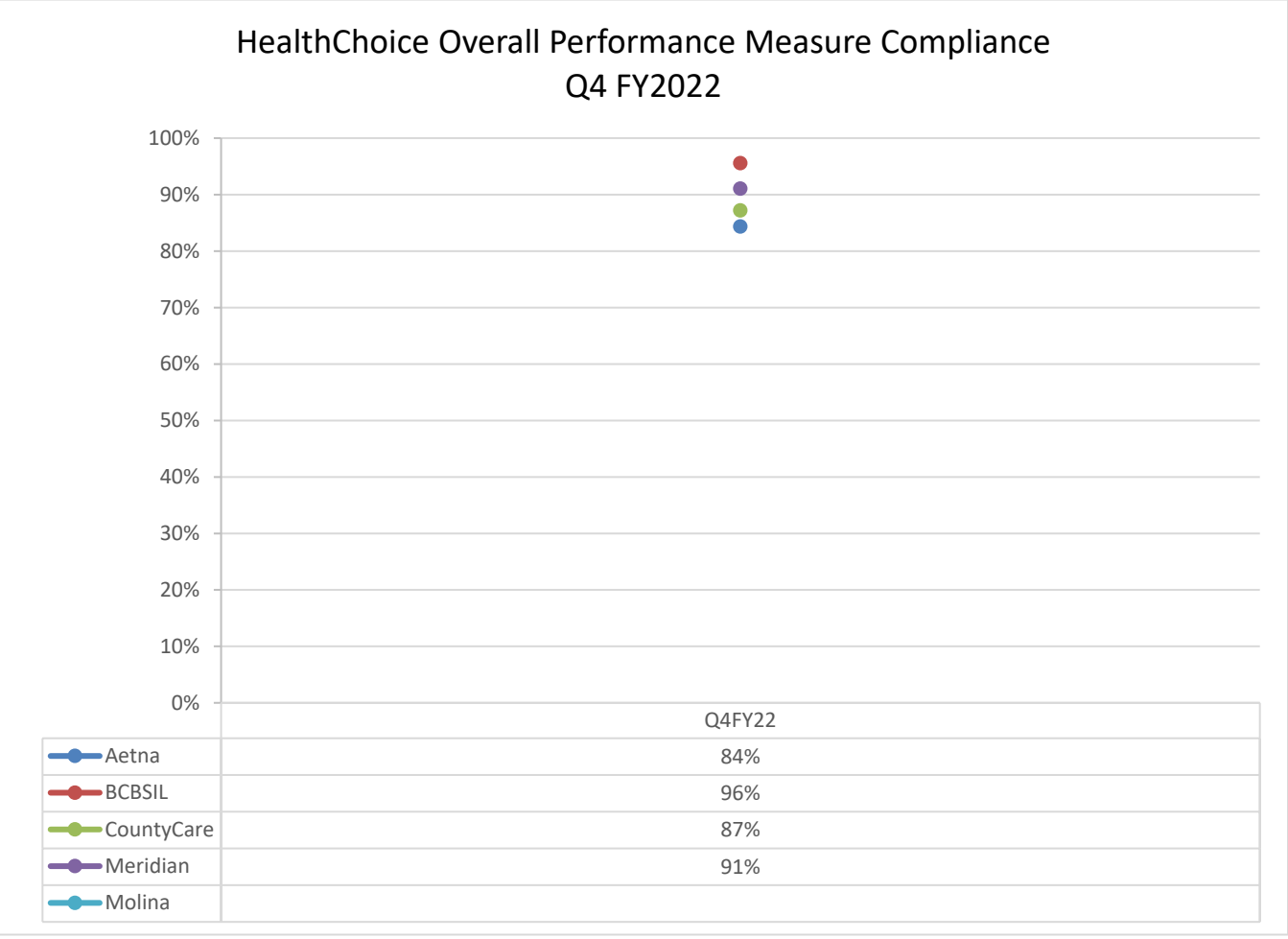
Historic Measure #	Measure # CY 2022	Measure Description
41D	**D10**	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	**G1**	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
44C	**44C**	The enrollee reported satisfaction with his/her PA. Captured only for enrollees with PA service
44G	**G7**	The enrollee reported he/she was being treated well by direct support staff. ELD waiver only
49G	**D4**	Most recent Service Plan includes a backup plan that includes the name of the backup. ELD, BI, HIV, and PD waivers only
Not collected prior to 2022	**A5**	Does the enrollee report the ADS facilitates independent choice while attending ADS? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**A5-ELD**	Does the enrollee report participation in meaningful activities that help meet their goals/needs? Captured only for ELD waiver enrollees receiving ADS
Not collected prior to 2022	**A6-SIGN**	Was the enrollee provided choice of directing services received at the ADS setting? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**A6-SUPP**	Did the enrollee report he/she feels supported in making decisions to remain independent? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**G8**	Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?

Appendix B. Performance Trending—HealthChoice

Overall Trend Performance

Figure B-1 displays a computed average of the performance achieved by each health plan on all 21 CMS waiver performance measures reviewed by HSAG. Due to an increase in the number of performance measures collected beginning Q4 FY2022, historic data are not comparable and only data beginning Q4 FY2022 are displayed.

Figure B-1—Overall Compliance



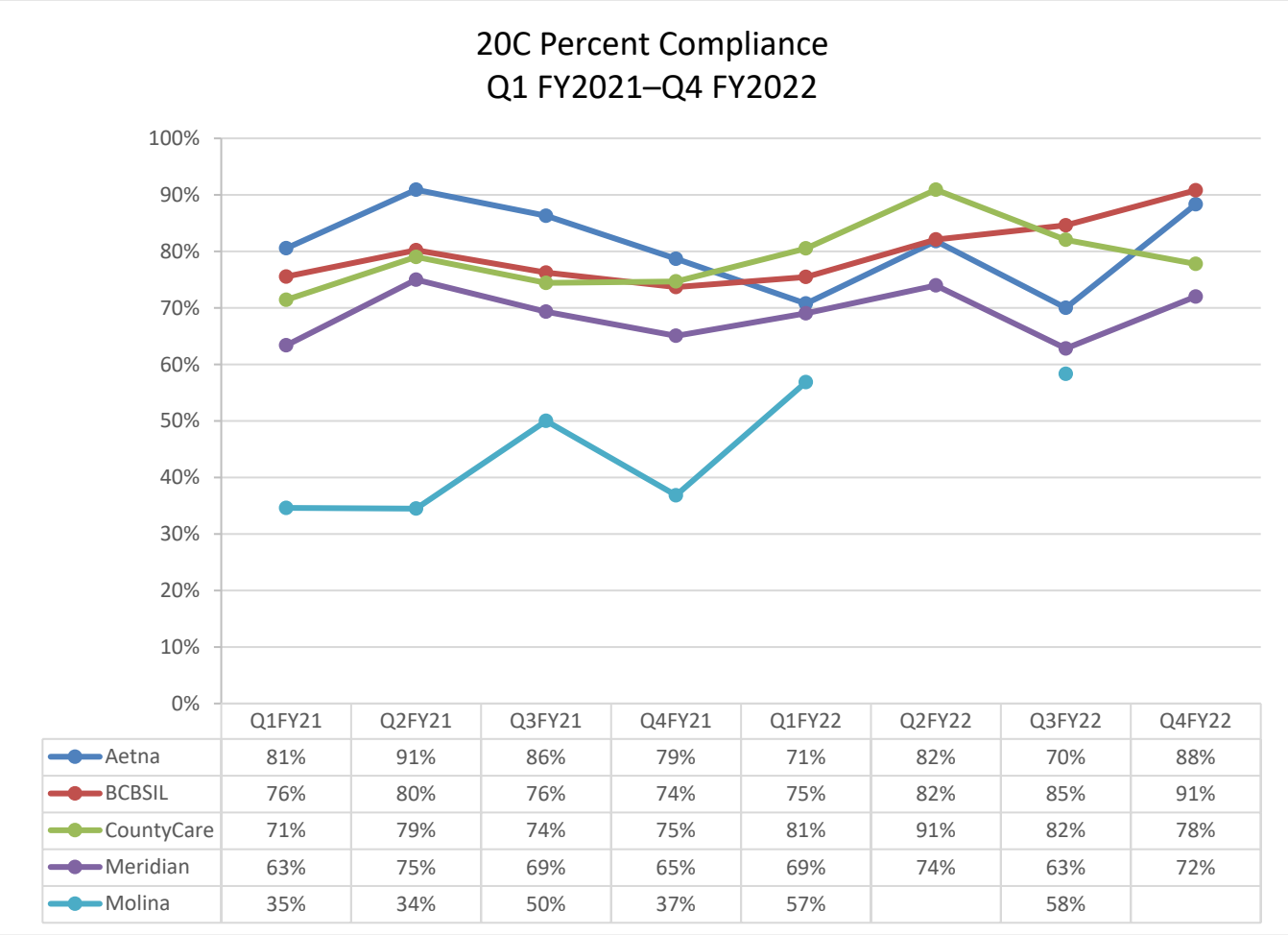
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Performance Measure Findings

Measure 20C—A PA evaluation was completed annually.

New measure beginning FY2021. Captured only for enrollees with PA service.

Figure B-2—Measure 20C

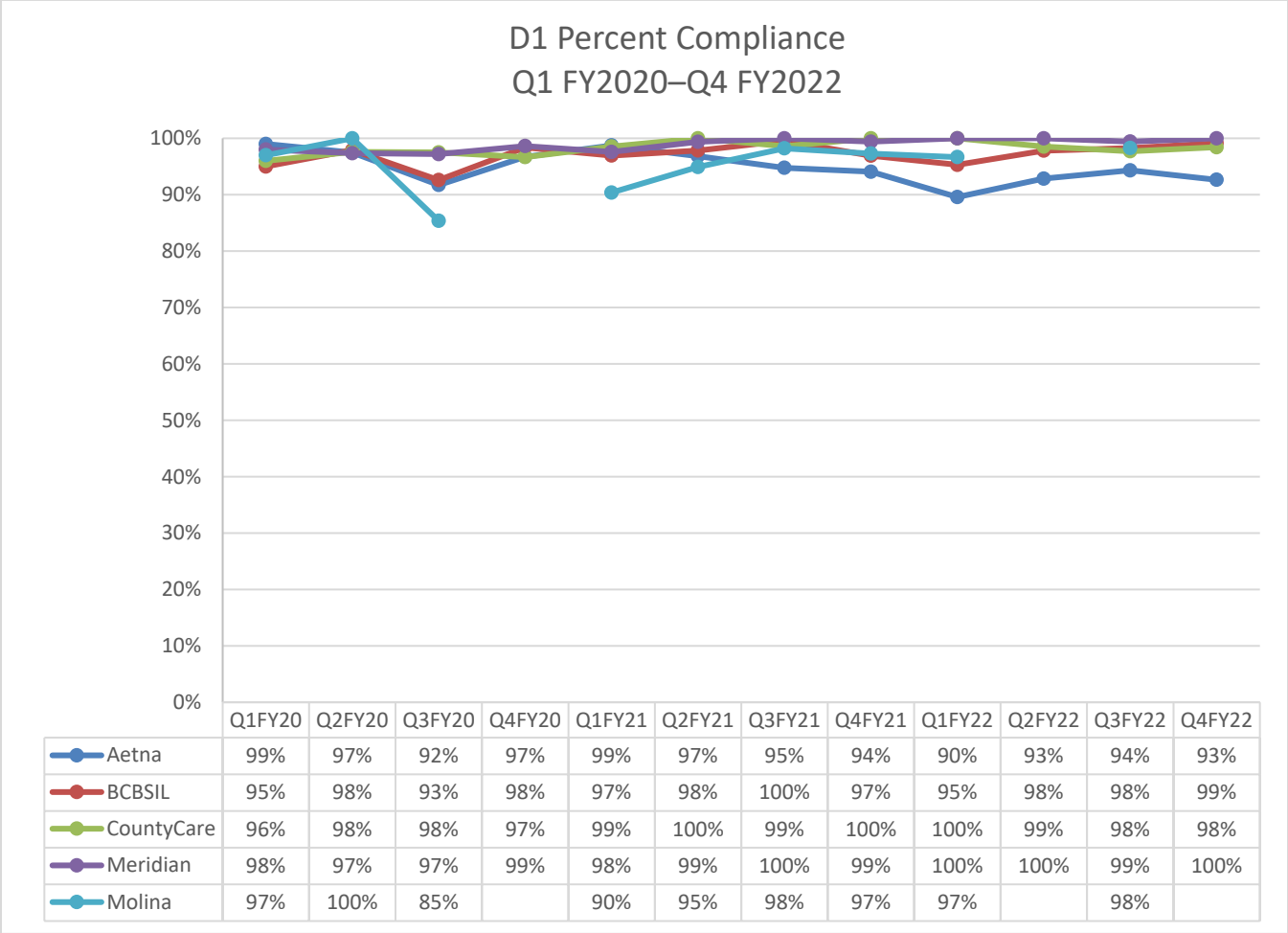


	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	81%	91%	86%	79%	71%	82%	70%	88%
BCBSIL	76%	80%	76%	74%	75%	82%	85%	91%
CountyCare	71%	79%	74%	75%	81%	91%	82%	78%
Meridian	63%	75%	69%	65%	69%	74%	63%	72%
Molina	35%	34%	50%	37%	57%		58%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure D1—The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.

Figure B-3—Measure D1

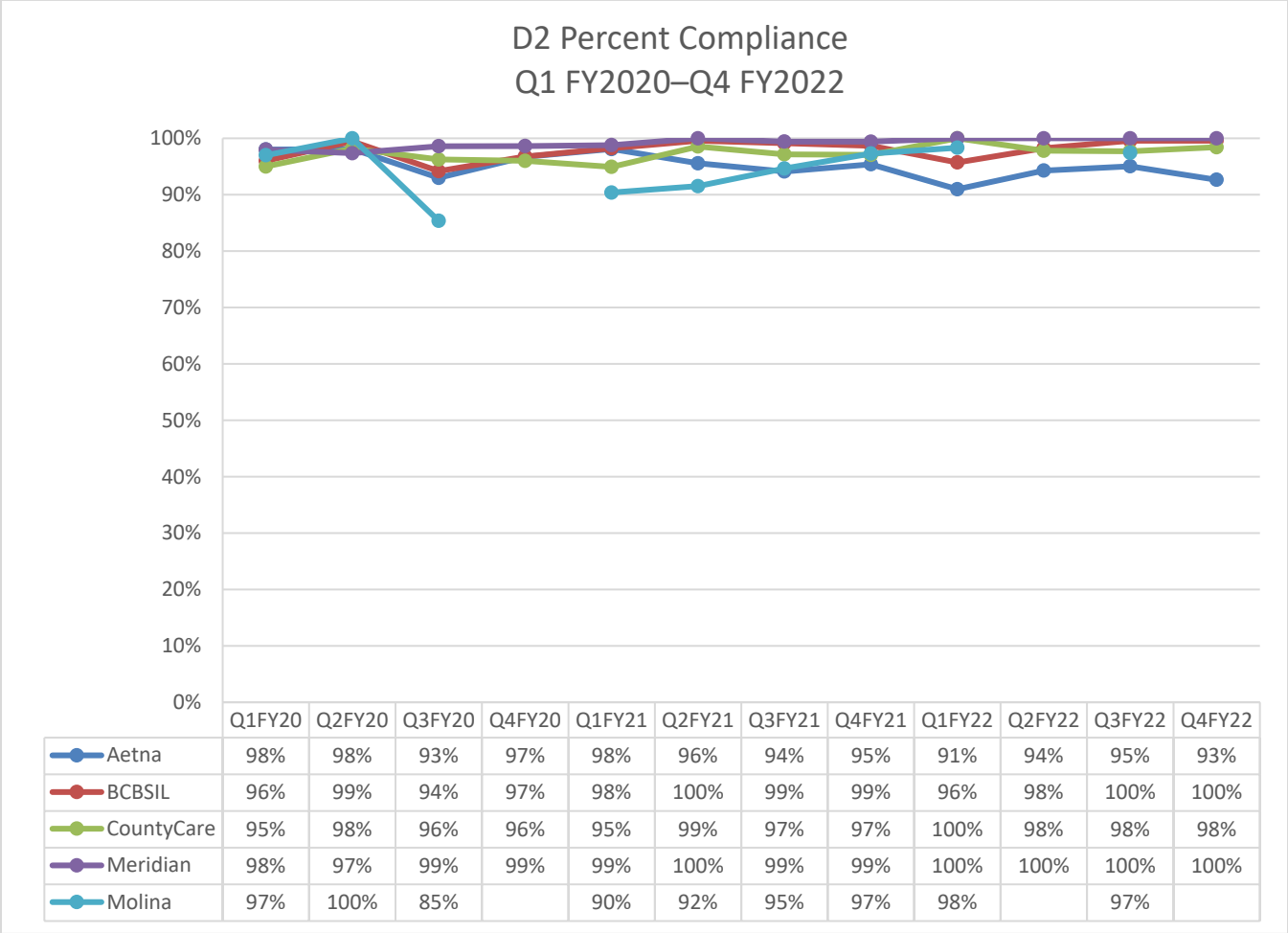


	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	99%	97%	92%	97%	99%	97%	95%	94%	90%	93%	94%	93%
BCBSIL	95%	98%	93%	98%	97%	98%	100%	97%	95%	98%	98%	99%
CountyCare	96%	98%	98%	97%	99%	100%	99%	100%	100%	99%	98%	98%
Meridian	98%	97%	97%	99%	98%	99%	100%	99%	100%	100%	99%	100%
Molina	97%	100%	85%		90%	95%	98%	97%	97%		98%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to FY2020 are available in previous years' reports.

Measure D2—The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).

Figure B-4—Measure D2

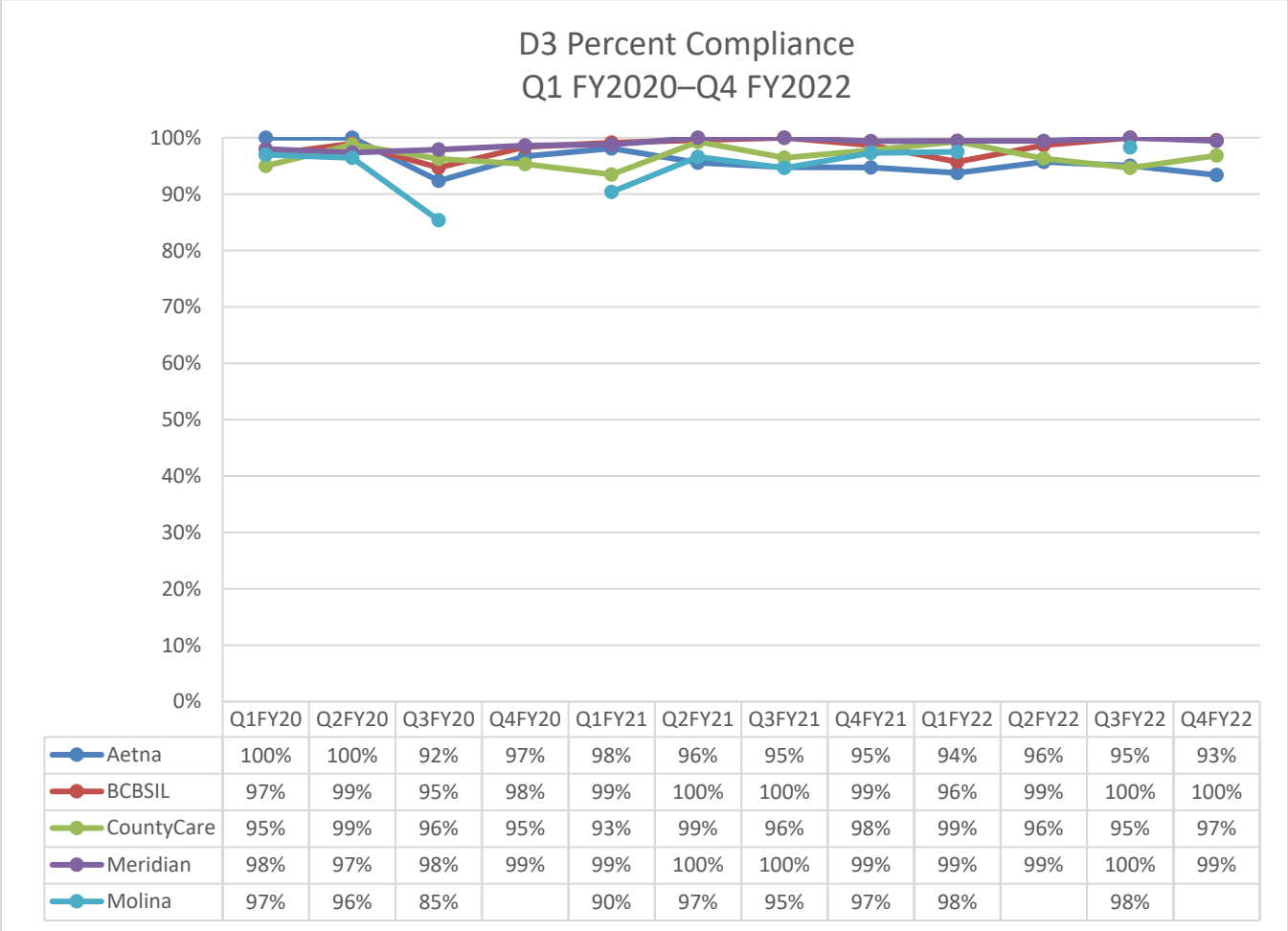


	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	98%	98%	93%	97%	98%	96%	94%	95%	91%	94%	95%	93%
BCBSIL	96%	99%	94%	97%	98%	100%	99%	99%	96%	98%	100%	100%
CountyCare	95%	98%	96%	96%	95%	99%	97%	97%	100%	98%	98%	98%
Meridian	98%	97%	99%	99%	99%	100%	99%	99%	100%	100%	100%	100%
Molina	97%	100%	85%		90%	92%	95%	97%	98%		97%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to FY2020 are available in previous years' reports.

Measure D3—The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.

Figure B-5—Measure D3

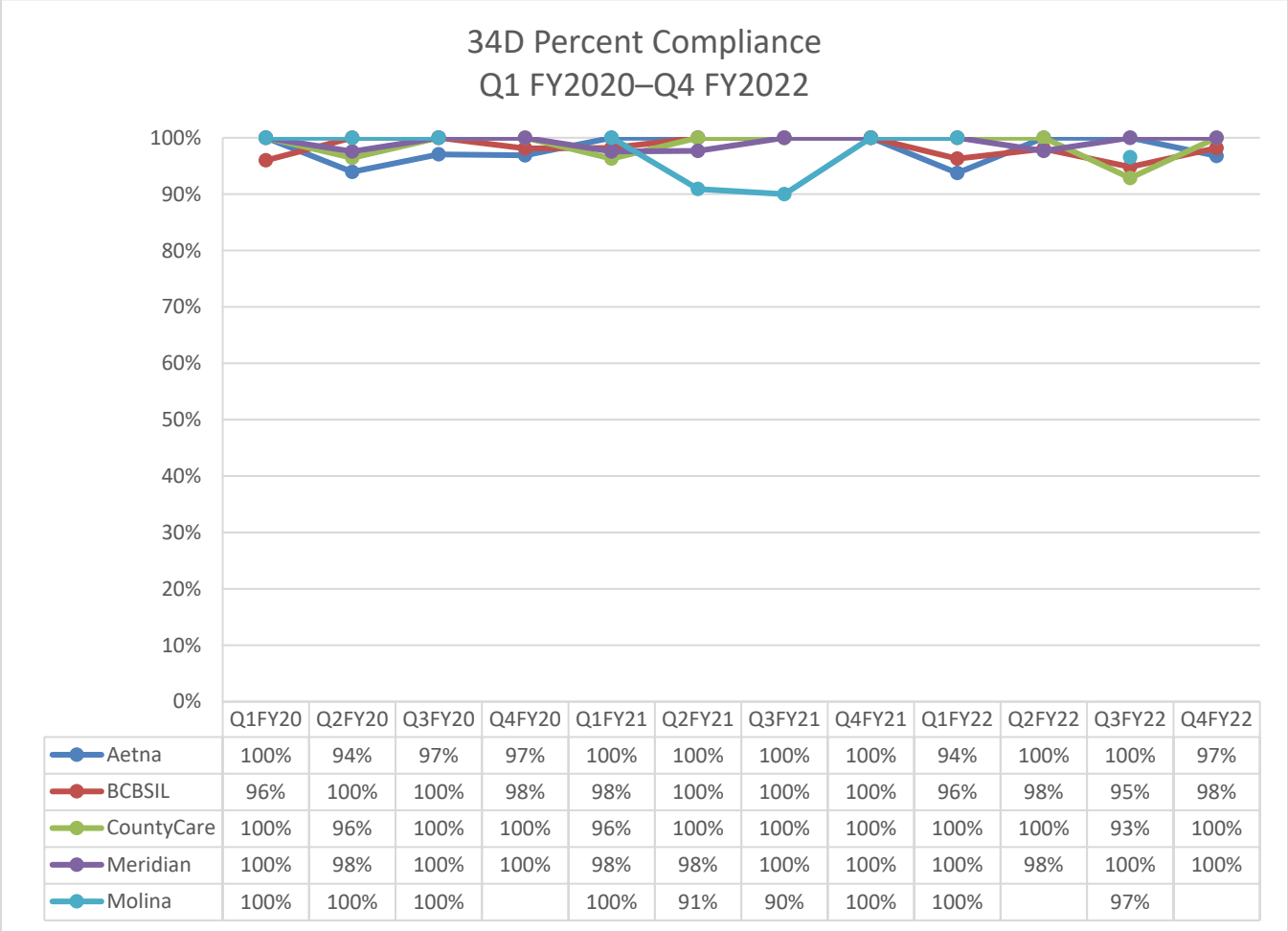


	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	100%	100%	92%	97%	98%	96%	95%	95%	94%	96%	95%	93%
BCBSIL	97%	99%	95%	98%	99%	100%	100%	99%	96%	99%	100%	100%
CountyCare	95%	99%	96%	95%	93%	99%	96%	98%	99%	96%	95%	97%
Meridian	98%	97%	98%	99%	99%	100%	100%	99%	99%	99%	100%	99%
Molina	97%	96%	85%		90%	97%	95%	97%	98%		98%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to FY2020 are available in previous years' reports.

Measure 34D—The enrollee reported he/she received the services he/she needed when he/she needed them. (ELD waiver only)

Figure B-6—Measure 34D

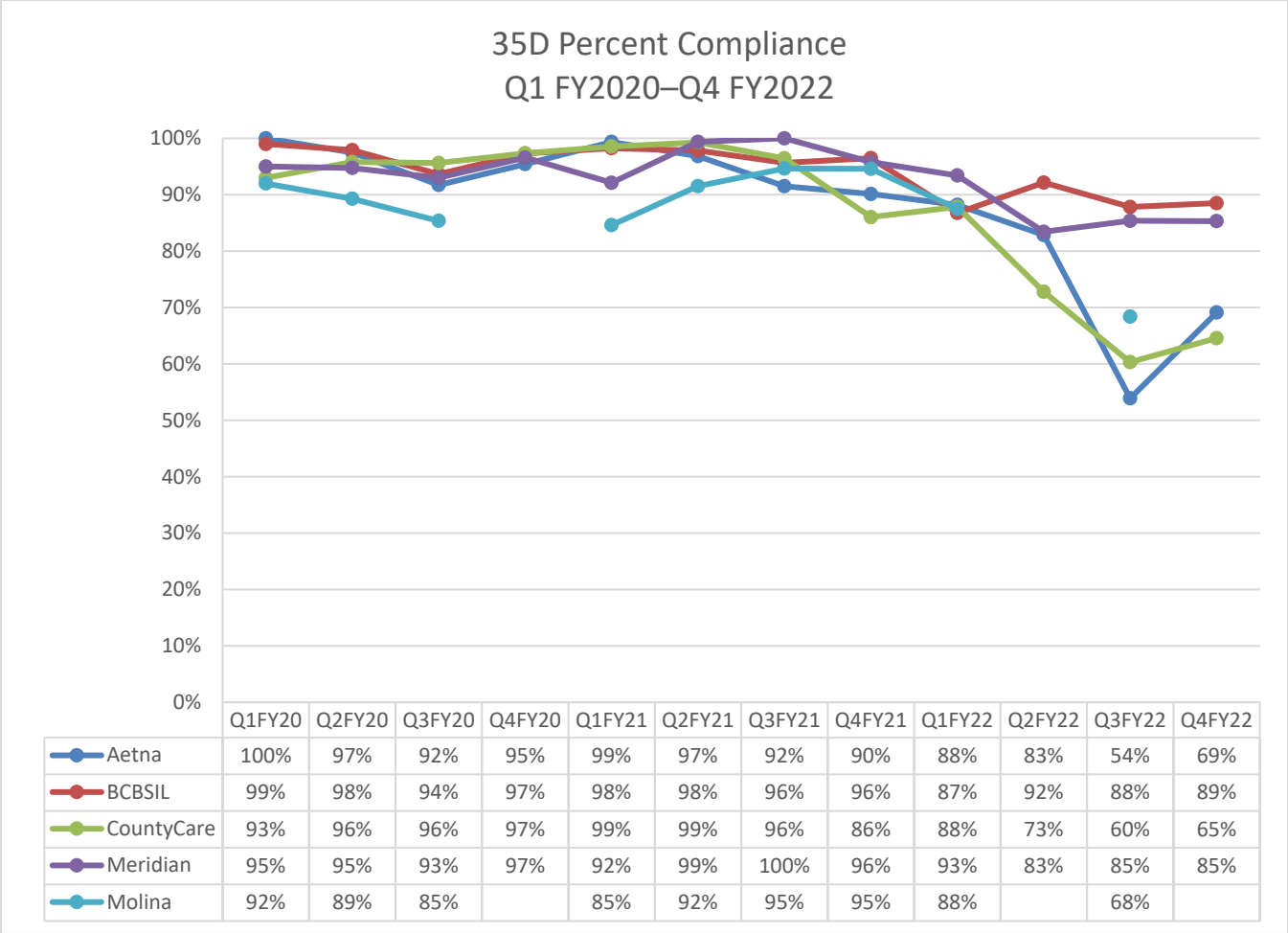


	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	100%	94%	97%	97%	100%	100%	100%	100%	94%	100%	100%	97%
BCBSIL	96%	100%	100%	98%	98%	100%	100%	100%	96%	98%	95%	98%
CountyCare	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%	93%	100%
Meridian	100%	98%	100%	100%	98%	98%	100%	100%	100%	98%	100%	100%
Molina	100%	100%	100%		100%	91%	90%	100%	100%		97%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to FY2020 are available in previous years' reports.

Measure 35D—The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.

Figure B-7—Measure 35D



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	100%	97%	92%	95%	99%	97%	92%	90%	88%	83%	54%	69%
BCBSIL	99%	98%	94%	97%	98%	98%	96%	96%	87%	92%	88%	89%
CountyCare	93%	96%	96%	97%	99%	99%	96%	86%	88%	73%	60%	65%
Meridian	95%	95%	93%	97%	92%	99%	100%	96%	93%	83%	85%	85%
Molina	92%	89%	85%		85%	92%	95%	95%	88%		68%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

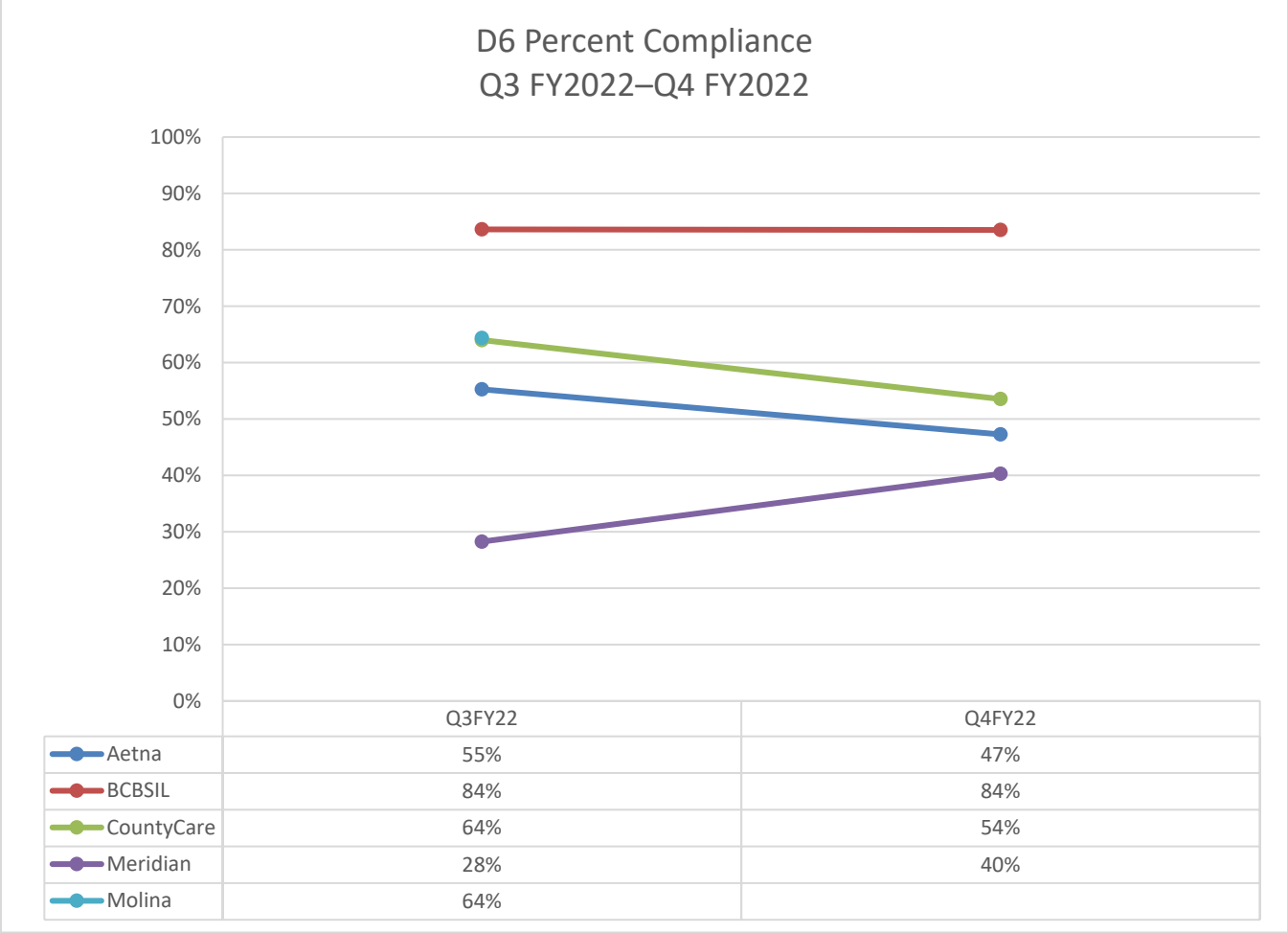
Data prior to FY2020 are available in previous years' reports.

Measure D6—The case manager made valid timely contact, or valid justification is documented in the enrollee's record.

HIV: One contact per month, with one contact face-to-face bimonthly.
BI: Monthly contact.
PD: Contact every 90 days.
ELD: Contact every 90 days.
SLP records are ineligible for this measure.

Due to the change in evaluation criteria for the PD and ELD waivers beginning Q3 FY2022, historic data are not comparable and only data beginning Q3 FY2022 are displayed.

Figure B-8—Measure D6

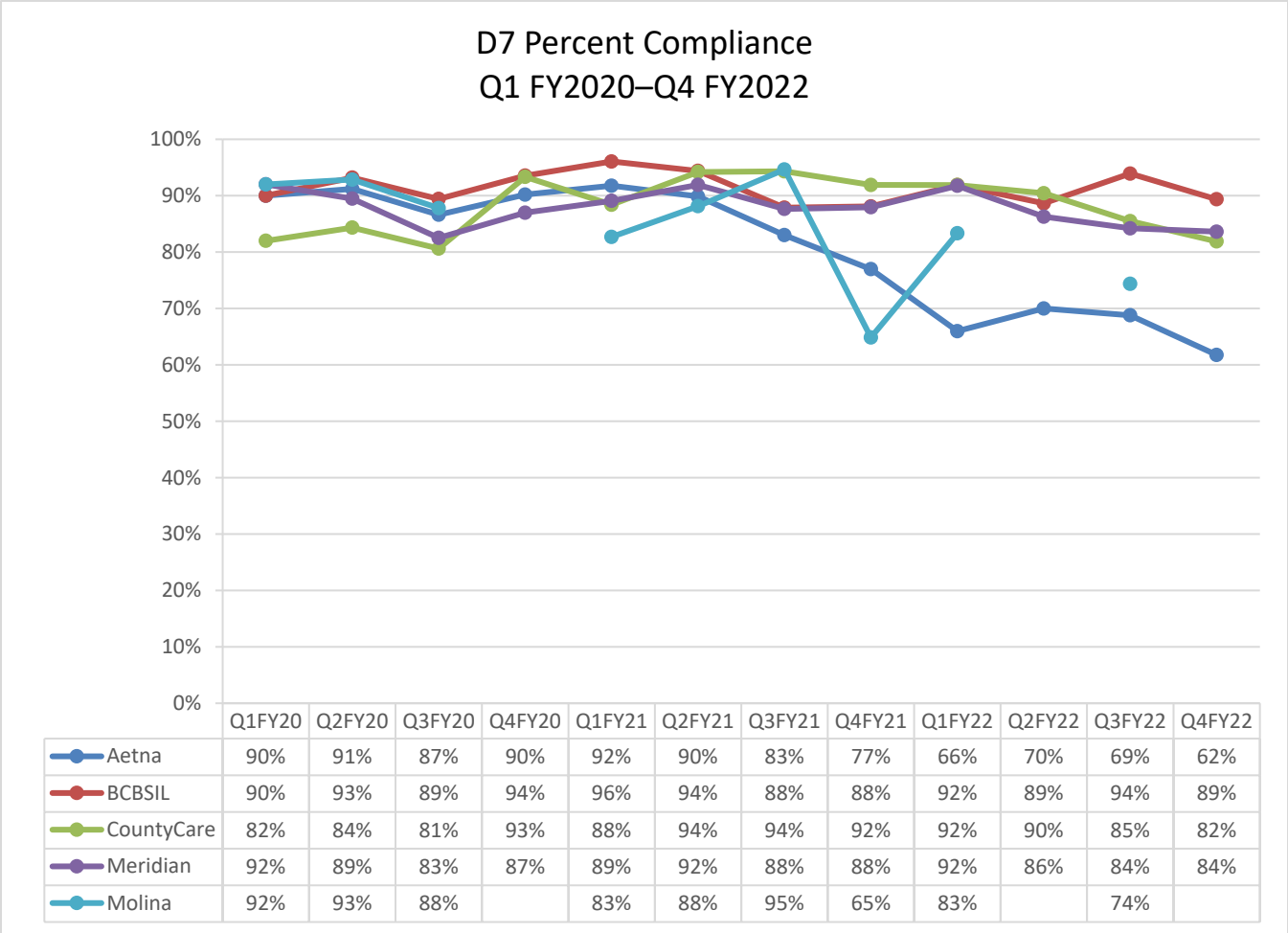


	Q3FY22	Q4FY22
Aetna	55%	47%
BCBSIL	84%	84%
CountyCare	64%	54%
Meridian	28%	40%
Molina	64%	

Measure D7—The most recent service plan is in the record and completed in a timely manner (annually).

Due to changes in performance measure definitions in FY2020, historic data are not comparable and only FY2020 to current data are displayed.

Figure B-9—Measure D7



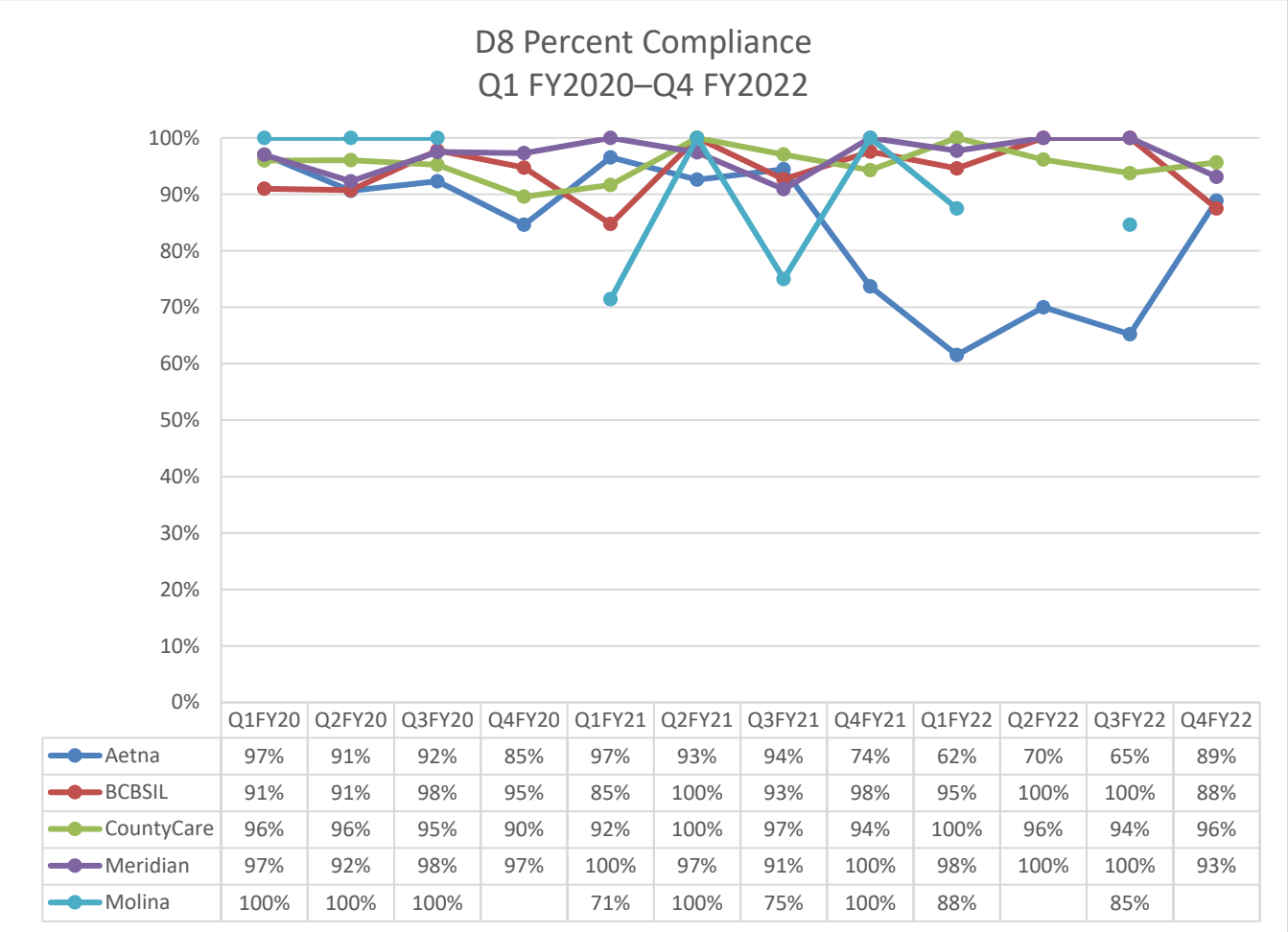
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	90%	91%	87%	90%	92%	90%	83%	77%	66%	70%	69%	62%
BCBSIL	90%	93%	89%	94%	96%	94%	88%	88%	92%	89%	94%	89%
CountyCare	82%	84%	81%	93%	88%	94%	94%	92%	92%	90%	85%	82%
Meridian	92%	89%	83%	87%	89%	92%	88%	88%	92%	86%	84%	84%
Molina	92%	93%	88%		83%	88%	95%	65%	83%		74%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D8—The service plan was updated when the enrollee needs changed or upon enrollee request.

Figure B-10—Measure D8



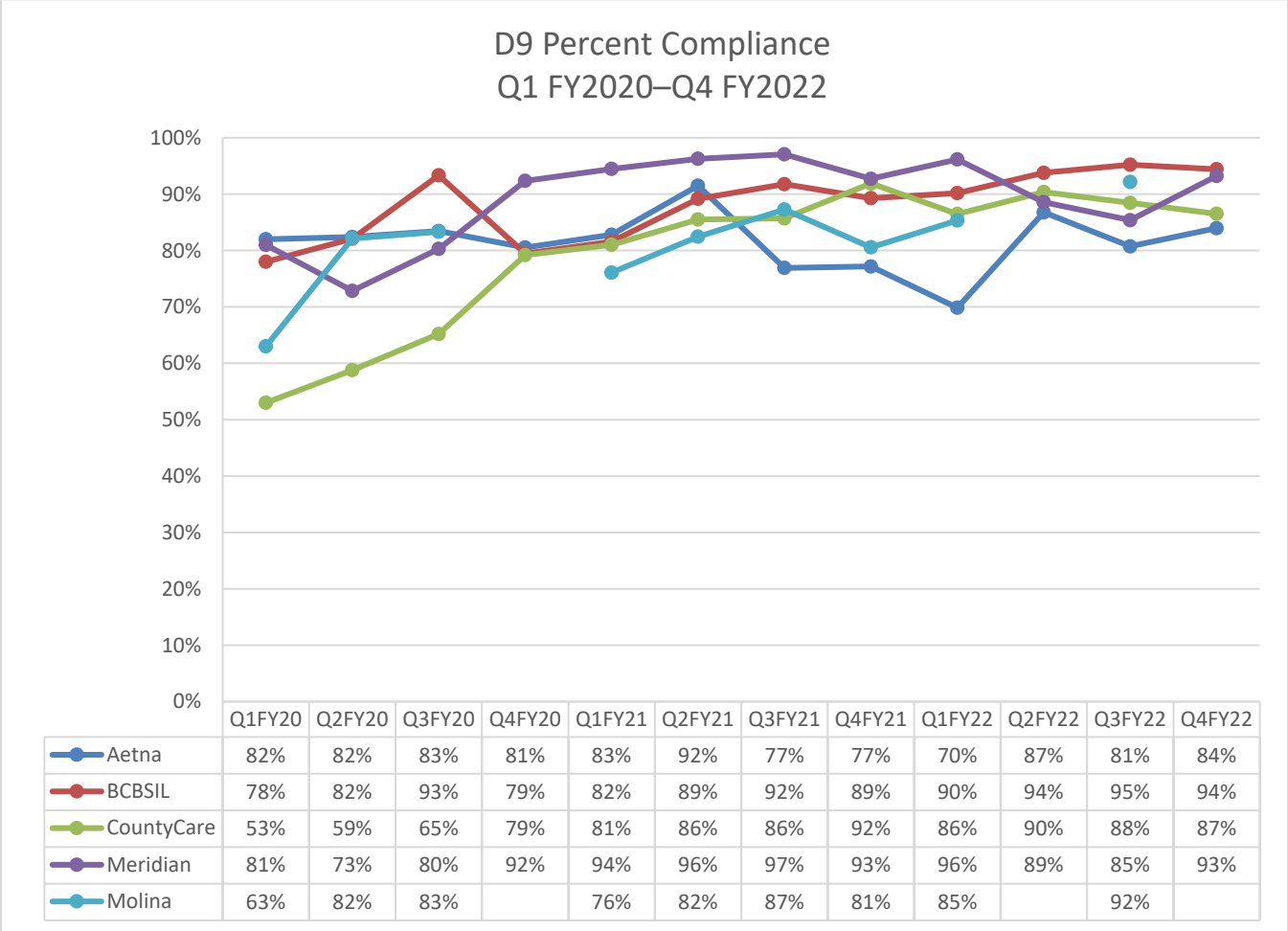
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	97%	91%	92%	85%	97%	93%	94%	74%	62%	70%	65%	89%
BCBSIL	91%	91%	98%	95%	85%	100%	93%	98%	95%	100%	100%	88%
CountyCare	96%	96%	95%	90%	92%	100%	97%	94%	100%	96%	94%	96%
Meridian	97%	92%	98%	97%	100%	97%	91%	100%	98%	100%	100%	93%
Molina	100%	100%	100%		71%	100%	75%	100%	88%		85%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D9—Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.

Figure B-11—Measure D9



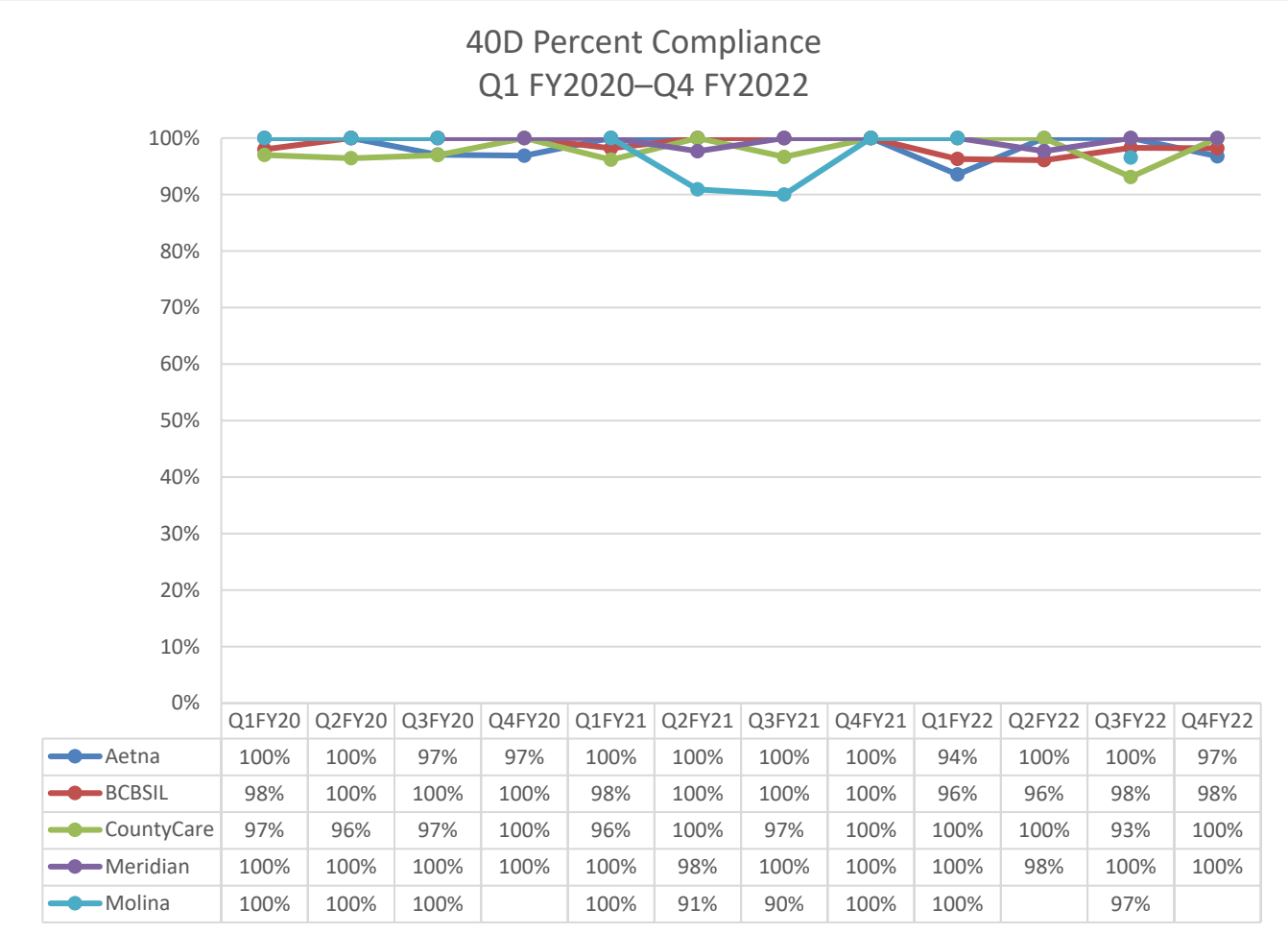
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	82%	82%	83%	81%	83%	92%	77%	77%	70%	87%	81%	84%
BCBSIL	78%	82%	93%	79%	82%	89%	92%	89%	90%	94%	95%	94%
CountyCare	53%	59%	65%	79%	81%	86%	86%	92%	86%	90%	88%	87%
Meridian	81%	73%	80%	92%	94%	96%	97%	93%	96%	89%	85%	93%
Molina	63%	82%	83%		76%	82%	87%	81%	85%		92%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure 40D—The enrollee reported he/she received all services listed in the plan of care. (ELD waiver only)

Figure B-12—Measure 40D



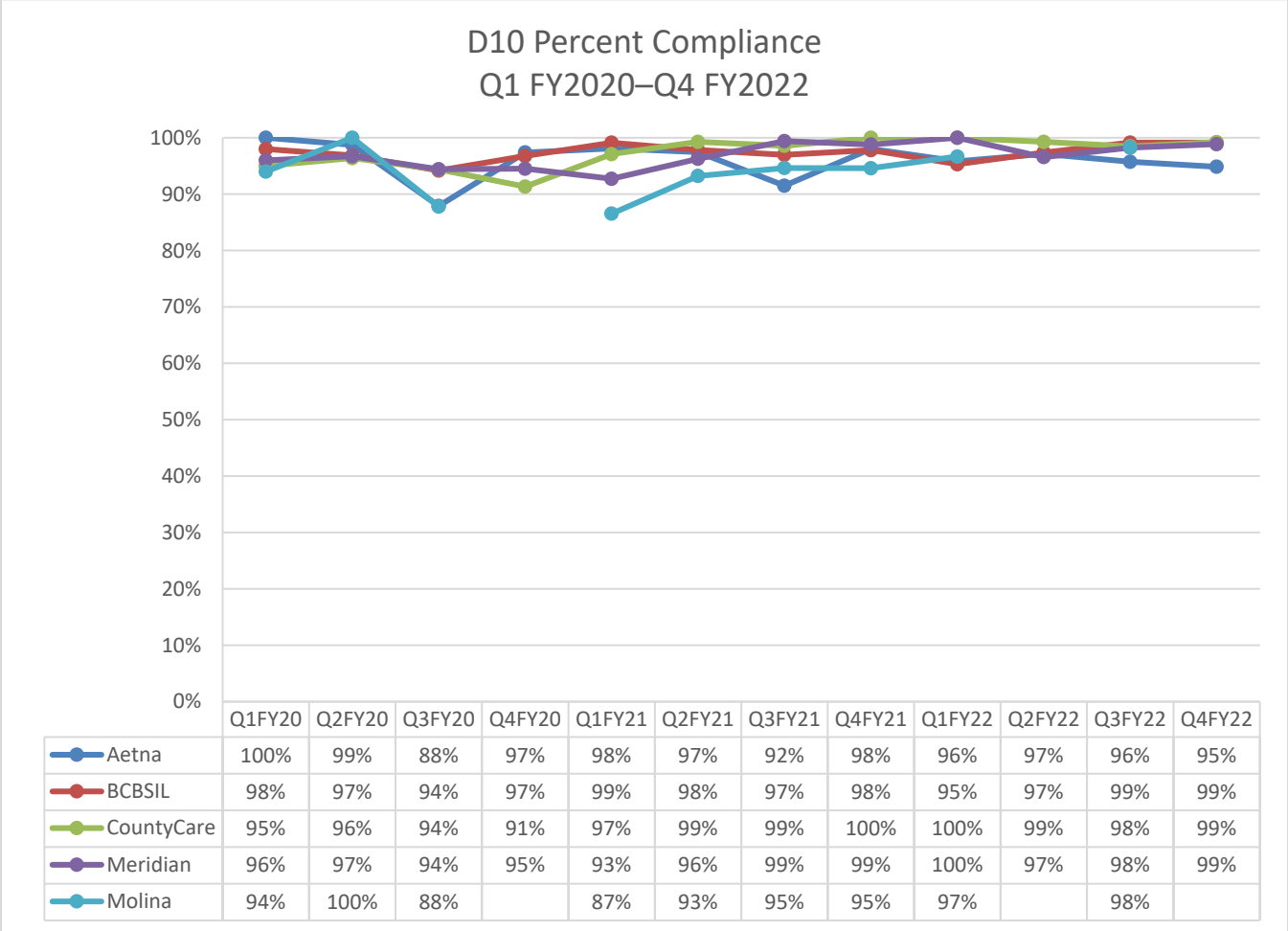
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	100%	100%	97%	97%	100%	100%	100%	100%	94%	100%	100%	97%
BCBSIL	98%	100%	100%	100%	98%	100%	100%	100%	96%	96%	98%	98%
CountyCare	97%	96%	97%	100%	96%	100%	97%	100%	100%	100%	93%	100%
Meridian	100%	100%	100%	100%	100%	98%	100%	100%	100%	98%	100%	100%
Molina	100%	100%	100%		100%	91%	90%	100%	100%		97%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D10—The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B-13—Measure D10



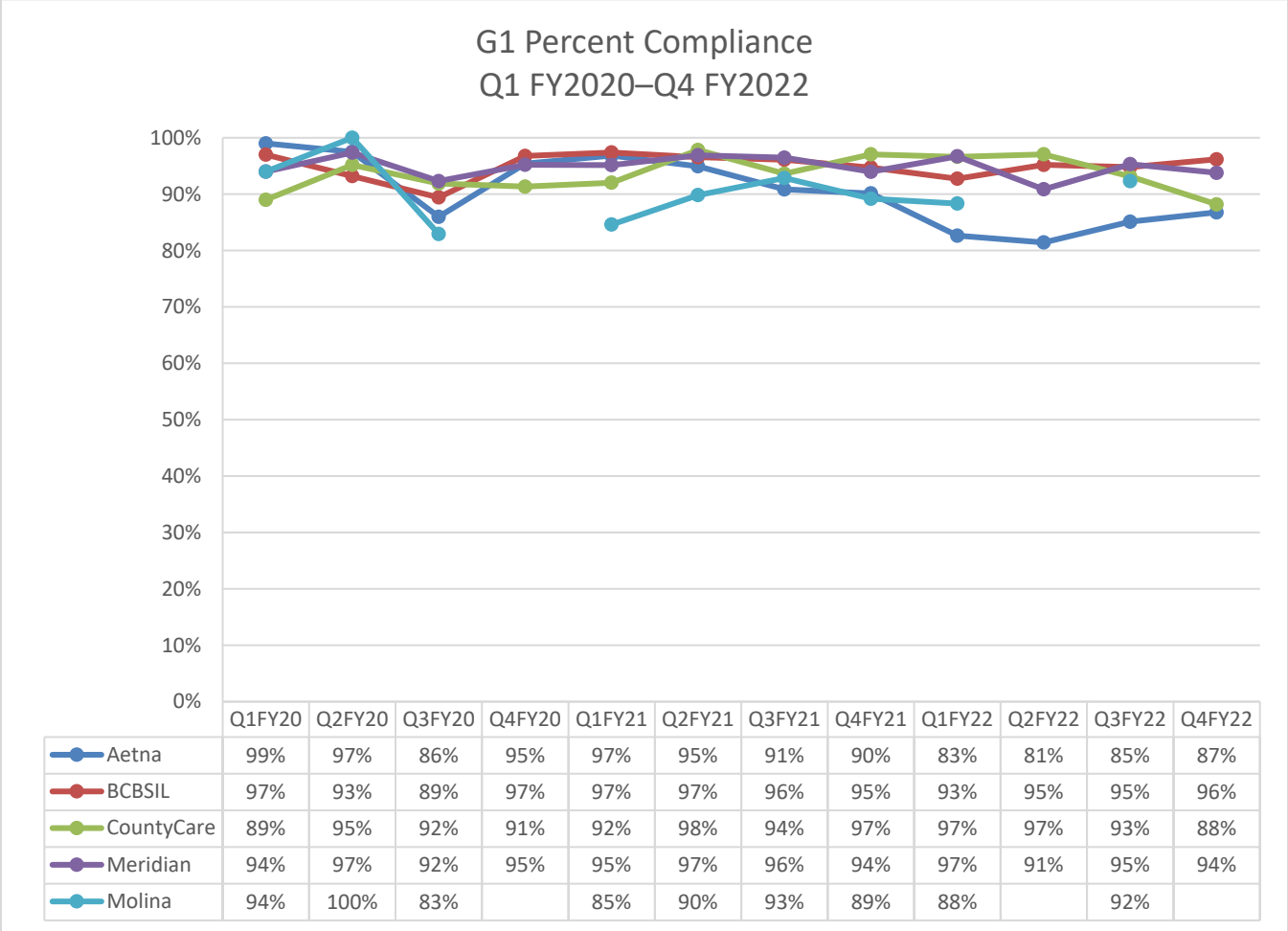
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	100%	99%	88%	97%	98%	97%	92%	98%	96%	97%	96%	95%
BCBSIL	98%	97%	94%	97%	99%	98%	97%	98%	95%	97%	99%	99%
CountyCare	95%	96%	94%	91%	97%	99%	99%	100%	100%	99%	98%	99%
Meridian	96%	97%	94%	95%	93%	96%	99%	99%	100%	97%	98%	99%
Molina	94%	100%	88%		87%	93%	95%	95%	97%		98%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure G1—The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.

Figure B-14—Measure G1



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	99%	97%	86%	95%	97%	95%	91%	90%	83%	81%	85%	87%
BCBSIL	97%	93%	89%	97%	97%	97%	96%	95%	93%	95%	95%	96%
CountyCare	89%	95%	92%	91%	92%	98%	94%	97%	97%	97%	93%	88%
Meridian	94%	97%	92%	95%	95%	97%	96%	94%	97%	91%	95%	94%
Molina	94%	100%	83%		85%	90%	93%	89%	88%		92%	

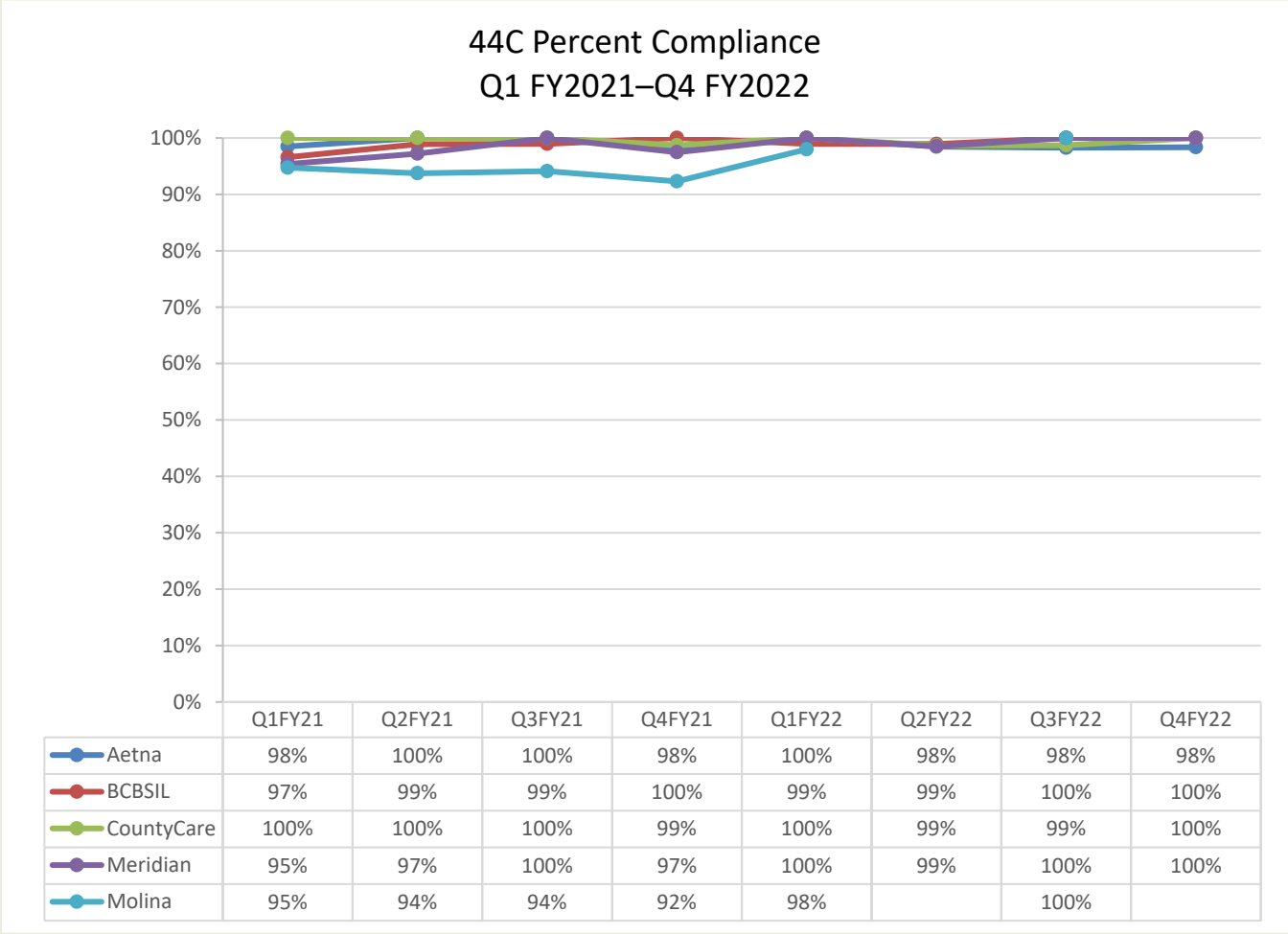
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure 44C—The enrollee reported satisfaction with his/her PA.

New measure beginning FY2021. Captured only for enrollees with PA service.

Figure B-15—Measure 44C

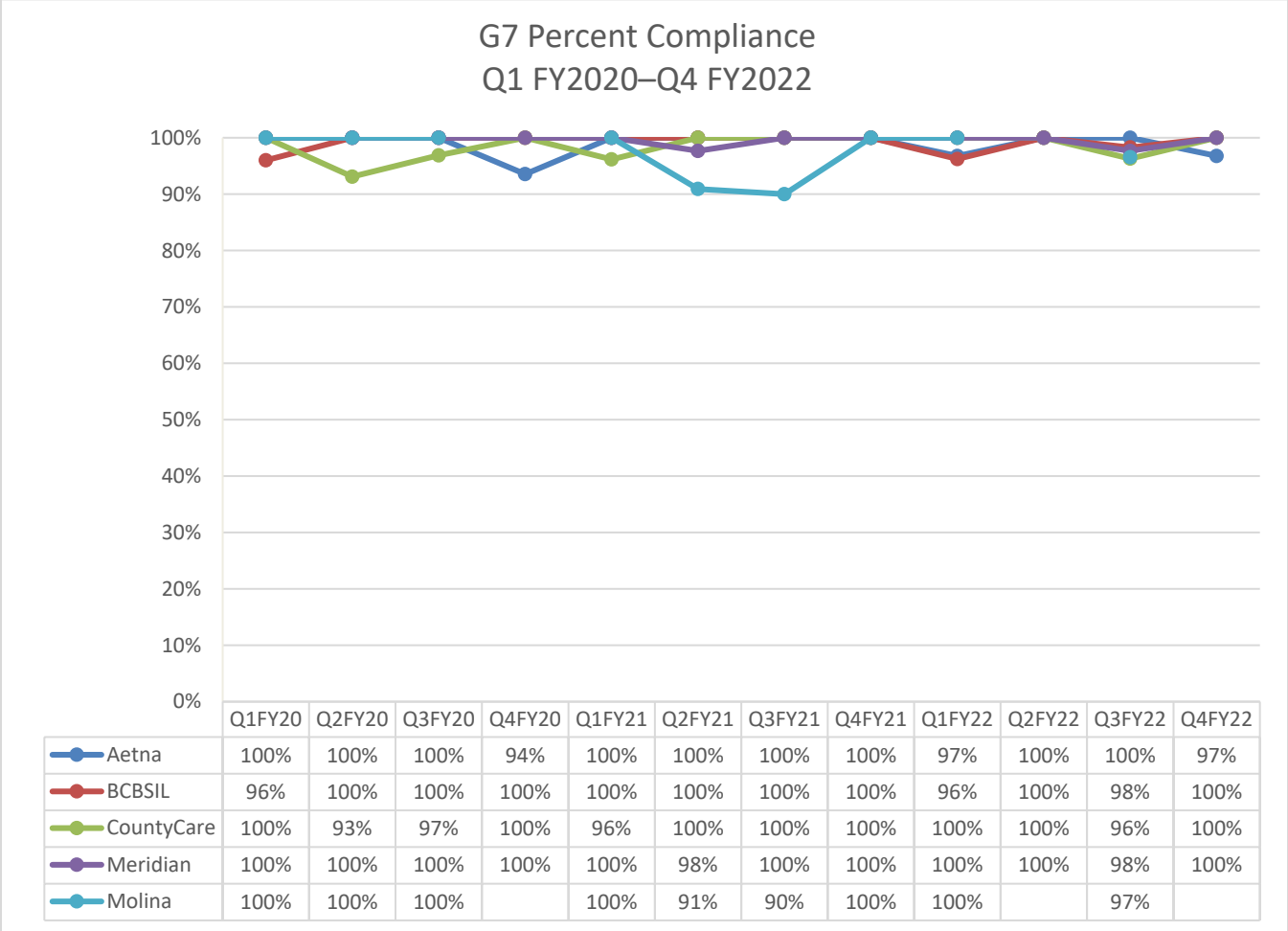


	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	98%	100%	100%	98%	100%	98%	98%	98%
BCBSIL	97%	99%	99%	100%	99%	99%	100%	100%
CountyCare	100%	100%	100%	99%	100%	99%	99%	100%
Meridian	95%	97%	100%	97%	100%	99%	100%	100%
Molina	95%	94%	94%	92%	98%		100%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure G7—The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B-16—Measure G7



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	100%	100%	100%	94%	100%	100%	100%	100%	97%	100%	100%	97%
BCBSIL	96%	100%	100%	100%	100%	100%	100%	100%	96%	100%	98%	100%
CountyCare	100%	93%	97%	100%	96%	100%	100%	100%	100%	100%	96%	100%
Meridian	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	98%	100%
Molina	100%	100%	100%		100%	91%	90%	100%	100%		97%	

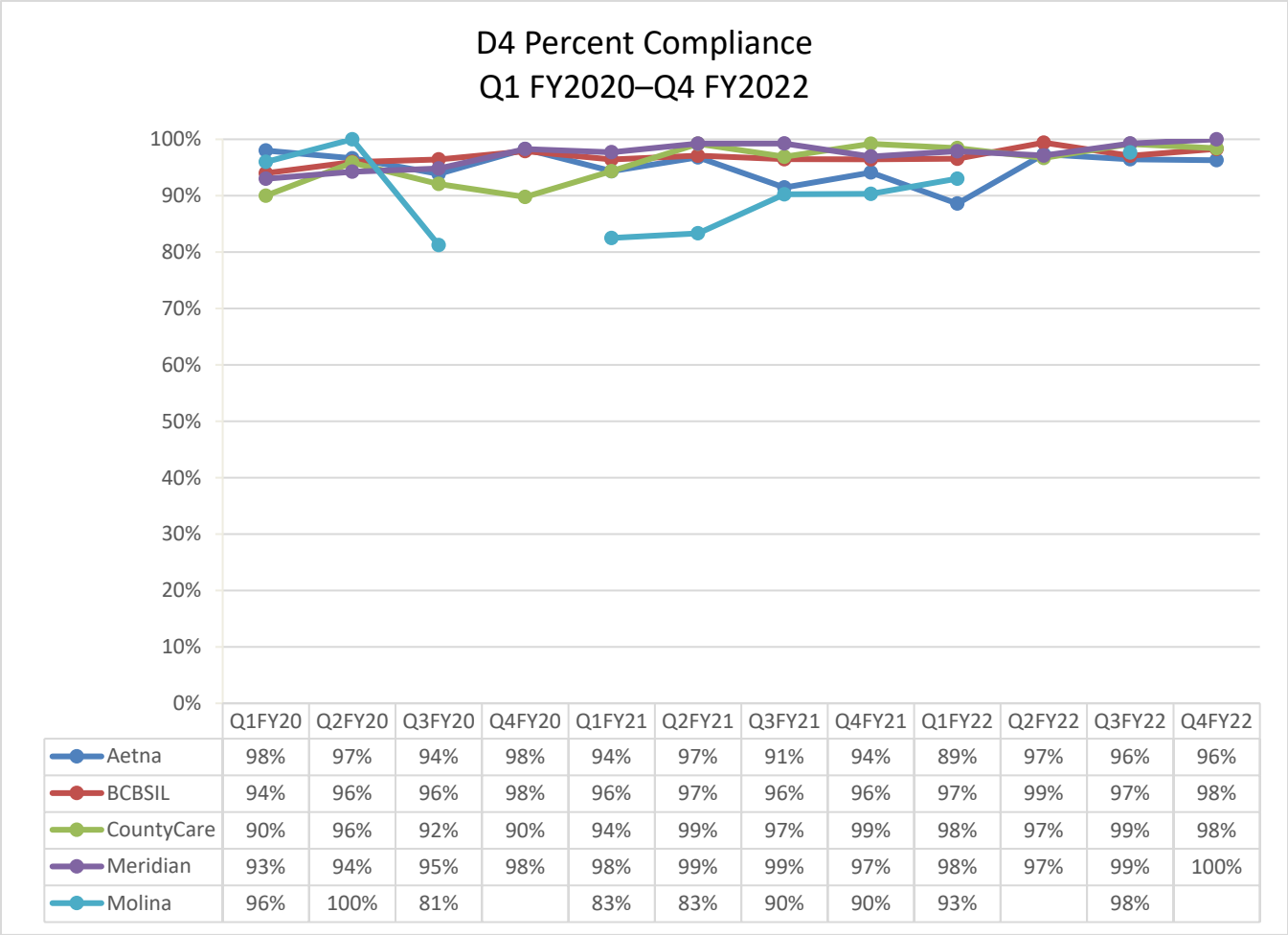
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records s.

Data prior to FY2020 are available in previous years' reports.

Measure D4—The most recent service plan includes a backup plan that includes the name of the backup. (ELD, BI, HIV, and PD waivers only)

Due to changes in performance measure definitions in FY2020, historic data are not comparable and only FY2020 to current data are displayed.

Figure B-17—Measure D4



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
Aetna	98%	97%	94%	98%	94%	97%	91%	94%	89%	97%	96%	96%
BCBSIL	94%	96%	96%	98%	96%	97%	96%	96%	97%	99%	97%	98%
CountyCare	90%	96%	92%	90%	94%	99%	97%	99%	98%	97%	99%	98%
Meridian	93%	94%	95%	98%	98%	99%	99%	97%	98%	97%	99%	100%
Molina	96%	100%	81%		83%	83%	90%	90%	93%		98%	

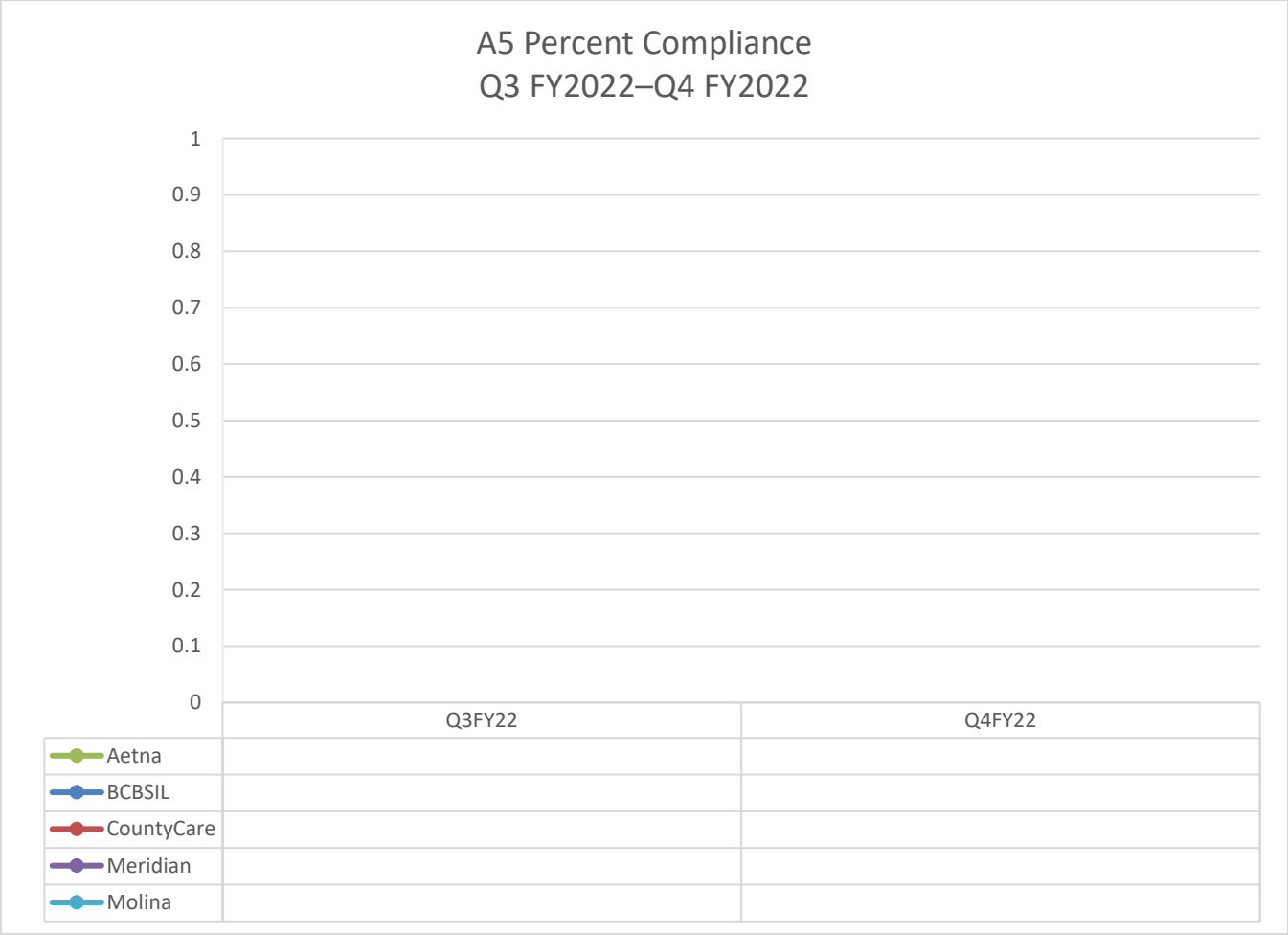
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure A5—Does the enrollee report the ADS facilitates independent choice while attending ADS? (Captured only for PD and ELD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-18—Measure A5

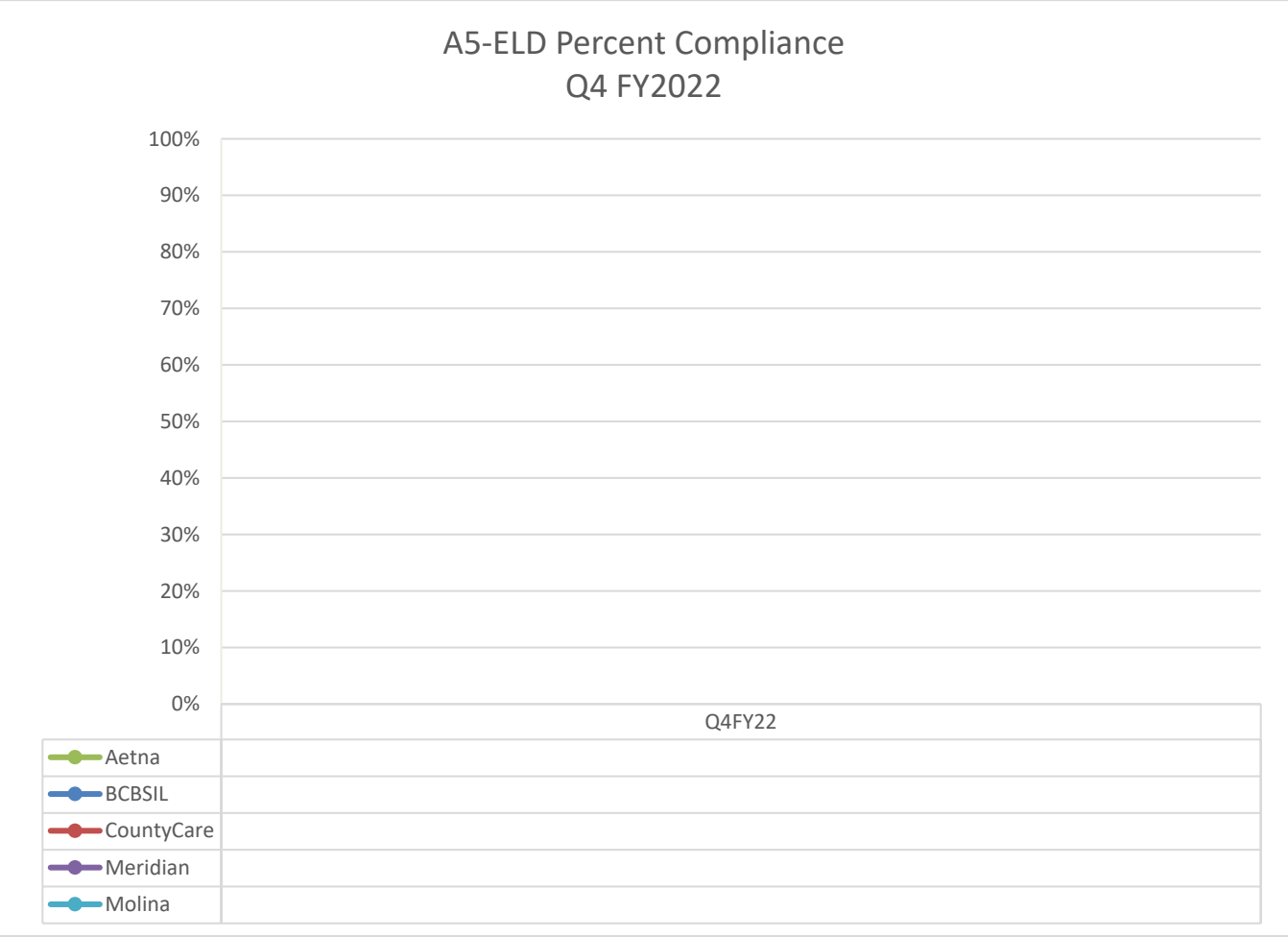


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A5-ELD—Does the enrollee report participation in meaningful activities that help meet their goals/needs? (Captured only for ELD waiver enrollees receiving ADS)

This new measure is effective Q4 FY2022.

Figure B-19—Measure A5-ELD

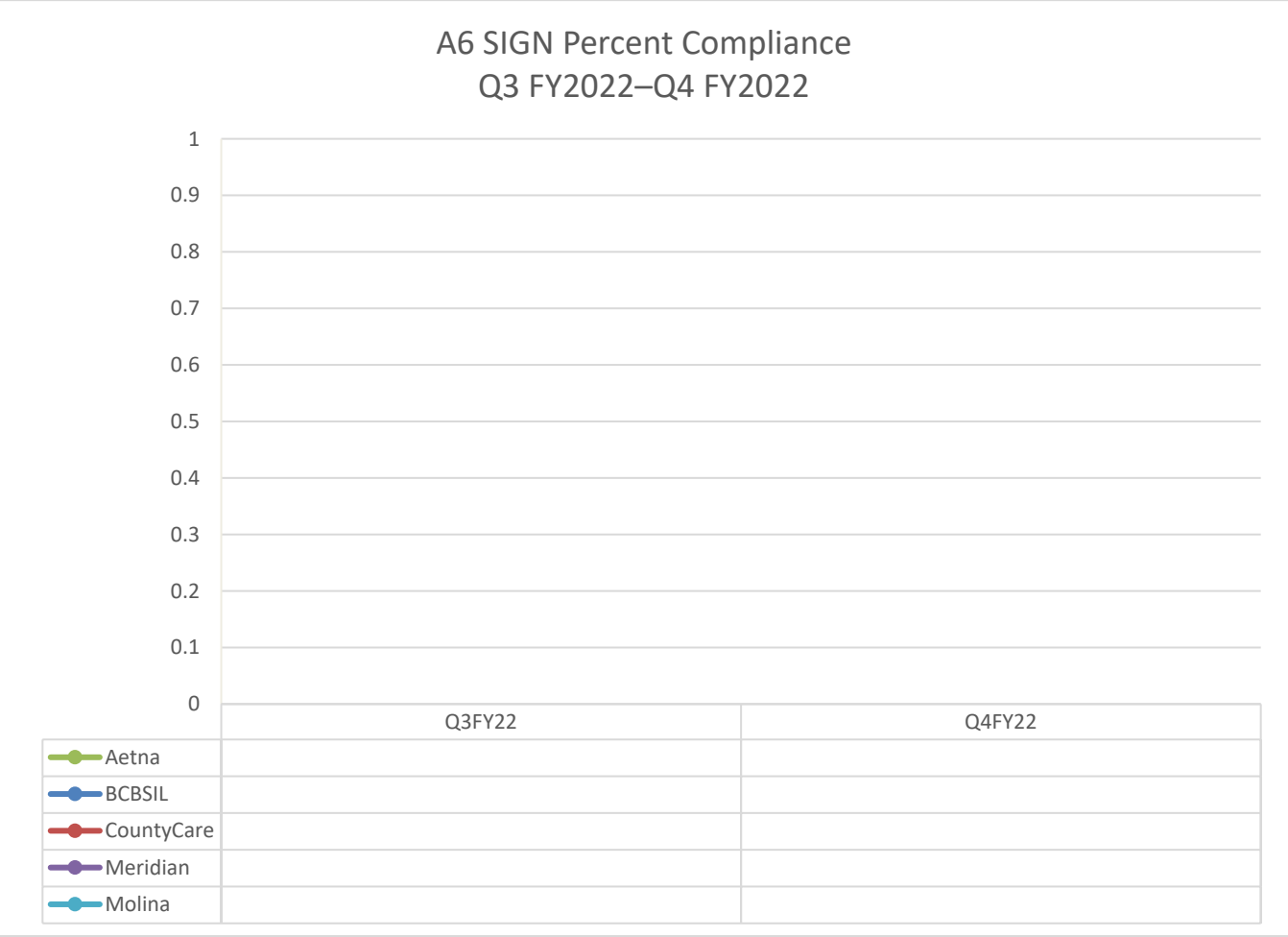


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A6-SIGN—Was the enrollee provided choice of directing services received at the ADS setting? (Captured only for ELD and PD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-20—Measure A6-SIGN

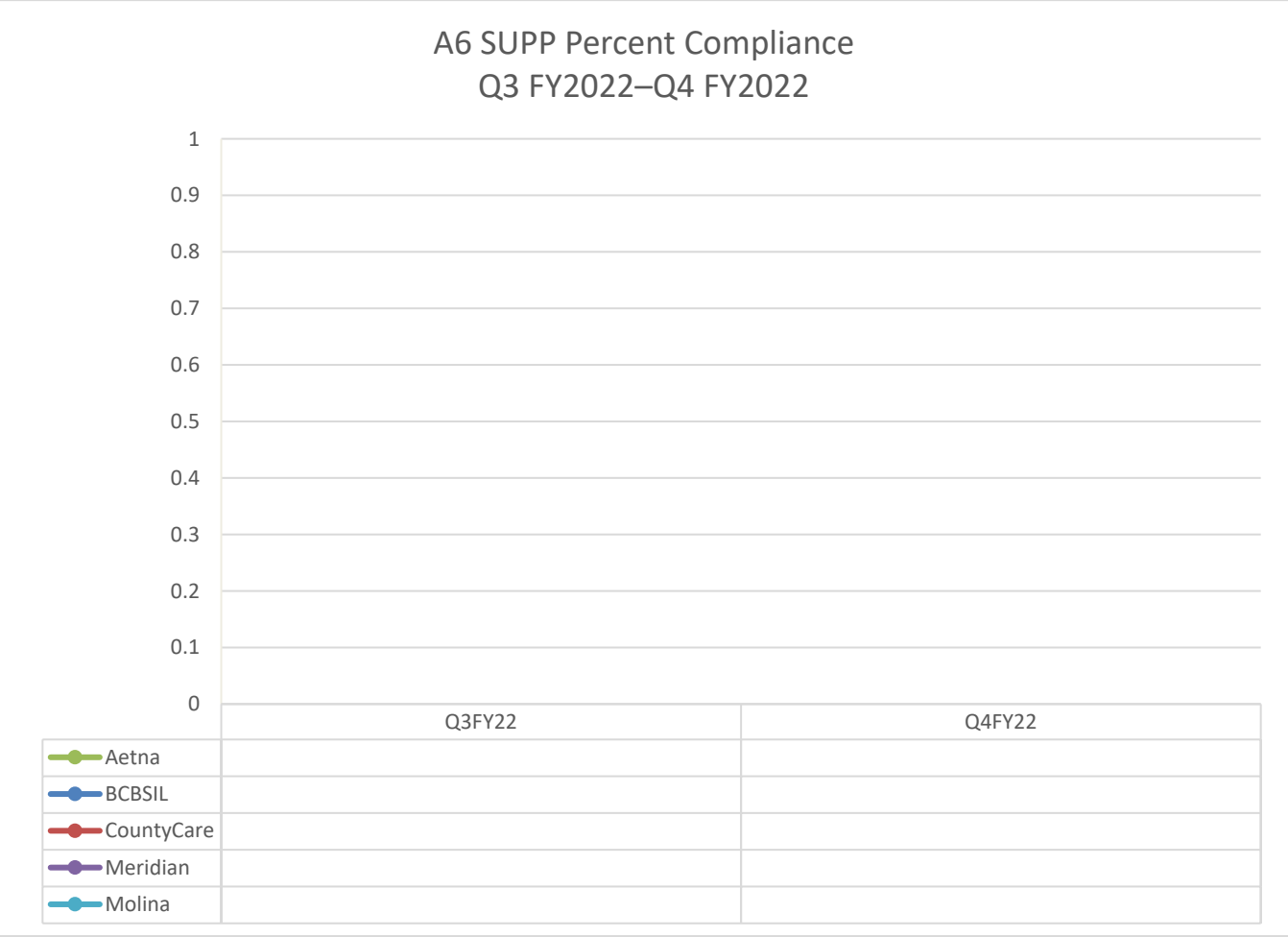


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A6-SUPP—Did the enrollee report he/she feels supported in making decisions to remain independent? (Captured only for ELD and PD waiver enrollees receiving ADS)

New measure effective Q3 FY2022. No records were eligible for this measure in Q3 FY2022.

Figure B-21—Measure A6-SUPP

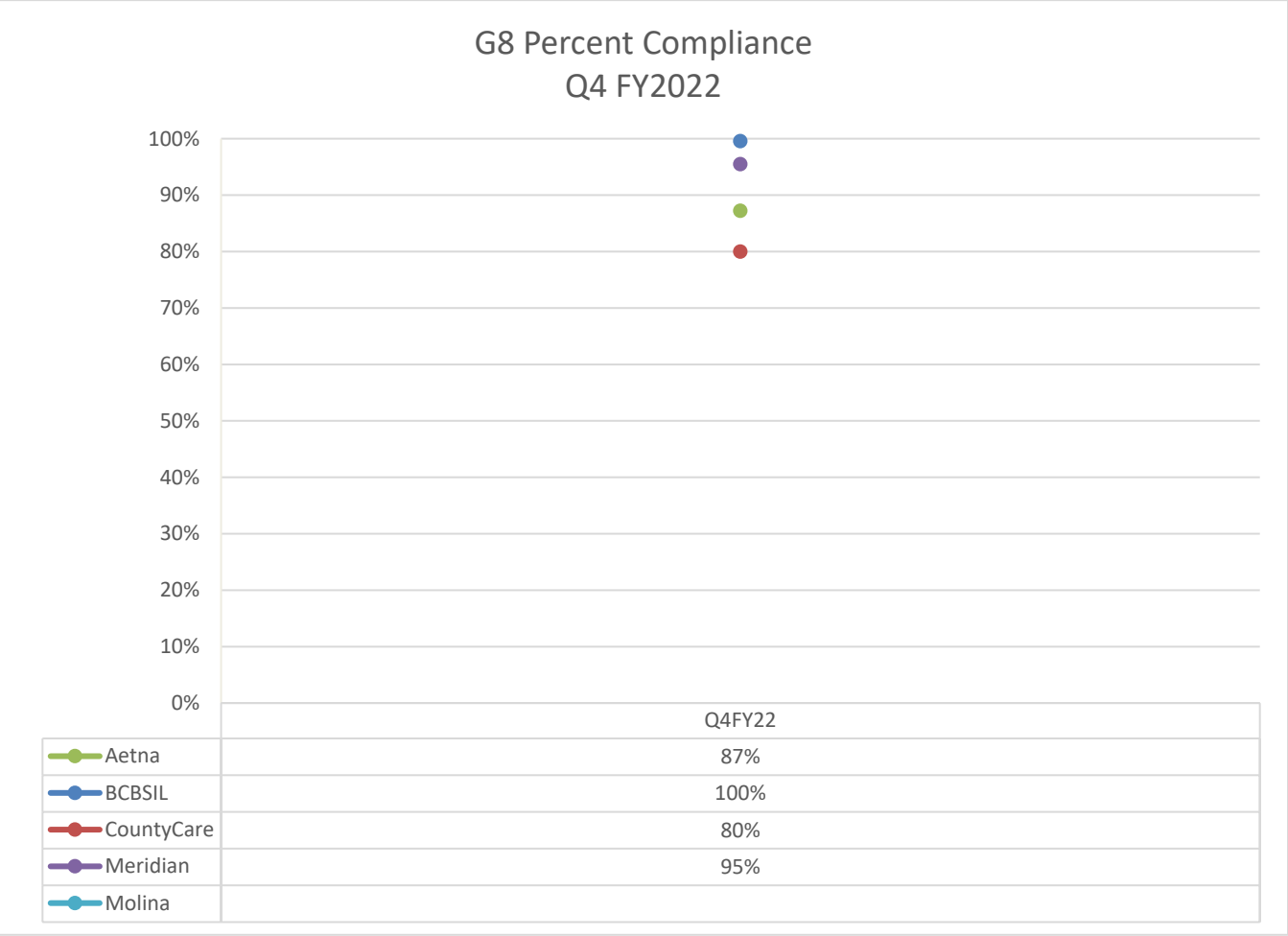


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure G8—Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?

This new measure is effective Q4 FY2022.

Figure B-22—Measure G8



Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Appendix C. Health Plan Performance, by Measure and Quarter—HealthChoice

Table C-1 displays health plan compliance per performance measure by quarter. Due to HFS performance measure numbering alignment across waivers that occurred Q3 FY2022, measure numbers are listed with their updated 2022 measure number for historic tracking.

Data prior to FY2020 and data for health plans previously included in HealthChoice are available in previous reports.

Table C-1—HealthChoice Performance Measure Findings Across Health Plans

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Aetna												
12C[4]					10%	14%	10%	38%	21%	20%		
20C[2]					81%	91%	86%	79%	71%	82%	70%	88%
31D/D1	99%	97%	92%	97%	99%	97%	95%	94%	90%	93%	94%	93%
32D/D2	98%	98%	93%	97%	98%	96%	94%	95%	91%	94%	95%	93%
33D/D3	100%	100%	92%	97%	98%	96%	95%	95%	94%	96%	95%	93%
34D	100%	94%	97%	97%	100%	100%	100%	100%	94%	100%	100%	97%
35D	100%	97%	92%	95%	99%	97%	92%	90%	88%	83%	54%	69%
36D/D6	82%	85%	71%	71%	81%	86%	83%	81%	73%	84%	55%	47%
37D/D7[1]	90%	91%	87%	90%	92%	90%	83%	77%	66%	70%	69%	62%
38D/D8	97%	91%	92%	85%	97%	93%	94%	74%	62%	70%	65%	89%
39D/D9	82%	82%	83%	81%	83%	92%	77%	77%	70%	87%	81%	84%
40D	100%	100%	97%	97%	100%	100%	100%	100%	94%	100%	100%	97%
41D/D10	100%	99%	88%	97%	98%	97%	92%	98%	96%	97%	96%	95%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
42G/G1	99%	97%	86%	95%	97%	95%	91%	90%	83%	81%	85%	87%
44C[2]					98%	100%	100%	98%	100%	98%	98%	98%
44G/G7	100%	100%	100%	94%	100%	100%	100%	100%	97%	100%	100%	97%
49G/D4[1]	98%	97%	94%	98%	94%	97%	91%	94%	89%	97%	96%	96%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												87%
BCBSIL												
12C[4]					4%	0%	0%	4%	16%	12%		
20C[2]					76%	80%	76%	74%	75%	82%	85%	91%
31D/D1	95%	98%	93%	98%	97%	98%	100%	97%	95%	98%	98%	99%
32D/D2	96%	99%	94%	97%	98%	100%	99%	99%	96%	98%	100%	100%
33D/D3	97%	99%	95%	98%	99%	100%	100%	99%	96%	99%	100%	100%
34D	96%	100%	100%	98%	98%	100%	100%	100%	96%	98%	95%	98%
35D	99%	98%	94%	97%	98%	98%	96%	96%	87%	92%	88%	89%
36D/D6	90%	92%	89%	92%	93%	95%	96%	95%	92%	99%	84%	84%
37D/D7[1]	90%	93%	89%	94%	96%	94%	88%	88%	92%	89%	94%	89%
38D/D8	91%	91%	98%	95%	85%	100%	93%	98%	95%	100%	100%	88%
39D/D9	78%	82%	93%	79%	82%	89%	92%	89%	90%	94%	95%	94%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
40D	98%	100%	100%	100%	98%	100%	100%	100%	96%	96%	98%	98%
41D/D10	98%	97%	94%	97%	99%	98%	97%	98%	95%	97%	99%	99%
42G/G1	97%	93%	89%	100%	97%	97%	96%	95%	93%	95%	95%	96%
44C[2]					97%	99%	99%	100%	99%	99%	100%	100%
44G/G7	96%	100%	100%	100%	100%	100%	100%	100%	96%	100%	98%	100%
49G/D4[1]	94%	96%	96%	98%	96%	97%	96%	96%	97%	99%	97%	98%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												100%
CountyCare												
12C[4]					0%	6%	9%	25%	7%	0%		
20C[2]					71%	79%	74%	75%	81%	91%	82%	78%
31D/D1	96%	98%	98%	97%	99%	100%	99%	100%	100%	99%	98%	98%
32D/D2	95%	98%	96%	96%	95%	99%	97%	97%	100%	98%	98%	98%
33D/D3	95%	99%	96%	95%	93%	99%	96%	98%	99%	96%	95%	97%
34D	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%	93%	100%
35D	93%	96%	96%	97%	99%	99%	96%	86%	88%	73%	60%	65%
36D/D6	66%	66%	75%	83%	79%	83%	84%	87%	87%	83%	64%	54%
37D/D7[1]	82%	84%	81%	93%	88%	94%	94%	92%	92%	90%	85%	82%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
38D/D8	96%	96%	95%	90%	92%	100%	97%	94%	100%	96%	94%	96%
39D/D9	53%	59%	65%	79%	81%	86%	86%	92%	86%	90%	88%	87%
40D	97%	96%	97%	100%	96%	100%	97%	100%	100%	100%	93%	100%
41D/D10	95%	96%	94%	91%	97%	99%	99%	100%	100%	99%	98%	99%
42G/G1	89%	95%	92%	91%	92%	98%	94%	97%	97%	97%	93%	88%
44C[2]					100%	100%	100%	99%	100%	99%	99%	100%
44G/G7	100%	93%	97%	100%	96%	100%	100%	100%	100%	100%	96%	100%
49G/D4[1]	90%	96%	92%	90%	94%	99%	97%	99%	98%	97%	99%	98%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												80%
Meridian												
12C[4]					4%	21%	9%	7%	15%	5%		
20C[2]					63%	75%	69%	65%	69%	74%	63%	72%
31D/D1	98%	97%	97%	99%	98%	99%	100%	99%	100%	100%	99%	100%
32D/D2	98%	97%	99%	99%	99%	100%	99%	99%	100%	100%	100%	100%
33D/D3	98%	97%	98%	99%	99%	100%	100%	99%	99%	99%	100%	99%
34D	100%	98%	100%	100%	98%	98%	100%	100%	100%	98%	100%	100%
35D	95%	95%	93%	97%	92%	99%	100%	96%	93%	83%	85%	85%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
36D/D6	80%	81%	79%	81%	74%	92%	88%	89%	82%	80%	28%	40%
37D/D7[1]	92%	89%	83%	87%	89%	92%	88%	88%	92%	86%	84%	84%
38D/D8	97%	92%	98%	97%	100%	97%	91%	100%	98%	100%	100%	93%
39D/D9	81%	73%	80%	92%	94%	96%	97%	93%	96%	89%	85%	93%
40D	100%	100%	100%	100%	100%	98%	100%	100%	100%	98%	100%	100%
41D/D10	96%	97%	94%	95%	93%	96%	99%	99%	100%	97%	98%	99%
42G/G1	94%	97%	92%	95%	95%	97%	96%	94%	97%	91%	95%	94%
44C[2]					95%	97%	100%	97%	100%	99%	100%	100%
44G/G7	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	98%	100%
49G/D4[1]	93%	94%	95%	98%	98%	99%	99%	97%	98%	97%	99%	100%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												95%
Molina												
12C[4]					0%	0%	0%	0%	0%			
20C[2]					35%	34%	50%	37%	57%		58%	
31D/D1	97%	100%	85%		90%	95%	98%	97%	97%		98%	
32D/D2	97%	100%	85%		90%	92%	95%	97%	98%		97%	
33D/D3	97%	96%	85%		90%	97%	95%	97%	98%		98%	

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
34D	100%	100%	100%		100%	91%	90%	100%	100%		97%	
35D	92%	89%	85%		85%	92%	95%	95%	88%		68%	
36D/D6	68%	75%	76%		79%	79%	80%	91%	90%		64%	
37D/D7[1]	92%	93%	88%		83%	88%	95%	65%	83%		74%	
38D/D8	100%	100%	100%		71%	100%	75%	100%	88%		85%	
39D/D9	63%	82%	83%		76%	82%	87%	81%	85%		92%	
40D	100%	100%	100%		100%	91%	90%	100%	100%		97%	
41D/D10	94%	100%	88%		87%	93%	95%	95%	97%		98%	
42G/G1	94%	100%	83%		85%	90%	93%	89%	88%		92%	
44C[2]					95%	94%	94%	92%	98%		100%	
44G/G7	100%	100%	100%		100%	91%	90%	100%	100%		97%	
49G/D4[1]	96%	100%	81%		83%	83%	90%	90%	93%		98%	
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												

Shaded rows/cells indicate a quarter during which a health plan was not reviewed or there were no eligible records.

[1]Revised measure effective Q1 FY2020.

[2]Measure added effective Q1 FY2021.

[3]Measure added for PD waiver effective Q3 FY2022.

[4]Measure retired effective Q3 FY2022.

[5]Measure added effective Q4 FY2022.

Appendix D. Waiver Measure Performance by Quarter—HealthChoice

Table D-1—HealthChoice Waiver Performance Measure Findings

Performance Measure Findings Across Waivers—Percent Compliant by Measure FY2022																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	91%	93%	93%	95%	94%	95%	90%	89%	92%	94%	93%	93%	89%	90%	86%	89%	88%	87%	87%	88%
12C[1]	15%	7%	Retired		Not applicable to waiver				6%	0%	Retired		13%	11%	Retired		Not applicable to waiver			
20C	78%	85%	83%	91%	Not applicable to waiver				82%	96%	85%	88%	62%	71%	61%	73%	Not applicable to waiver			
31D/D1	99%	99%	99%	99%	97%	98%	97%	95%	98%	99%	100%	100%	97%	97%	97%	99%	93%	95%	96%	97%
32D/D2	99%	99%	100%	99%	98%	98%	98%	97%	99%	100%	100%	100%	98%	98%	97%	99%	93%	95%	97%	97%
33D/D3	99%	100%	100%	98%	98%	99%	98%	97%	99%	100%	100%	100%	98%	97%	96%	99%	92%	94%	97%	97%
34D	Not applicable to waiver				98%	99%	97%	99%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
35D	93%	90%	82%	93%	92%	92%	79%	78%	97%	85%	86%	85%	93%	90%	78%	84%	72%	60%	46%	57%
36D/D6	70%	67%	65%	72%	96%	98%	58%	53%	63%	74%	61%	55%	96%	98%	58%	55%				
37D/D7	91%	96%	94%	96%	84%	79%	74%	72%	91%	91%	94%	95%	83%	82%	79%	76%	85%	80%	83%	75%
38D/D8	94%	100%	84%	100%	90%	85%	88%	87%	88%	93%	94%	100%	90%	96%	90%	90%	75%	100%	83%	60%
39D/D9	90%	97%	92%	97%	77%	85%	82%	81%	94%	94%	95%	91%	82%	83%	84%	90%	98%	98%	97%	98%
40D	Not applicable to waiver				98%	98%	98%	99%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
41D/D10	99%	99%	99%	100%	98%	98%	99%	98%	99%	100%	100%	100%	99%	98%	98%	99%	93%	93%	95%	94%
42G/G1	98%	96%	97%	98%	91%	91%	93%	89%	97%	97%	99%	99%	93%	91%	91%	91%	83%	85%	86%	87%
44C	99%	99%	100%	100%	Not applicable to waiver				99%	99%	99%	100%	100%	98%	99%	99%	Not applicable to waiver			
44G/G7	Not applicable to waiver				98%	100%	98%	99%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
49G/D4	94%	99%	99%	98%	98%	99%	99%	98%	98%	100%	100%	100%	92%	94%	95%	98%	Not applicable to waiver			

Performance Measure Findings Across Waivers—Percent Compliant by Measure FY2022																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3				Not applicable to waiver			
A5-ELD[3]	Not applicable to waiver				Collected beginning Q4				Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
A6-SIGN[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3				Not applicable to waiver			
A6-SUPP[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3				Not applicable to waiver			
G8[3]	Collected beginning Q4			89%	Collected beginning Q4			94%	Collected beginning Q4			92%	Collected beginning Q4			93%	Collected beginning Q4			94%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.

[1]*Measure retired effective Q3 FY2022*

[2]*New measure effective Q3 FY2022*

[3]*New measure effective Q4 FY2022*

Table D-2—HealthChoice Waiver Performance Measure Findings: BI Waiver

HealthChoice Performance Measure Findings: BI Waiver—Percent Compliant by Measure FY2018–FY2021				
Performance Measure	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	81%	83%	91%	92%
4A[1,2]	36%	33%	0%	55%
12C[3]				3%
20C[3]				80%
31D	96%	94%	99%	99%
32D	97%	98%	98%	99%
33D	97%	97%	99%	99%
34D				
35D	99%	98%	98%	98%
36D[2]	51%	51%	52%	68%
37D	59%	68%	96%	96%
38D	95%	92%	94%	97%
39D[2]	39%	49%	78%	88%
40D				
41D	98%	98%	99%	99%
42G	94%	96%	97%	99%
44C[3]				99%
44G				
49G	100%	94%	92%	94%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.
Data prior to Q3 FY2018 (FHP/ACA, ICP) are available in previous years' reports.
[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.
[2]New measure SFY2018
[3]New measure SFY2021

Table D-3—HealthChoice Waiver Performance Measure Findings: ELD Waiver

HealthChoice Performance Measure Findings: ELD Waiver—Percent Compliant by Measure FY2018–FY2021				
Performance Measure	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	92%	89%	93%	95%
4A[1,2]	41%	29%	17%	26%
12C[3]				
20C[3]				
31D	99%	91%	95%	97%
32D	98%	94%	96%	97%
33D	99%	95%	97%	97%
34D	96%	99%	99%	99%
35D	98%	95%	95%	96%
36D[2]	99%	94%	97%	99%
37D	87%	82%	87%	88%
38D	94%	83%	93%	94%
39D[2]	47%	46%	68%	80%
40D	96%	99%	99%	99%
41D	97%	95%	94%	97%
42G	96%	92%	92%	94%
44C[3]				
44G	98%	98%	99%	99%
49G	75%	88%	98%	98%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.
Data prior to Q3 FY2018 (FHP/ACA, ICP) are available in previous years' reports.
[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.
[2]New measure SFY2018
[3]New measure SFY2021

Table D-4—HealthChoice Waiver Performance Measure Findings: HIV Waiver

HealthChoice Performance Measure Findings: HIV Waiver—Percent Compliant by Measure FY2018–FY2021				
Performance Measure	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	87%	87%	91%	92%
4A[1,2]	25%	68%	20%	50%
12C[3]				10%
20C[3]				81%
31D	98%	96%	98%	99%
32D	99%	98%	98%	98%
33D	100%	98%	99%	99%
34D				
35D	100%	98%	98%	96%
36D[2]	37%	42%	44%	66%
37D	91%	94%	97%	97%
38D	100%	91%	96%	91%
39D[2]	52%	59%	81%	90%
40D				
41D	99%	99%	98%	99%
42G	99%	97%	98%	99%
44C[3]				99%
44G				
49G	100%	94%	95%	98%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.
Data prior to Q3 FY2018 (FHP/ACA, ICP) are available in previous years' reports.
[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.
[2]New measure SFY2018
[3]New measure SFY2021

Table D-5—HealthChoice Waiver Performance Measure Findings: PD Waiver

HealthChoice Performance Measure Findings: PD Waiver—Percent Compliant by Measure FY2018–FY2021				
Performance Measure	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	91%	87%	91%	90%
4A[1,2]	34%	22%	30%	29%
12C[3]				8%
20C[3]				64%
31D	99%	91%	96%	98%
32D	99%	93%	97%	98%
33D	99%	94%	97%	98%
34D				
35D	98%	96%	97%	97%
36D[2]	100%	95%	98%	99%
37D	85%	86%	86%	89%
38D	96%	85%	94%	93%
39D[2]	45%	48%	70%	85%
40D				
41D	97%	95%	95%	97%
42G	96%	91%	93%	94%
44C[3]				97%
44G				
49G	97%	91%	93%	94%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.
Data prior to Q3 FY2018 (FHP/ACA, ICP) are available in previous years' reports.
[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.
[2]New measure SFY2018
[3]New measure SFY2021

Table D-6—HealthChoice Waiver Performance Measure Findings: SLP Waiver

HealthChoice Performance Measure Findings: SLP Waiver—Percent Compliant by Measure FY2018–FY2021				
Performance Measure	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	90%	85%	93%	92%
4A[1,2]	30%	21%		21%
12C[3]				
20C[3]				
31D	97%	87%	95%	96%
32D	96%	87%	95%	97%
33D	96%	90%	96%	97%
34D				
35D	96%	89%	91%	92%
36D[2]	80%	80%		
37D	76%	76%	83%	81%
38D		33%	100%	96%
39D[2]	92%	93%	99%	98%
40D				
41D	92%	89%	93%	94%
42G	91%	87%	91%	91%
44C[3]				
44G				
49G				

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.
Data prior to Q3 FY2018 (FHP/ACA, ICP) are available in previous years' reports.
[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.
[2]New measure SFY2018
[3]New measure SFY2021

Appendix E. Acronyms

ACA	Affordable Care Act
ADS	Adult Day Service
AIDS	Acquired Immune Deficiency Syndrome
BI	Persons with Brain Injury Waiver
CMS	Centers for Medicare & Medicaid Services
COVID-19 PHE	Coronavirus Disease 2019 Public Health Emergency
CY	Calendar Year
ELD	Persons who are Elderly Waiver
EQRO	External Quality Review Organization
FHP	Family Health Plan
FY	Fiscal Year
HCBS	Home- and Community-Based Services
HCI	HealthChoice Illinois
HFS	The Illinois Department of Healthcare and Family Services
HIV	Persons with Human Immunodeficiency Virus (HIV)/AIDS Waiver
HRA	Health Risk Assessment
HSAG	Health Services Advisory Group, Inc.
ICP	Integrated Care Program
IRR	Interrater Reliability
MCP	Managed Care Plan
MLTSS	Managed Long-Term Services and Supports
MMAI	Medicare-Medicaid Alignment Initiative
N/A	Not Applicable
PA	Personal Assistant
PD	Persons with Physical Disabilities Waiver
Q	Quarter
SFY	State Fiscal Year
SLP	Persons in a Supportive Living Program Waiver
VMC	Voluntary Managed Care

HealthChoice Illinois

Illinois Department of Healthcare and Family Services

Home- and Community-Based Services (HCBS) Waivers

Centers for Medicare & Medicaid Services (CMS) Performance Measures

Record Review

of

Managed Long Term Services and Supports Managed Care Plans (MCPs)

Summary of Findings and Recommendations

State Fiscal Year 2022 Report

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to identify opportunities within the Home- and Community-Based Services (HCBS) waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG), conduct on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This State Fiscal Year (SFY) 2022 MLTSS HCBS Waivers CMS Performance Measures Record Review of HealthChoice Illinois MCPs Summary of Findings and Recommendations Report provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for the Managed Long Term Services and Supports (MLTSS) 1915(b) waiver program.

Overview

This report provides an overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

The report includes a summary of trended performance across health plans during SFY 2022 and across review years, and also contains a review of remediation activities conducted within the required time frames and a summary of technical assistance that HSAG provided to the health plans.

For the SFY 2022 review, HFS initially identified 17 CMS waiver performance measures for review. These performances measures were aligned with the state-approved 1915(c) waiver applications. Due to waiver renewals that occurred, the following changes were made to ensure alignment and 19 measures were collected beginning in the third quarter (Q3) SFY 2022:

- Measure 12C, *If the PA [personal assistant] evaluation was not completed annually, it was completed within 60 days of the expected annual date*, was retired.
- Measure A5, *Does the enrollee report the ADS [adult day service] facilitates independent choice while attending ADS?* was added.
- Measure A6-SIGN, *Was the enrollee provided choice of directing services received at the ADS setting?* was added.

- Measure A6-SUPP, *Did the enrollee report he/she feels supported in making decisions to remain independent?* was added.

In addition, evaluation criteria for 36D/D6 were revised to align with contact requirements for enrollees receiving services in the Persons with Disabilities (PD) and Persons who are Elderly (ELD) waivers.

Due to waiver renewals that occurred, the following changes were made to ensure alignment and 21 performance measures were collected beginning Q4 SFY 2022:

- Measure A5-ELD, *Does the enrollee report participation in meaningful activities that help meet their goals/needs?* was added.
- Measure G8, *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?* was added.

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Methodology

HSAG conducted quarterly record reviews to determine health plan compliance to the CMS waiver performance measures and to additional HealthChoice contract measures. During SFY 2022, 1,516 MLTSS records were reviewed using HSAG's web-based data collection tool. As a result, 1,697 MLTSS findings of noncompliance were identified. The SFY 2022 reviews assessed performance during a lookback period of December 1, 2020, through February 28, 2022.

Detailed descriptions of the sampling methodology and data collection processes are provided in Section 2 of this report.

Summary of Findings

Health Plan Participation

Table 1-1 displays the health plans that were reviewed during SFY 2022.

Table 1-1—SFY 2022 MLTSS Health Plans

Health Plan Name
Aetna Better Health (Aetna)
Blue Cross Blue Shield of Illinois (BCBSIL)
CountyCare
Meridian
Molina Healthcare of Illinois (Molina)

Successes

SFY 2022 represented the fourth year of review for the MLTSS population, and several successes were identified.

☑ Twelve of the 21 CMS performance measures[1] averaged 90 percent or greater compliance.

☑ Two performance measures realized statistically significant increases in compliance in SFY 2022 when compared to SFY 2021.

☑ Three of the five health plans averaged 90 percent or greater compliance.

☑ Compared to SFY 2021, Molina realized a statistically significant increase in performance for five measures in SFY 2022.

☑ Three of the five waiver types averaged greater than 90 percent compliance.

☑ Compared to SFY 2021, the Persons with Brain Injury (BI) waiver realized a statistically significant increase in compliance for two measures in SFY 2022.

Opportunities for Improvement

Review of SFY 2022 performance identified the following opportunities for improvement:

Aetna demonstrated a statistically significant decrease in five performance measures in SFY 2022 when compared to SFY 2021.

Four performance measures demonstrated statistically significant decreases in compliance in SFY 2022 when compared to SFY 2021.

Four of the five health plans and all five waivers demonstrated a statistically significant decrease in compliance with Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP [persons in a supportive living program] provider (if applicable) and dates of signatures*, when SFY 2022 was compared to SFY 2021. A detailed analysis is provided in Section 3 of this report.

[1] A listing of performance measures is available in Appendix A.

Two of the five health plans and three of the five waivers demonstrated a statistically significant decrease in compliance with Measure D7, *the most recent service plan is in the record and completed in a timely manner*, when SFY 2022 was compared to SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 73 percent compliance in SFY 2022. A detailed analysis is provided in Section 3 of this report.

Although HFS provided the health plans with guidance regarding documentation expectations for enrollee contacts, service plan updates, and enrollee signatures during the coronavirus disease 2019 (COVID-19) public health emergency (PHE) restrictions, the health plans demonstrated significant decreases in compliance for those measures, as indicated above.

External Quality Review Organization (EQRO) Technical Assistance

To assist the health plans with improvement efforts, HSAG provided ongoing technical assistance throughout SFY 2022. Technical assistance was also provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- How to prepare for quarterly record reviews and remediation validation.
- How to use the HSAG web-based tool to run reports and complete remediation.
- How to complete health, safety, and welfare reports remediation.
- Validation of waiver service provision.
- Timely completion of annual reassessments, care plan, and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.
- Compliance with HFS' guidance regarding SLP documentation expectations.
- Documentation of language required to meet HFS' expectations for enrollee contacts, service plan updates, and enrollee signatures during the COVID-19 PHE restrictions.

In addition, HSAG conducted health plan trainings in July 2021 and January 2022 to provide updates to evaluation criteria and record review expectations.

HFS Policy Guidance

As a result of HFS' efforts for continuous quality improvement for the waiver record reviews and management of waiver enrollees, HFS provided guidance via formal policies to the health plans on the following topics:

- Procedures specific to management of enrollees during the COVID-19 pandemic, including timelines for resuming face-to-face enrollee contacts and expectations for documenting SLP care coordination activities.
- Expectations for conducting a new health risk assessment (HRA) for newly eligible enrollees with a previous HRA.
- CMS' approval of PD and ELD waiver renewals and resulting updated performance measures.

Recommendations

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Recommendations specific to health plans, waivers, and performance measures are identified below.

Health Plan-Specific

Aetna should focus efforts on measures 35D, D6, D7, D8, and G1.

BCSBIL should focus efforts on measures 35D and D6.

CountyCare should focus efforts on measures 35D, D6, D7, and G8.

Meridian should focus efforts on measures 35D and D6.

Molina should focus efforts on measures 35D and D6.

All health plans may benefit from implementing the *Performance Measure-Specific* recommendations listed below.

Waiver-Specific

Brain injury (BI) waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month (Measure D6). Health plans should analyze their staffing to ensure

that care managers/care coordinators[2] have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

Human immunodeficiency virus (HIV) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly (Measure D6). Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

Persons with Disabilities (PD) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once every 90 days (Measure D6). Health plans should target efforts for contact to those care managers/care coordinators managing PD caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of PD cases, to identify timely mitigation opportunities.

Persons who are Elderly (ELD) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once every 90 days (Measure D6). Health plans should target efforts for contact to those care managers/care coordinators managing ELD caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of ELD cases, to identify timely mitigation opportunities.

Performance Measure-Specific

All health plans should focus improvement efforts on measures D6, D7, and 35D.

For Measure D6, efforts might include:

- Conduct root cause analysis to determine opportunities to effect change.
- Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS' guidance for valid enrollee contact and valid justification when contact is not completed as required.

[2] The terms "case manager(s)" and "care coordinator(s)" are used interchangeably in this report.

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

For Measure D7, efforts might include:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete annual service plan updates.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

For Measure 35D, efforts might include:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete timely service plan updates.
- Ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

2. Data Collection and Methodology

Background

HFS implemented the MLTSS waiver upon approval from CMS effective July 1, 2016. The MLTSS waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based long term services and supports who were not enrolled in the State's Medicare-Medicaid Alignment Initiative (MMAI) but were eligible for both Medicare and Medicaid, unless they met the eligibility exclusions.

Beginning in July 2016, the MLTSS waiver was implemented in the Greater Chicago service area only. Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois Managed Care Program (HealthChoice), on January 1, 2018, which consolidated multiple programs, including MLTSS, into a single program. MLTSS services were further expanded statewide effective July 1, 2019.

All waiver beneficiaries enrolled in HealthChoice and the MLTSS waiver receive care management services. This person-centered, team-based approach supports care coordination across the continuum of care, promoting improved health outcomes, increased beneficiary satisfaction, and improved coordination and integration of benefits.

The program was designed to ensure that beneficiaries receive assistance with clinical and nonclinical needs by assigning an accountable care manager who develops a care plan and service plan with the beneficiary, coordinates frequent personal contact to monitor the beneficiary's progress toward achieving care plan goals, and implements interventions to overcome barriers to care.

To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that HSAG conduct on-site reviews of waiver beneficiary records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

HCBS Waiver Program Implementation and Monitoring

As the EQRO for Illinois, HSAG assisted HFS in assessing the readiness of each health plan to participate in the HCBS waiver program. Prior to receiving HCBS waiver program enrollees, the health plans were required to participate in and pass a readiness review to demonstrate that the health plan was ready to provide services to HCBS waiver enrollees safely and efficiently.

Under the HealthChoice model, HSAG began on-site record reviews in Q3 FY2018 to monitor MLTSS health plan performance on the HCBS waiver performance measures.

Waiver Programs and Performance Measures Included in Reviews

Waiver Programs

The following HCBS waiver programs were included in the CMS performance measure record reviews:

- Persons with Disabilities (PD): Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility and can be safely maintained in the home or community-based setting with the services provided in the plan of care. Individuals 60 years of age or older, who began services before age 60, may choose to remain in this waiver.
- Persons with HIV/AIDS (HIV): Persons of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or acquired immune deficiency syndrome (AIDS) and are at risk of placement in a nursing facility.
- Persons with Brain Injury (BI): Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- Persons who are Elderly (ELD): Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are ages 65 and older, and those who are physically disabled, ages 60 through 64.
- Persons in a Supportive Living Program (SLP): Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

Performance Measures

For the SFY 2022 review, HFS initially identified 17 CMS waiver performance measures for review. These performances measures were aligned with the state-approved 1915(c) waiver applications. Due to waiver renewals that occurred, the following changes were made to ensure alignment, and 19 measures were collected beginning Q3 SFY 2022:

- Measure 12C, *If the PA [personal assistant] evaluation was not completed annually, it was completed within 60 days of the expected annual date*, was retired.
- Measure A5, *Does the enrollee report the ADS [adult day service] facilitates independent choice while attending ADS?* was added.
- Measure A6-SIGN, *Was the enrollee provided choice of directing services received at the ADS setting?* was added.
- Measure A6-SUPP, *Did the enrollee report he/she feels supported in making decisions to remain independent?* was added.

In addition, evaluation criteria for 36D/D6 were revised to align with contact requirements for enrollees receiving services in the Persons with Disabilities (PD) and Persons who are Elderly (ELD) waivers.

Due to waiver renewals that occurred, the following changes were made to ensure alignment, and 21 performance measures were collected beginning Q4 SFY 2022:

- Measure A5-ELD, *Does the enrollee report participation in meaningful activities that help meet their goals/needs?* was added.
- Measure G8, *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?* was added.

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

To collect samples for record review, HSAG selects a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selects a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group will be determined based on the number of eligible members in each waiver program. Once the required sample sizes have been identified, a proportional random sample will be selected based on the distribution of the health plans' populations within each designated waiver program. Each sample is selected to ensure a 95 percent confidence level and 5 percent margin of error at the waiver program level. Additionally, a 10 percent oversample based on the proportional distribution of enrollees across health plans is selected to replace ineligible cases.

This sampling method is designed to ensure that when the samples are combined, there is sufficient statistical power to meet the CMS HCBS reporting requirements. Samples will be selected without resampling, and sample sets will be refreshed for each review using HFS' eligibility file data. Limitations to the sampling methodology include known variables such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g., previously enrolled as MMAI and transferred to MLTSS).

To be included in the sample, a beneficiary must meet the following criteria:

1. Continuously enrolled with the health plan for at least six months as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.
2. At least three months of continuous HCBS waiver coverage during the most recent six months of enrollment as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

Upon receipt of the sample, health plans are expected to review the cases to ensure they meet the above eligibility criteria, notifying HSAG of any cases that should be excluded. Health plans will also notify HSAG of any of the following, who may be excluded from the sample:

- Beneficiaries who have disenrolled from the health plan.
- Beneficiaries who have expired.
- Beneficiaries who have Operating Agency-confirmed waiver case closure.
- Beneficiaries whose current waiver type is different from the waiver type identified on the sample.
- Beneficiaries whose current program (HealthChoice, MLTSS, or MMAI) differs from the program type identified on the sample.
- Beneficiaries in long-term care.

The final sample sizes were calculated based on data extracted in April 2021 and included waiver members enrolled as of April 1, 2021. Table 2-1 displays the FY 2022 record review sample size by health plan and waiver program for MLTSS.

Table 2-1—MLTSS Sample Size, by Health Plan and Waiver Program

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLF
Aetna	7,933	302	77	53	27	76	69
BCBSIL	13,225	521	125	73	56	117	150
CountyCare	5,410	212	58	55	36	48	15
Meridian	8,958	356	85	56	45	87	83
Molina	3,545	130	34	12	12	35	37
Statewide Total	**39,071**	**1,521**	**379**	**249**	**176**	**363**	**354**

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this report, including tables and graphs, reflect the quarters in which the health plans were reviewed. The six-month lookback periods during SFY 2022 consisted of the following:

- Quarter 1, SFY 2021: December 1, 2020–May 31, 2021
- Quarter 2, SFY 2021: March 1, 2021–August 31, 2021
- Quarter 3, SFY 2021: June 1, 2021–November 30, 2021
- Quarter 4, SFY 2021: September 1, 2021–February 28, 2022

Web-Based Abstraction Tool and Scoring Methodology

HSAG collaborated with HFS to develop a web-based abstraction tool and reporting database, which included requirements set forth in the HealthChoice contract and the HCBS waivers. The review tool was developed to conduct the review at the individual case level and was modeled after the tool used by the State to monitor the fee-for-service population to ensure waiver enrollees are monitored similarly for similar performance measures. The tool was used to assess compliance with case management activities, including comprehensive assessments, care planning, waiver service planning, beneficiary interaction, and specialized waiver evaluations.

During the on-site review, the HSAG review team reviewed documentation for the selected cases for each review period, consisting of a six-month lookback period from the date of the review. The review team determined evidence of case compliance with each of the HFS-selected scored elements. A score of *Yes*, *No*, or *Not Applicable (N/A)* was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Yes* or *No*. These scores indicated the health plan's compliance with the requirements. HSAG also used a designation of *N/A* if the requirement was not applicable to a record; *N/A* findings were not included in the two-point scoring methodology.

HSAG calculated the score by adding the score from each eligible case and dividing the summed scores by the total number of eligible cases. HSAG aggregated the results across all records by health plan, waiver population, and performance measure.

Interrater Reliability (IRR)

To ensure accuracy of the reviews, HSAG conducted IRR on all review team members. The IRR reviews were conducted by the HSAG senior project manager for 10 percent of all records completed by each individual reviewer via over-read of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95 percent was required, with the reviewer completing retraining if required. Reviews were completed across all waivers, program types, and health plans to ensure continued compliance to the 95 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent.

Remediation Actions and Tracking

As a result of the on-site reviews, HSAG identified noncompliant performance and contract measures. HSAG's web-based abstraction tool and reporting database included a remediation tracking function which detailed the findings of noncompliance related to waiver performance measures and HealthChoice contract requirements. Health plans and HFS had access to their respective reports and the remediation tracking database via the HSAG Web portal.

HSAG notified HFS of the online availability of each health plan's report of findings within 30 days of each review. Once approved by the State, the report of findings was forwarded to each health plan to complete remediation actions. Remediation actions were defined in the HealthChoice contract and were specific to each CMS waiver performance measure and contract finding. The remediation tracking database tracked the date the health plan was notified of findings, the date the health plan reported the remediation action was completed, and the number of days from notification of the finding until the remediation action was completed.

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of enrollees was maintained. HSAG completed remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans. The results of the remediation validation reviews are reported in Section 3 of this report.

3. MLTSS Overall Summary of Record Review Findings for SFY 2022

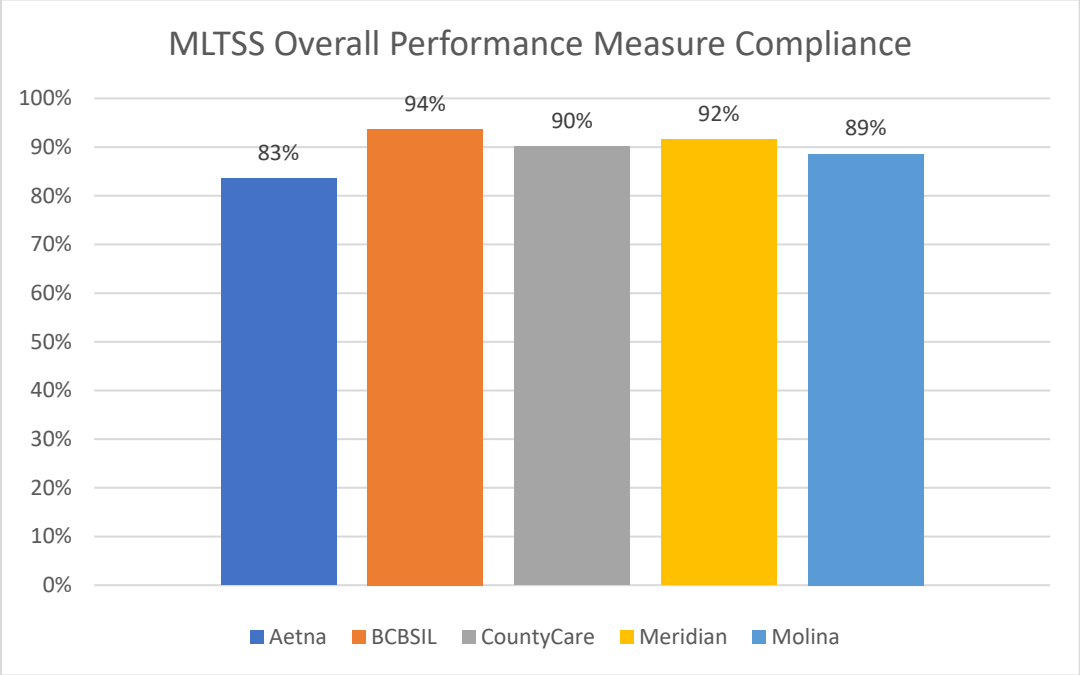
Overall Performance

Overall Health Plan Performance and Comparisons

Five health plans were reviewed during SFY 2022. Figure 3-1 displays a computed average of the total performance achieved by each health plan on the 21 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 21 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Three of the five health plans averaged 90 percent or greater compliance in SFY 2022. There was an 11-percentage-point difference (83 percent to 94 percent) among health plans.

Figure 3-1—Overall Compliance



Statistical significance testing was also performed to compare each health plan's average overall compliance against all other health plans, and the following differences were identified:

- BCBSIL performed at a statistically significantly higher rate than all other health plans.
- Aetna performed at a statistically significantly lower rate than all other health plans.
- Molina performed at a statistically significantly lower rate than BCBSIL, CountyCare, and Meridian.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2022. Comparisons for overall performance from SFY 2021 to SFY 2022 were not completed, as the total number of performance measures reviewed was different in each FY. Health plan-specific performance on all performance measures by quarter is included in Appendix C. Individual health plan performance analyses identified the following for measures that were in place at the end of SFY 2022.

Aetna

Analysis identified that Aetna achieved a compliance rate of 90 percent or greater in nine of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Aetna achieved a statistically significant increase in three performance measures and demonstrated a statistically significant decrease in one measure. When SFY 2022 performance was compared to SFY 2021 performance, Aetna demonstrated a statistically significant decrease in six measures.

Analysis identified that Aetna's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 60 percent compliance rate. Aetna also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with a 65 percent compliance rate; and Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 71 percent compliance rate.

BCBSIL

Analysis identified that BCBSIL achieved a compliance rate of 90 percent or greater in 14 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, BCBSIL achieved a statistically significant increase in four performance measures. When SFY 2022 performance was compared to SFY 2021 performance, BCBSIL achieved a statistically significant increase in one measure and demonstrated a statistically significant decrease in one measure.

Analysis identified that BCBSIL's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with an 87 percent compliance rate. BCBSIL also had opportunity for improvement in Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with an 88 percent compliance rate.

CountyCare

Analysis identified that CountyCare achieved a compliance rate of 90 percent or greater in 11 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, CountyCare demonstrated a statistically significant decrease in three performance measures. When SFY 2022 performance was compared to SFY 2021 performance, CountyCare achieved a statistically significant increase in one performance measure and demonstrated a statistically significant decrease in one measure.

Analysis identified that CountyCare's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 71 percent compliance rate. CountyCare also had opportunity for improvement in Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 75 percent compliance rate.

Meridian

Analysis identified that Meridian achieved a 90 percent or greater compliance rate in 13 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Meridian achieved a statistically significant increase in one performance measure and demonstrated a statistically significant decrease in one performance measure. When SFY 2022 performance was compared to SFY 2021 performance, Meridian demonstrated a statistically significant decrease in three measures.

Analysis identified that Meridian's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 56 percent compliance rate. Meridian also had opportunity for improvement in Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with an 86 percent compliance rate.

Molina

Analysis identified that Molina achieved a 90 percent or greater compliance rate in 11 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Molina demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, Molina achieved a statistically significant increase in two measures.

Analysis identified that Molina's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, and Measure 35D, *the most recent service plan includes signature of enrollee (or*

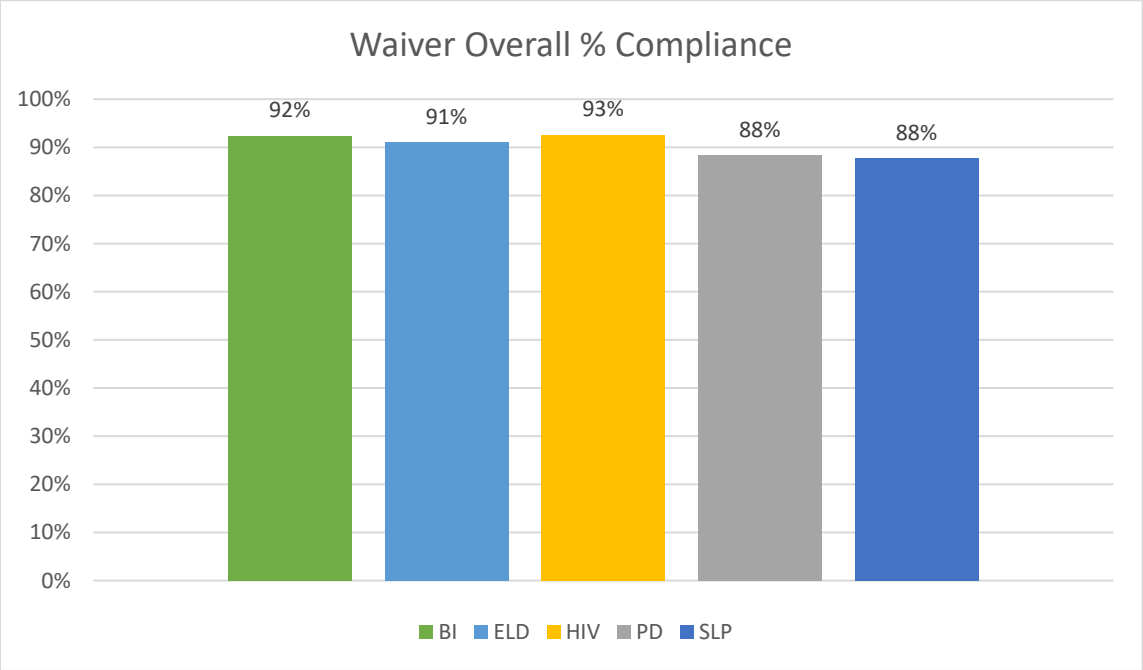
representative), Case Manager, and SLP provider (if applicable) and dates of signatures, both with a 77 percent compliance rate.

Performance by Waiver Type

Comparisons were also analyzed by waiver type, to determine differences and improvement opportunities that may be waiver-specific as opposed to health plan-specific. Appendix D displays waiver compliance per performance measure by quarter.

As Figure 3-2 displays, three of the five waiver types averaged greater than 90 percent overall compliance in SFY 2022.

Figure 3-2—Overall Compliance Across Waiver Types



Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver type's overall compliance from Q1 2022 to Q4 SFY 2022. Comparisons for overall performance from SFY 2021 to SFY 2022 were not completed, as the total number of performance measures reviewed was different in each FY. Individual waiver performance analyses identified the following for measures that were in place at the end of SFY 2022.

BI Waiver

Fourteen performance measures were assessed for the BI waiver. Analysis identified that the BI waiver achieved a 90 percent or greater compliance rate in 12 of the 14 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the BI waiver achieved a statistically significant increase in one performance measure. When SFY 2022 performance was compared to SFY 2021 performance, the BI waiver achieved a statistically significant increase in two performance measures and demonstrated a statistically significant decrease in one performance measure.

Analysis identified that the greatest opportunity for improvement for the BI waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 65 percent compliance rate.

ELD Waiver

Twenty performance measures were assessed for the ELD waiver. Analysis identified that the ELD waiver achieved a 90 percent or greater compliance rate in ten of the 20 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the ELD waiver demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, the ELD waiver demonstrated a statistically significant decrease in three performance measures.

Analysis identified that the greatest opportunity for improvement for the ELD waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 75 percent compliance rate. The ELD waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with a 77 percent compliance rate.

HIV Waiver

Fourteen performance measures were assessed for the HIV waiver. Analysis identified that the HIV waiver achieved a 90 percent or greater compliance rate in 11 of the 14 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the HIV waiver demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, the HIV waiver achieved a statistically significant increase in one measure.

Analysis identified that the greatest opportunity for improvement for the HIV waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 64 percent compliance rate.

PD Waiver

Seventeen performance measures were assessed for the PD waiver. Analysis identified that the PD waiver achieved a 90 percent or greater compliance rate in nine of the 17 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the PD waiver achieved a statistically significant increase in two measures and demonstrated a statistically significant decrease in one measure. When SFY 2022 performance was compared to SFY 2021 performance, the PD waiver demonstrated a statistically significant decrease in two measures.

Analysis identified that the greatest opportunity for improvement for the PD waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 75 percent compliance rate. The PD waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with an 81 percent compliance rate.

SLP Waiver

Ten performance measures were assessed for the SLP waiver. Analysis identified that the SLP waiver achieved a 90 percent or greater compliance rate in six of the 10 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the SLP waiver demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, the SLP waiver demonstrated a statistically significant decrease in four performance measures.

Analysis identified that the greatest opportunity for improvement for the SLP waiver related to Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 61 percent compliance rate. The SLP waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with an 83 percent compliance rate.

Performance by Measure

Comparisons were also analyzed by performance measure. Trending analysis graphs are included in Appendix B.

Table 3-1—Analysis of CMS Performance Measure Compliance

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
20C *A PA evaluation was completed annually.*	This measure achieved a statistically significant increase from Q1 to Q4. Aetna, BCBSIL, and Meridian achieved a statistically significant increase from Q1 to Q4. The BI and PD waivers achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, CountyCare and Molina achieved a statistically significant increase in SFY 2022.
31D/D1 *The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Aetna demonstrated a statistically significant decrease in SFY 2022.
32D/D2 *The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).*	This measure demonstrated stable performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Aetna demonstrated a statistically significant decrease in SFY 2022.
33D/D3 *The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.*	This measure demonstrated stable performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, the SLP waiver demonstrated a statistically significant decrease in SFY 2022.
34D *(ELD waiver)* *The enrollee reported he/she received the services he/she needed when he/she needed them.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
35D *The most recent service plan includes signature of enrollee (or representative), case manager, and SLP provider (if applicable) and dates of signatures.*	This measure demonstrated a statistically significant decrease from Q1 to Q4. Compared to Q1, Aetna and CountyCare demonstrated a statistically significant rate decrease in Q4. Compared to Q1, the PD waiver demonstrated a statistically significant rate decrease in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna, BCBSIL, CountyCare, and Meridian demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, the BI, ELD, PD, and SLP waivers demonstrated a statistically significant decrease in SFY 2022.
36D/D6 *PD and ELD waiver—The case manager made contact every 90 days with the enrollee, or there is valid justification in the record.* *HIV waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.* *BI waiver—The case manager made valid contact with the enrollee at least once a month, or valid justification is documented in the enrollee's record.*	The evaluation criteria for this measure were revised in Q3 for the PD and ELD waivers to align contact requirements with contract language; therefore, statistical analysis could not be conducted for the SFY. Rates for all health plans significantly decreased after the evaluation criteria revision, indicating that the health plans were less successful in meeting 90-day time frames for PD and ELD waiver enrollees (previously assessed as annual contact).	Due to evaluation criteria changes in Q3 SFY 2022, historic data were not comparable and statistical analysis could not be completed.
37D/D7 *The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	This measure demonstrated stable performance from Q1 to Q4. Compared to Q1, CountyCare and Meridian demonstrated a statistically significant rate decrease in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna and Meridian demonstrated a statistically significant rate decrease in this measure in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
		Compared to SFY 2021, the ELD and PD waivers demonstrated a statistically significant rate decrease in this measure in SFY 2022.
38D/D8 *The care/service plan was updated when the enrollee needs changed or upon enrollee request.*	This measure demonstrated stable performance from Q1 to Q4. Compared to Q1, Aetna achieved a statistically significant rate increase in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna demonstrated a statistically significant rate decrease in this measure in SFY 2022. Compared to SFY 2021, the ELD and SLP waivers demonstrated a statistically significant rate decrease in this measure in SFY 2022.
39D/D9 *Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.*	This measure achieved a statistically significant increase from Q1 to Q4. Compared to Q1, Aetna and BCBSIL achieved a statistically significant rate increase in Q4. Compared to Q1, the PD waiver realized a statistically significant rate increase in Q4.	Compared to SFY 2021, this measure realized a statistically significant rate increase in SFY 2022. Compared to SFY 2021, BCBSIL achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, the BI and HIV waivers realized a statistically significant rate increase in this measure in SFY 2022.
40D *(ELD waiver)* *The enrollee reported he/she received all services listed in the plan of care.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
41D/D10 *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
42G/G1 *The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	This measure demonstrated stable performance from Q1 to Q4. Compared to Q1, CountyCare demonstrated a statistically significant rate decrease in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Aetna and Meridian demonstrated a statistically significant decrease in this measure in SFY 2022. Compared to SFY 2021, the SLP waiver demonstrated a statistically significant decrease in this measure in SFY 2022.
44C *The enrollee reported satisfaction with his/her PA.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
44G/G7 *(ELD waiver)* *The enrollee reported he/she was being treated well by direct support staff.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
49G/D4 *(ELD, BI, HIV, and PD waivers)* *The most recent service plan includes a backup plan that includes the name of the backup.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, Molina achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, the BI waiver realized a statistically significant rate increase in this measure in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
A5 *(ELD and PD waivers)* *Does the enrollee report the ADS facilitates independent choice while attending ADS?*	There were no cases eligible for this measure during FY2022.	Not applicable; new measure effective FY2022.
A5-ELD *(ELD waiver)* *Does the enrollee report participation in meaningful activities that help meet their goals/needs?*	New measure effective Q4 FY2022.	Not applicable; new measure effective FY2022.
A6-SIGN *(ELD and PD waivers)* *Was the enrollee provided choice of directing services received at the ADS setting?*	There were no cases eligible for this measure during FY2022.	Not applicable; new measure effective FY2022.
A6-SUPP *(ELD and PD waivers)* *Did the enrollee report he/she feels supported in making decisions to remain independent?*	There were no cases eligible for this measure during FY2022.	Not applicable; new measure effective FY2022.
G8 *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?*	New measure effective Q4 FY2022.	Not applicable; new measure effective FY2022.

Analysis of Lowest-Scoring Measures

The health plans had the greatest opportunities for improvement related to the following performance measures:

- Measure D6, *the case manager made timely contact with the enrollee, or there is valid justification in the record*, which averaged a 71 percent compliance rate.
- Measure D7, *the most recent service plan is in the record and completed in a timely manner*, which averaged an 84 percent compliance rate.
- Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, which averaged a compliance rate of 82 percent.

Measure D6

Overall compliance rates on Measure D6 averaged 71 percent. In Q3 FY2022, evaluation criteria for this measure for the PD and ELD waivers were aligned with contract language, requiring enrollee contact

every 90 days; historic performance for the PD and ELD waivers measured enrollee contact once annually. When compliance with contact every 90 days was compared to annual contact, the health plans performed worse, indicating that the health plans were less successful in contacting the enrollee every 90 days than annually.

Each waiver type has a different requirement for contact, ranging from once a month to annually. A health plan may be more successful maintaining annual contact rather than monthly contact; as a result, performance in D6 can be significantly different across waivers. The greater frequency of contact for the BI and HIV waivers may result in lower performance.

Health plans should conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads. In addition, health plans should ensure that audit processes for the PD and ELD waivers measure performance against contract (and now waiver) requirements, and that case managers are held accountable to meeting contact standards for enrollees in the PD and ELD waivers.

Measure D7

Measure D7 collects information related to the health plan's success in completing annual service plan documentation in a timely manner.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual service plans in a timely manner. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely completion of service plans. Health plans should review COVID-19 PHE processes to ensure that case managers are knowledgeable of documentation requirements related to annual service plan completion.

Measure 35D

Measure 35D collects information related to the health plan's success in obtaining the enrollee's signature on the most recent service plan. In calendar year (CY) 2020, HFS provided guidance to the health plans regarding obtaining verbal consent on service plan renewals due to restrictions from the COVID-19 PHE, including requirements for documentation of witnessed verbal consent. As COVID-19 restrictions have not been lifted, the HCBS record reviews evaluate the health plans' success in documenting witnessed verbal consent for those enrollees unable to be visited at home.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals and witnessed verbal consent indicating a signature on the service plan.

Remediation and Remediation Validation

Remediation

As a result of the on-site reviews, HSAG identified noncompliant performance measures. The health plans received their individualized report of findings subsequent to each on-site record review and were required to remediate the noncompliant findings and implement performance improvement strategies to improve the quality of care management/care coordination activities for the waiver enrollees.

Remediation actions were defined in the HealthChoice contract and were specific to each CMS waiver performance measure. The time frame for remediation of findings was 60 days, except for two measures, G1 and D4, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. HSAG monitored compliance with timely remediation of these findings through review of completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2022, all health plans demonstrated full compliance with completion of remediation action documentation for all noncompliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semiannually to determine if health plans had appropriately completed remediation actions. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed. Table 3-2 indicates the number of cases reviewed per health plan for MLTSS.

Table 3-2—Health Plan Remediation Validation Review Totals: MLTSS

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Aetna	12/12	12/13
BCBSIL	9/9	12/12
CountyCare	14/14	14/14
Meridian	13/13	9/10
Molina	12/12	7/7

All health plans received their remediation sample 10 days prior to on-site remediation validation review and were responsible for ensuring all necessary remediation documentation was available during the on-site review. Remediation validation included review of each record in the sample and supporting documentation, to ensure the action taken and completion date documented in the remediation tracking database were consistent with the information in the health plan's care management record and/or staff training records.

Overall remediation validation among the five MLTSS health plans with remediation validation cases averaged 99 percent. Three of the five health plans achieved 100 percent compliance with remediation validation. Aetna and Meridian did not achieve 100 percent compliance; noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2023 and will include review of any records that were found to be not fully remediated during the SFY 2022 reviews.

Appendix A. CMS Performance Measures Description

Table A-1 provides a description of each CMS performance measure, including the identification of waiver-specific measures. Due to HFS performance measure numbering alignment across waivers, measure numbers are listed with their CY2022 measure number for historic tracking.

Table A-1—CMS Waiver Performance Measure Descriptions

Historic Measure #	Measure # CY 2022	Measure Description
20C	**20C**	A PA evaluation was completed annually. Captured only for enrollees with PA service
31D	**D1**	The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.
32D	**D2**	The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).
33D	**D3**	The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.
34D	**34D**	The enrollee reported he/she received the services he/she needed when he/she needed them. ELD waiver only
35D	**35D**	The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.
36D	**D6**	PD and ELD waivers—The case manager made valid contact with the enrollee every 90 days or valid justification is documented in the enrollee's record.
		HIV waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.
		BI waiver—The case manager made valid contact with the enrollee at least one time a month, or valid justification is documented in the enrollee's record.
37D	**D7**	The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
38D	**D8**	The service plan was updated when the enrollee needs changed or upon enrollee request.
39D	**D9**	Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.
40D	**40D**	The enrollee reported he/she received all services listed in the plan of care. ELD waiver only

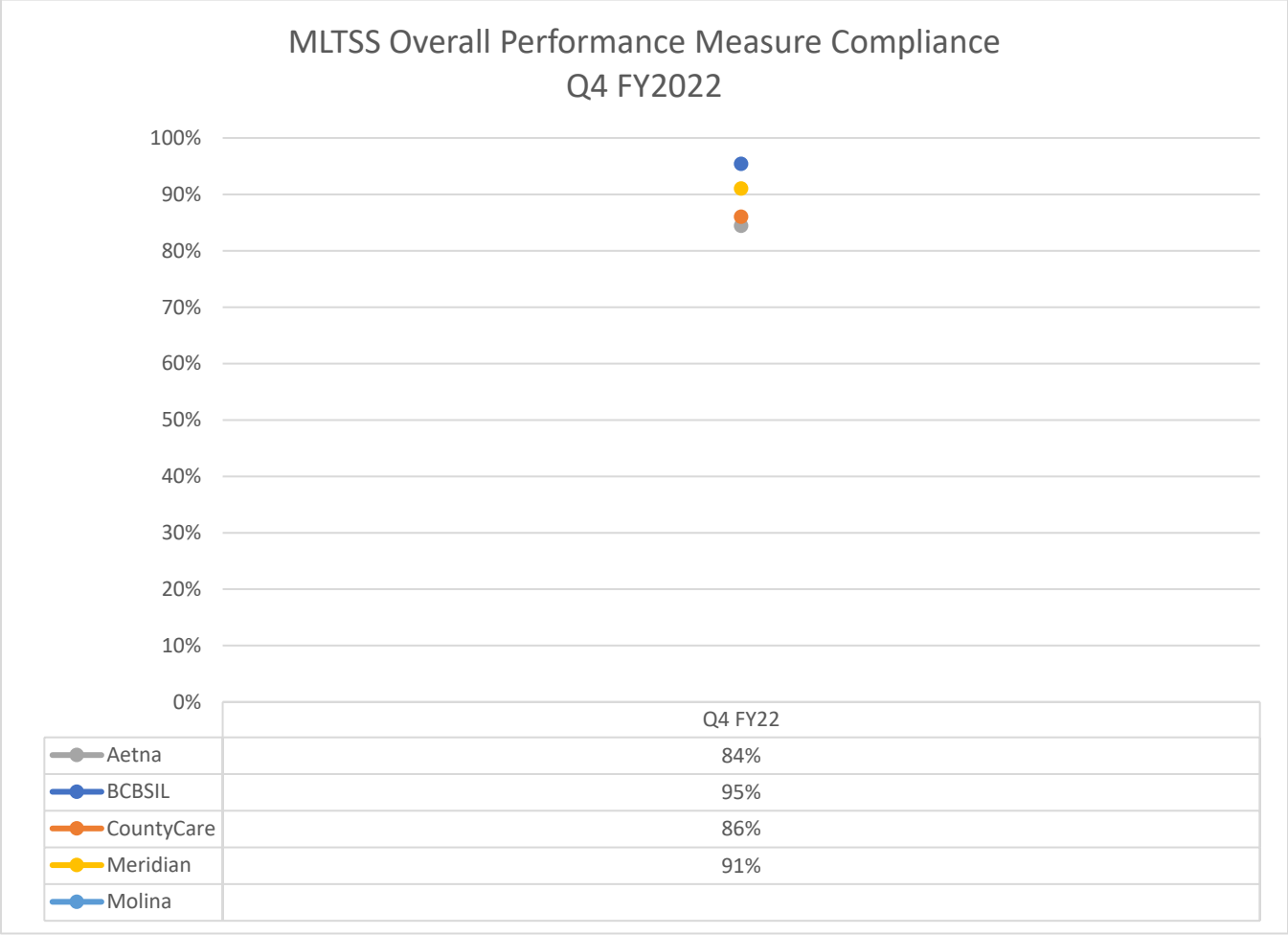
Historic Measure #	Measure # CY 2022	Measure Description
41D	**D10**	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	**G1**	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
44C	**44C**	The enrollee reported satisfaction with his/her PA. Captured only for enrollees with PA service
44G	**G7**	The enrollee reported he/she was being treated well by direct support staff. ELD waiver only
49G	**D4**	Most recent Service Plan includes a backup plan that includes the name of the backup. ELD, BI, HIV, and PD waivers only
Not collected prior to 2022	**A5**	Does the enrollee report the ADS facilitates independent choice while attending ADS? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**A5-ELD**	Does the enrollee report participation in meaningful activities that help meet their goals/needs? Captured only for ELD waiver enrollees receiving ADS
Not collected prior to 2022	**A6-SIGN**	Was the enrollee provided choice of directing services received at the ADS setting? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**A6-SUPP**	Did the enrollee report he/she feel supported in making decisions to remain independent? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**G8**	Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?

Appendix B. Performance Trending—MLTSS

Overall Trend Performance

Figure B-1 displays a computed average of the performance achieved by each health plan on all 21 CMS waiver performance measures reviewed by HSAG. Due to an increase in the number of performance measures collected beginning Q4 FY2022, historic data are not comparable and only data beginning Q4 FY2022 are displayed.

Figure B-1—Overall Compliance



	Q4 FY22
Aetna	84%
BCBSIL	95%
CountyCare	86%
Meridian	91%
Molina	

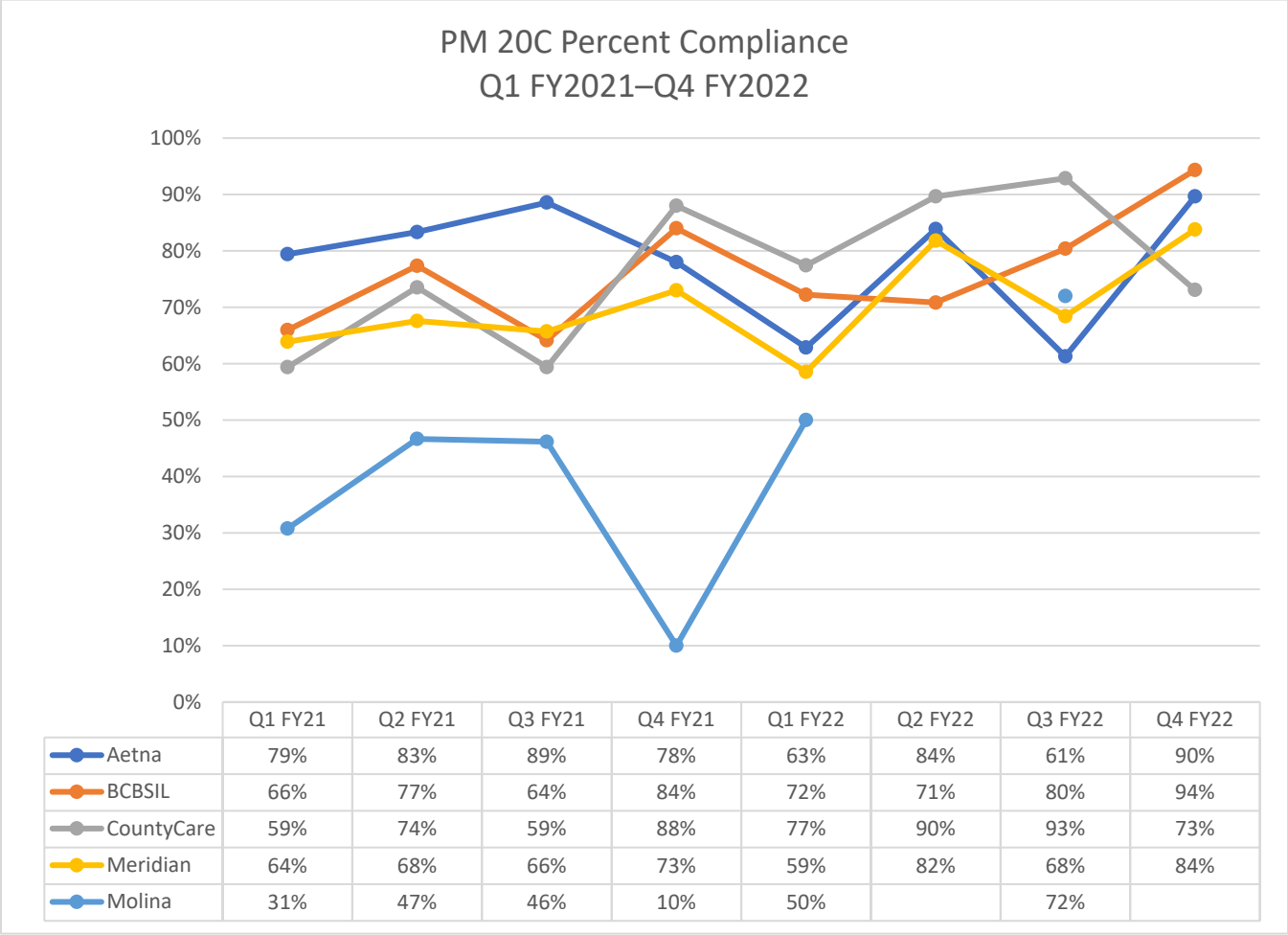
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Performance Measure Findings

Measure 20C—A PA evaluation was completed annually.

New measure beginning FY2021. Captured only for enrollees with PA service.

Figure B-2—Measure 20C

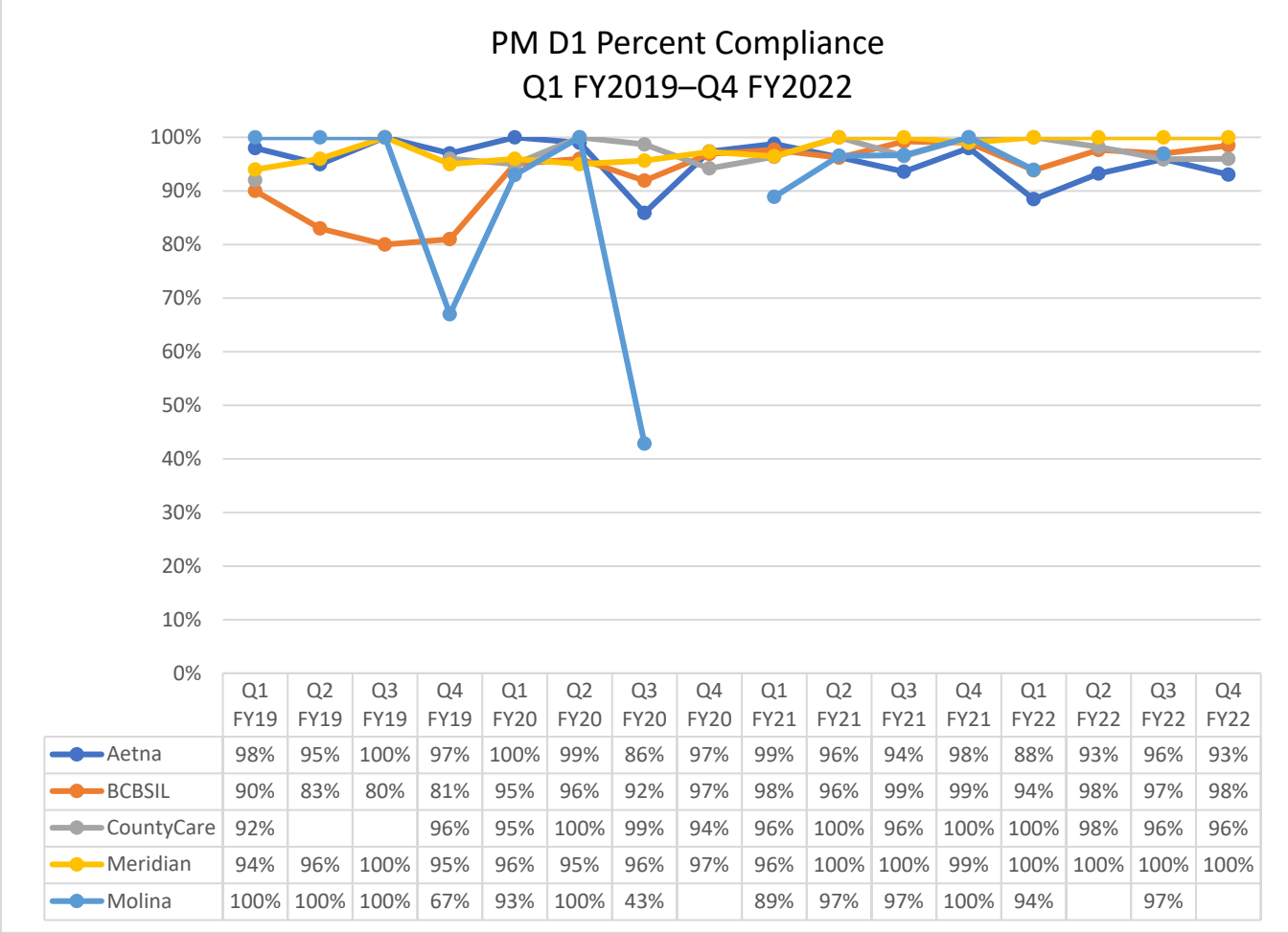


	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	79%	83%	89%	78%	63%	84%	61%	90%
BCBSIL	66%	77%	64%	84%	72%	71%	80%	94%
CountyCare	59%	74%	59%	88%	77%	90%	93%	73%
Meridian	64%	68%	66%	73%	59%	82%	68%	84%
Molina	31%	47%	46%	10%	50%		72%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure D1—The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.

Figure B-3—Measure D1



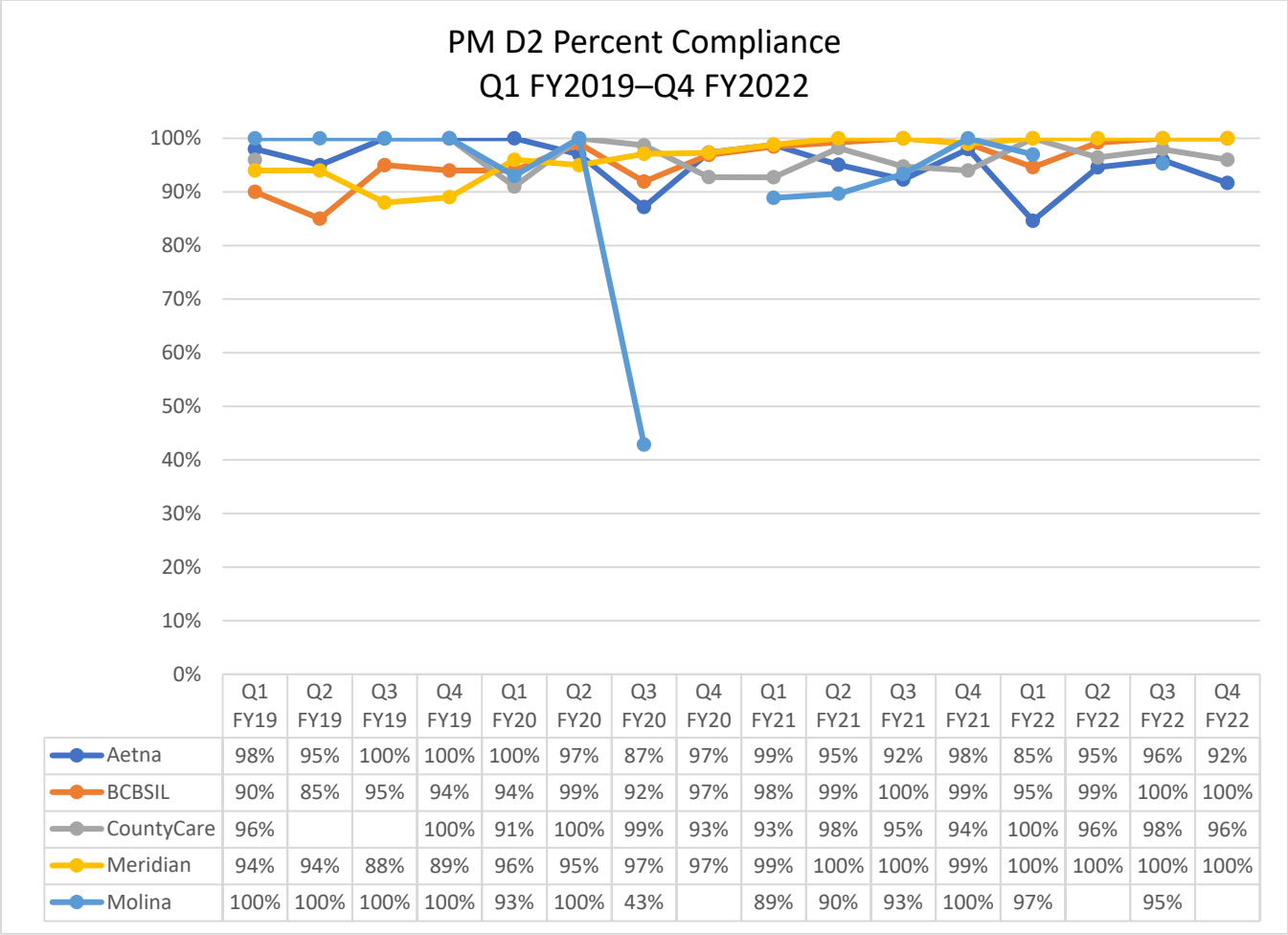
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	98%	95%	100%	97%	100%	99%	86%	97%	99%	96%	94%	98%	88%	93%	96%	93%
BCBSIL	90%	83%	80%	81%	95%	96%	92%	97%	98%	96%	99%	99%	94%	98%	97%	98%
CountyCare	92%			96%	95%	100%	99%	94%	96%	100%	96%	100%	100%	98%	96%	96%
Meridian	94%	96%	100%	95%	96%	95%	96%	97%	96%	100%	100%	99%	100%	100%	100%	100%
Molina	100%	100%	100%	67%	93%	100%	43%		89%	97%	97%	100%	94%		97%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D2—The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).

Figure B-4—Measure D2



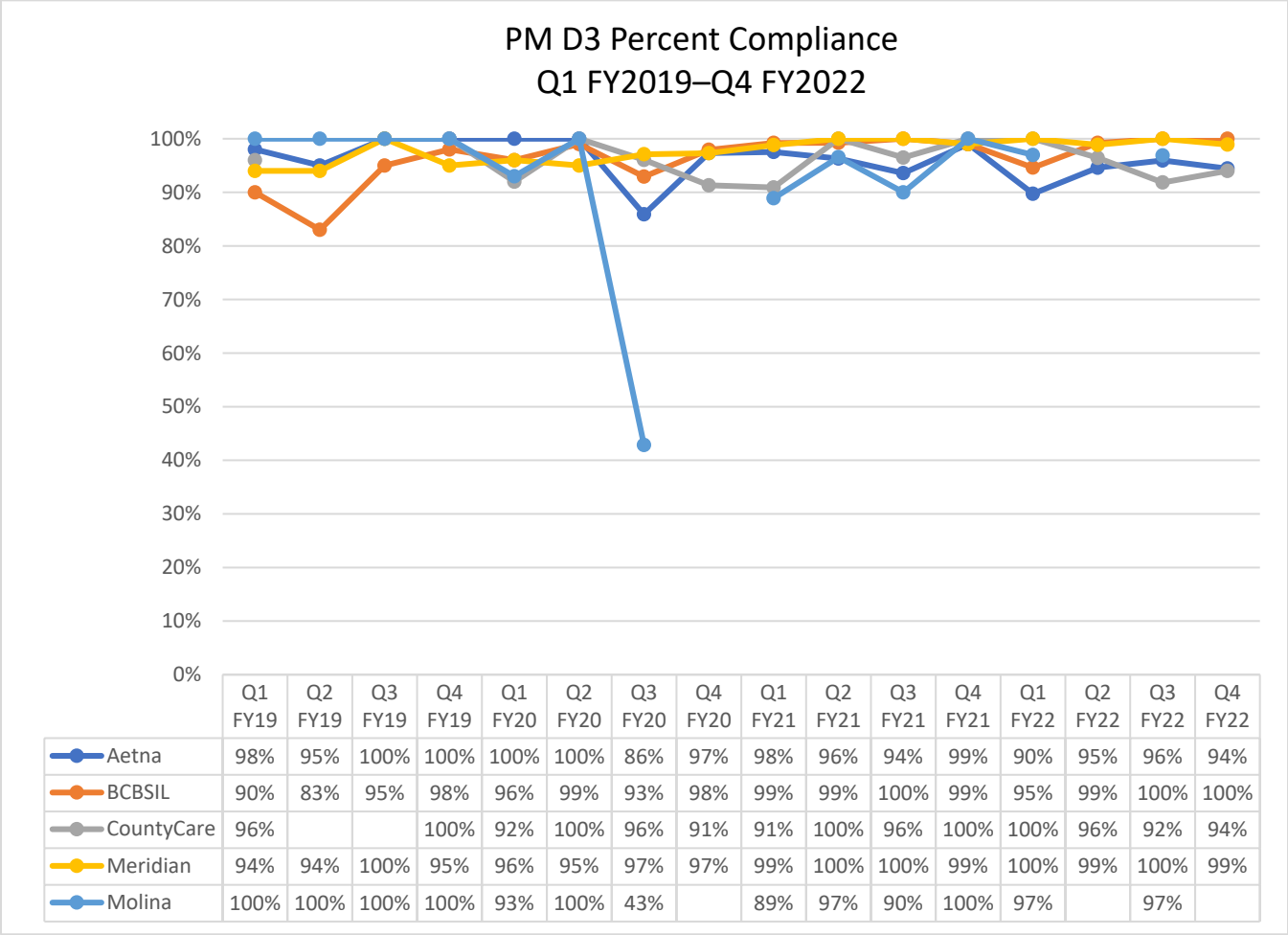
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	98%	95%	100%	100%	100%	97%	87%	97%	99%	95%	92%	98%	85%	95%	96%	92%
BCBSIL	90%	85%	95%	94%	94%	99%	92%	97%	98%	99%	100%	99%	95%	99%	100%	100%
CountyCare	96%			100%	91%	100%	99%	93%	93%	98%	95%	94%	100%	96%	98%	96%
Meridian	94%	94%	88%	89%	96%	95%	97%	97%	99%	100%	100%	99%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	93%	100%	43%		89%	90%	93%	100%	97%		95%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D3—The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.

Figure B-5—Measure D3



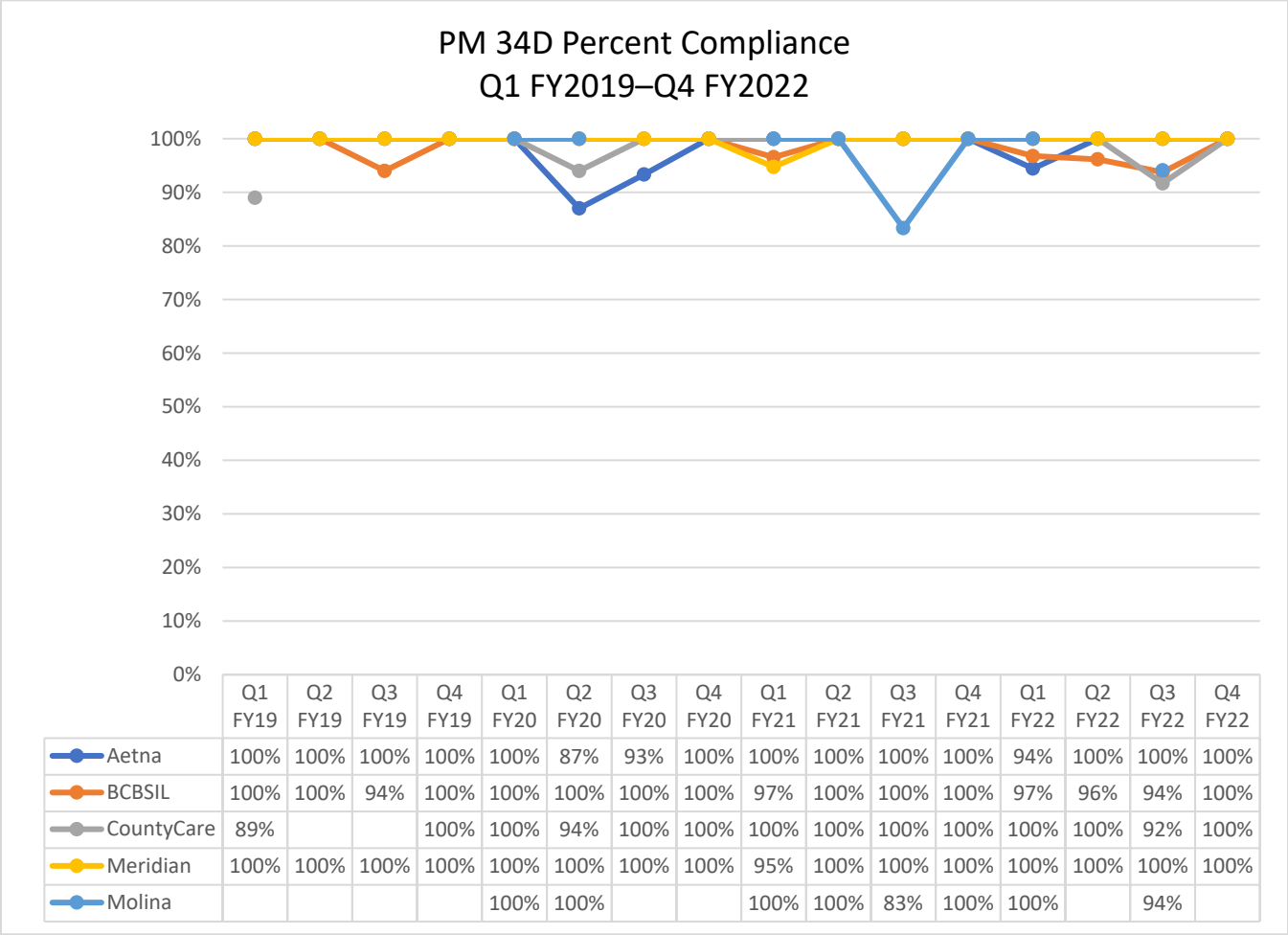
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	98%	95%	100%	100%	100%	100%	86%	97%	98%	96%	94%	99%	90%	95%	96%	94%
BCBSIL	90%	83%	95%	98%	96%	99%	93%	98%	99%	99%	100%	99%	95%	99%	100%	100%
CountyCare	96%			100%	92%	100%	96%	91%	91%	100%	96%	100%	100%	96%	92%	94%
Meridian	94%	94%	100%	95%	96%	95%	97%	97%	99%	100%	100%	99%	100%	99%	100%	99%
Molina	100%	100%	100%	100%	93%	100%	43%		89%	97%	90%	100%	97%		97%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure 34D—The enrollee reported he/she received the services he/she needed when he/she needed them. (ELD waiver only)

Figure B-6—Measure 34D



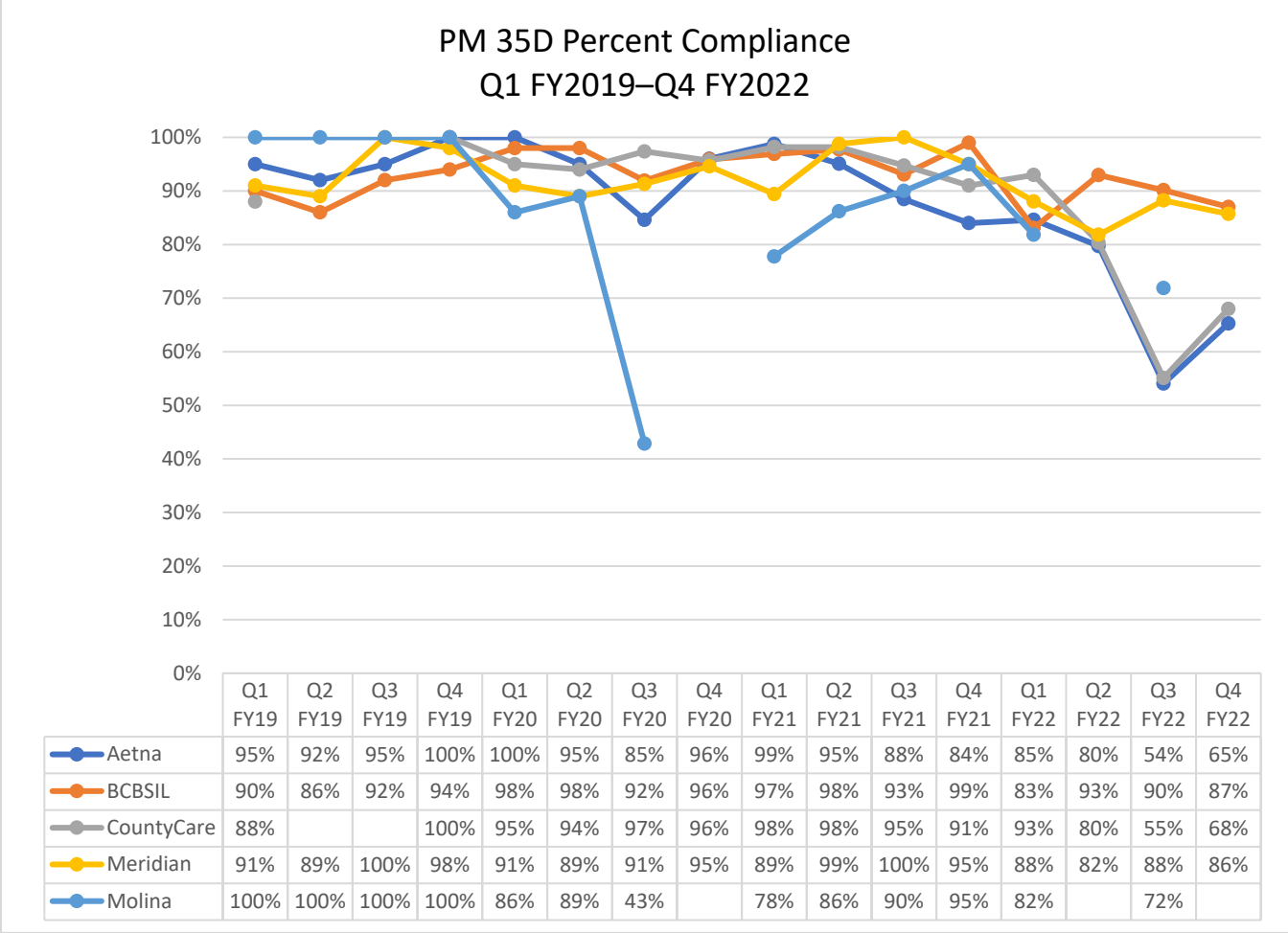
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	100%	100%	100%	100%	100%	87%	93%	100%	100%	100%	100%	100%	94%	100%	100%	100%
BCBSIL	100%	100%	94%	100%	100%	100%	100%	100%	97%	100%	100%	100%	97%	96%	94%	100%
CountyCare	89%			100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%
Molina					100%	100%			100%	100%	83%	100%	100%		94%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure 35D—The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.

Figure B-7—Measure 35D



	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	95%	92%	95%	100%	100%	95%	85%	96%	99%	95%	88%	84%	85%	80%	54%	65%
BCBSIL	90%	86%	92%	94%	98%	98%	92%	96%	97%	98%	93%	99%	83%	93%	90%	87%
CountyCare	88%			100%	95%	94%	97%	96%	98%	98%	95%	91%	93%	80%	55%	68%
Meridian	91%	89%	100%	98%	91%	89%	91%	95%	89%	99%	100%	95%	88%	82%	88%	86%
Molina	100%	100%	100%	100%	86%	89%	43%		78%	86%	90%	95%	82%		72%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

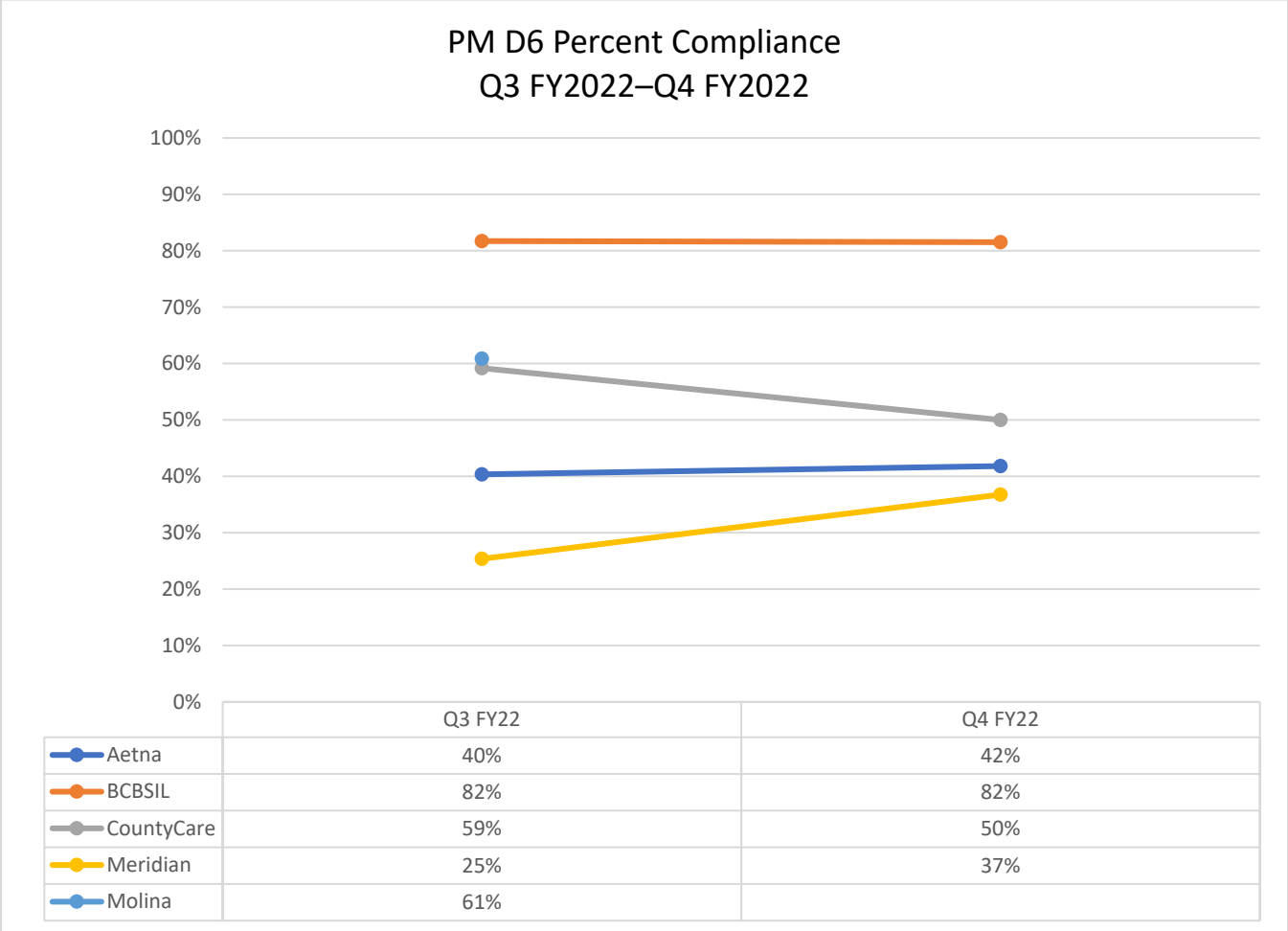
Data prior to FY2019 are available in previous years' reports.

Measure D6—the Case Manager made valid timely contact or valid justification is documented in the enrollee's record.

HIV: One contact per month, with one contact face-to-face bimonthly.
BI: Monthly contact.
PD: Contact every 90 days.
ELD: Contact every 90 days.
SLP records are ineligible for this measure.

Due to the change in evaluation criteria for the PD and ELD waivers beginning Q3 FY2022, historic data are not comparable and only data beginning Q3 FY2022 are displayed.

Figure B-8—Measure D6



	Q3 FY22	Q4 FY22
Aetna	40%	42%
BCBSIL	82%	82%
CountyCare	59%	50%
Meridian	25%	37%
Molina	61%	

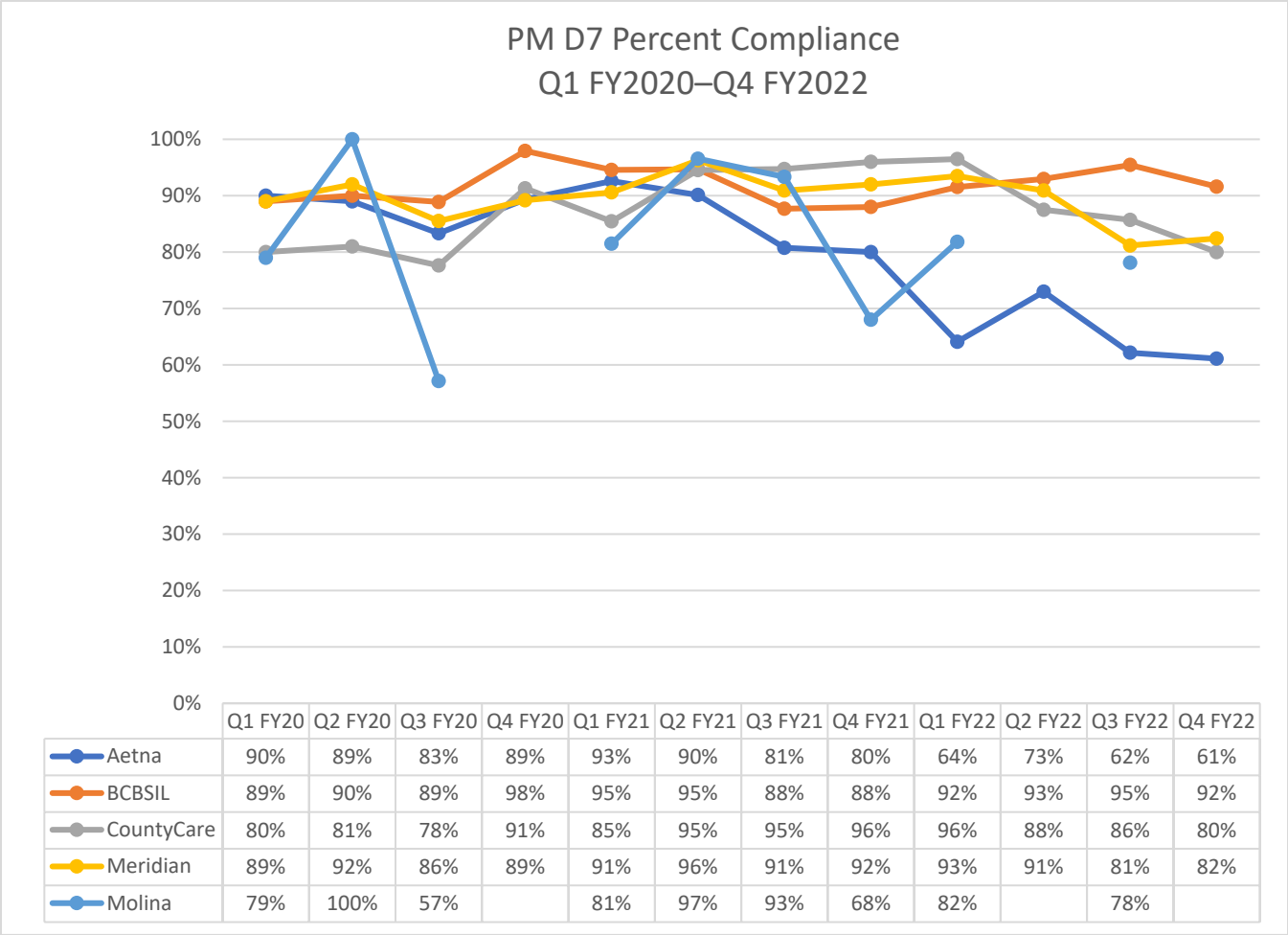
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D7—The most recent service plan is in the record and completed in a timely manner (annually).

Due to changes in performance measure definitions in FY2020, historic data are not comparable and only FY2020 to current data are displayed.

Figure B-9—Measure D7



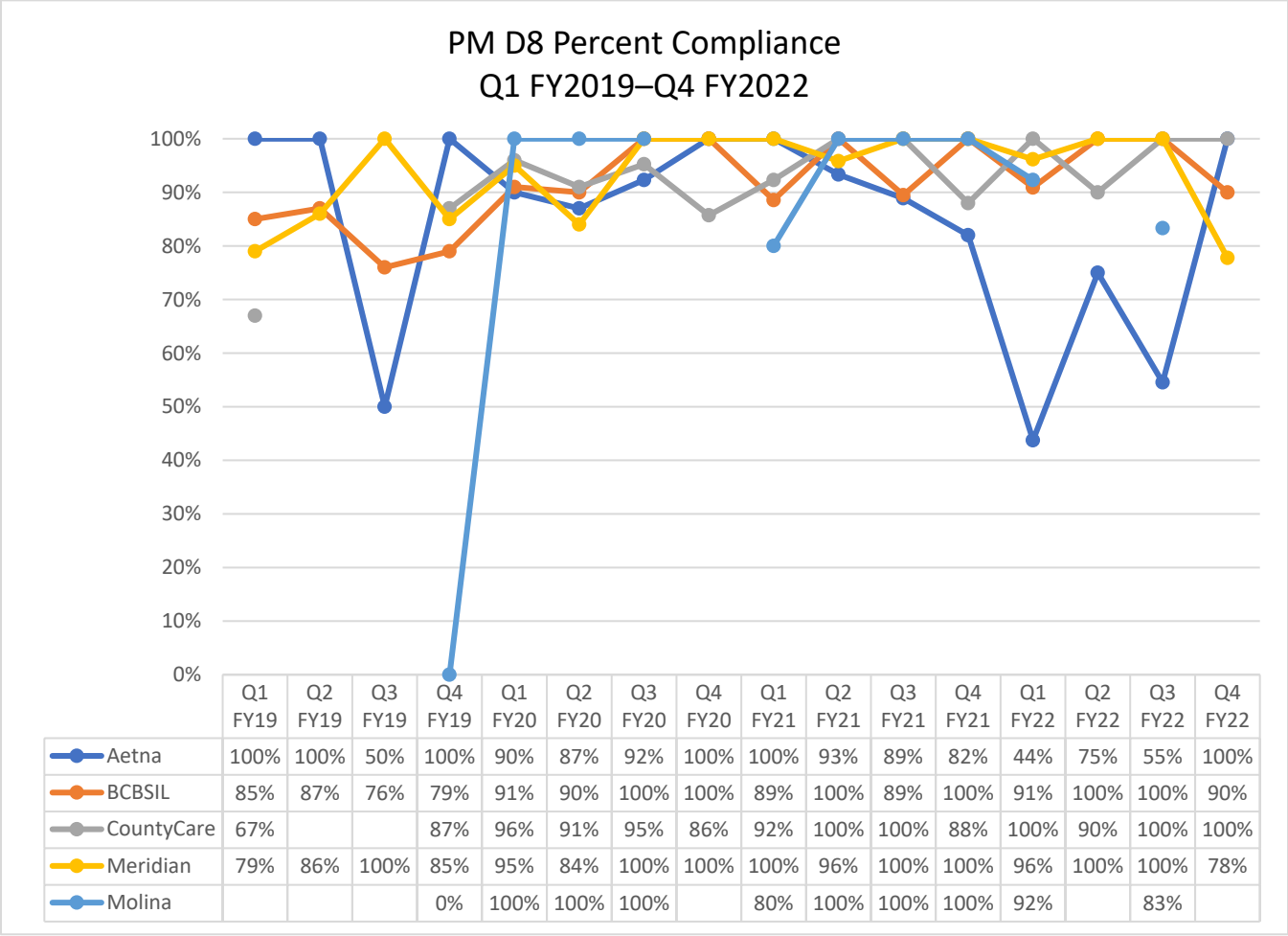
	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	90%	89%	83%	89%	93%	90%	81%	80%	64%	73%	62%	61%
BCBSIL	89%	90%	89%	98%	95%	95%	88%	88%	92%	93%	95%	92%
CountyCare	80%	81%	78%	91%	85%	95%	95%	96%	96%	88%	86%	80%
Meridian	89%	92%	86%	89%	91%	96%	91%	92%	93%	91%	81%	82%
Molina	79%	100%	57%		81%	97%	93%	68%	82%		78%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D8—The service plan was updated when the enrollee needs changed or upon enrollee request.

Figure B-10—Measure D8



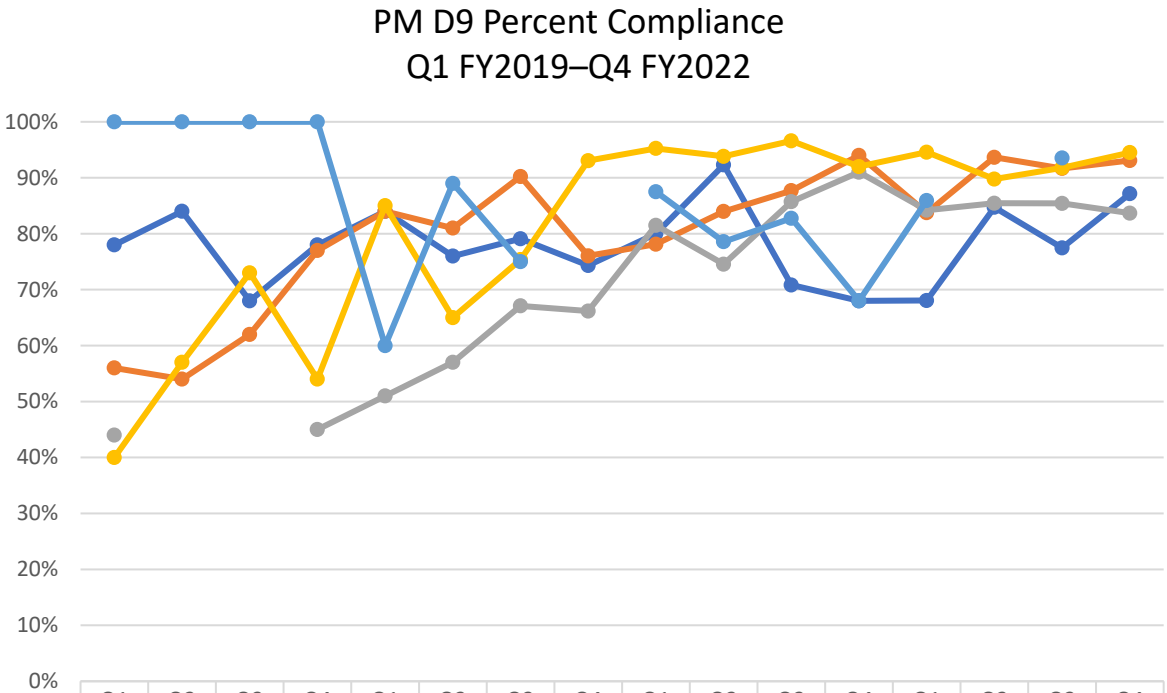
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	100%	100%	50%	100%	90%	87%	92%	100%	100%	93%	89%	82%	44%	75%	55%	100%
BCBSIL	85%	87%	76%	79%	91%	90%	100%	100%	89%	100%	89%	100%	91%	100%	100%	90%
CountyCare	67%			87%	96%	91%	95%	86%	92%	100%	100%	88%	100%	90%	100%	100%
Meridian	79%	86%	100%	85%	95%	84%	100%	100%	100%	96%	100%	100%	96%	100%	100%	78%
Molina				0%	100%	100%	100%		80%	100%	100%	100%	92%		83%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D9—Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.

Figure B-11—Measure D9



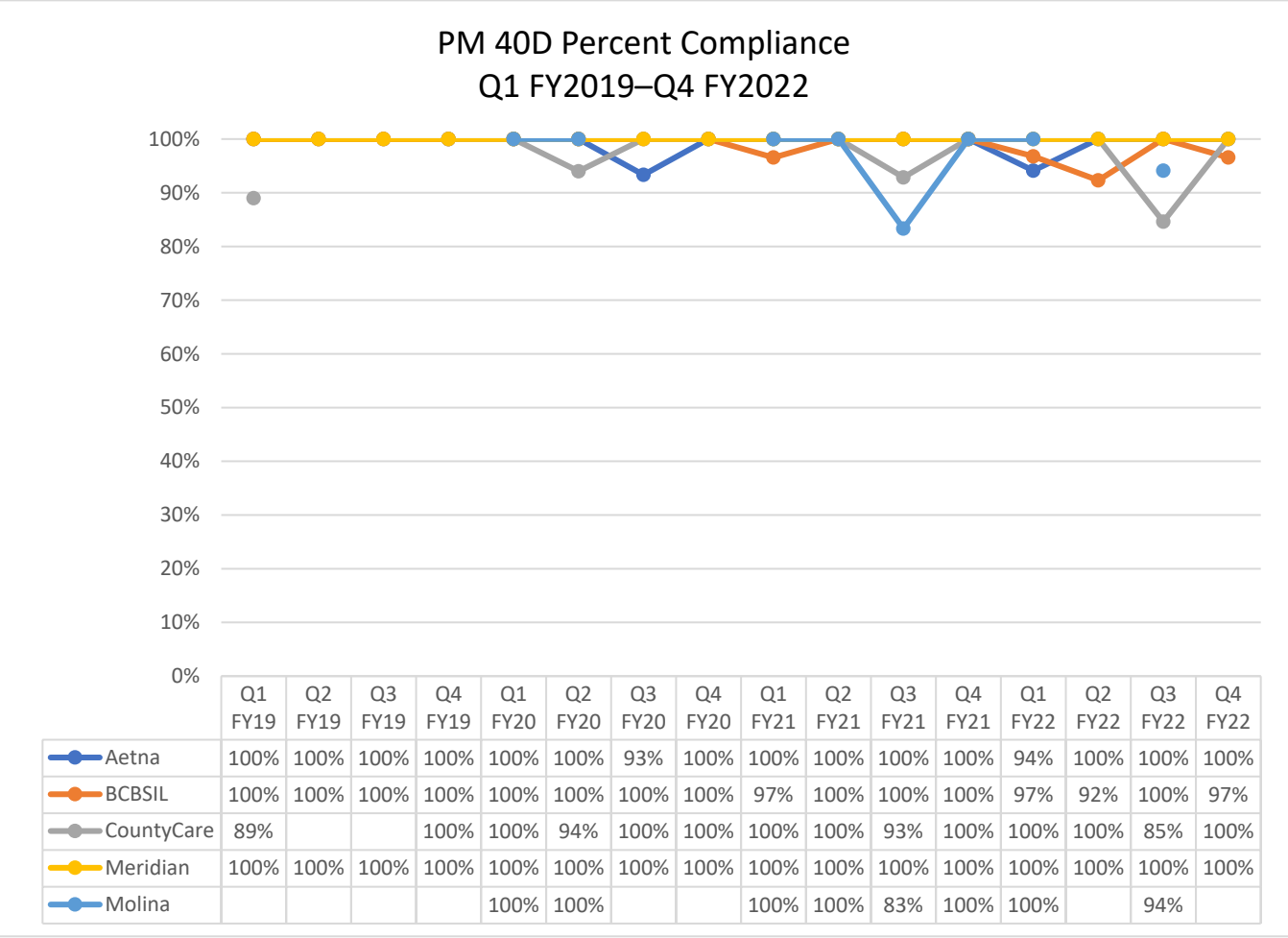
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	78%	84%	68%	78%	84%	76%	79%	74%	80%	92%	71%	68%	68%	85%	77%	87%
BCBSIL	56%	54%	62%	77%	84%	81%	90%	76%	78%	84%	88%	94%	84%	94%	92%	93%
CountyCare	44%			45%	51%	57%	67%	66%	81%	75%	86%	91%	84%	85%	85%	84%
Meridian	40%	57%	73%	54%	85%	65%	75%	93%	95%	94%	97%	92%	95%	90%	92%	95%
Molina	100%	100%	100%	100%	60%	89%	75%		88%	79%	83%	68%	86%		94%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure 40D—The enrollee reported he/she received all services listed in the plan of care. (ELD waiver only)

Figure B-12—Measure 40D



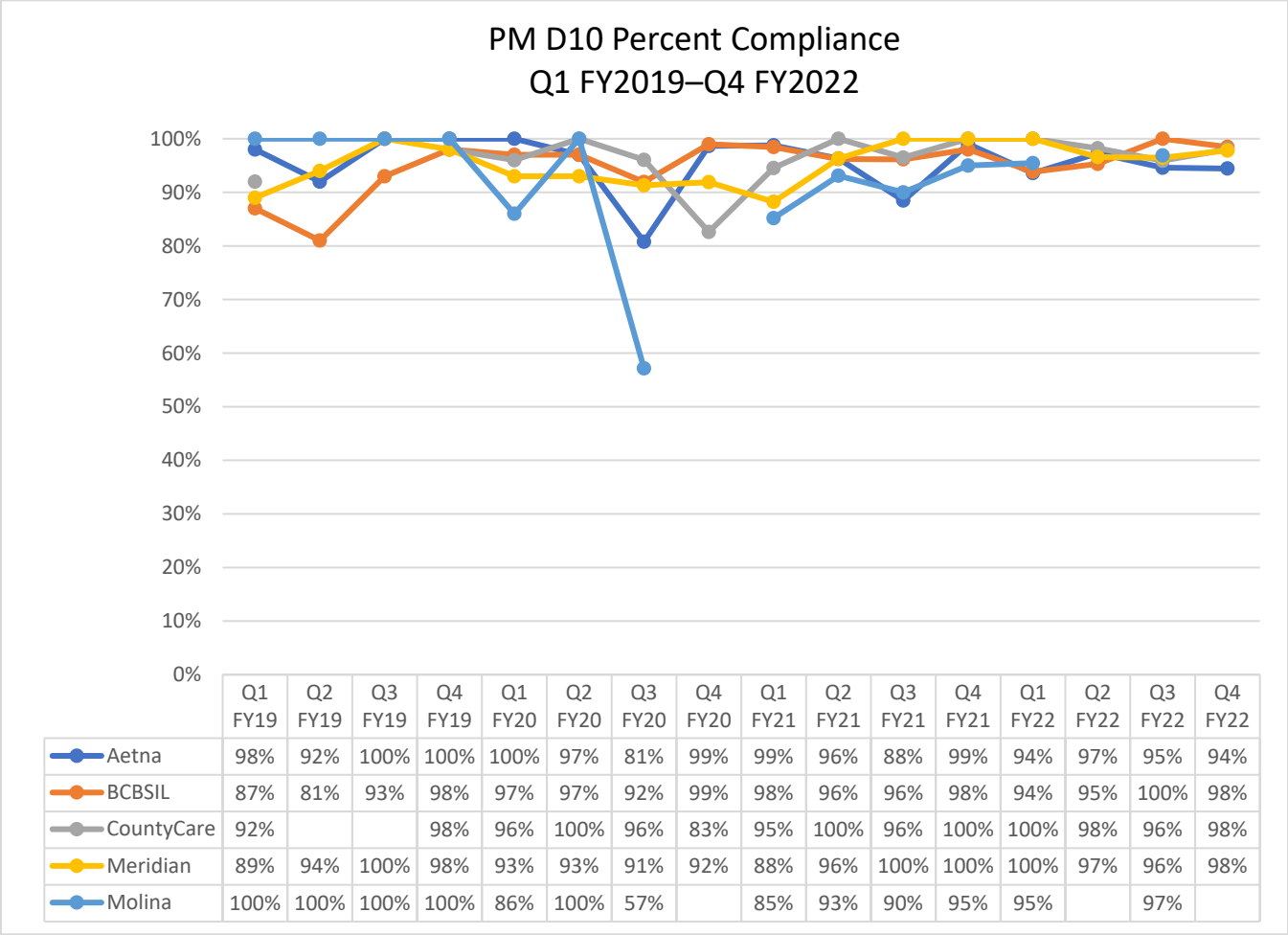
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	94%	100%	100%	100%
BCBSIL	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	97%	92%	100%	97%
CountyCare	89%			100%	100%	94%	100%	100%	100%	100%	93%	100%	100%	100%	85%	100%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina					100%	100%			100%	100%	83%	100%	100%		94%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D10—The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B-13—Measure D10



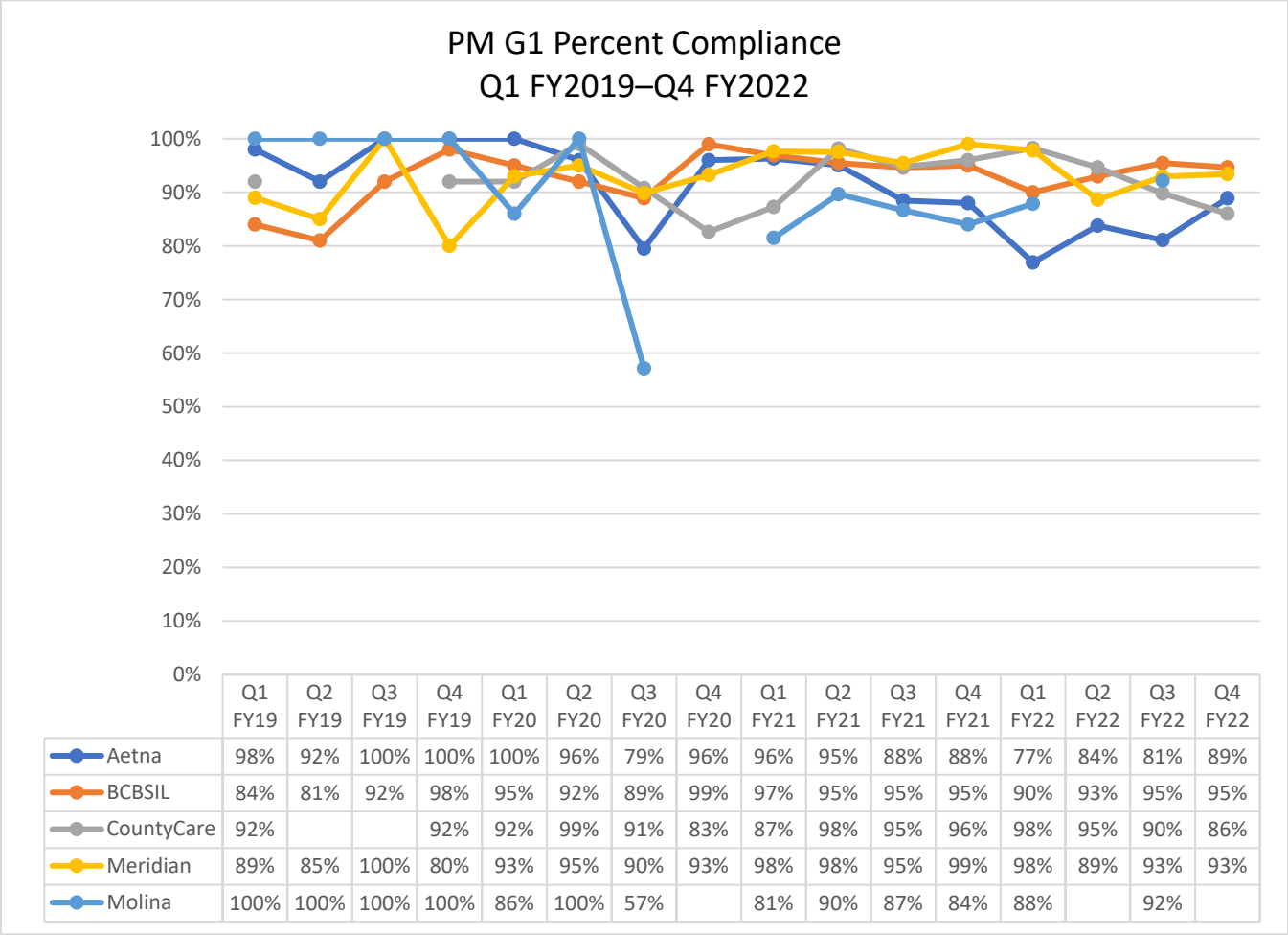
	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	98%	92%	100%	100%	100%	97%	81%	99%	99%	96%	88%	99%	94%	97%	95%	94%
BCBSIL	87%	81%	93%	98%	97%	97%	92%	99%	98%	96%	96%	98%	94%	95%	100%	98%
CountyCare	92%			98%	96%	100%	96%	83%	95%	100%	96%	100%	100%	98%	96%	98%
Meridian	89%	94%	100%	98%	93%	93%	91%	92%	88%	96%	100%	100%	100%	97%	96%	98%
Molina	100%	100%	100%	100%	86%	100%	57%		85%	93%	90%	95%	95%		97%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure G1—The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.

Figure B-14—Measure G1



	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	98%	92%	100%	100%	100%	96%	79%	96%	96%	95%	88%	88%	77%	84%	81%	89%
BCBSIL	84%	81%	92%	98%	95%	92%	89%	99%	97%	95%	95%	95%	90%	93%	95%	95%
CountyCare	92%			92%	92%	99%	91%	83%	87%	98%	95%	96%	98%	95%	90%	86%
Meridian	89%	85%	100%	80%	93%	95%	90%	93%	98%	98%	95%	99%	98%	89%	93%	93%
Molina	100%	100%	100%	100%	86%	100%	57%		81%	90%	87%	84%	88%		92%	

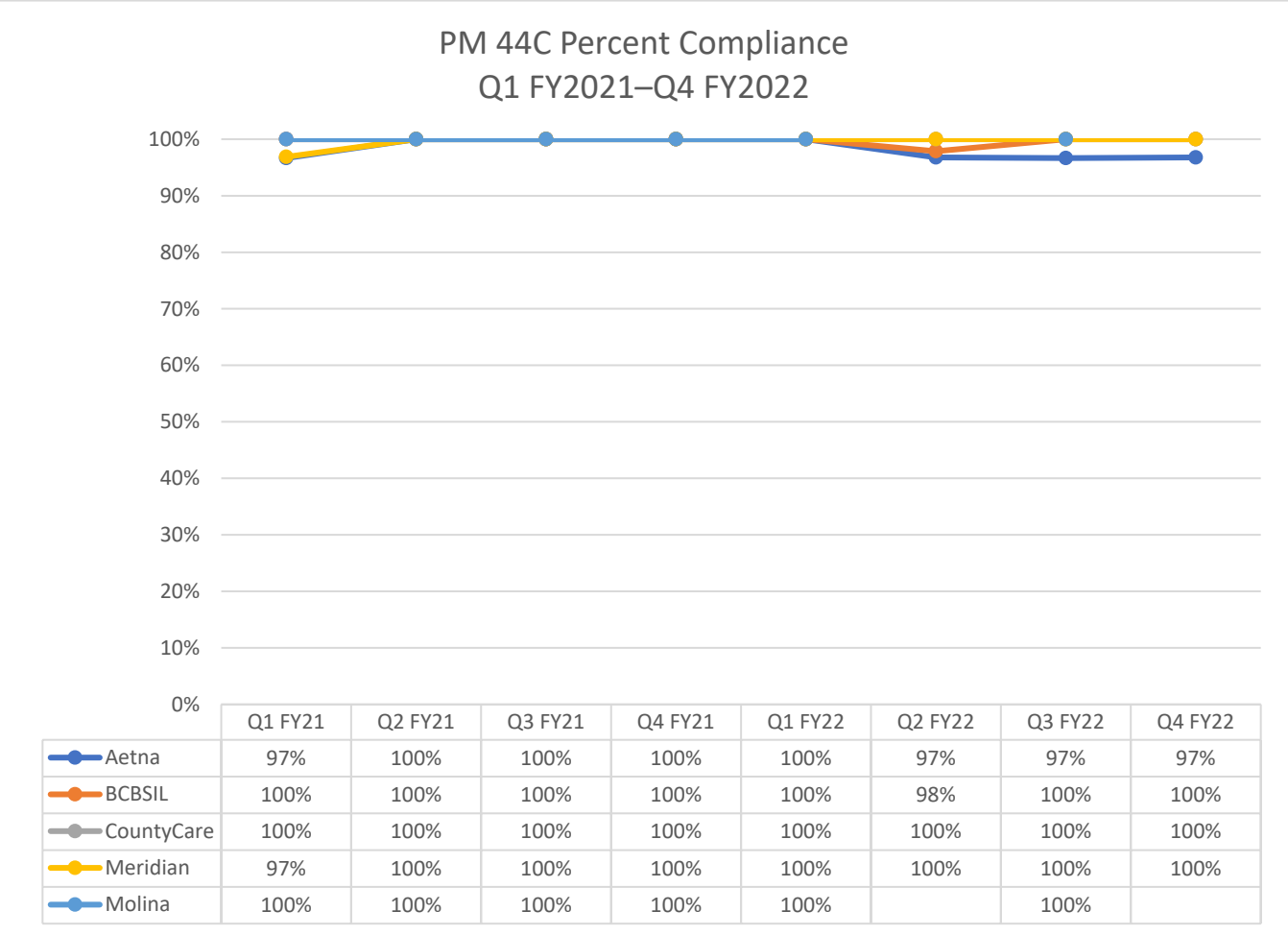
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure 44C—The enrollee reported satisfaction with his/her PA.

New measure beginning FY2021. Captured only for enrollees with PA service.

Figure B-15—Measure 44C

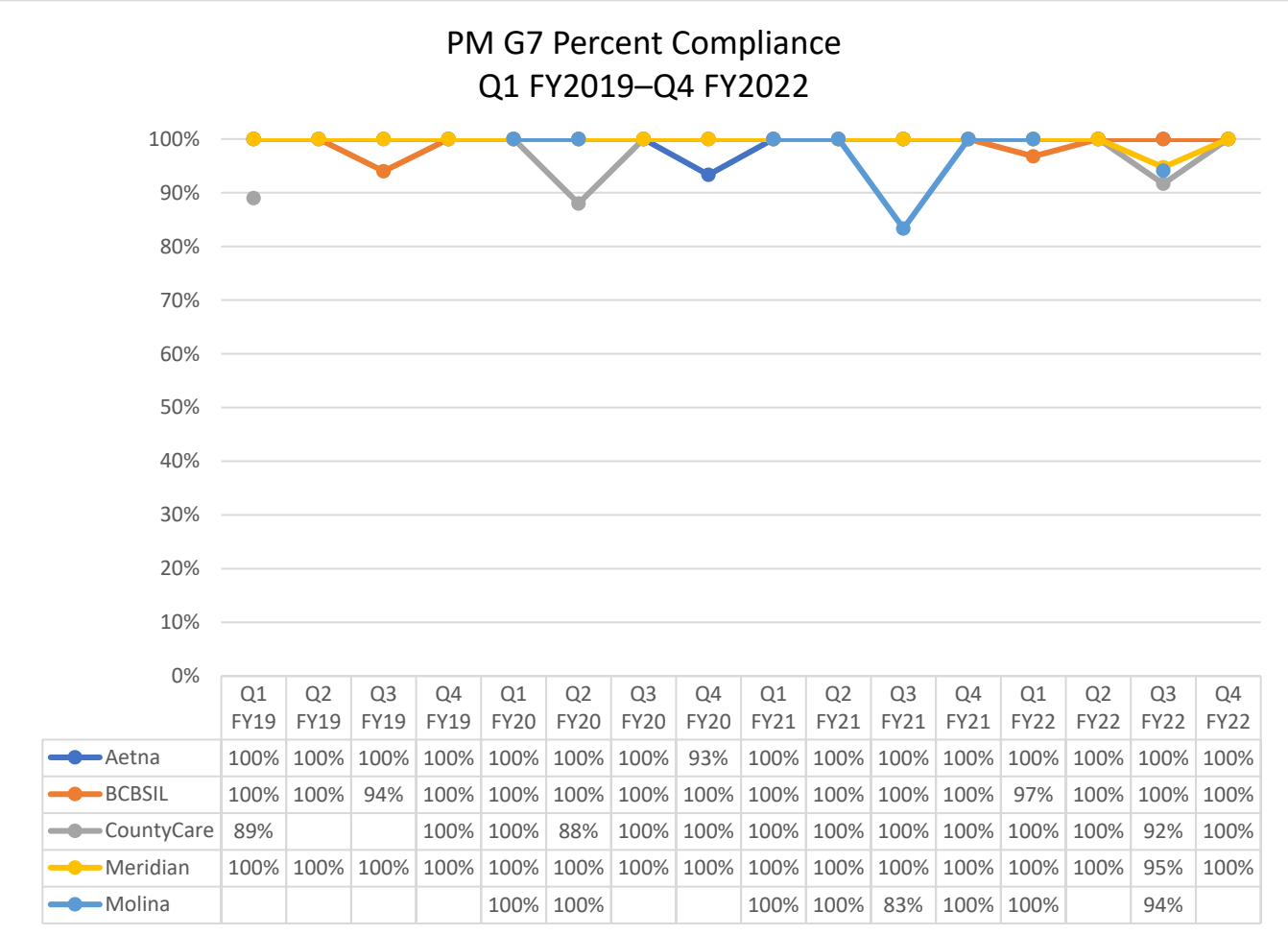


	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	97%	100%	100%	100%	100%	97%	97%	97%
BCBSIL	100%	100%	100%	100%	100%	98%	100%	100%
CountyCare	100%	100%	100%	100%	100%	100%	100%	100%
Meridian	97%	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%		100%	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure G7—The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B-16—Measure G7



	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%
BCBSIL	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%
CountyCare	89%			100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%
Molina					100%	100%			100%	100%	83%	100%	100%		94%	

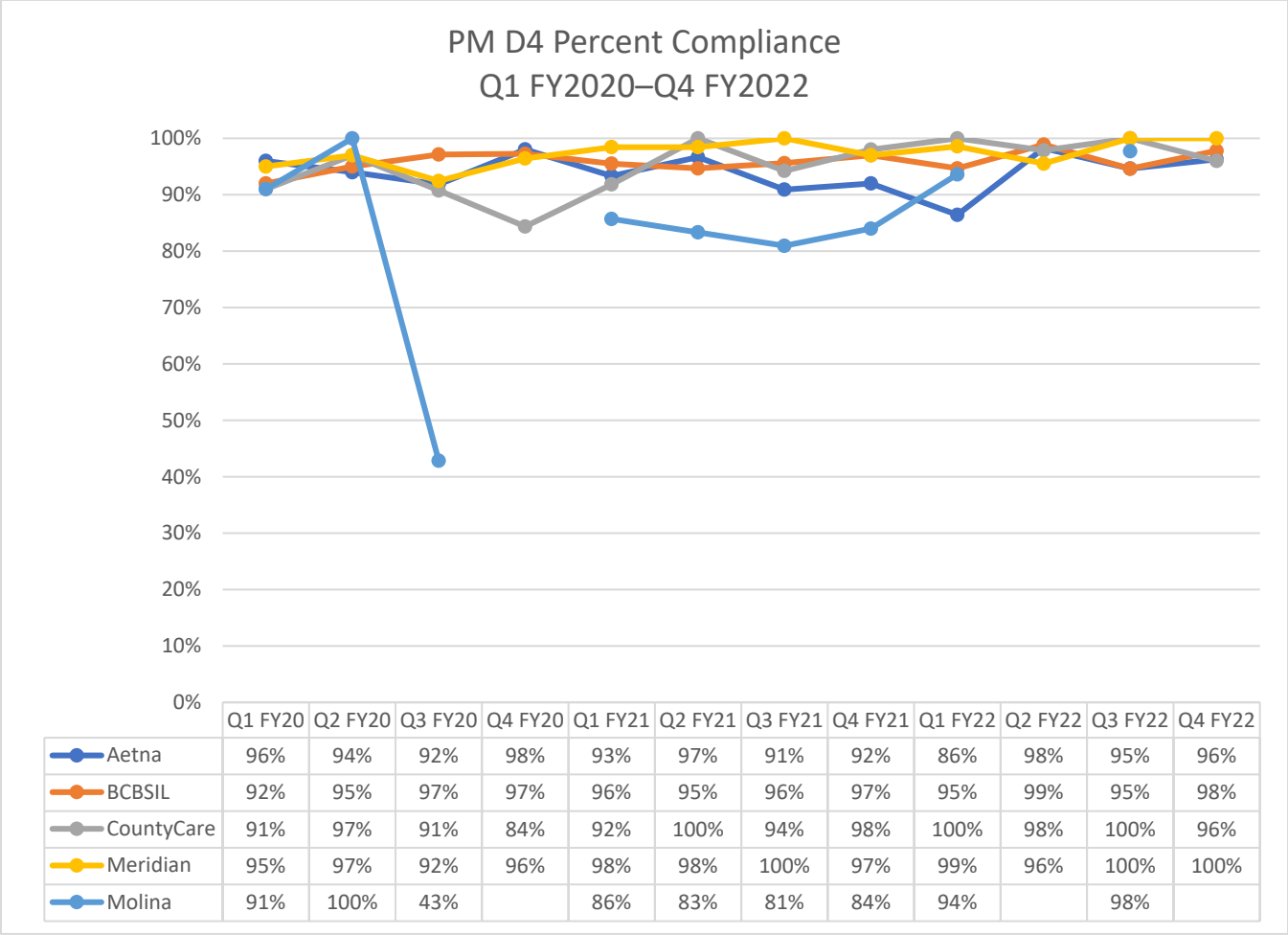
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2019 are available in previous years' reports.

Measure D4—The most recent service plan includes a backup plan that includes the name of the backup. (ELD, BI, HIV, and PD waivers only)

Due to changes in performance measure definitions in FY2020, historic data are not comparable and only FY2020 to current data are displayed.

Figure B-17—Measure D4



	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22
Aetna	96%	94%	92%	98%	93%	97%	91%	92%	86%	98%	95%	96%
BCBSIL	92%	95%	97%	97%	96%	95%	96%	97%	95%	99%	95%	98%
CountyCare	91%	97%	91%	84%	92%	100%	94%	98%	100%	98%	100%	96%
Meridian	95%	97%	92%	96%	98%	98%	100%	97%	99%	96%	100%	100%
Molina	91%	100%	43%		86%	83%	81%	84%	94%		98%	

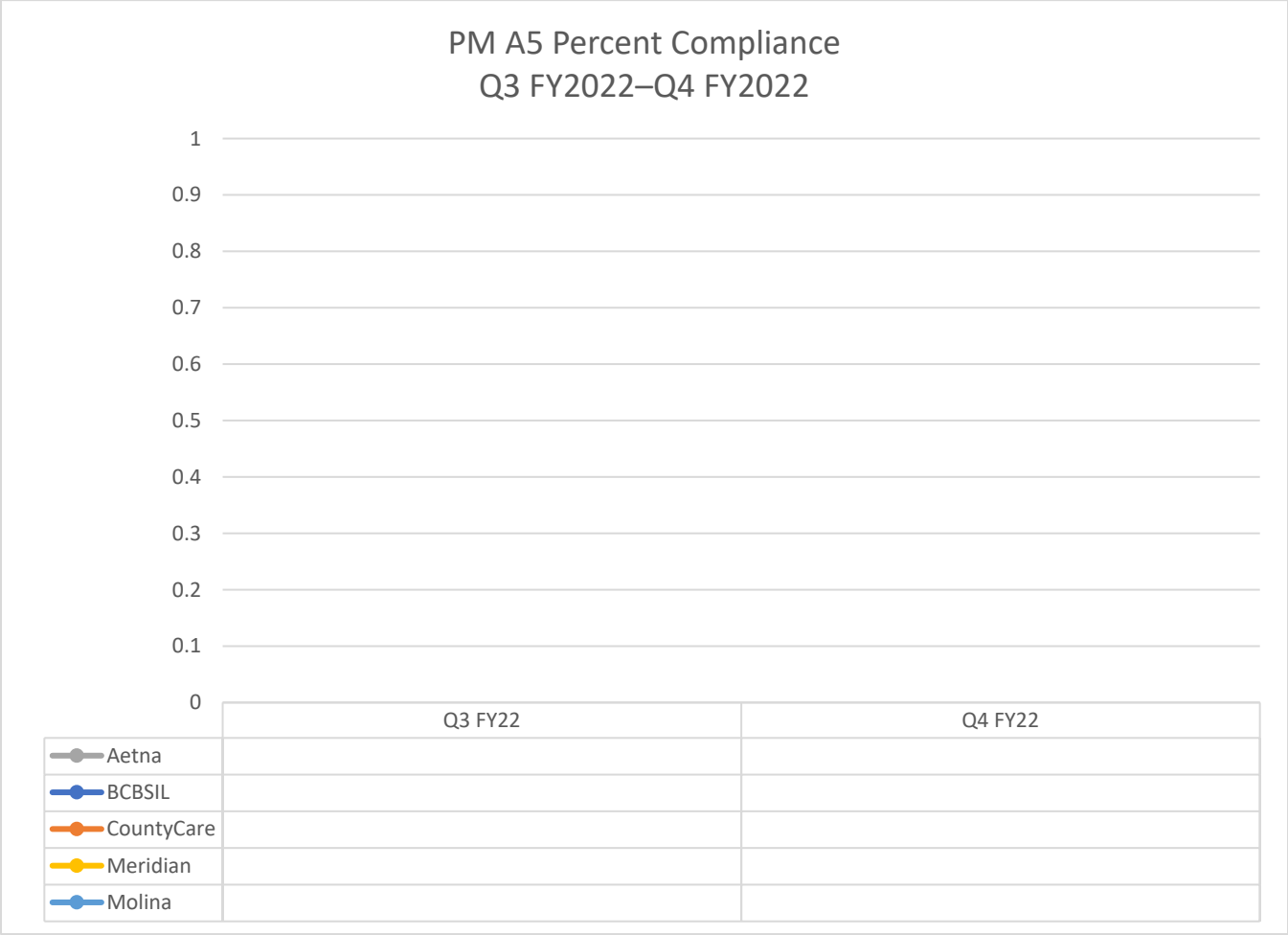
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure A5—Does the enrollee report the ADS facilitates independent choice while attending ADS? (Captured only for PD and ELD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-18—Measure A5

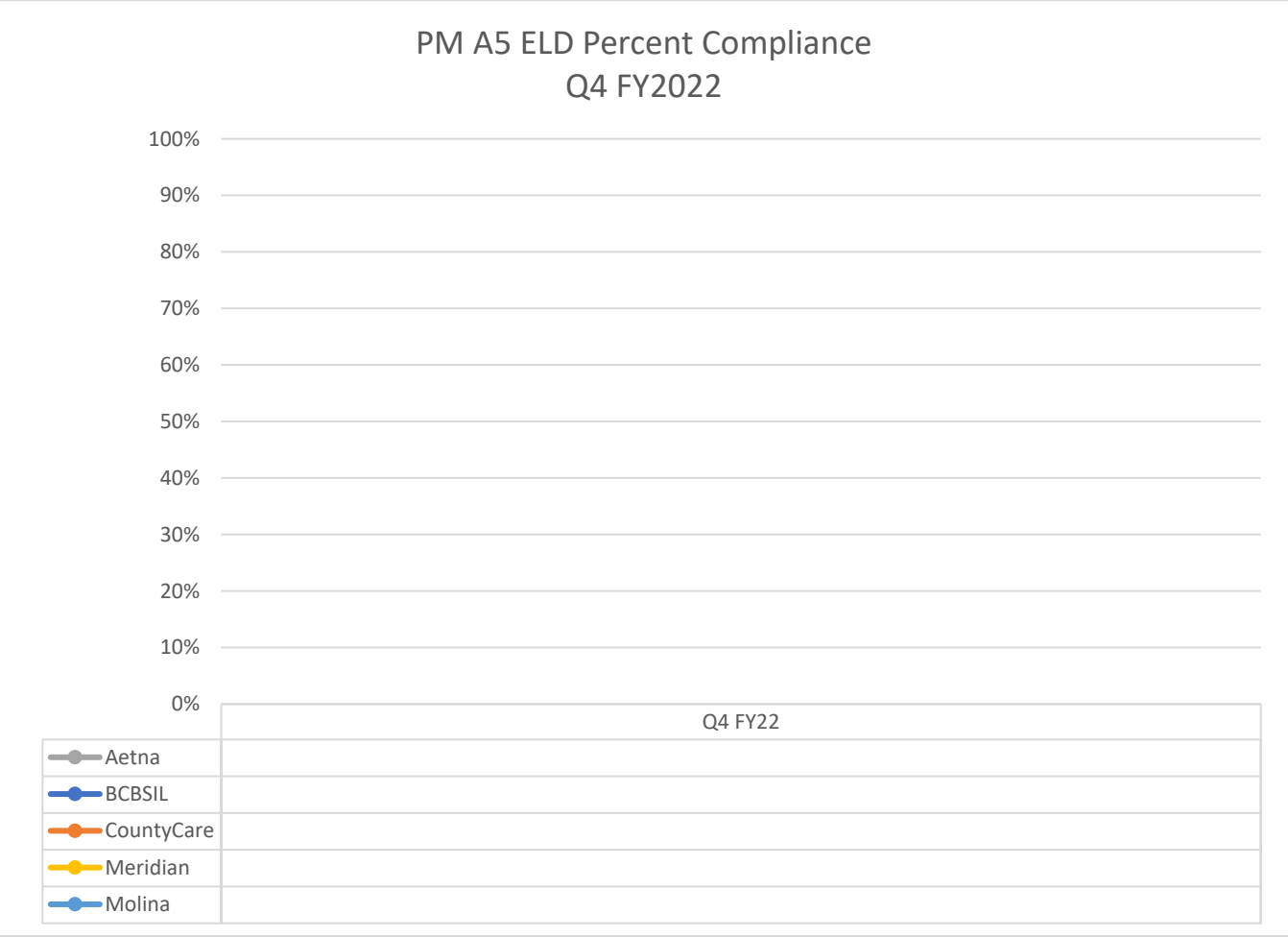


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A5-ELD—Does the enrollee report participation in meaningful activities that help meet their goals/needs? (Captured only for ELD waiver enrollees receiving ADS)

This new measure is effective Q4 FY2022.

Figure B-19—Measure A5-ELD

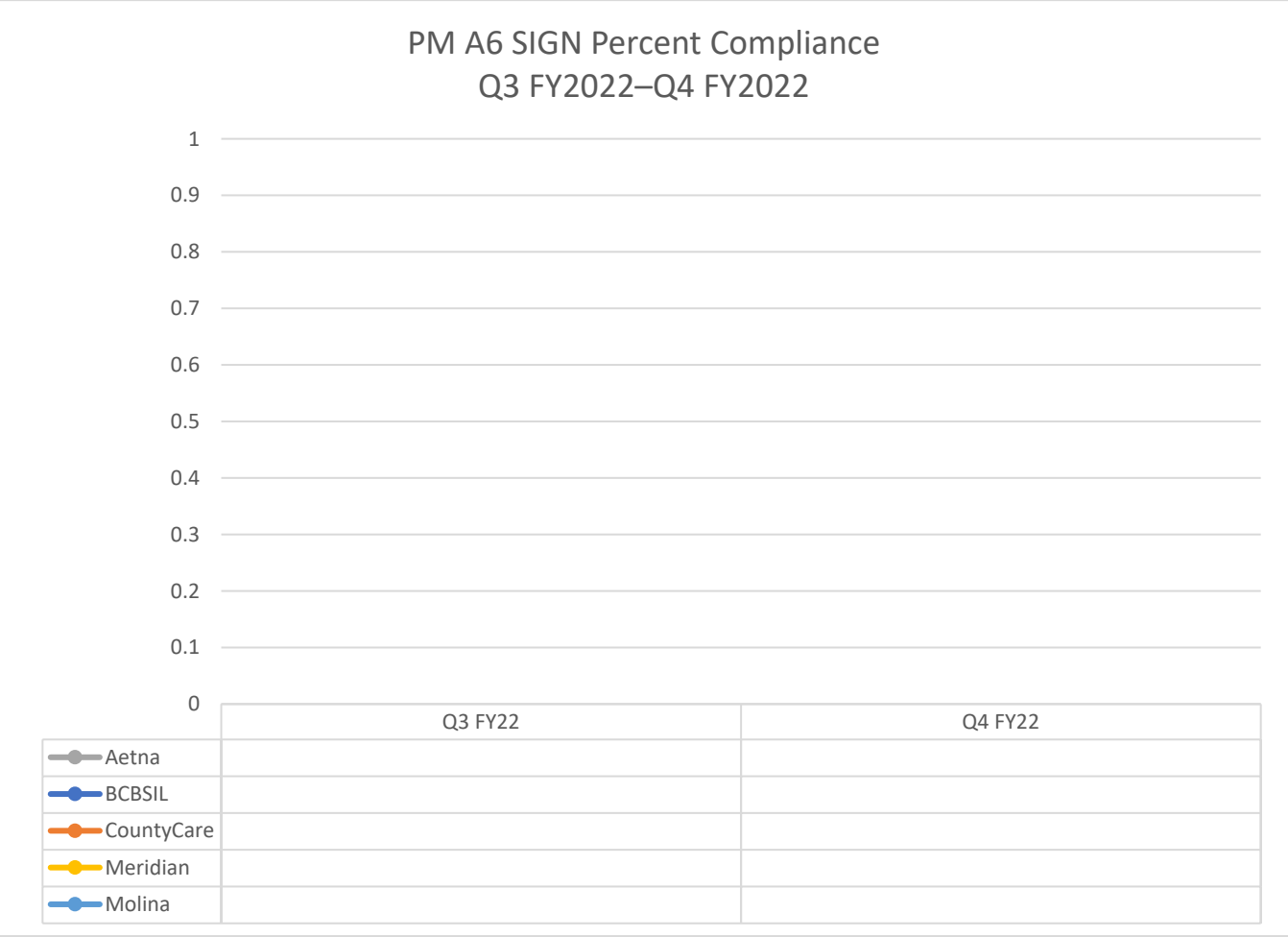


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A6-SIGN—Was the enrollee provided choice of directing services received at the ADS setting? (Captured only for ELD and PD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-20—Measure A6-SIGN

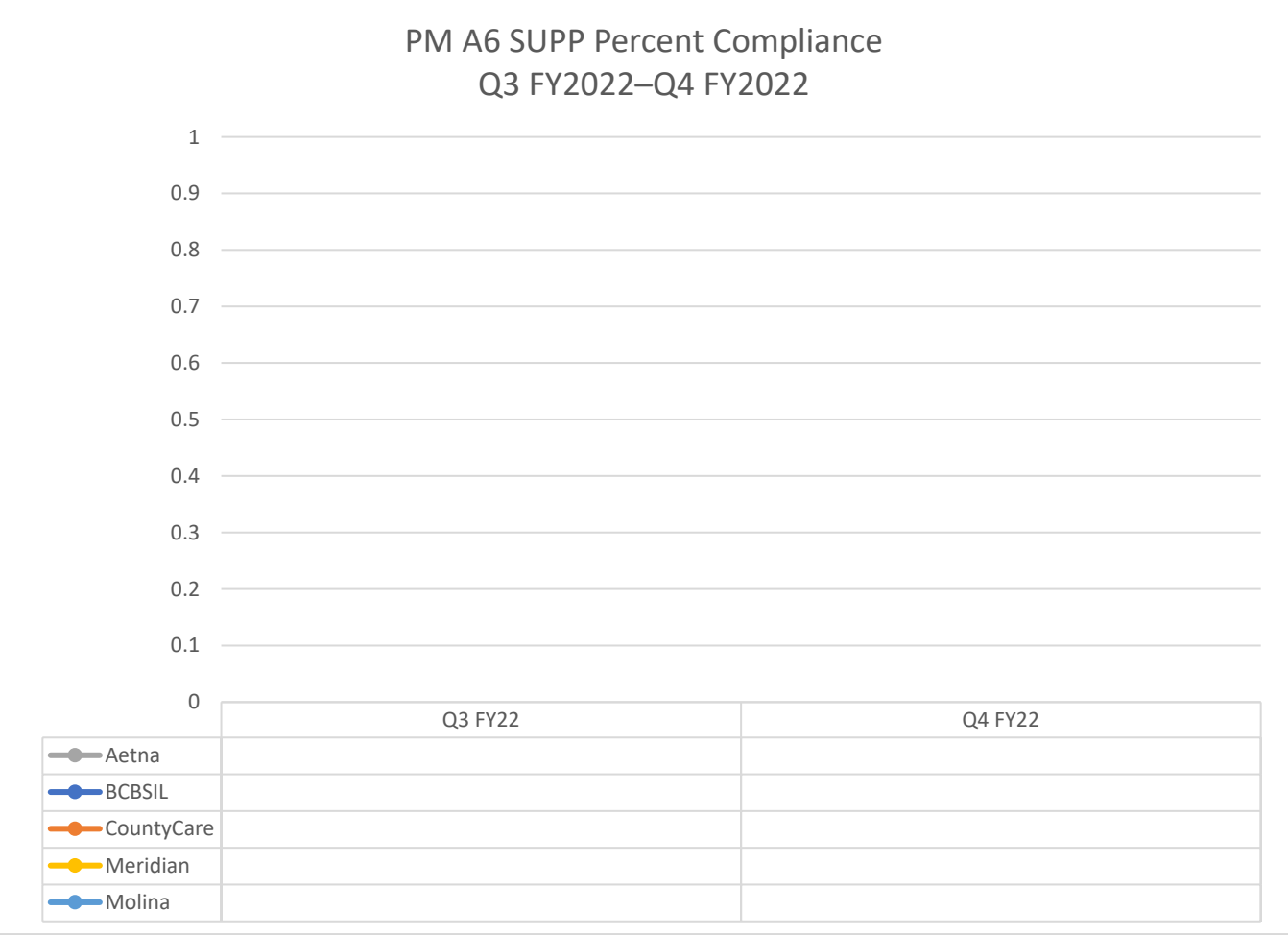


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A6-SUPP—Did the enrollee report he/she feels supported in making decisions to remain independent? (Captured only for ELD and PD waiver enrollees receiving ADS)

New measure effective Q3 FY2022.

Figure B-21—Measure A6-SUPP

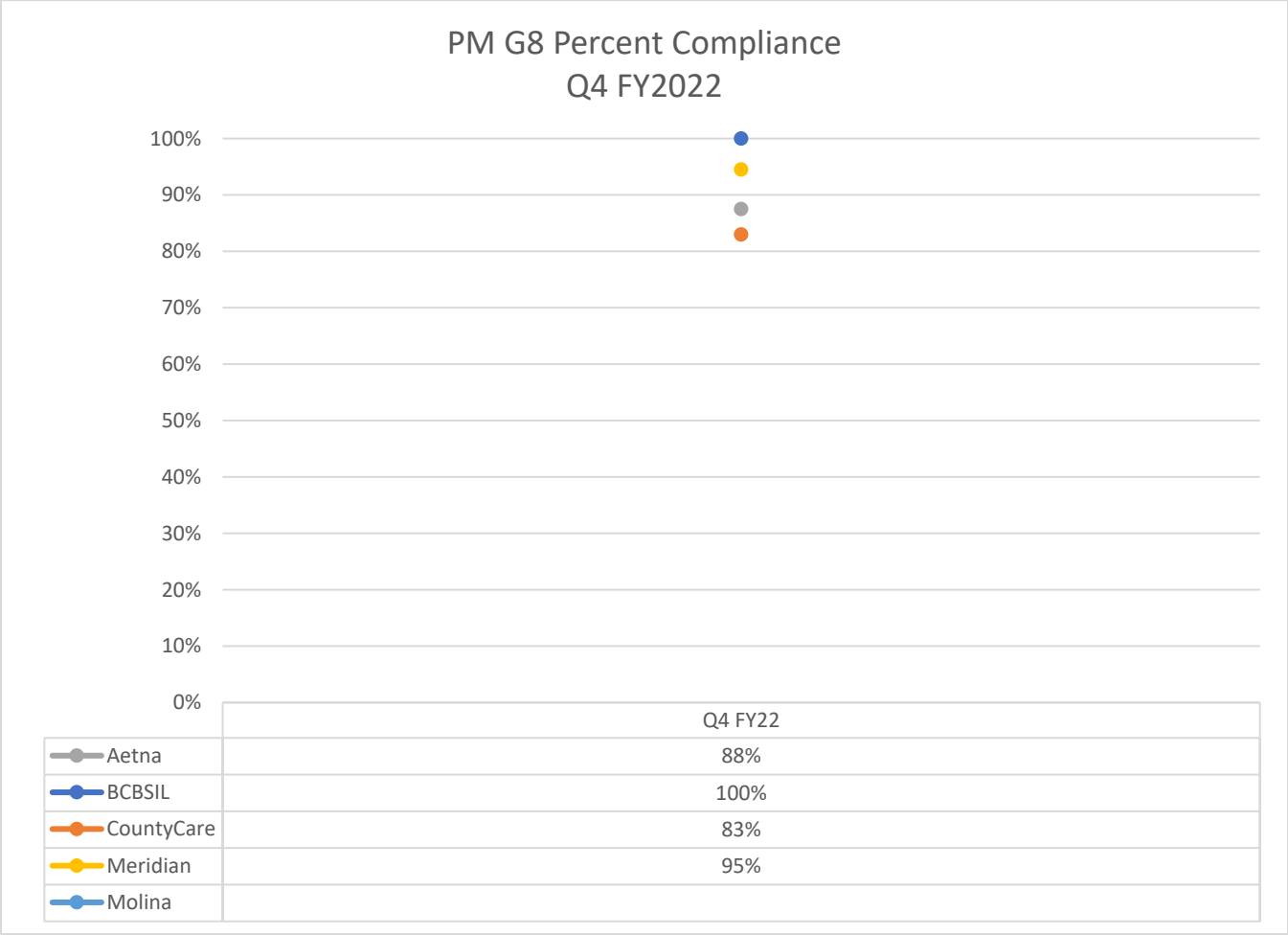


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure G8—Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?

This new measure is effective Q4 FY2022.

Figure B-22—Measure G8



	Q4 FY22
Aetna	88%
BCBSIL	100%
CountyCare	83%
Meridian	95%
Molina	

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Appendix C. Health Plan Performance, by Measure and Quarter—MLTSS

Table C-1 displays health plan compliance per performance measure by quarter. Due to HFS' performance measure numbering alignment across waivers that occurred Q3 FY2022, measure numbers are listed with their updated 2022 measure number for historic tracking.

Data prior to FY2020 and data for health plans previously included in HealthChoice are available on previous reports.

Table C-1—MLTSS Performance Measure Findings Across Health Plans

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Aetna												
12C[4]					0%	17%	25%	50%	23%	50%		
20C[2]					79%	83%	85%	78%	63%	84%	61%	90%
31D/D1	100%	99%	86%	97%	99%	96%	94%	98%	88%	93%	96%	93%
32D/D2	100%	97%	87%	97%	99%	95%	92%	98%	85%	95%	96%	92%
33D/D3	100%	100%	86%	97%	98%	96%	94%	99%	90%	95%	96%	94%
34D	100%	87%	93%	100%	100%	100%	100%	100%	94%	100%	100%	100%
35D	100%	95%	85%	96%	99%	95%	88%	84%	85%	80%	54%	65%
36D/D6	94%	94%	72%	75%	85%	84%	83%	83%	70%	88%	40%	42%
37D/D7[1]	90%	89%	83%	89%	93%	90%	81%	80%	64%	73%	62%	61%
38D/D8	90%	87%	92%	100%	100%	93%	89%	82%	44%	75%	55%	100%
39D/D9	84%	76%	79%	74%	80%	92%	71%	68%	68%	85%	77%	87%
40D	100%	100%	93%	100%	100%	100%	100%	100%	94%	100%	100%	100%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
41D/D10	100%	97%	81%	99%	99%	96%	88%	99%	94%	97%	95%	94%
42G/G1	100%	96%	79%	96%	96%	95%	88%	88%	77%	84%	81%	89%
44C[2]					97%	100%	100%	100%	100%	97%	97%	97%
44G/G7	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%
49G/D4[1]	96%	94%	92%	98%	93%	97%	91%	92%	86%	98%	95%	96%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												88%
BCBSIL												
12C[4]					0%	0%	0%	14%	21%	14%		
20C[2]					66%	77%	64%	84%	72%	71%	80%	94%
31D/D1	95%	96%	92%	97%	98%	96%	99%	99%	94%	98%	97%	98%
32D/D2	94%	99%	92%	97%	98%	99%	100%	99%	95%	99%	100%	100%
33D/D3	96%	99%	93%	98%	99%	99%	100%	99%	95%	99%	100%	100%
34D	100%	100%	100%	100%	97%	100%	100%	100%	97%	96%	94%	100%
35D	98%	98%	92%	96%	97%	98%	93%	99%	83%	93%	90%	87%
36D/D6	94%	91%	89%	91%	96%	96%	98%	96%	88%	98%	82%	82%
37D/D7[1]	89%	90%	89%	98%	95%	95%	88%	88%	92%	93%	95%	92%
38D/D8	91%	90%	100%	100%	89%	100%	89%	100%	91%	100%	100%	90%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
39D/D9	84%	81%	90%	76%	78%	84%	88%	94%	84%	94%	92%	93%
40D	100%	100%	100%	100%	97%	100%	100%	100%	97%	92%	100%	97%
41D/D10	97%	97%	92%	99%	98%	96%	96%	98%	94%	95%	100%	98%
42G/G1	95%	92%	89%	99%	97%	95%	95%	95%	90%	93%	95%	95%
44C[2]					100%	100%	100%	100%	100%	98%	100%	100%
44G/G7	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%
49G/D4[1]	92%	95%	97%	97%	96%	95%	96%	97%	95%	99%	95%	98%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												100%
CountyCare												
12C[4]					0%	0%	8%	0%	0%	0%		
20C[2]					59%	74%	59%	88%	77%	90%	93%	73%
31D/D1	95%	100%	99%	94%	96%	100%	96%	100%	100%	98%	96%	96%
32D/D2	91%	100%	99%	93%	93%	98%	95%	94%	100%	96%	98%	96%
33D/D3	92%	100%	96%	91%	91%	100%	96%	100%	100%	96%	92%	94%
34D	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%
35D	95%	94%	97%	96%	98%	98%	95%	91%	93%	80%	55%	68%
36D/D6	65%	71%	80%	86%	84%	90%	90%	92%	98%	75%	59%	50%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
37D/D7[1]	80%	81%	78%	91%	85%	95%	95%	96%	96%	88%	86%	80%
38D/D8	96%	91%	95%	86%	92%	100%	100%	88%	100%	90%	100%	100%
39D/D9	51%	57%	67%	66%	81%	75%	86%	91%	84%	85%	85%	84%
40D	100%	94%	100%	100%	100%	100%	93%	100%	100%	100%	85%	100%
41D/D10	96%	100%	96%	83%	95%	100%	96%	100%	100%	98%	96%	98%
42G/G1	92%	99%	91%	83%	97%	98%	95%	96%	98%	95%	90%	86%
44C[2]					100%	100%	100%	100%	100%	100%	100%	100%
44G/G7	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%
49G/D4[1]	91%	97%	91%	84%	92%	100%	94%	98%	100%	98%	100%	96%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												83%
Meridian												
12C[4]					8%	8%	8%	9%	24%	17%		
20C[2]					64%	68%	66%	73%	59%	82%	68%	84%
31D/D1	96%	95%	96%	97%	96%	100%	100%	99%	100%	100%	100%	100%
32D/D2	96%	95%	97%	97%	99%	100%	100%	99%	100%	100%	100%	100%
33D/D3	96%	95%	97%	97%	99%	100%	100%	99%	100%	99%	100%	99%
34D	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	**Q1 2020**	**Q2 2020**	**Q3 2020**	**Q4 2020**	**Q1 2021**	**Q2 2021**	**Q3 2021**	**Q4 2021**	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**
35D	91%	89%	91%	95%	89%	99%	100%	95%	88%	82%	88%	86%
36D/D6	78%	83%	78%	81%	75%	89%	88%	90%	81%	79%	25%	37%
37D/D7[1]	89%	92%	86%	89%	91%	96%	91%	92%	93%	91%	81%	82%
38D/D8	95%	84%	100%	100%	100%	96%	100%	100%	96%	100%	100%	78%
39D/D9	85%	65%	75%	93%	95%	94%	97%	92%	95%	90%	92%	95%
40D	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
41D/D10	93%	93%	91%	92%	88%	96%	100%	100%	100%	97%	96%	98%
42G/G1	93%	95%	90%	93%	98%	98%	95%	99%	98%	89%	93%	93%
44C[2]					97%	100%	100%	100%	100%	100%	100%	100%
44G/G7	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%
49G/D4[1]	95%	97%	92%	96%	98%	98%	100%	97%	99%	96%	100%	100%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												95%
Molina												
12C[4]					0%	0%	0%	0%	0%			
20C[2]					31%	47%	46%	10%	50%		72%	
31D/D1	93%	100%	43%		89%	97%	97%	100%	94%		97%	
32D/D2	93%	100%	43%		89%	90%	93%	100%	97%		95%	

Performance Measure Findings Across Health Plans—Percent Compliant, by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
33D/D3	93%	100%	43%		89%	97%	90%	100%	97%		97%	
34D	100%	100%			100%	100%	83%	100%	100%		94%	
35D	86%	89%	43%		78%	86%	90%	95%	82%		72%	
36D/D6	55%	67%	86%		77%	79%	81%	95%	94%		61%	
37D/D7[1]	79%	100%	57%		81%	97%	93%	68%	82%		78%	
38D/D8	100%	100%	100%		80%	100%	100%	100%	92%		83%	
39D/D9	60%	89%	75%		88%	79%	83%	68%	86%		94%	
40D	100%	100%			100%	100%	83%	100%	100%		94%	
41D/D10	86%	100%	57%		85%	93%	90%	95%	95%		97%	
42G/G1	86%	100%	57%		81%	90%	87%	84%	88%		92%	
44C[2]					100%	100%	100%	100%	100%		100%	
44G/G7	100%	100%			100%	100%	83%	100%	100%		94%	
49G/D4[1]	91%	100%	43%		86%	83%	81%	84%	94%		98%	
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												

Shaded rows/cells indicate a quarter during which a health plan was not reviewed or there were no eligible records.

[1]Revised measure effective Q1 FY2020.

[2]Measure added effective Q1 FY2021.

[3]Measure added for PD waiver effective Q3 FY2022.

[4]Measure retired effective Q3 FY2022.

[5]Measure added effective Q4 FY2022.

Appendix D. Waiver Measure Performance by Quarter—MLTSS

Table D-1—MLTSS Waiver Performance Measure Findings

Performance Measure Findings Across Waivers—Percent Compliant by Measure FY2022																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	91%	92%	92%	94%	93%	94%	89%	89%	90%	94%	93%	93%	87%	92%	85%	90%	85%	89%	89%	88%
12C[1]	21%	10%	Retired		Not applicable to waiver				10%	0%	Retired		15%	27%	Retired		Not applicable to waiver			
20C	76%	78%	81%	96%	Not applicable to waiver				78%	94%	81%	82%	51%	74%	69%	82%	Not applicable to waiver			
31D/D1	99%	100%	98%	98%	96%	96%	96%	95%	98%	98%	100%	100%	96%	98%	96%	99%	89%	96%	98%	96%
32D/D2	97%	100%	100%	98%	96%	96%	98%	97%	98%	100%	100%	100%	97%	99%	96%	99%	89%	96%	99%	96%
33D/D3	100%	100%	100%	97%	97%	98%	98%	98%	98%	100%	100%	100%	98%	98%	94%	99%	89%	95%	99%	96%
34D	Not applicable to waiver				98%	99%	96%	100%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
35D	91%	90%	89%	95%	89%	91%	82%	78%	96%	90%	85%	90%	94%	93%	80%	84%	65%	67%	51%	59%
36D/D6	70%	64%	55%	69%	96%	98%	56%	50%	67%	70%	64%	54%	94%	100%	51%	53%	Not applicable to waiver			
37D/D7	94%	97%	95%	95%	83%	80%	71%	72%	90%	98%	94%	95%	84%	86%	77%	77%	84%	84%	87%	77%
38D/D8	95%	100%	80%	100%	83%	92%	82%	91%	75%	83%	100%	100%	90%	91%	92%	91%	50%		75%	50%
39D/D9	93%	97%	89%	95%	69%	84%	82%	80%	94%	95%	96%	93%	77%	80%	83%	92%	97%	96%	98%	97%
40D	Not applicable to waiver				98%	97%	97%	99%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
41D/D10	99%	98%	100%	100%	97%	96%	97%	98%	98%	100%	100%	100%	98%	99%	97%	99%	91%	91%	95%	92%
42G/G1	99%	95%	95%	97%	90%	89%	92%	92%	96%	95%	98%	98%	91%	90%	88%	94%	81%	85%	87%	84%
44C	100%	100%	100%	100%	Not applicable to waiver				100%	97%	100%	100%	100%	98%	99%	98%	Not applicable to waiver			
44G/G7	Not applicable to waiver				99%	100%	97%	100%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
49G/D4	94%	100%	98%	97%	97%	98%	100%	98%	96%	100%	100%	100%	92%	95%	92%	97%	Not applicable to waiver			

Performance Measure Findings Across Waivers—Percent Compliant by Measure FY2022																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3				Not applicable to waiver			
A5-ELD[3]	Not applicable to waiver				Collected beginning Q4				Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
A6-SIGN[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3				Not applicable to waiver			
A6-SUPP[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3				Not applicable to waiver			
G8[3]	Collected beginning Q4			90%	Collected beginning Q4			92%	Collected beginning Q4			95%	Collected beginning Q4			97%	Collected beginning Q4			94%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.

[1]*Measure retired effective Q3 FY2022*

[2]*New measure effective Q3 FY2022*

[3]*New measure effective Q4 FY2022*

Table D-2—MLTSS Waiver Performance Measure Findings: BI Waiver

MLTSS Performance Measure Findings: BI Waiver—Percent Compliant by Measure FY2019—FY2021			
Performance Measure	**FY2019**	**FY2020**	**FY2021**
Overall[1]	84%	91%	92%
4A[1]	84%	0%	57%
12C[2]			0%
20C[2]			78%
31D	97%	99%	99%
32D	100%	98%	99%
33D	99%	98%	99%
34D			
35D	99%	97%	97%
36D	51%	53%	71%
37D	65%	95%	97%
38D	93%	92%	97%
39D	53%	77%	85%
40D			
41D	99%	99%	99%
42G	95%	99%	99%
44C[2]			100%
44G			
49G	93%	91%	91%

**Shaded cells reflect time periods in which there were no records in the sample eligible for the measure indicated or the measure was not collected. Distinct sampling for MLTSS in the HealthChoice program began FY2019.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2021. Historic data are not comparable.

[2]New measure SFY2021

Table D-3—MLTSS Waiver Performance Measure Findings: ELD Waiver

MLTSS Performance Measure Findings: ELD Waiver—Percent Compliant by Measure FY2019—FY2021			
Performance Measure	**FY2019**	**FY2020**	**FY2021**
Overall[1]	89%	92%	94%
4A[1]	30%	19%	24%
12C[2]			
20C[2]			
31D	93%	94%	97%
32D	96%	95%	96%
33D	97%	96%	97%
34D	99%	99%	99%
35D	96%	95%	95%
36D	94%	97%	99%
37D	79%	85%	89%
38D	82%	92%	97%
39D	43%	62%	76%
40D	99%	99%	99%
41D	96%	94%	96%
42G	92%	91%	93%
44C[2]			
44G	99%	99%	100%
49G	75%	98%	98%

**Shaded cells reflect time periods in which there were no records in the sample eligible for the measure indicated or the measure was not collected. Distinct sampling for MLTSS in the HealthChoice program began FY2019.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2021. Historic data are not comparable.

[2]New measure SFY2021

Table D-4—MLTSS Waiver Performance Measure Findings: HIV Waiver

MLTSS Performance Measure Findings: HIV Waiver—Percent Compliant by Measure FY2019–FY2021			
Performance Measure	**FY2019**	**FY2020**	**FY2021**
Overall[1]	86%	90%	92%
4A[1]	100%	25%	60%
12C[2]			6%
20C[2]			75%
31D	94%	97%	99%
32D	97%	97%	100%
33D	99%	98%	100%
34D			
35D	96%	96%	96%
36D	44%	50%	72%
37D	91%	97%	97%
38D	89%	98%	94%
39D	54%	81%	85%
40D			
41D	99%	97%	99%
42G	94%	97%	99%
44C[2]			100%
44G			
49G	92%	94%	99%

**Shaded cells reflect time periods in which there were no records in the sample eligible for the measure indicated or the measure was not collected. Distinct sampling for MLTSS in the HealthChoice program began FY2019.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2021. Historic data are not comparable.

[2]New measure SFY2021

Table D-5—MLTSS Waiver Performance Measure Findings: PD Waiver

MLTSS Performance Measure Findings: PD Waiver—Percent Compliant by Measure FY2019–FY2021			
Performance Measure	**FY2019**	**FY2020**	**FY2021**
Overall[1]	84%	89%	89%
4A[1]	20%	28%	36%
12C[2]			8%
20C[2]			62%
31D	91%	94%	98%
32D	93%	94%	97%
33D	93%	94%	98%
34D			
35D	94%	95%	95%
36D	92%	97%	99%
37D	83%	86%	89%
38D	79%	93%	92%
39D	41%	66%	83%
40D			
41D	92%	92%	96%
42G	86%	90%	93%
44C[2]			100%
44G			
49G	88%	90%	93%

**Shaded cells reflect time periods in which there were no records in the sample eligible for the measure indicated or the measure was not collected. Distinct sampling for MLTSS in the HealthChoice program began FY2019.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2021. Historic data are not comparable.

[2]New measure SFY2021

Table D-6—MLTSS Waiver Performance Measure Findings: SLP Waiver

MLTSS Performance Measure Findings: SLP Waiver—Percent Compliant by Measure FY2019–FY2021			
Performance Measure	**FY2019**	**FY2020**	**FY2021**
Overall[1]	85%	92%	93%
4A[1]	19%	0%	19%
12C[2]			
20C[2]			
31D	87%	95%	97%
32D	87%	95%	97%
33D	90%	95%	98%
34D			
35D	88%	88%	92%
36D			
37D	74%	83%	84%
38D	25%	100%	100%
39D	93%	100%	98%
40D			
41D	89%	93%	94%
42G	87%	91%	91%
44C[2]			
44G			
49G			

**Shaded cells reflect time periods in which there were no records in the sample eligible for the measure indicated or the measure was not collected. Distinct sampling for MLTSS in the HealthChoice program began FY2019.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2021. Historic data are not comparable.

[2]New measure SFY2021

Appendix E. Acronyms

ACA	Affordable Care Act
ADS	Adult Day Service
AIDS	Acquired Immune Deficiency Syndrome
BI	Persons with Brain Injury Waiver
CMS	Centers for Medicare & Medicaid Services
COVID-19 PHE	Coronavirus Disease 2019 Public Health Emergency
ELD	Persons who are Elderly Waiver
EQRO	External Quality Review Organization
FHP	Family Health Plan
FY	Fiscal Year
HCBS	Home- and Community-Based Services
HCI	HealthChoice Illinois
HFS	The Illinois Department of Healthcare and Family Services
HIV	Persons with Human Immunodeficiency Virus (HIV)/AIDS Waiver
HRA	Health Risk Assessment
HSAG	Health Services Advisory Group, Inc.
ICP	Integrated Care Program
IRR	Interrater Reliability
MCP	Managed Care Plan
MLTSS	Managed Long-Term Services and Supports
MMAI	Medicare-Medicaid Alignment Initiative
N/A	Not Applicable
PA	Personal Assistant
PD	Persons with Disabilities Waiver
PM	Performance Measure
Q	Quarter
SFY	State Fiscal Year
SLP	Persons in a Supportive Living Program Waiver
VMC	Voluntary Managed Care

HFS

Illinois Department of
Healthcare and Family Services

Medicare-Medicaid Alignment Initiative (MMAI) Home- and Community-Based Services (HCBS) Waivers

Centers for Medicare & Medicaid Services (CMS) Performance Measures

Record Review

of

Managed Care Plans (MCPs)

Summary of Findings and Recommendations

State Fiscal Year 2022 Report

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

HFS Illinois Department of Healthcare and Family Services

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to identify opportunities within the Home- and Community-Based Services (HCBS) waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG), conduct on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This State Fiscal Year (SFY) 2022 MMAI HCBS Waivers CMS Performance Measures Record Review of MCPs Summary of Findings and Recommendations Report provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for the MMAI managed care population.

Overview

This report provides an overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

The report includes a summary of trended performance across health plans during SFY 2022 and across review years, and also contains a review of remediation activities conducted within the required time frames and a summary of technical assistance that HSAG provided to the health plans.

For the SFY 2022 review, HFS initially identified 17 CMS waiver performance measures for review. These performances measures were aligned with the state-approved 1915(c) waiver applications. Due to waiver renewals that occurred, the following changes were made to ensure alignment and 19 measures were collected beginning in the third quarter (Q3) SFY 2022:

- Measure 12C, *If the PA [personal assistant] evaluation was not completed annually, it was completed within 60 days of the expected annual date*, was retired.
- Measure A5, *Does the enrollee report the ADS [adult day service] facilitates independent choice while attending ADS?* was added.
- Measure A6-SIGN, *Was the enrollee provided choice of directing services received at the ADS setting?* was added.

- Measure A6-SUPP, *Did the enrollee report he/she feels supported in making decisions to remain independent?* was added.

In addition, evaluation criteria for 36D/D6 were revised to align with contact requirements for enrollees receiving services in the Persons with Disabilities (PD) and Persons who are Elderly (ELD) waivers.

Due to waiver renewals that occurred, the following changes were made to ensure alignment and 21 performance measures were collected beginning Q4 SFY 2022:

- Measure A5-ELD, *Does the enrollee report participation in meaningful activities that help meet their goals/needs?* was added.
- Measure G8, *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?* was added.

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Methodology

HSAG conducted quarterly record reviews to determine health plan compliance to the CMS waiver performance measures and to additional MMAI contract measures. During SFY 2022, 1,227 records were reviewed using HSAG's web-based data collection tool. As a result, 1,485 findings of noncompliance were identified. The SFY 2022 reviews assessed performance during a lookback period of December 1, 2020, through February 28, 2022.

Detailed descriptions of the sampling methodology and data collection processes are provided in Section 2 of this report.

Summary of Findings

Health Plan Participation

Table 1-1 displays the health plans that were reviewed during SFY 2022.

Table 1-1—SFY 2022 MMAI Health Plans

Health Plan Name
Aetna Better Health Premier Plan (Aetna)
Blue Cross Community MMAI (BCBSIL)
Humana Gold Plan Integrated (Humana)
Meridian
Molina Dual Options Medicare-Medicaid Plan (Molina)

Successes

SFY 2022 represented the eighth year of review for the MMAI population, and several successes were identified.

☑ Twelve of the 21 CMS performance measures[1] averaged 90 percent or greater compliance.

☑ Three of the five health plans averaged 90 percent or greater compliance.

☑ Compared to SFY 2021, Humana realized a statistically significant increase in performance for five measures in SFY 2022.

☑ Three of the five waiver types averaged greater than 90 percent compliance.

☑ Compared to SFY 2021, the Persons who are Elderly (ELD) waiver realized a statistically significant increase in compliance for four measures in SFY 2022.

Opportunities for Improvement

Review of SFY 2022 performance identified the following opportunities for improvement:

☞ BCBSIL demonstrated a statistically significant decrease in eight performance measures in SFY 2022 when compared to SFY 2021.

☞ Meridian and Molina demonstrated a statistically significant decrease in three performance measures in SFY 2022 when compared to SFY 2021.

☞ Three performance measures demonstrated statistically significant decreases in compliance in SFY 2022 when compared to SFY 2021.

☞ The SLP waiver demonstrated a statistically significant decrease in four performance measures in SFY 2022 when compared to SFY 2021.

☞ All five health plans and all five waivers demonstrated a statistically significant decrease in compliance with Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP [persons in a supportive living program] provider (if applicable) and dates of signatures*, when SFY 2022 was compared to SFY 2021. A detailed analysis is provided in Section 3 of this report.

[1] A listing of performance measures is available in Appendix A.

Two of the five health plans and two of the five waivers demonstrated a statistically significant decrease in compliance with Measure D7, *the most recent service plan is in the record and completed in a timely manner*, when SFY 2022 was compared to SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 78 percent compliance in SFY 2022. A detailed analysis is provided in Section 3 of this report.

Although HFS provided the health plans with guidance regarding documentation expectations for enrollee contacts, service plan updates, and enrollee signatures during the coronavirus disease 2019 (COVID-19) public health emergency (PHE) restrictions, the health plans demonstrated significant decreases in compliance for those measures, as indicated above.

External Quality Review Organization (EQRO) Technical Assistance

To assist the health plans with improvement efforts, HSAG provided ongoing technical assistance throughout SFY 2022. Technical assistance was also provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- How to prepare for quarterly record reviews and remediation validation.
- How to use the HSAG web-based tool to run reports and complete remediation.
- How to complete health, safety, and welfare reports remediation.
- Validation of waiver service provision.
- Timely completion of annual reassessments, care plan, and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.
- Compliance with HFS' guidance regarding SLP documentation expectations.
- Documentation of language required to meet HFS' expectations for enrollee contacts, service plan updates, and enrollee signatures during the COVID-19 PHE restrictions.

In addition, HSAG conducted health plan trainings in July 2021 and January 2022 to provide updates to evaluation criteria and record review expectations.

HFS Policy Guidance

As a result of HFS' efforts for continuous quality improvement for the waiver record reviews and management of waiver enrollees, HFS provided guidance via formal policies to the health plans on the following topics:

- Procedures specific to management of enrollees during the COVID-19 pandemic, including timelines for resuming face-to-face enrollee contacts and expectations for documenting SLP care coordination activities.
- Expectations for conducting a new health risk assessment (HRA) for newly eligible enrollees with a previous HRA.
- CMS' approval of PD and ELD waiver renewals and resulting updated performance measures.

Recommendations

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Recommendations specific to health plans, waivers, and performance measures are identified below.

Health Plan-Specific

Aetna should focus efforts on Measure 35D.

BCSBIL should focus efforts on measures 35D and D6.

Humana should focus efforts on measures 35D and D9.

Meridian should focus efforts on measures D6 and D7.

Molina should focus efforts on measures 35D, D6, D7, and D9.

All health plans may benefit from implementing the *Performance Measure-Specific* recommendations listed below.

Waiver-Specific

Brain injury (BI) waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month (Measure D6). Health plans should analyze their staffing to ensure

that care managers/care coordinators[2] have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

Human immunodeficiency virus (HIV) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly (Measure D6). Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

Persons with Disabilities (PD) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once every 90 days (Measure D6). Health plans should target efforts for contact to those care managers/care coordinators managing PD caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of PD cases, to identify timely mitigation opportunities.

Persons who are Elderly (ELD) waiver: Health plans should focus on improving documentation of valid contact with the enrollee once every 90 days (Measure D6). Health plans should target efforts for contact to those care managers/care coordinators managing ELD caseloads to ensure timely contact is completed. Health plans should ensure that all internal auditing processes include a representative sample of ELD cases, to identify timely mitigation opportunities.

Performance Measure-Specific

All health plans should focus improvement efforts on measures D6, D7, and 35D.

For Measure D6, efforts might include:

- Conduct root cause analysis to determine opportunities to effect change.
- Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS' guidance for valid enrollee contact and valid justification when contact is not completed as required.

[2] The terms "case manager(s)" and "care coordinator(s)" are used interchangeably in this report.

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

For Measure D7, efforts might include:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete annual service plan updates.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

For Measure 35D, efforts might include:

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to complete timely service plan updates.
- Ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent.
- Reeducate care managers on appropriate documentation to meet HFS' expectations during the PHE.

2. Data Collection and Methodology

Background

HFS implemented the MMAI demonstration project in March 2014 for clients eligible for both Medicare and Medicaid services ("dual eligible"). MMAI voluntary enrollment began in March 2014, passive enrollment began in June 2014, and enrollment concluded in December 2014. The program was expanded statewide in 2021.

All waiver beneficiaries enrolled in MMAI receive care management services. This person-centered, team-based approach supports care coordination across the continuum of care, promoting improved health outcomes, increased beneficiary satisfaction, and improved coordination and integration of benefits.

The program was designed to ensure that beneficiaries receive assistance with clinical and nonclinical needs by assigning an accountable care manager who develops a care plan and service plan with the beneficiary, coordinates frequent personal contact to monitor the beneficiary's progress toward achieving care plan goals, and implements interventions to overcome barriers to care.

To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that HSAG, conduct on-site reviews of waiver beneficiary records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

HCBS Waiver Program Implementation and Monitoring

As the EQRO for Illinois, HSAG assisted HFS in assessing the readiness of each health plan to participate in the HCBS waiver program. Prior to receiving HCBS waiver program enrollees, the health plans were required to participate in and pass a readiness review to demonstrate that the health plan was ready to provide services to HCBS waiver enrollees safely and efficiently.

HSAG began on-site record reviews in state fiscal year 2015 to monitor MMAI health plan performance on the HCBS waiver performance measures.

Waiver Programs and Performance Measures Included in Reviews

Waiver Programs

The following HCBS waiver programs were included in the CMS performance measure record reviews:

- Persons with Disabilities (PD): Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility and can be safely maintained in the home or

community-based setting with the services provided in the plan of care. Individuals 60 years of age or older, who began services before age 60, may choose to remain in this waiver.

- Persons with HIV/AIDS (HIV): Persons of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or acquired immune deficiency syndrome (AIDS) and are at risk of placement in a nursing facility.
- Persons with Brain Injury (BI): Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- Persons who are Elderly (ELD): Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are ages 65 and older, and those who are physically disabled, ages 60 through 64.
- Persons in a Supportive Living Program (SLP): Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

Performance Measures

For the SFY 2022 review, HFS initially identified 17 CMS waiver performance measures for review. These performances measures were aligned with the state-approved 1915(c) waiver applications. Due to waiver renewals that occurred, the following changes were made to ensure alignment, and 19 measures were collected beginning Q3 SFY 2022:

- Measure 12C, *If the PA [personal assistant] evaluation was not completed annually, it was completed within 60 days of the expected annual date*, was retired.
- Measure A5, *Does the enrollee report the ADS [adult day service] facilitates independent choice while attending ADS?* was added.
- Measure A6-SIGN, *Was the enrollee provided choice of directing services received at the ADS setting?* was added.
- Measure A6-SUPP, *Did the enrollee report he/she feels supported in making decisions to remain independent?* was added.

In addition, evaluation criteria for 36D/D6 were revised to align with contact requirements for enrollees receiving services in the Persons with Disabilities (PD) and Persons who are Elderly (ELD) waivers.

Due to waiver renewals that occurred, the following changes were made to ensure alignment, and 21 performance measures were collected beginning Q4 SFY 2022:

- Measure A5-ELD, *Does the enrollee report participation in meaningful activities that help meet their goals/needs?* was added.
- Measure G8, *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?* was added.

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

To collect samples for record review, HSAG selects a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selects a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group will be determined based on the number of eligible members in each waiver program. Once the required sample sizes have been identified, a proportional random sample will be selected based on the distribution of the health plans' populations within each designated waiver program. Each sample is selected to ensure a 95 percent confidence level and 5 percent margin of error at the waiver program level. Additionally, a 10 percent oversample based on the proportional distribution of enrollees across health plans is selected to replace ineligible cases.

This sampling method is designed to ensure that when the samples are combined, there is sufficient statistical power to meet the CMS HCBS reporting requirements. Samples will be selected without resampling, and sample sets will be refreshed for each review using HFS' eligibility file data. Limitations to the sampling methodology include known variables such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g., previously enrolled as MMAI and transferred to MLTSS).

To be included in the sample, a beneficiary must meet the following criteria:

1. Continuously enrolled with the health plan for at least six months as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.
2. At least three months of continuous HCBS waiver coverage during the most recent six months of enrollment as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

Upon receipt of the sample, health plans are expected to review the cases to ensure they meet the above eligibility criteria, notifying HSAG of any cases that should be excluded. Health plans will also notify HSAG of any of the following, who may be excluded from the sample:

- Beneficiaries who have disenrolled from the health plan.
- Beneficiaries who have expired.
- Beneficiaries who have Operating Agency-confirmed waiver case closure.
- Beneficiaries whose current waiver type is different from the waiver type identified on the sample.
- Beneficiaries whose current program (HealthChoice, MLTSS, or MMAI) differs from the program type identified on the sample.
- Beneficiaries in long-term care.

The final sample sizes were calculated based on data extracted in April 2021 and included waiver members enrolled as of April 1, 2021. Table 2-1 displays the FY 2022 record review sample size by health plan and waiver program for MMAI.

Table 2-1—MMAI Sample Size, by Health Plan and Waiver Program

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLF
Aetna	1,414	144	42	19	19	31	33
BCBSIL	5,492	526	159	61	43	137	126
Humana	2,016	157	66	16	5	33	37
Meridian	2,278	239	63	37	21	67	51
Molina	1,637	181	38	18	7	58	60
Statewide Total	**12,837**	**1,247**	**368**	**151**	**95**	**326**	**307**

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this report, including tables and graphs, reflect the quarters in which the health plans were reviewed. The six-month lookback periods during SFY 2022 consisted of the following:

- Quarter 1, SFY 2021: December 1, 2020–May 31, 2021
- Quarter 2, SFY 2021: March 1, 2021–August 31, 2021
- Quarter 3, SFY 2021: June 1, 2021–November 30, 2021
- Quarter 4, SFY 2021: September 1, 2021–February 28, 2022

Web-Based Abstraction Tool and Scoring Methodology

HSAG collaborated with HFS to develop a web-based abstraction tool and reporting database, which included requirements set forth in the MMAI contract and the HCBS waivers. The review tool was developed to conduct the review at the individual case level and was modeled after the tool used by the State to monitor the fee-for-service population to ensure waiver enrollees are monitored similarly for similar performance measures. The tool was used to assess compliance with case management activities, including comprehensive assessments, care planning, waiver service planning, beneficiary interaction, and specialized waiver evaluations.

During the on-site review, the HSAG review team reviewed documentation for the selected cases for each review period, consisting of a six-month lookback period from the date of the review. The review team determined evidence of case compliance with each of the HFS-selected scored elements. A score of *Yes*, *No*, or *Not Applicable (N/A)* was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Yes* or *No*. These scores indicated the health plan's compliance with the requirements. HSAG also used a designation of *N/A* if the requirement was not applicable to a record; *N/A* findings were not included in the two-point scoring methodology.

HSAG calculated the score by adding the score from each eligible case and dividing the summed scores by the total number of eligible cases. HSAG aggregated the results across all records by health plan, waiver population, and performance measure.

Interrater Reliability (IRR)

To ensure accuracy of the reviews, HSAG conducted IRR on all review team members. The IRR reviews were conducted by the HSAG senior project manager for 10 percent of all records completed by each individual reviewer via over-read of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95 percent was required, with the reviewer completing retraining if required. Reviews were completed across all waivers, program types, and health plans to ensure continued compliance to the 95 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent.

Remediation Actions and Tracking

As a result of the on-site reviews, HSAG identified noncompliant performance and contract measures. HSAG's web-based abstraction tool and reporting database included a remediation tracking function which detailed the findings of noncompliance related to waiver performance measures and HealthChoice contract requirements. Health plans and HFS had access to their respective reports and the remediation tracking database via the HSAG Web portal.

HSAG notified HFS of the online availability of each health plan's report of findings within 30 days of each review. Once approved by the State, the report of findings was forwarded to each health plan to complete remediation actions. Remediation actions were defined in the MMAI contract and were specific to each CMS waiver performance measure and contract finding. The remediation tracking database tracked the date the health plan was notified of findings, the date the health plan reported the remediation action was completed, and the number of days from notification of the finding until the remediation action was completed.

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of enrollees was maintained. HSAG completed remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans. The results of the remediation validation reviews are reported in Section 3 of this report.

3. MMAI Overall Summary of Record Review Findings for SFY 2022

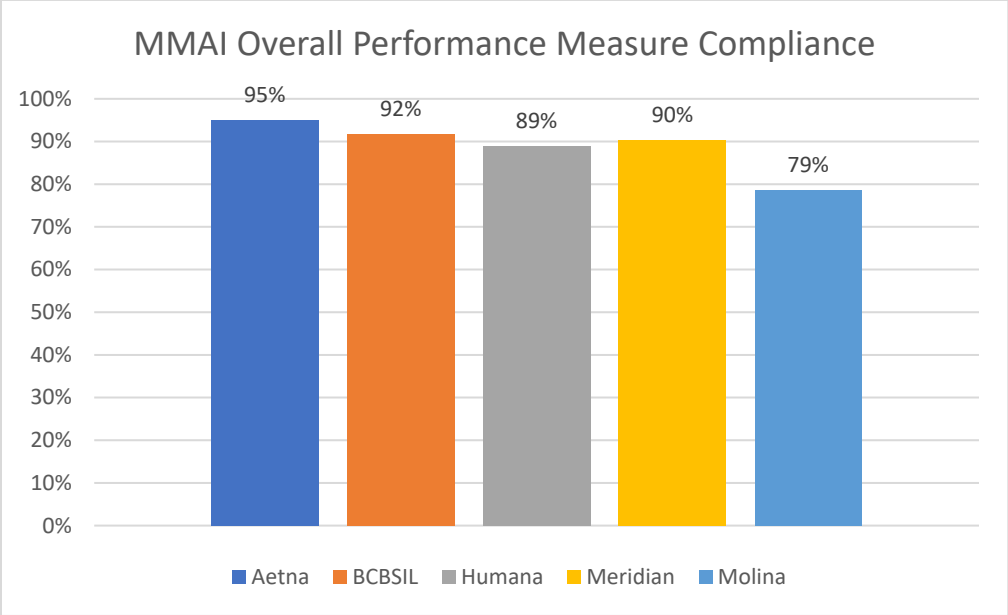
Overall Performance

Overall Health Plan Performance and Comparisons

Five health plans were reviewed during SFY 2022. Figure 3-1 displays a computed average of the total performance achieved by each health plan on the 21 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 21 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Three of the five health plans averaged 90 percent or greater compliance in SFY 2022. There was a 16-percentage-point difference (79 percent to 95 percent) among health plans.

Figure 3-1—Overall Compliance



Statistical significance testing was also performed to compare each health plan's average overall compliance against all other health plans, and the following differences were identified:

- Aetna performed at a statistically significantly higher rate than all other health plans.
- BCBSIL performed at a statistically significantly higher rate than Humana and Meridian.
- Molina performed at a statistically significantly lower rate than all other health plans.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2022. Comparisons for overall performance from SFY 2021 to SFY 2022 were not completed, as the total number of performance measures reviewed was different in each FY. Health plan-specific performance on all performance measures by quarter is included in Appendix C. Individual health plan performance analyses identified the following for measures that were in place at the end of SFY 2022.

Aetna

Analysis identified that Aetna achieved a compliance rate of 90 percent or greater in 15 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Aetna demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, Aetna demonstrated a statistically significant decrease in one measure.

Analysis identified that Aetna's greatest opportunity for improvement related to Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 74 percent compliance rate.

BCBSIL

Analysis identified that BCBSIL achieved a compliance rate of 90 percent or greater in 14 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, BCBSIL achieved a statistically significant increase in three performance measures and demonstrated a statistically significant decrease in one performance measure. When SFY 2022 performance was compared to SFY 2021 performance, BCBSIL demonstrated a statistically significant decrease in eight performance measures.

Analysis identified that BCBSIL's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 78 percent compliance rate. BCBSIL also had opportunity for improvement in Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with an 83 percent compliance rate; and Measure D7, *the most recent service plan is in the record and completed in a timely manner,* with an 82 percent compliance rate.

Humana

Analysis identified that Humana achieved a compliance rate of 90 percent or greater in 11 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Humana achieved a statistically significant increase in two performance measures. When SFY 2022 performance was compared to SFY 2021 performance, Humana achieved a statistically significant increase in five performance measures and demonstrated a statistically significant decrease in one measure.

Analysis identified that Humana's greatest opportunity for improvement related to Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 76 percent compliance rate. Humana also had opportunity for improvement in Measure D9, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan*, with a 77 percent compliance rate.

Meridian

Analysis identified that Meridian achieved a 90 percent or greater compliance rate in 11 of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Meridian demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, Meridian achieved a statistically significant increase in one performance measure and demonstrated a statistically significant decrease in three measures.

Analysis identified that Meridian's greatest opportunity for improvement related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 73 percent compliance rate. Meridian also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner,* with a 79 percent compliance rate.

Molina

Analysis identified that Molina achieved a 90 percent or greater compliance rate in nine of the 21 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, Molina demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, Molina demonstrated a statistically significant decrease in three measures.

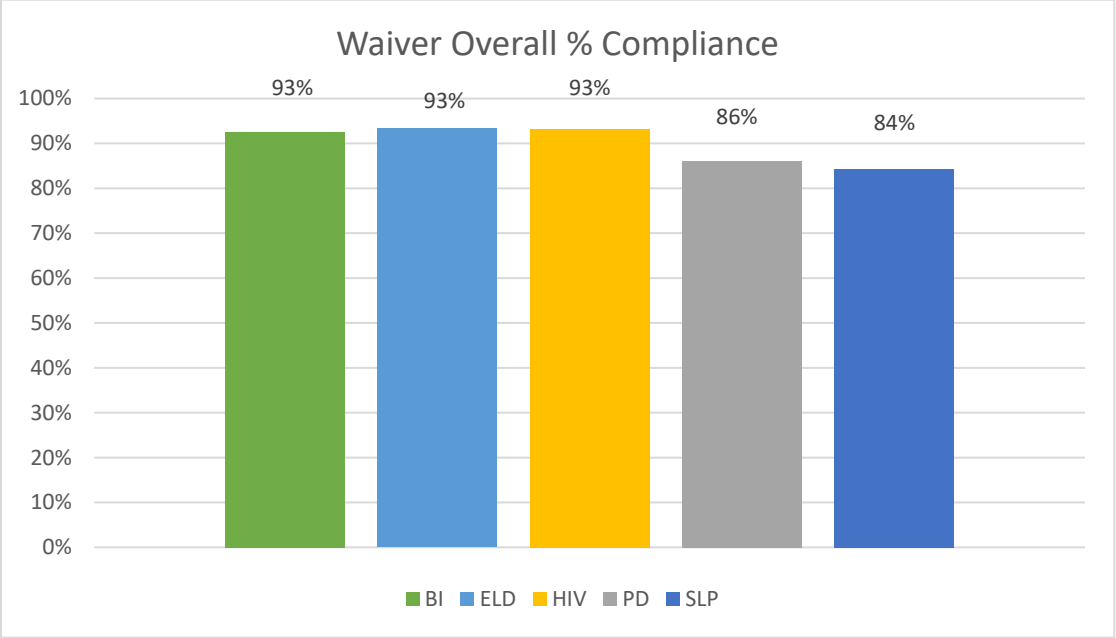
Analysis identified that Molina's greatest opportunity for improvement related to Measure D7, *the most recent service plan is in the record and completed in a timely manner,* with a 57 percent compliance rate. Molina also had opportunity for improvement in Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 58 percent compliance rate; and Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 62 percent compliance rate.

Performance by Waiver Type

Comparisons were also analyzed by waiver type, to determine differences and improvement opportunities that may be waiver-specific as opposed to health plan-specific. Appendix D displays waiver compliance per performance measure by quarter.

As Figure 3-2 displays, three of the five waiver types averaged greater than 90 percent overall compliance in SFY 2022.

Figure 3-2—Overall Compliance Across Waiver Types



Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver type's overall compliance from Q1 2022 to Q4 SFY 2022. Comparisons for overall performance from SFY 2021 to SFY 2022 were not completed, as the total number of performance measures reviewed was different in each FY. Individual waiver performance analyses identified the following for measures that were in place at the end of SFY 2022.

BI Waiver

Fourteen performance measures were assessed for the BI waiver. Analysis identified that the BI waiver achieved a 90 percent or greater compliance rate in eight of the 14 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the BI waiver achieved a statistically significant increase in one performance measure. When SFY 2022 performance was compared to SFY

2021 performance, the BI waiver demonstrated a statistically significant decrease in one performance measure.

Analysis identified that the greatest opportunity for improvement for the BI waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 77 percent compliance rate.

ELD Waiver

Twenty performance measures were assessed for the ELD waiver. Analysis identified that the ELD waiver achieved a 90 percent or greater compliance rate in 10 of the 20 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the ELD waiver demonstrated a statistically significant decrease in two performance measures. When SFY 2022 performance was compared to SFY 2021 performance, the ELD waiver achieved a statistically significant increase in four performance measures and demonstrated a statistically significant decrease in one measure.

Analysis identified that the greatest opportunity for improvement for the ELD waiver related to Measure D9, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan,* with a 79 percent compliance rate. The ELD waiver also had opportunity for improvement in Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with an 82 percent compliance rate.

HIV Waiver

Fourteen performance measures were assessed for the HIV waiver. Analysis identified that the HIV waiver achieved a 90 percent or greater compliance rate in nine of the 14 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the HIV waiver demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, the HIV waiver demonstrated a statistically significant decrease in one measure.

Analysis identified that the greatest opportunity for improvement for the HIV waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 71 percent compliance rate.

PD Waiver

Seventeen performance measures were assessed for the PD waiver. Analysis identified that the PD waiver achieved a 90 percent or greater compliance rate in nine of the 17 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the PD waiver achieved a statistically significant increase in two measures and demonstrated a statistically significant decrease in one

measure. When SFY 2022 performance was compared to SFY 2021 performance, the PD waiver demonstrated a statistically significant decrease in two measures.

Analysis identified that the greatest opportunity for improvement for the PD waiver related to Measure D6, *the case manager made valid timely contact with the enrollee, or valid justification is documented in the enrollee's record*, with a 76 percent compliance rate. The PD waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with a 77 percent compliance rate.

SLP Waiver

Ten performance measures were assessed for the SLP waiver. Analysis identified that the SLP waiver achieved a 90 percent or greater compliance rate in six of the 10 measures during SFY 2022.

When Q4 performance was compared to Q1 performance, the SLP waiver demonstrated stable performance. When SFY 2022 performance was compared to SFY 2021 performance, the SLP waiver demonstrated a statistically significant decrease in four performance measures.

Analysis identified that the greatest opportunity for improvement for the SLP waiver related to Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, with a 61 percent compliance rate. The SLP waiver also had opportunity for improvement in Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with a 69 percent compliance rate.

Performance was analyzed for the subset of SLP waiver members enrolled in the dementia care program. Results are shown in Table 3-1.

Table 3-1—SLP Dementia Care: Compliance With CMS Performance Measures

Measure	Measure Text	FY2019	FY2020	FY2021	FY2022
4A	*Overdue service plan was completed within 30 days of expected renewal.*	NA (0/0)	NA (0/0)	50% (1/2)	*
31D	*The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.*	100% (11/11)	100% (8/8)	90% (9/10)	96% (27/28)
32D	*The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.*	100% (11/11)	100% (8/8)	90% (9/10)	96% (27/28)
33D	*The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.*	100% (11/11)	100% (8/8)	90% (9/10)	96% (27/28)
35D	*The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	91% (10/11)	100% (8/8)	80% (8/10)	54% (15/28)

Measure	Measure Text	FY2019	FY2020	FY2021	FY2022
37D	*The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	100% (11/11)	63% (5/8)	80% (26/28)	75% (21/28)
38D	*The service plan was updated when the enrollee needs changed.*	0% (0/1)	NA (0/0)	NA (0/0)	NA (0/0)
39D	*Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	100% (11/11)	100% (8/8)	100% (9/9)	100% (27/27)
41D	*The enrollee has been given the opportunity to participate in choosing types of services and providers.*	100% (11/11)	100% (8/8)	80% (8/10)	93% (26/28)
42G	*The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	100% (11/11)	88% (7/8)	80% (8/10)	75% (21/28)
DC1[1]	*Does the service plan include the need for delayed egress as a safety intervention?*				67% (2/3)

* *Measure retired; not collected*

[1] *New measure effective FY2022*

Performance by Measure

Comparisons were also analyzed by performance measure. Trending analysis graphs are included in Appendix B.

Table 3-2—Analysis of CMS Performance Measure Compliance

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
20C *A PA evaluation was completed annually.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, BCBSIL demonstrated a statistically significant increase in SFY 2022. Compared to SFY 2021, the PD waiver demonstrated a statistically significant decrease in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
31D/D1 *The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.*	This measure achieved a statistically significant increase in performance from Q1 to Q4. BCBSIL achieved a statistically significant increase in performance from Q1 to Q4. The SLP waiver achieved a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Humana achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, BCBSIL demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, the ELD waiver achieved a statistically significant rate increase in this measure in SFY 2022.
32D/D2 *The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).*	This measure achieved a statistically significant increase in performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4. The SLP waiver achieved a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, BCBSIL and Meridian demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, the ELD waiver achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, the SLP waiver demonstrated a statistically significant rate decrease in this measure in SFY 2022.
33D/D3 *The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.*	This measure achieved a statistically significant increase in performance from Q1 to Q4. BCBSIL achieved a statistically significant increase from Q1 to Q4. The SLP waiver achieved a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, BCBSIL demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, the ELD waiver achieved a statistically significant rate increase in this measure in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
34D *(ELD waiver)* *The enrollee reported he/she received the services he/she needed when he/she needed them.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
35D *The most recent service plan includes signature of enrollee (or representative), case manager, and SLP provider (if applicable) and dates of signatures.*	This measure demonstrated a statistically significant decrease from Q1 to Q4. Compared to Q1, BCBSIL demonstrated a statistically significant rate decrease in Q4. Compared to Q1, the ELD waiver demonstrated a statistically significant rate decrease in this measure in Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, all five health plans demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, all five waivers demonstrated a statistically significant decrease in SFY 2022.
36D/D6 *PD and ELD waiver—The case manager made contact every 90 days with the enrollee, or there is valid justification in the record.* *HIV waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.* *BI waiver—The case manager made valid contact with the enrollee at least once a month, or valid justification is documented in the enrollee's record.*	The evaluation criteria for this measure were revised in Q3 for the PD and ELD waivers to align contact requirements with contract language; therefore, statistical analysis could not be conducted for the SFY. Rates for all health plans significantly decreased after the evaluation criteria revision, indicating that the health plans were less successful in meeting 90-day time frames for PD and ELD waiver enrollees (previously assessed as annual contact).	Due to evaluation criteria changes in Q3 SFY 2022, historic data were not comparable and statistical analysis could not be completed.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
37D/D7 *The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	This measure demonstrated a statistically significant rate decrease from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Humana achieved a statistically significant increase in SFY 2022. Compared to SFY 2021, BCBSIL and Molina demonstrated a statistically significant rate decrease in this measure in SFY 2022. Compared to SFY 2021, the PD and SLP waivers demonstrated a statistically significant rate decrease in this measure in SFY 2022.
38D/D8 *The care/service plan was updated when the enrollee needs changed or upon enrollee request.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
39D/D9 *Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.*	This measure demonstrated stable performance from Q1 to Q4. Compared to Q1, Humana achieved a statistically significant rate increase in Q4. Compared to Q1, the BI waiver realized a statistically significant rate increase in Q4. Compared to Q1, the ELD waiver demonstrated a statistically significant rate decrease in Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022. Compared to SFY 2021, Humana achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, BCBSIL and Meridian demonstrated a statistically significant rate decrease in this measure in SFY 2022.
40D *(ELD waiver)* *The enrollee reported he/she received all services listed in the plan of care.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
41D/D10 *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure achieved a statistically significant rate increase in SFY 2022. Compared to SFY 2021, Humana and Meridian achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, the ELD and PD waivers achieved a statistically significant rate increase in this measure in SFY 2022.
42G/G1 *The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated a statistically significant decrease in SFY 2022. Compared to SFY 2021, Humana achieved a statistically significant rate increase in this measure in SFY 2022. Compared to SFY 2021, BCBSIL and Molina demonstrated a statistically significant decrease in this measure in SFY 2022. Compared to SFY 2021, the SLP waiver demonstrated a statistically significant decrease in this measure in SFY 2022.
44C *The enrollee reported satisfaction with his/her PA.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
44G/G7 *(ELD waiver)* *The enrollee reported he/she was being treated well by direct support staff.*	This measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2022 Analysis**	**Trend Analysis to SFY 2021**
49G/D4 *(ELD, BI, HIV, and PD waivers)* *The most recent service plan includes a backup plan that includes the name of the backup.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2021, this measure demonstrated stable performance in SFY 2022.
A5 *(ELD and PD waivers)* *Does the enrollee report the ADS facilitates independent choice while attending ADS?*	New measure effective Q3 FY2022.	Not applicable; new measure effective FY2022.
A5-ELD *(ELD waiver)* *Does the enrollee report participation in meaningful activities that help meet their goals/needs?*	New measure effective Q4 FY2022.	Not applicable; new measure effective FY2022.
A6-SIGN *(ELD and PD waivers)* *Was the enrollee provided choice of directing services received at the ADS setting?*	New measure effective Q3 FY2022.	Not applicable; new measure effective FY2022.
A6-SUPP *(ELD and PD waivers)* *Did the enrollee report he/she feels supported in making decisions to remain independent?*	New measure effective Q3 FY2022.	Not applicable; new measure effective FY2022.
G8 *Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?*	New measure effective Q4 FY2022.	Not applicable; new measure effective FY2022.

Analysis of Lowest-Scoring Measures

The health plans had the greatest opportunities for improvement related to the following performance measures:

- Measure D6, *the case manager made timely contact with the enrollee, or there is valid justification in the record*, which averaged a 78 percent compliance rate.
- Measure D7, *the most recent service plan is in the record and completed in a timely manner*, which averaged a 79 percent compliance rate.

- Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*, which averaged a compliance rate of 79 percent.

Measure D6

Overall compliance rates on Measure D6 averaged 78 percent. In Q3 FY2022, evaluation criteria for this measure for the PD and ELD waivers were aligned with contract language, requiring enrollee contact every 90 days; historic performance for the PD and ELD waivers measured enrollee contact once annually. When compliance with contact every 90 days was compared to annual contact, the health plans performed worse, indicating that the health plans were less successful in contacting the enrollee every 90 days than annually.

Each waiver type has a different requirement for contact, ranging from once a month to annually. A health plan may be more successful maintaining annual contact rather than monthly contact; as a result, performance in D6 can be significantly different across waivers. The greater frequency of contact for the BI and HIV waivers may result in lower performance.

Health plans should conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads. In addition, health plans should ensure that audit processes for the PD and ELD waivers measure performance against contract (and now waiver) requirements, and that case managers are held accountable to meeting contact standards for enrollees in the PD and ELD waivers.

Measure D7

Measure D7 collects information related to the health plan's success in completing annual service plan documentation in a timely manner.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual service plans in a timely manner. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely completion of service plans. Health plans should review COVID-19 PHE processes to ensure that case managers are knowledgeable of documentation requirements related to annual service plan completion.

Measure 35D

Measure 35D collects information related to the health plan's success in obtaining the enrollee's signature on the most recent service plan. In calendar year (CY) 2020, HFS provided guidance to the health plans regarding obtaining verbal consent on service plan renewals due to restrictions from the COVID-19 PHE, including requirements for documentation of witnessed verbal consent. As COVID-19 restrictions have not been lifted, the HCBS record reviews evaluate the health plans' success in documenting witnessed verbal consent for those enrollees unable to be visited at home.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals and witnessed verbal consent indicating a signature on the service plan.

Remediation and Remediation Validation

Remediation

As a result of the on-site reviews, HSAG identified noncompliant performance measures. The health plans received their individualized report of findings subsequent to each on-site record review and were required to remediate the noncompliant findings and implement performance improvement strategies to improve the quality of care management/care coordination activities for the waiver enrollees.

Remediation actions were defined in the MMAI contract and were specific to each CMS waiver performance measure. The time frame for remediation of findings was 60 days, except for two measures, G1 and D4, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. HSAG monitored compliance with timely remediation of these findings through review of completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2022, all health plans demonstrated full compliance with completion of remediation action documentation for all noncompliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semiannually to determine if health plans had appropriately completed remediation actions. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed. Table 3-3 indicates the number of cases reviewed per health plan for MMAI.

Table 3-3—Health Plan Remediation Validation Review Totals: MMAI

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Aetna	8/8	7/7
BCBSIL	10/10	14/14
Humana	23/32	32/32

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Meridian	7/8	9/9
Molina	9/10	16/16

All health plans received their remediation sample 10 days prior to on-site remediation validation review and were responsible for ensuring all necessary remediation documentation was available during the on-site review. Remediation validation included review of each record in the sample and supporting documentation, to ensure the action taken and completion date documented in the remediation tracking database were consistent with the information in the health plan's care management record and/or staff training records.

Two of the five health plans demonstrated 100 percent compliance with remediation validation. Humana's noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database, or case manager training did not include the topics required for remediation. Meridian's noncompliant remediation validation cases did not demonstrate that case manager training included the topics required for remediation. Molina's noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2023 and will include review of any records that were found to be not fully remediated during the SFY 2022 reviews.

Appendix A. CMS Performance Measures Description

Table A-1 provides a description of each CMS performance measure, including the identification of waiver-specific measures. Due to HFS performance measure numbering alignment across waivers, measure numbers are listed with their CY 2022 measure number for historic tracking.

Table A-1—CMS Waiver Performance Measure Descriptions

Historic Measure #	Measure # CY 2022	Measure Description
20C	**20C**	A PA evaluation was completed annually. Captured only for enrollees with PA service
31D	**D1**	The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.
32D	**D2**	The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).
33D	**D3**	The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.
34D	**34D**	The enrollee reported he/she received the services he/she needed when he/she needed them. ELD waiver only
35D	**35D**	The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.
36D	**D6**	PD and ELD waiver—The case manager made valid contact with the enrollee every 90 days or valid justification is documented in the enrollee's record.
		HIV waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.
		BI waiver—The case manager made valid contact with the enrollee at least one time a month, or valid justification is documented in the enrollee's record.
37D	**D7**	The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
38D	**D8**	The service plan was updated when the enrollee needs changed or upon enrollee request.
39D	**D9**	Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.
40D	**40D**	The enrollee reported he/she received all services listed in the plan of care. ELD waiver only

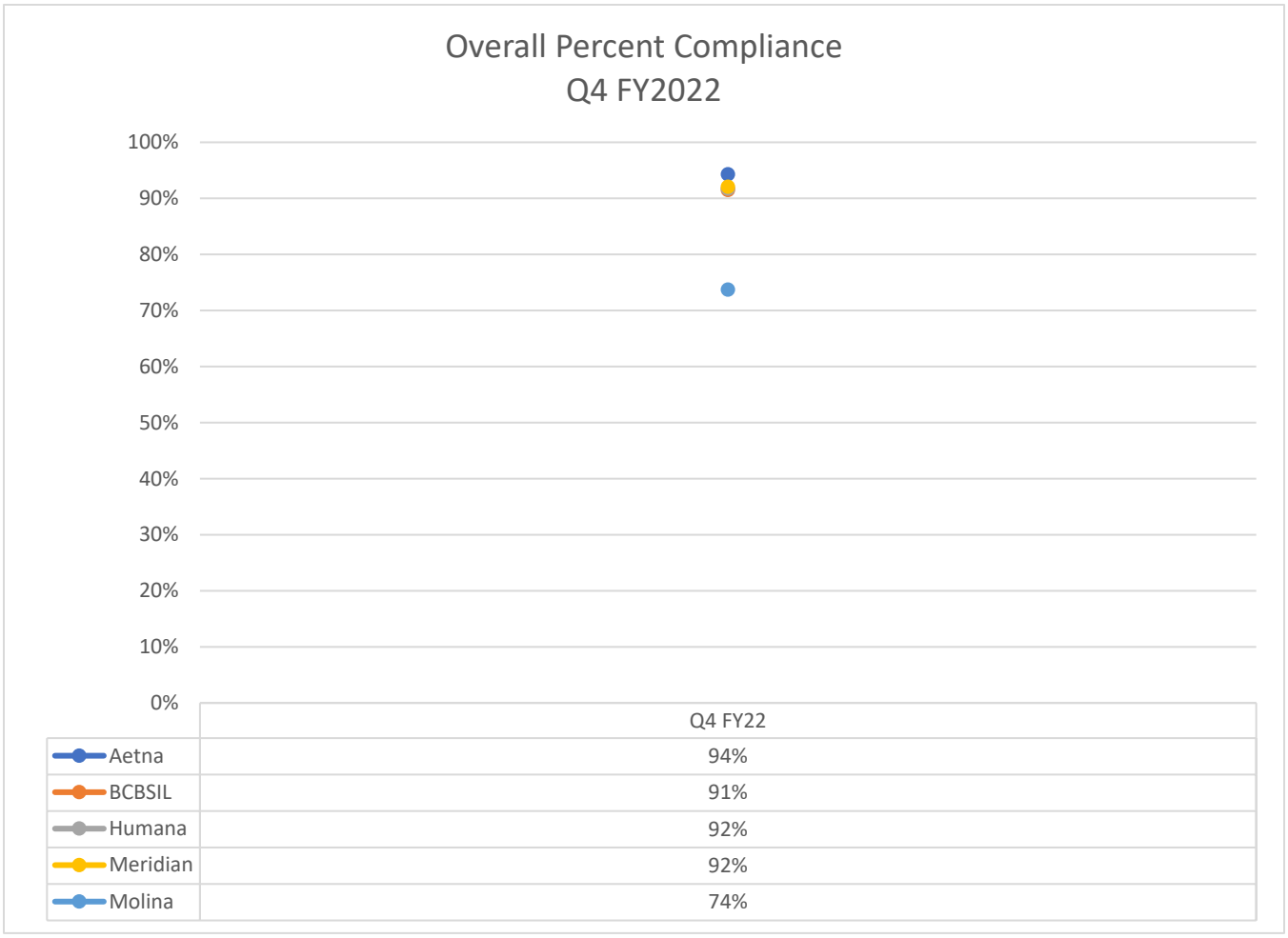
Historic Measure #	Measure # CY 2022	Measure Description
41D	**D10**	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	**G1**	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
44C	**44C**	The enrollee reported satisfaction with his/her PA. Captured only for enrollees with PA service
44G	**G7**	The enrollee reported he/she was being treated well by direct support staff. ELD waiver only
49G	**D4**	Most recent Service Plan includes a backup plan that includes the name of the backup. ELD, BI, HIV and PD waivers
Not collected prior to 2022	**A5**	Does the enrollee report the ADS facilitates independent choice while attending ADS? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**A5-ELD**	Does the enrollee report participation in meaningful activities that help meet their goals/needs? Captured only for ELD waiver enrollees receiving ADS
Not collected prior to 2022	**A6-SIGN**	Was the enrollee provided choice of directing services received at the ADS setting? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**A6-SUPP**	Did the enrollee report he/she feel supported in making decisions to remain independent? Captured only for ELD and PD waiver enrollees receiving ADS
Not collected prior to 2022	**G8**	Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?

Appendix B. Performance Trending—MMAI

Overall Trend Performance

Figure B-1 displays a computed average of the performance achieved by each health plan on all 21 CMS waiver performance measures reviewed by HSAG. Due to an increase in the number of performance measures collected beginning Q4 FY2022, historic data are not comparable and only data beginning Q4 FY2022 are displayed.

Figure B-1—Overall Compliance



	Q4 FY22
Aetna	94%
BCBSIL	91%
Humana	92%
Meridian	92%
Molina	74%

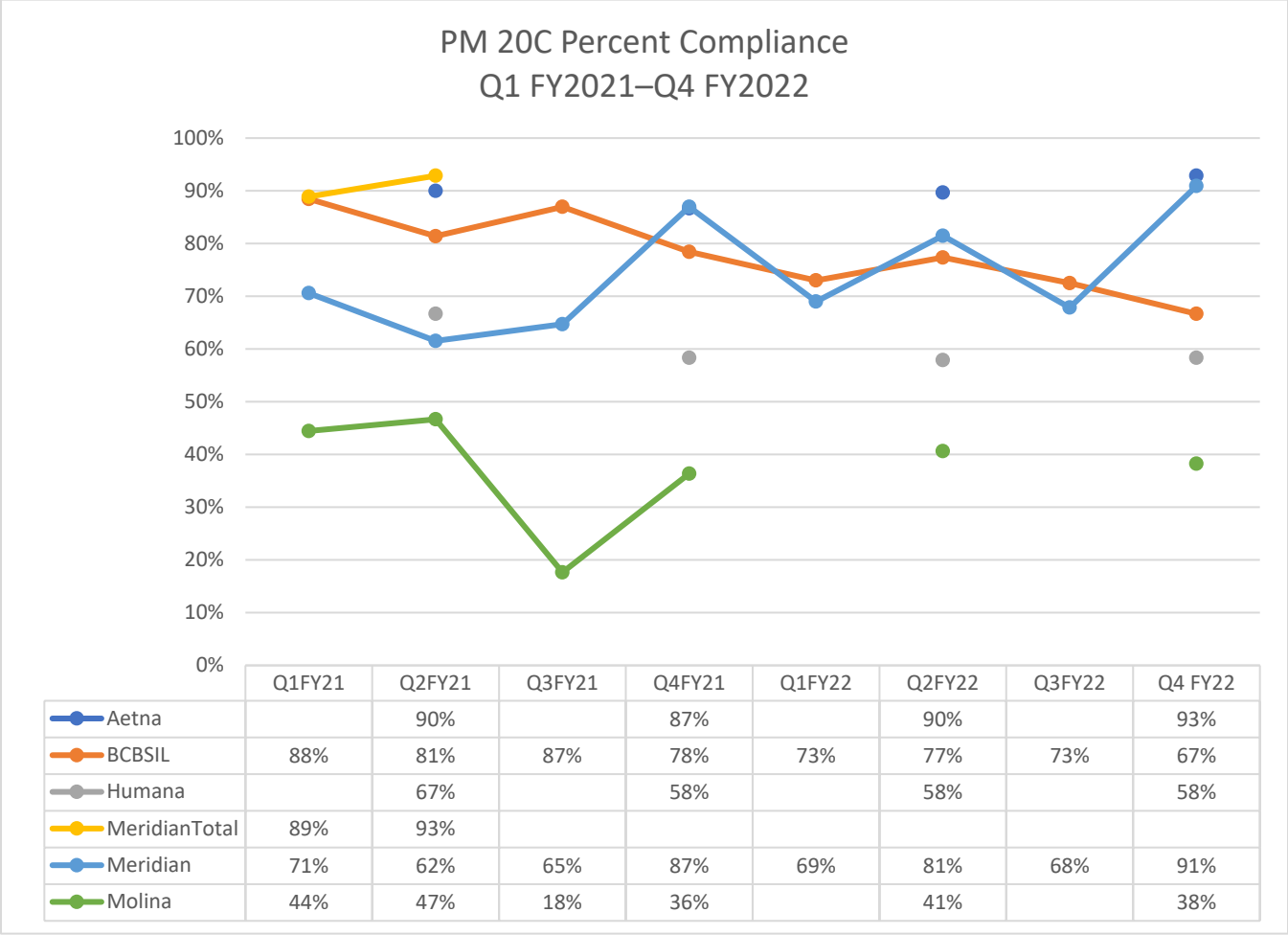
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Performance Measure Findings

Measure 20C—A PA evaluation was completed annually.

New measure beginning FY2021. Captured only for enrollees with PA service.

Figure B-2—Measure 20C

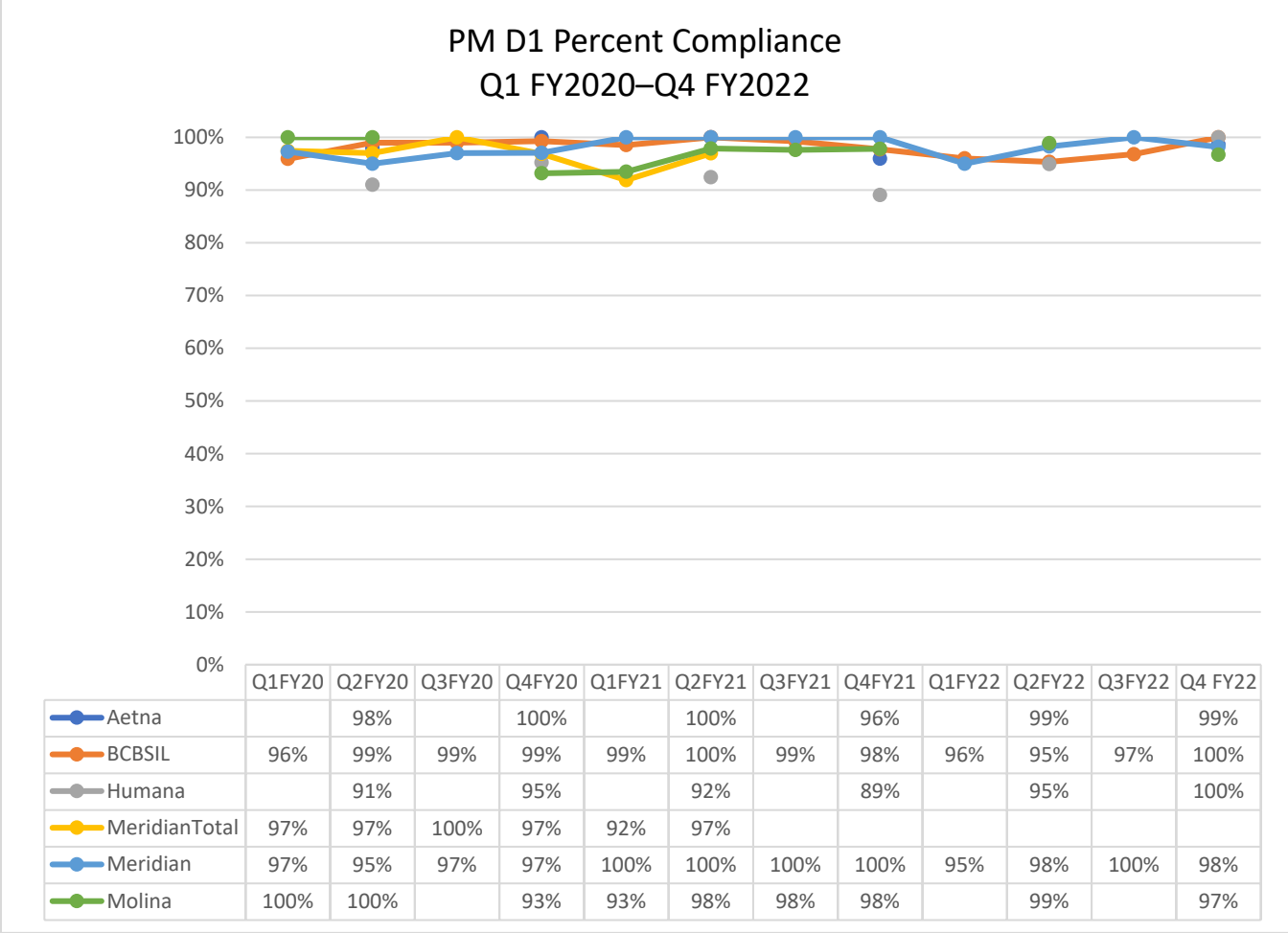


	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		90%		87%		90%		93%
BCBSIL	88%	81%	87%	78%	73%	77%	73%	67%
Humana		67%		58%		58%		58%
MeridianTotal	89%	93%						
Meridian	71%	62%	65%	87%	69%	81%	68%	91%
Molina	44%	47%	18%	36%		41%		38%

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure D1—The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.

Figure B-3—Measure D1



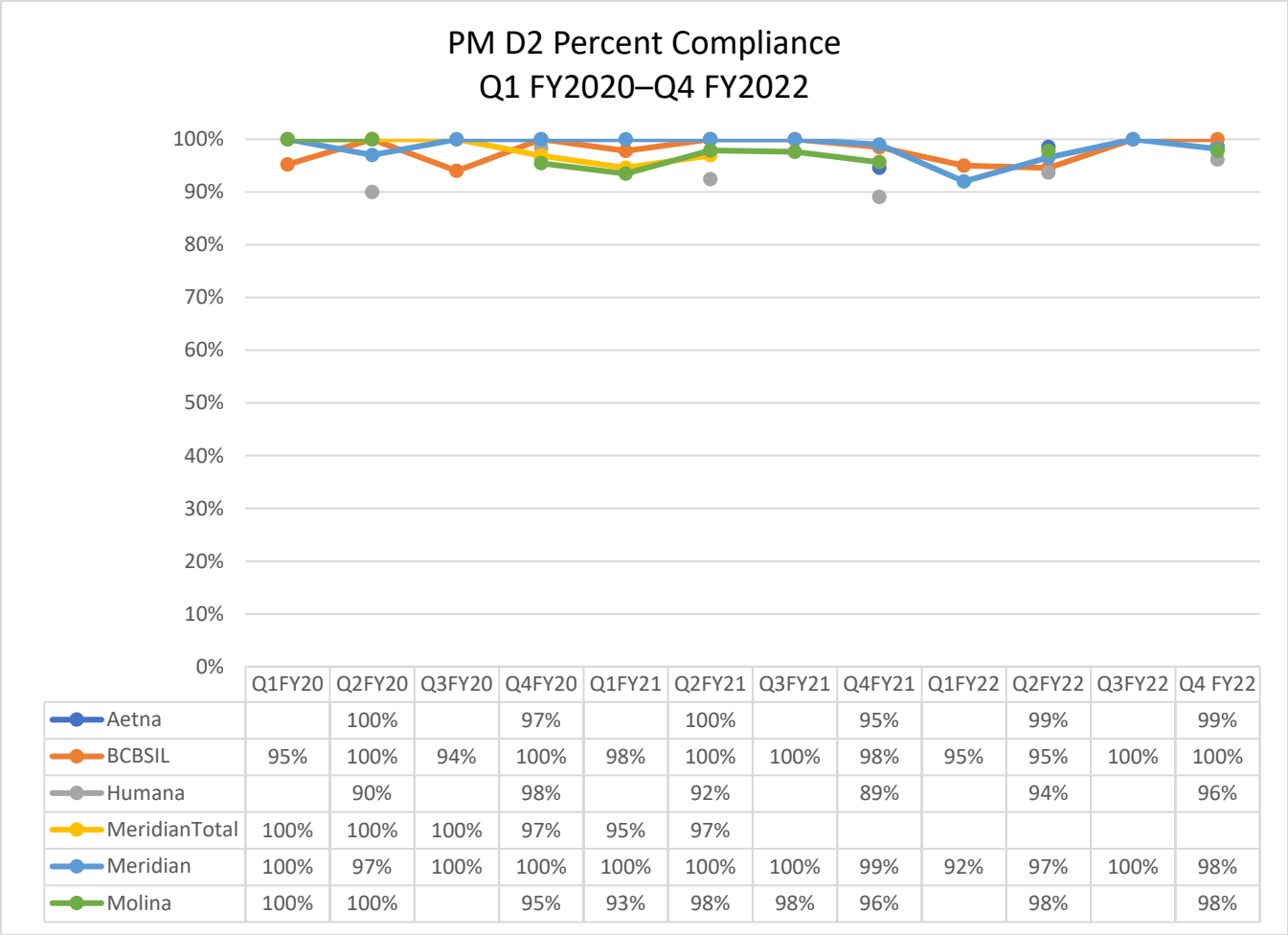
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		98%		100%		100%		96%		99%		99%
BCBSIL	96%	99%	99%	99%	99%	100%	99%	98%	96%	95%	97%	100%
Humana		91%		95%		92%		89%		95%		100%
MeridianTotal	97%	97%	100%	97%	92%	97%						
Meridian	97%	95%	97%	97%	100%	100%	100%	100%	95%	98%	100%	98%
Molina	100%	100%		93%	93%	98%	98%	98%		99%		97%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D2—The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).

Figure B-4—Measure D2



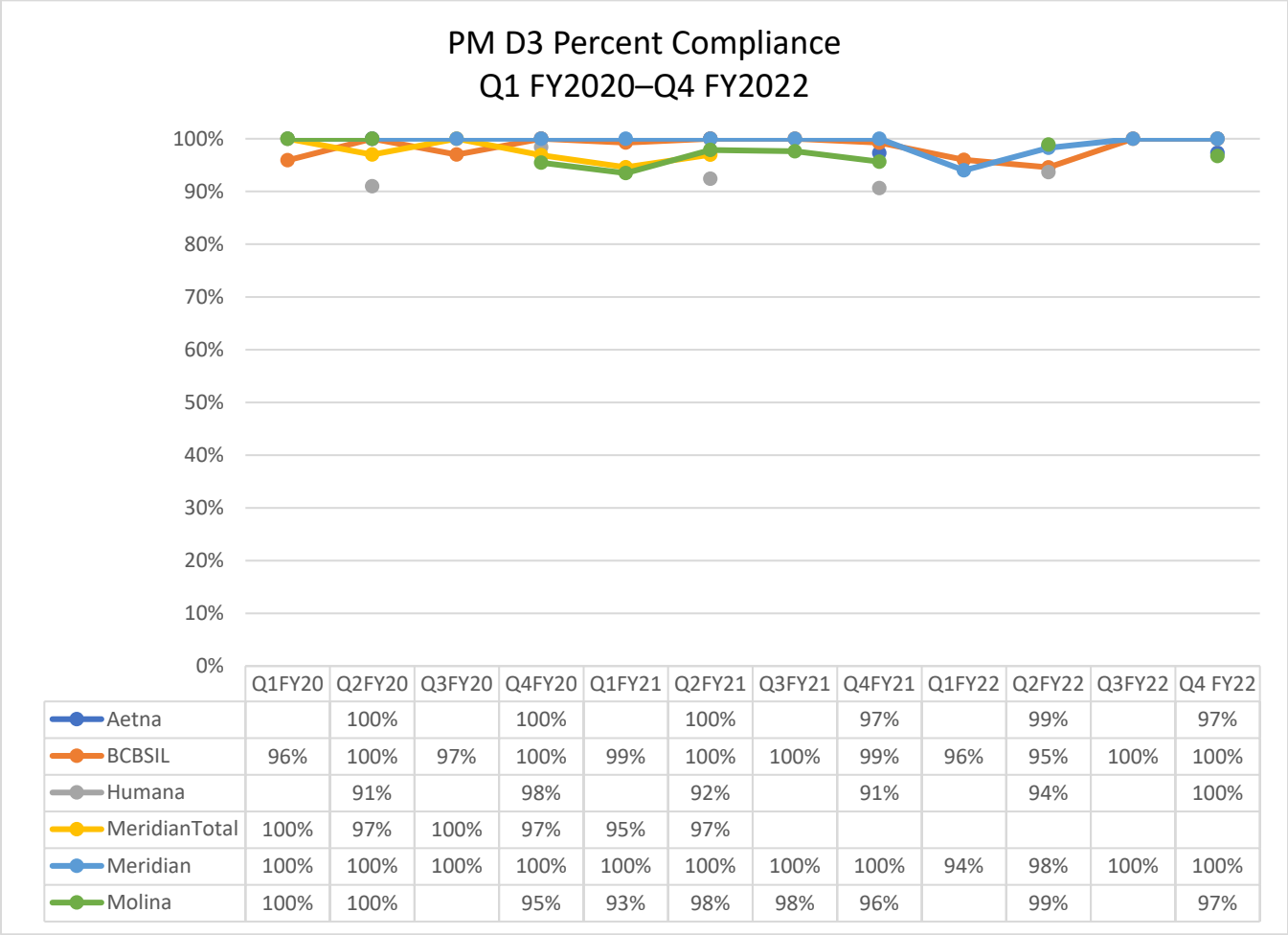
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		97%		100%		95%		99%		99%
BCBSIL	95%	100%	94%	100%	98%	100%	100%	98%	95%	95%	100%	100%
Humana		90%		98%		92%		89%		94%		96%
MeridianTotal	100%	100%	100%	97%	95%	97%						
Meridian	100%	97%	100%	100%	100%	100%	100%	99%	92%	97%	100%	98%
Molina	100%	100%		95%	93%	98%	98%	96%		98%		98%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D3—The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.

Figure B-5—Measure D3



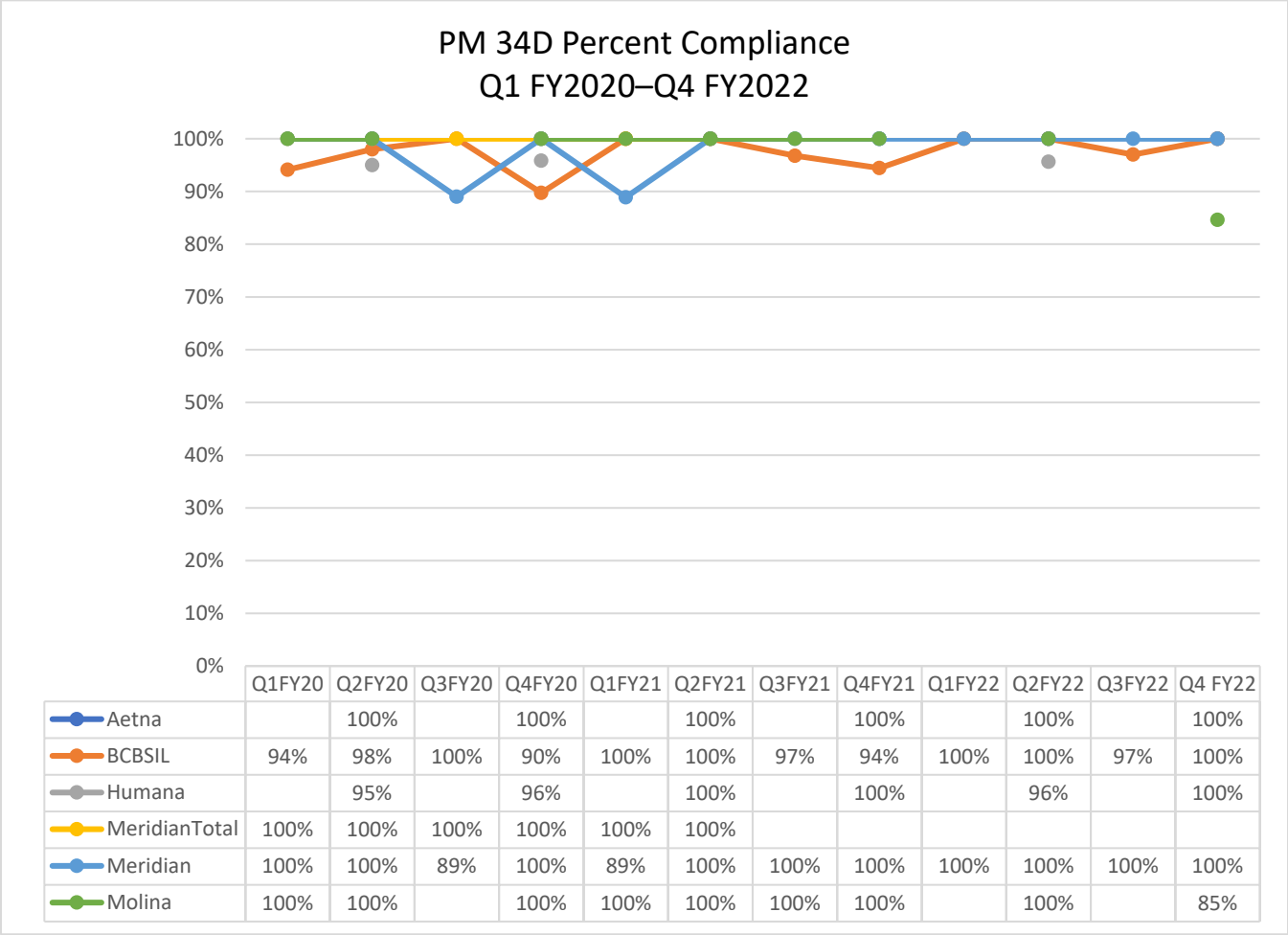
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		97%		99%		97%
BCBSIL	96%	100%	97%	100%	99%	100%	100%	99%	96%	95%	100%	100%
Humana		91%		98%		92%		91%		94%		100%
MeridianTotal	100%	97%	100%	97%	95%	97%						
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	94%	98%	100%	100%
Molina	100%	100%		95%	93%	98%	98%	96%		99%		97%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure 34D—The enrollee reported he/she received the services he/she needed when he/she needed them. (ELD waiver only)

Figure B-6—Measure 34D



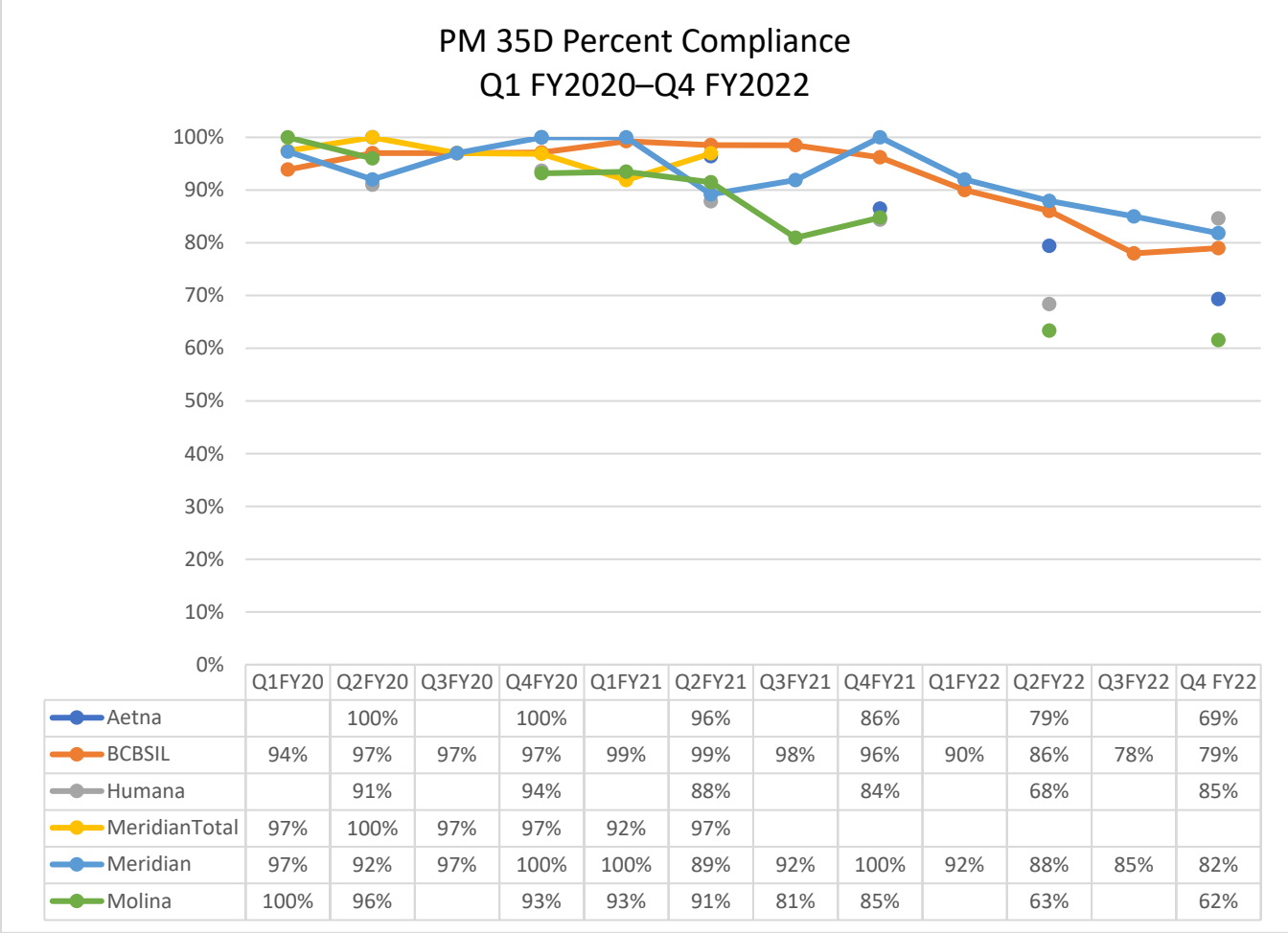
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		100%		100%		100%
BCBSIL	94%	98%	100%	90%	100%	100%	97%	94%	100%	100%	97%	100%
Humana		95%		96%		100%		100%		96%		100%
MeridianTotal	100%	100%	100%	100%	100%	100%						
Meridian	100%	100%	89%	100%	89%	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%		100%	100%	100%	100%	100%		100%		85%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure 35D—The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.

Figure B-7—Measure 35D



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		96%		86%		79%		69%
BCBSIL	94%	97%	97%	97%	99%	99%	98%	96%	90%	86%	78%	79%
Humana		91%		94%		88%		84%		68%		85%
MeridianTotal	97%	100%	97%	97%	92%	97%						
Meridian	97%	92%	97%	100%	100%	89%	92%	100%	92%	88%	85%	82%
Molina	100%	96%		93%	93%	91%	81%	85%		63%		62%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

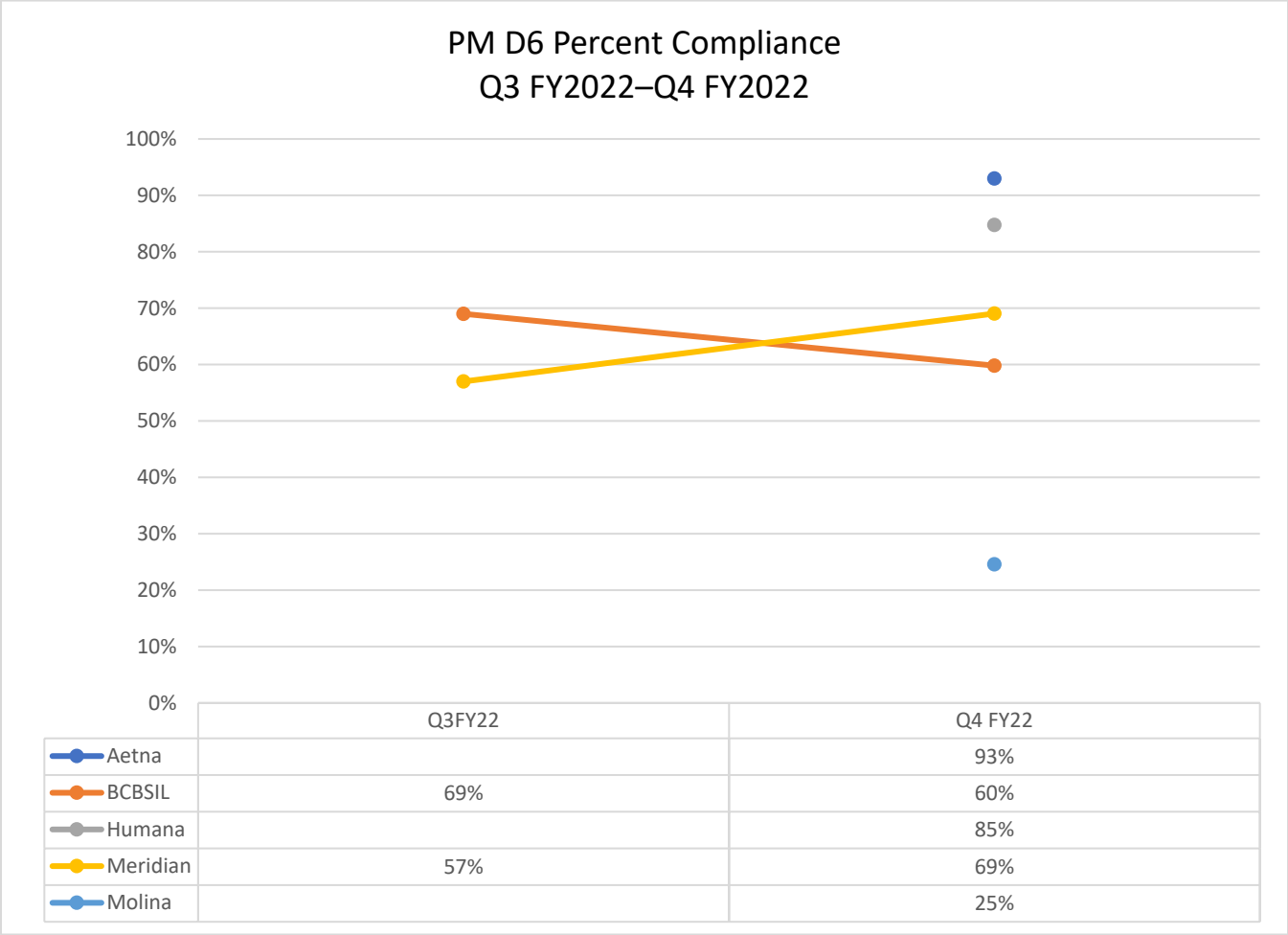
Data prior to FY2020 are available in previous years' reports.

Measure D6—The Case Manager made valid timely contact or valid justification is documented in the enrollee's record.

HIV: One contact per month, with one face-to-face contact bimonthly.
BI: Monthly contact.
PD: Annual contact.
ELD: Annual contact.
SLP records are ineligible for this measure.

Due to the change in evaluation criteria for the PD and ELD waivers beginning Q3 FY2022, historic data are not comparable and only data beginning Q3 FY2022 are displayed.

Figure B-8—Measure D6



	Q3FY22	Q4 FY22
Aetna		93%
BCBSIL	69%	60%
Humana		85%
Meridian	57%	69%
Molina		25%

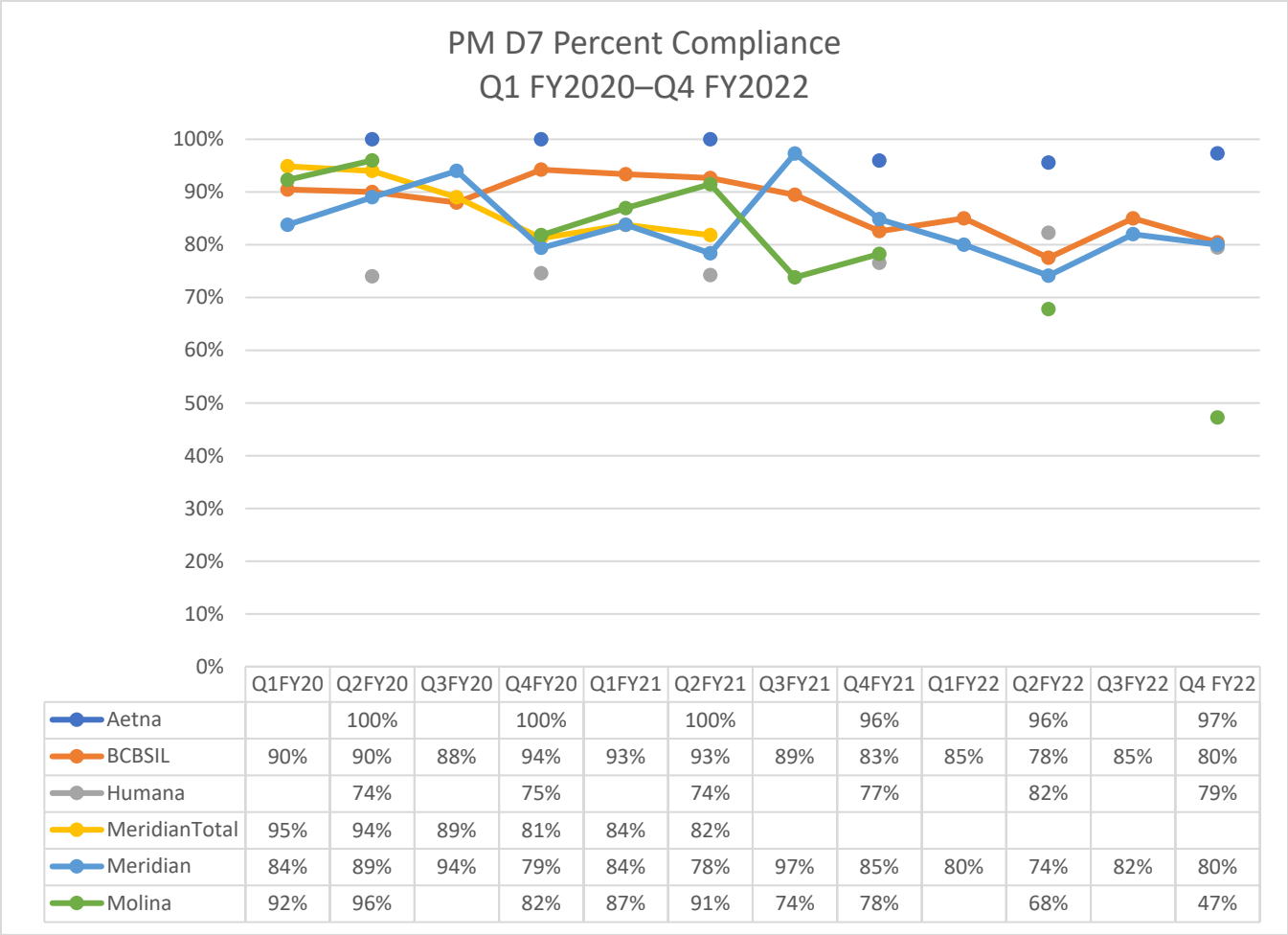
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D7—The most recent service plan is in the record and completed in a timely manner (annually).

Due to changes in performance measure definitions in FY2020, historic data are not comparable and only FY2020 to current data are displayed.

Figure B-9—Measure D7



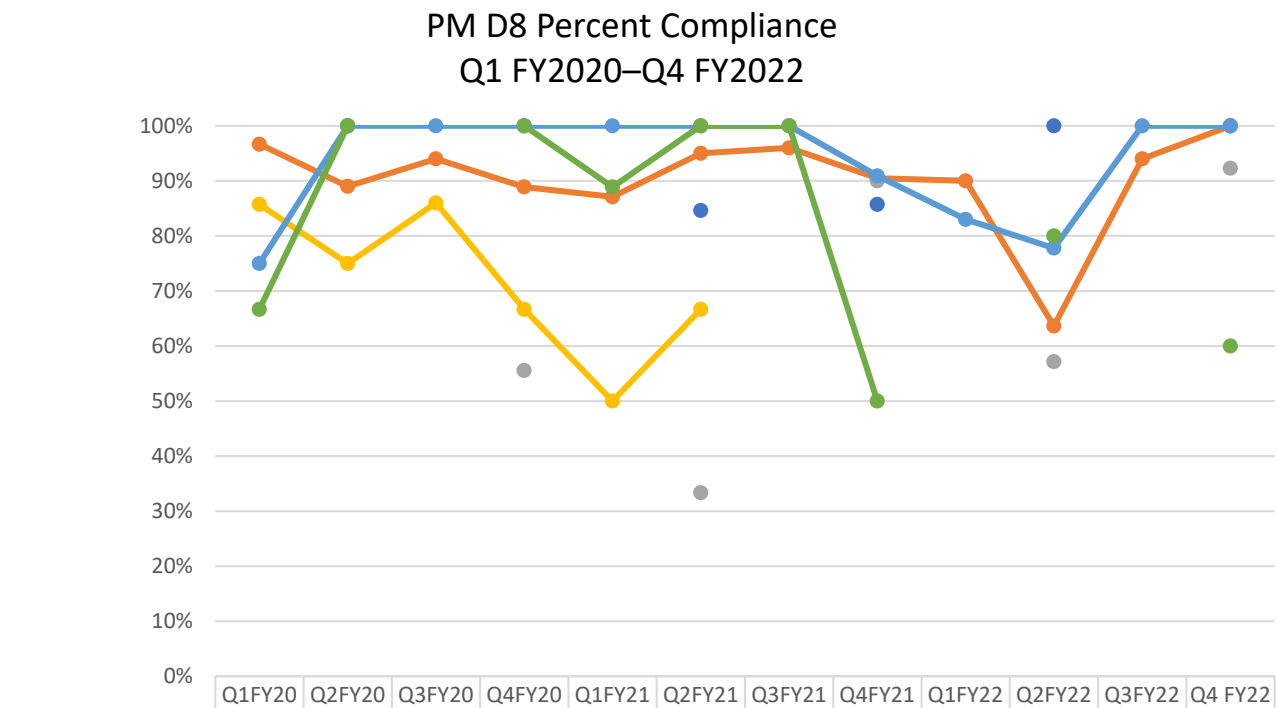
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		96%		96%		97%
BCBSIL	90%	90%	88%	94%	93%	93%	89%	83%	85%	78%	85%	80%
Humana		74%		75%		74%		77%		82%		79%
MeridianTotal	95%	94%	89%	81%	84%	82%						
Meridian	84%	89%	94%	79%	84%	78%	97%	85%	80%	74%	82%	80%
Molina	92%	96%		82%	87%	91%	74%	78%		68%		47%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D8—The service plan was updated when the enrollee needs changed or upon enrollee request.

Figure B-10—Measure D8



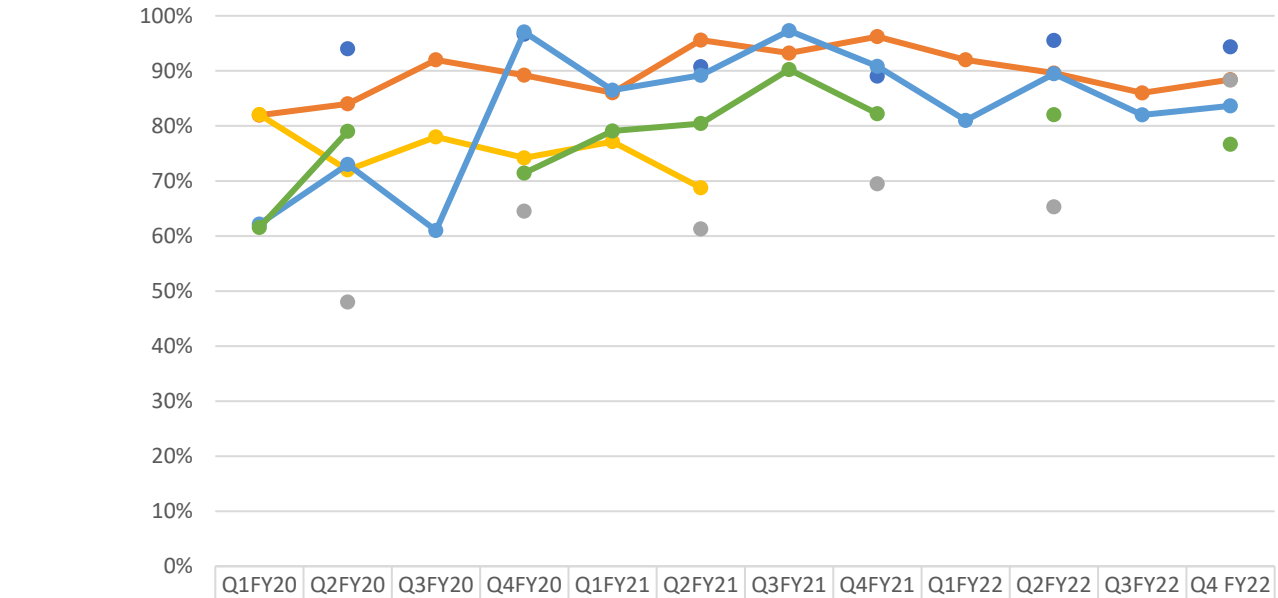
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		85%		86%		100%		100%
BCBSIL	97%	89%	94%	89%	87%	95%	96%	90%	90%	64%	94%	100%
Humana		100%		56%		33%		90%		57%		92%
MeridianTotal	86%	75%	86%	67%	50%	67%						
Meridian	75%	100%	100%	100%	100%	100%	100%	91%	83%	78%	100%	100%
Molina	67%	100%		100%	89%	100%	100%	50%		80%		60%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D9—Services were delivered in accordance with the waiver service plan, including the type, amount, frequency, and scope specified in the waiver service plan.

Figure B-11—Measure D9



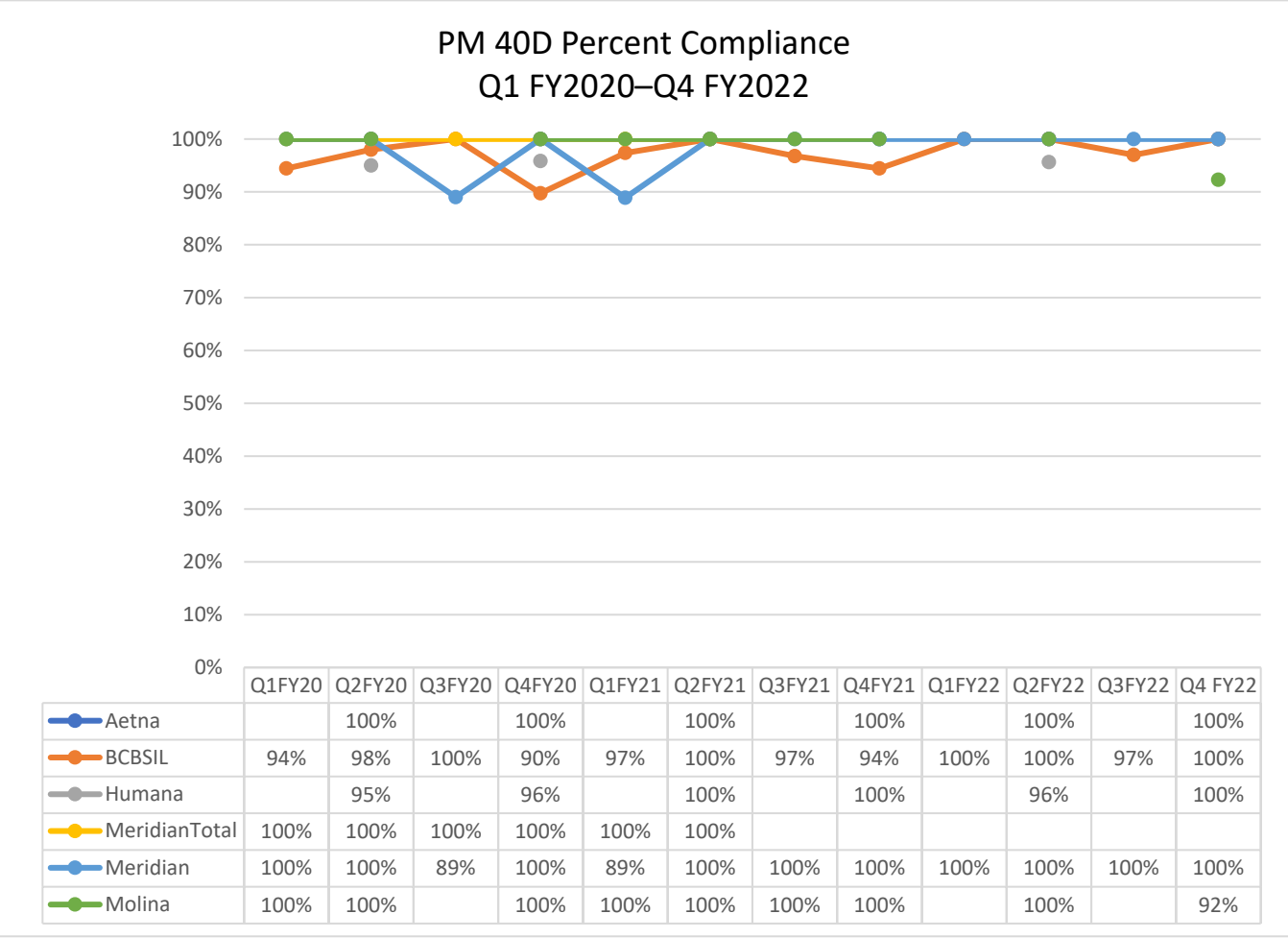
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		94%		97%		91%		89%		96%		94%
BCBSIL	82%	84%	92%	89%	86%	96%	93%	96%	92%	90%	86%	88%
Humana		48%		65%		61%		69%		65%		88%
MeridianTotal	82%	72%	78%	74%	77%	69%						
Meridian	62%	73%	61%	97%	86%	89%	97%	91%	81%	89%	82%	84%
Molina	62%	79%		71%	79%	80%	90%	82%		82%		77%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure 40D—The enrollee reported he/she received all services listed in the plan of care. (ELD waiver only)

Figure B-12—Measure 40D



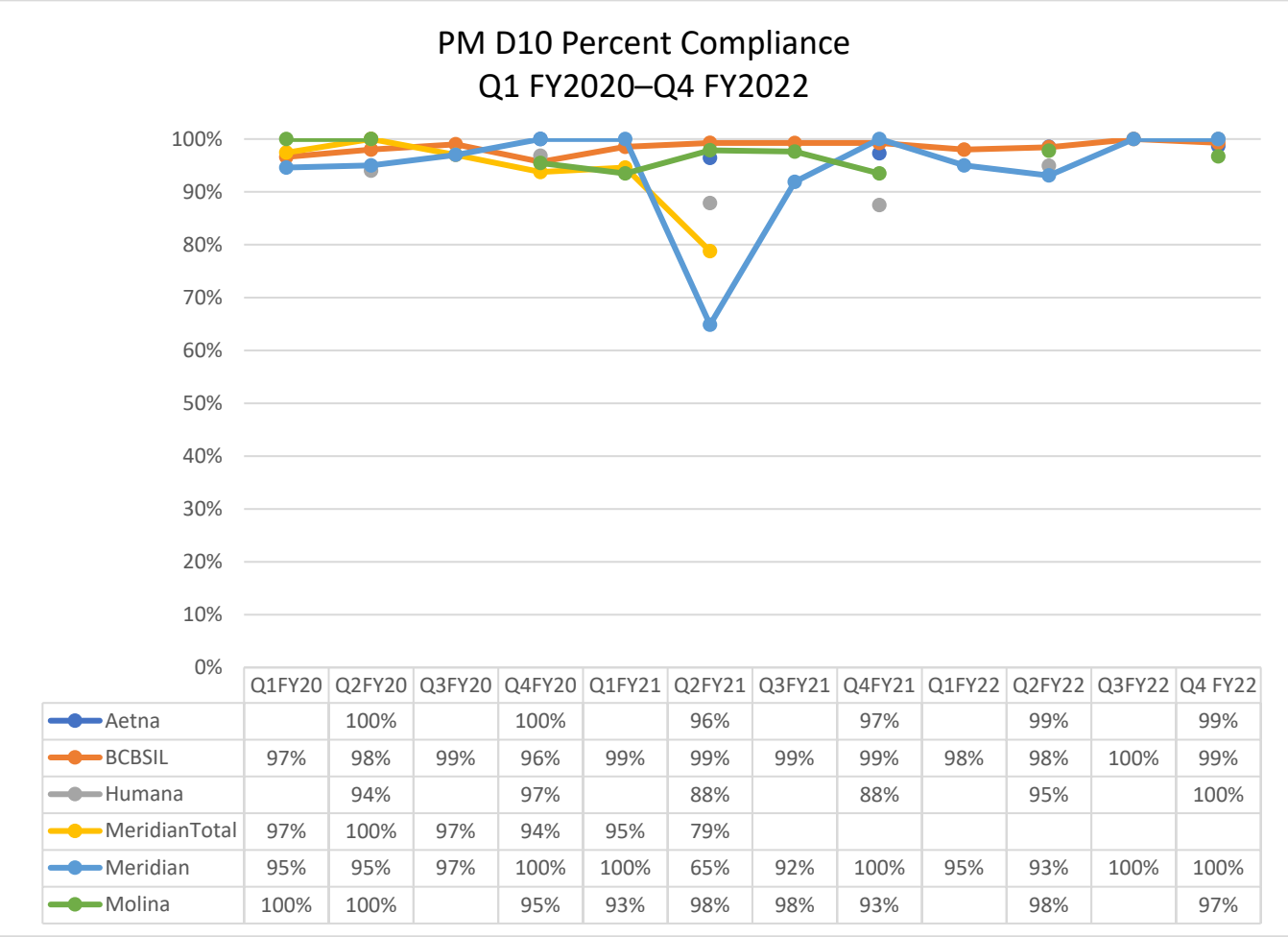
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		100%		100%		100%
BCBSIL	94%	98%	100%	90%	97%	100%	97%	94%	100%	100%	97%	100%
Humana		95%		96%		100%		100%		96%		100%
MeridianTotal	100%	100%	100%	100%	100%	100%						
Meridian	100%	100%	89%	100%	89%	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%		100%	100%	100%	100%	100%		100%		92%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D10—The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B-13—Measure D10



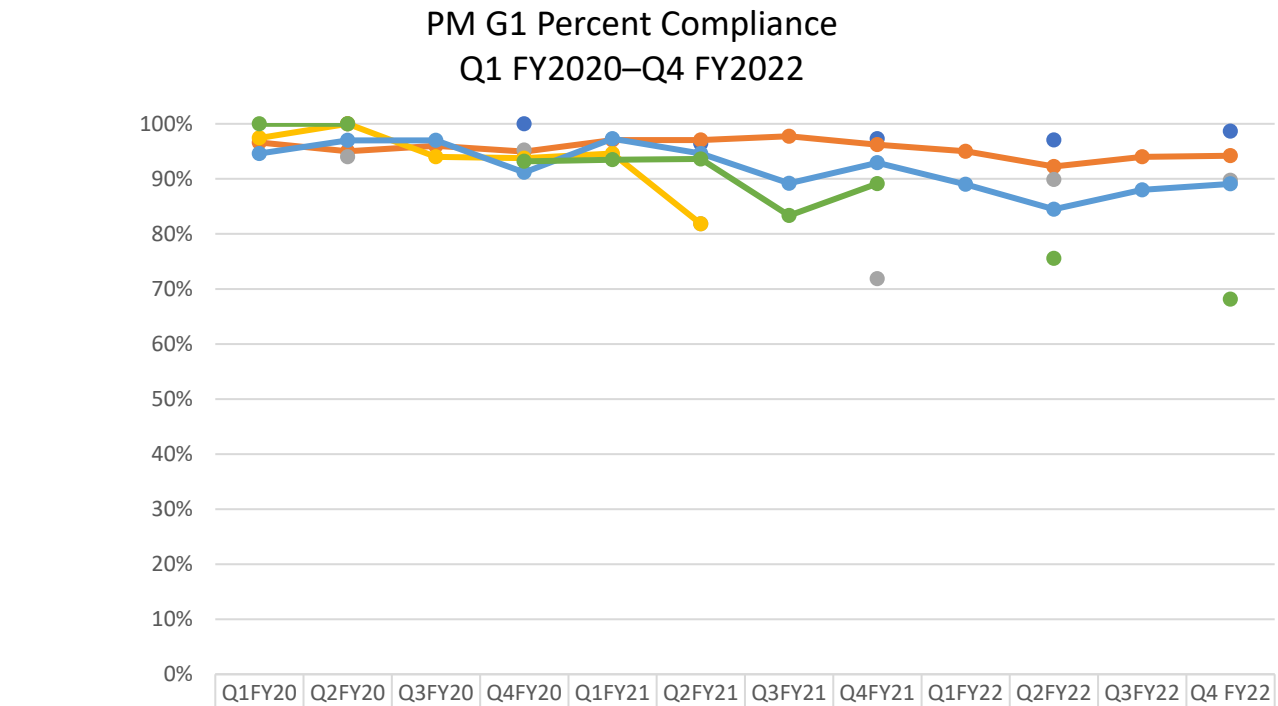
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		96%		97%		99%		99%
BCBSIL	97%	98%	99%	96%	99%	99%	99%	99%	98%	98%	100%	99%
Humana		94%		97%		88%		88%		95%		100%
MeridianTotal	97%	100%	97%	94%	95%	79%						
Meridian	95%	95%	97%	100%	100%	65%	92%	100%	95%	93%	100%	100%
Molina	100%	100%		95%	93%	98%	98%	93%		98%		97%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure G1—The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.

Figure B-14—Measure G1



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		96%		97%		97%		99%
BCBSIL	97%	95%	96%	95%	97%	97%	98%	96%	95%	92%	94%	94%
Humana		94%		95%		82%		72%		90%		90%
MeridianTotal	97%	100%	94%	94%	95%	82%						
Meridian	95%	97%	97%	91%	97%	95%	89%	93%	89%	84%	88%	89%
Molina	100%	100%		93%	93%	94%	83%	89%		76%		68%

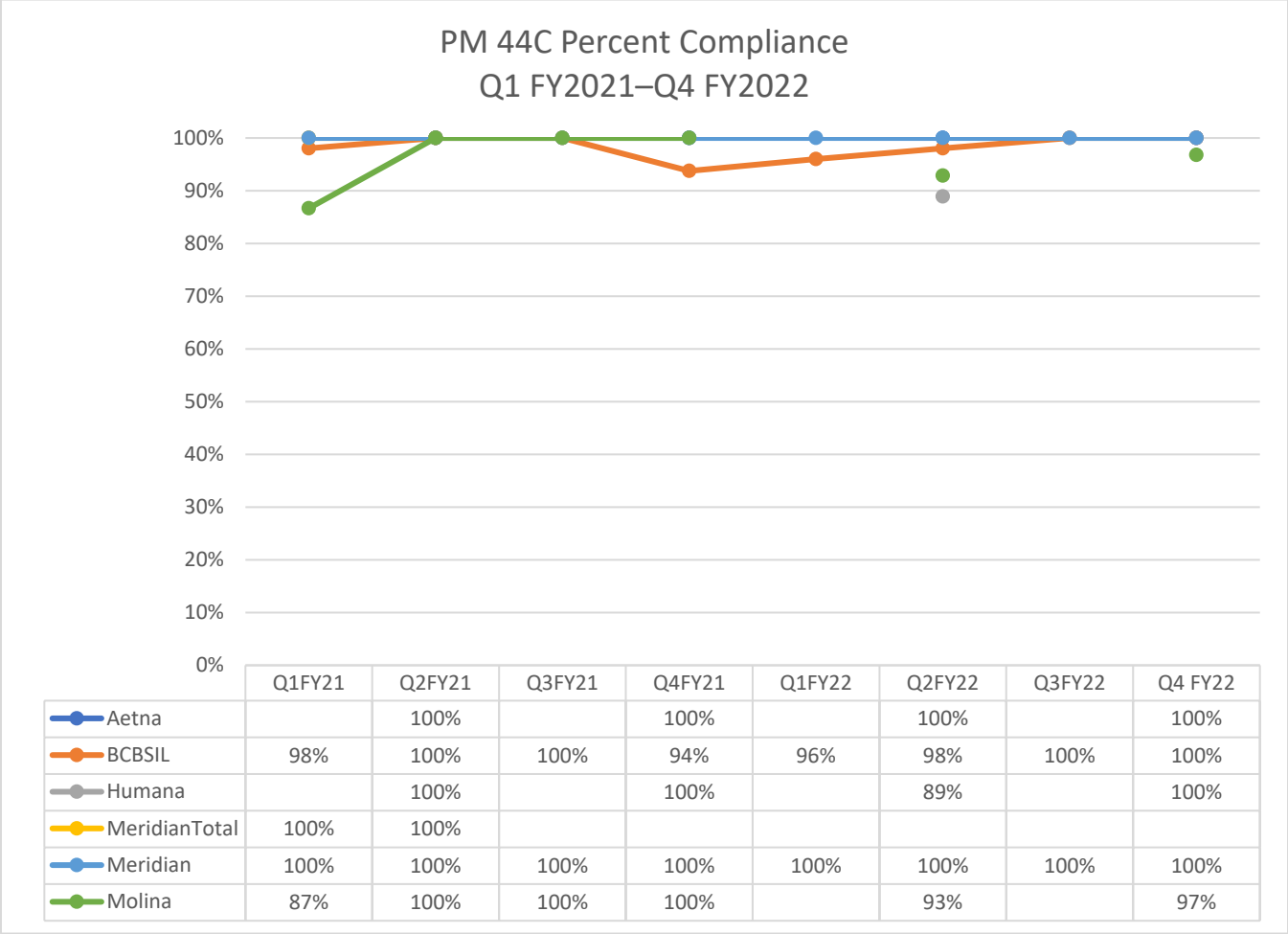
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure 44C—The enrollee reported satisfaction with his/her PA.

New measure beginning FY2021. Captured only for enrollees with PA service.

Figure B-15—Measure 44C

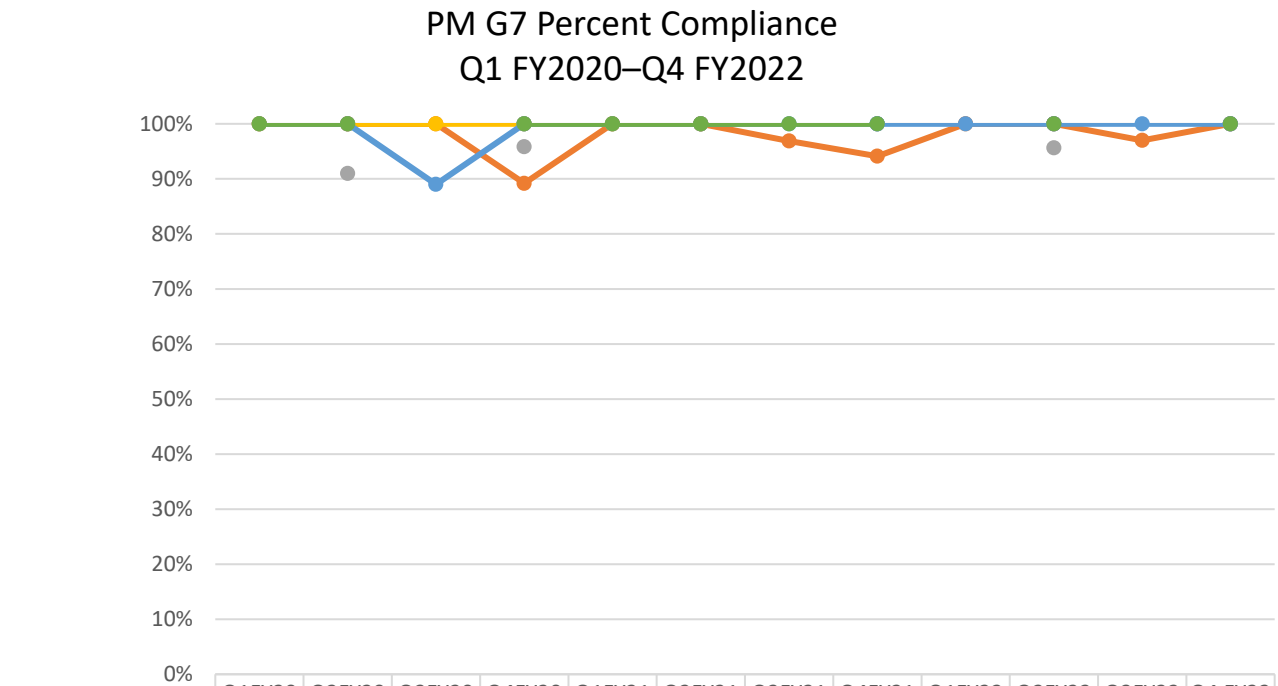


	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		100%
BCBSIL	98%	100%	100%	94%	96%	98%	100%	100%
Humana		100%		100%		89%		100%
MeridianTotal	100%	100%						
Meridian	100%	100%	100%	100%	100%	100%	100%	100%
Molina	87%	100%	100%	100%		93%		97%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure G7—The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B-16—Measure G7



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		100%		100%		100%
BCBSIL	100%	100%	100%	89%	100%	100%	97%	94%	100%	100%	97%	100%
Humana		91%		96%		100%		100%		96%		100%
MeridianTotal	100%	100%	100%	100%	100%	100%						
Meridian	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%		100%	100%	100%	100%	100%		100%		100%

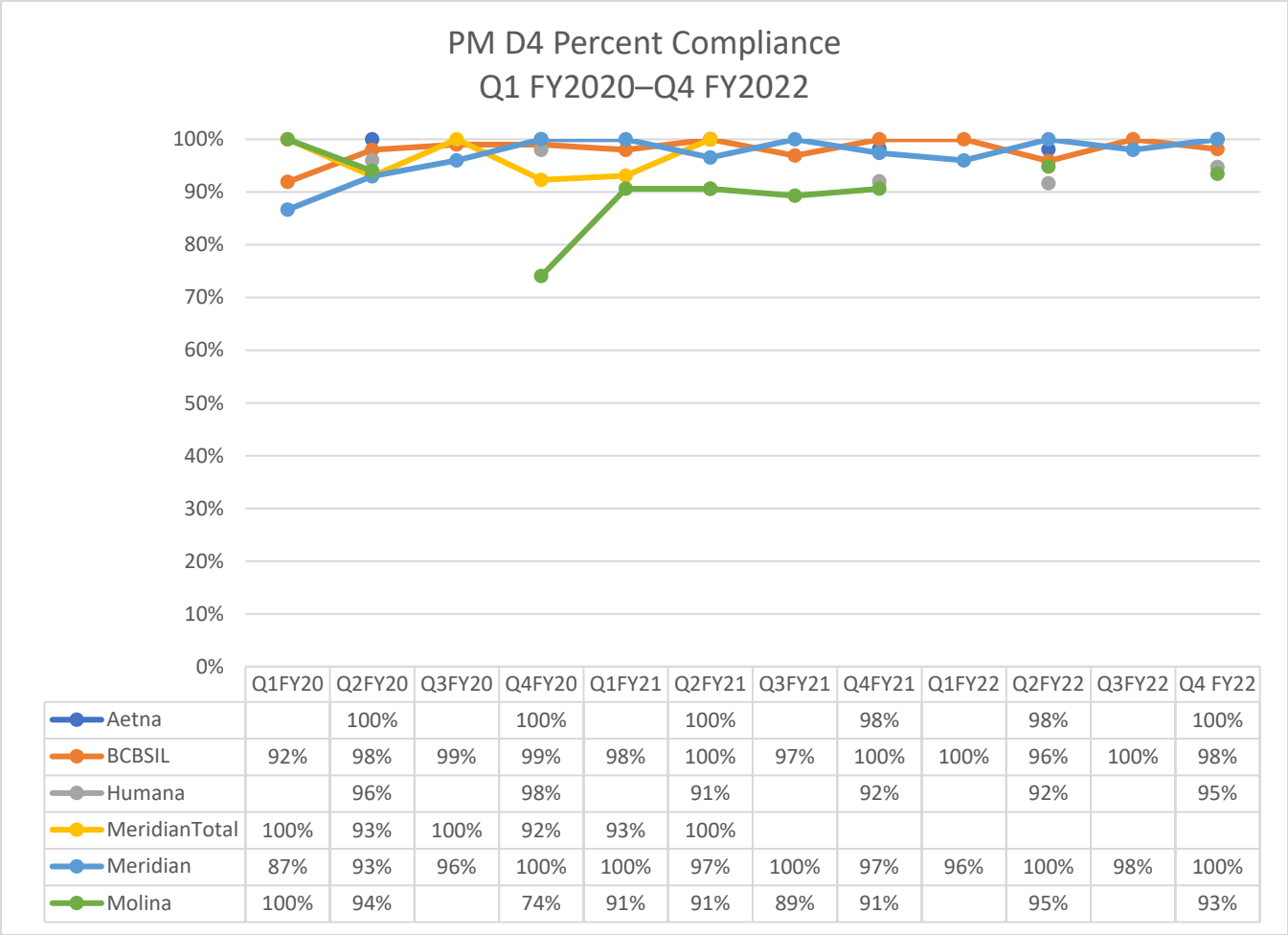
Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to FY2020 are available in previous years' reports.

Measure D4—The most recent service plan includes a backup plan that includes the name of the backup. (ELD, BI, HIV and PD waivers only)

Due to changes in performance measure definitions in FY2020, historic data are not comparable and only FY2020 to current data are displayed.

Figure B-17—Measure D4



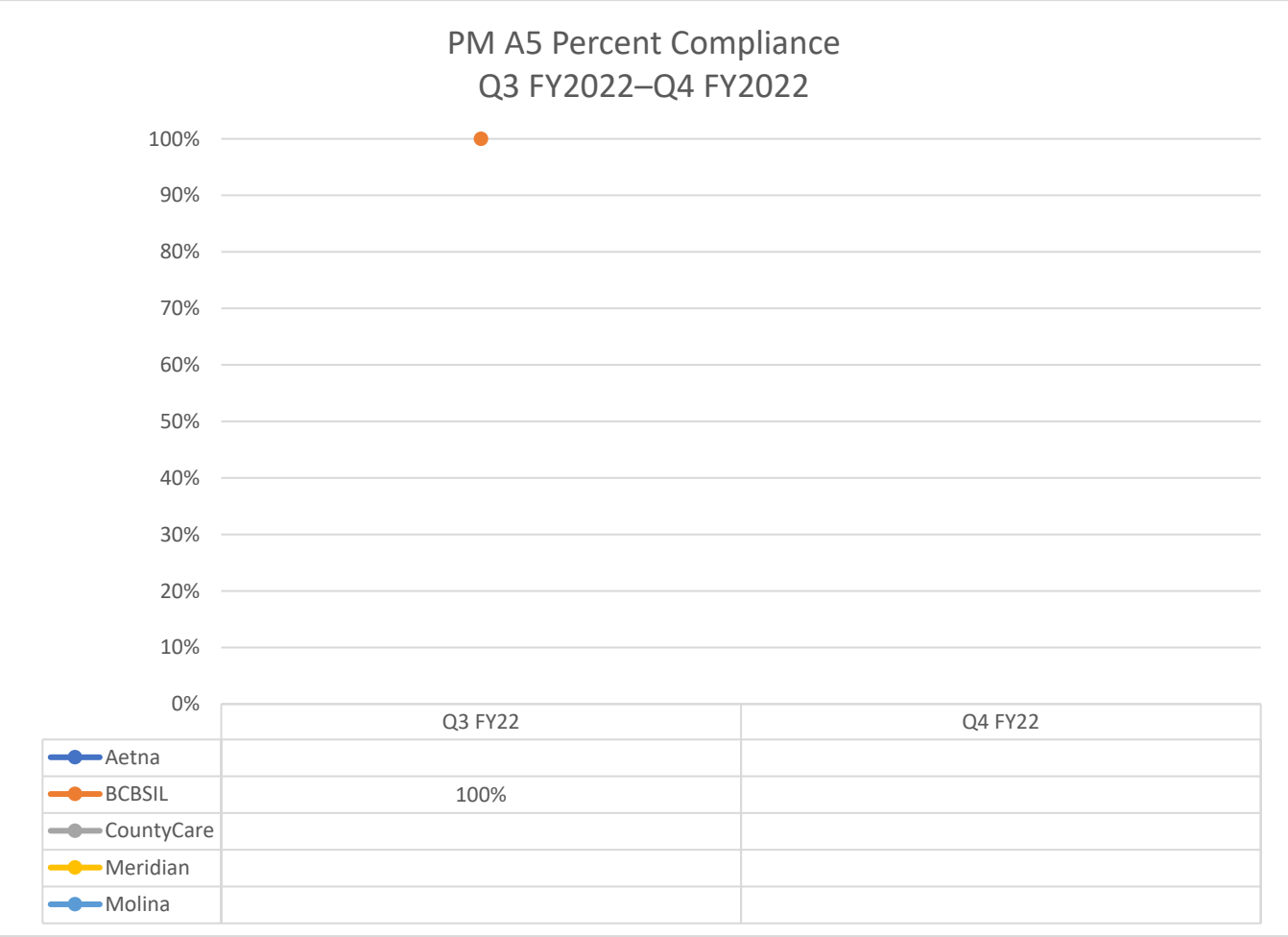
	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4 FY22
Aetna		100%		100%		100%		98%		98%		100%
BCBSIL	92%	98%	99%	99%	98%	100%	97%	100%	100%	96%	100%	98%
Humana		96%		98%		91%		92%		92%		95%
MeridianTotal	100%	93%	100%	92%	93%	100%						
Meridian	87%	93%	96%	100%	100%	97%	100%	97%	96%	100%	98%	100%
Molina	100%	94%		74%	91%	91%	89%	91%		95%		93%

Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A5—Does the enrollee report the ADS facilitates independent choice while attending ADS? (Captured only for PD and ELD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-18—Measure A5

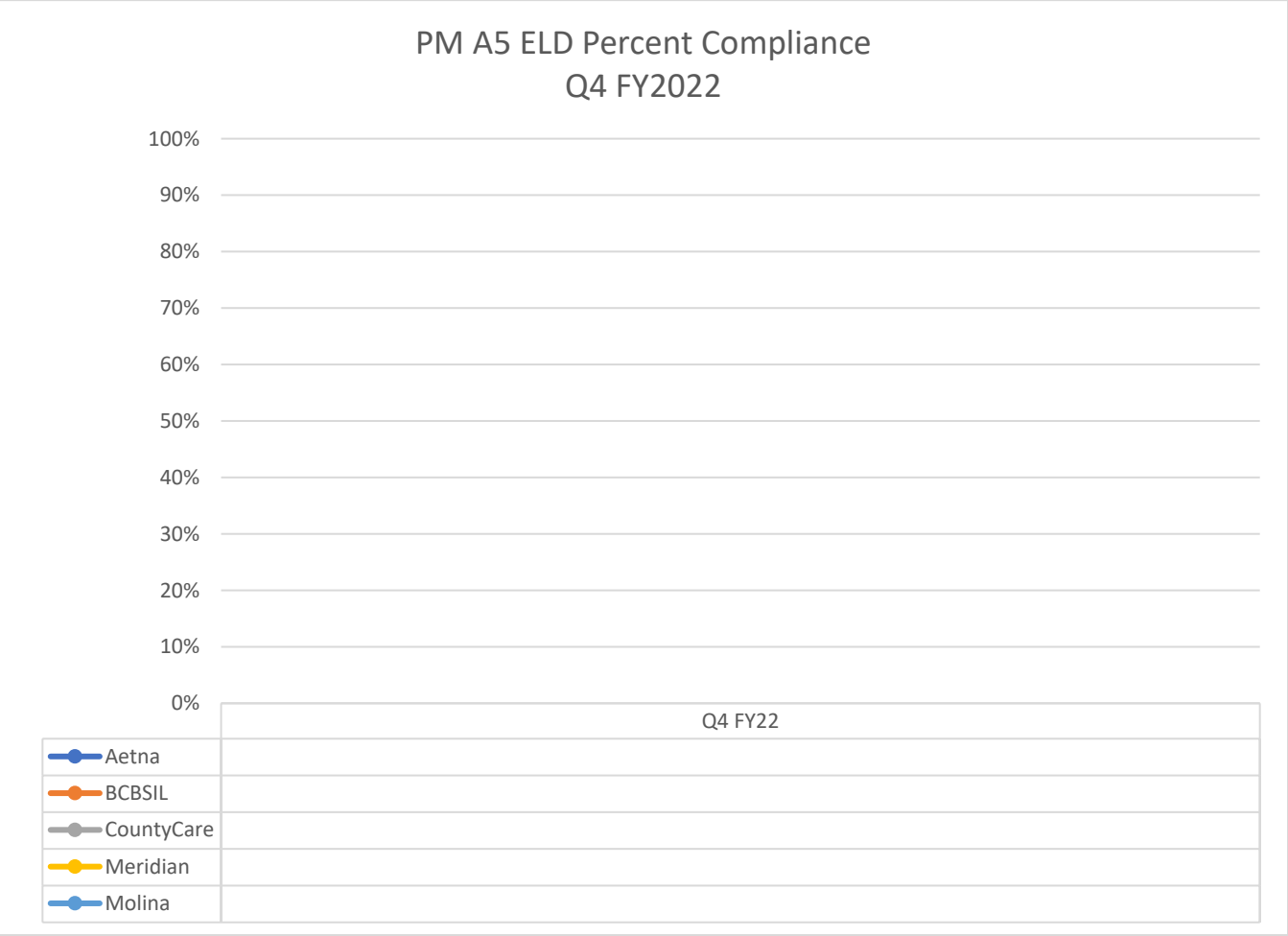


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A5-ELD—Does the enrollee report participation in meaningful activities that help meet their goals/needs? (Captured only for ELD waiver enrollees receiving ADS)

This new measure is effective Q4 FY2022.

Figure B-19—Measure A5-ELD

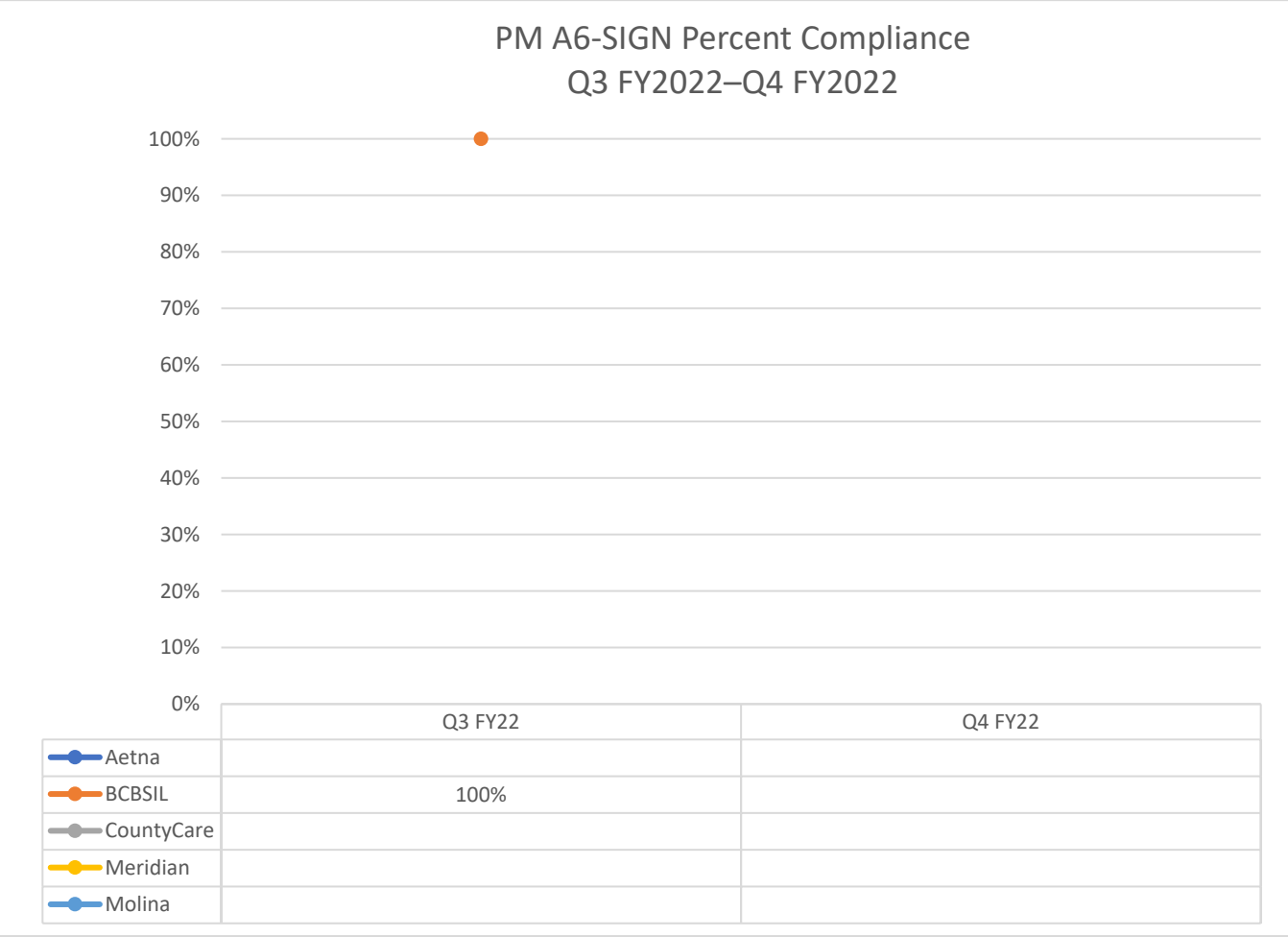


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A6-SIGN—Was the enrollee provided choice of directing services received at the ADS setting? (Captured only for ELD and PD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-20—Measure A6-SIGN

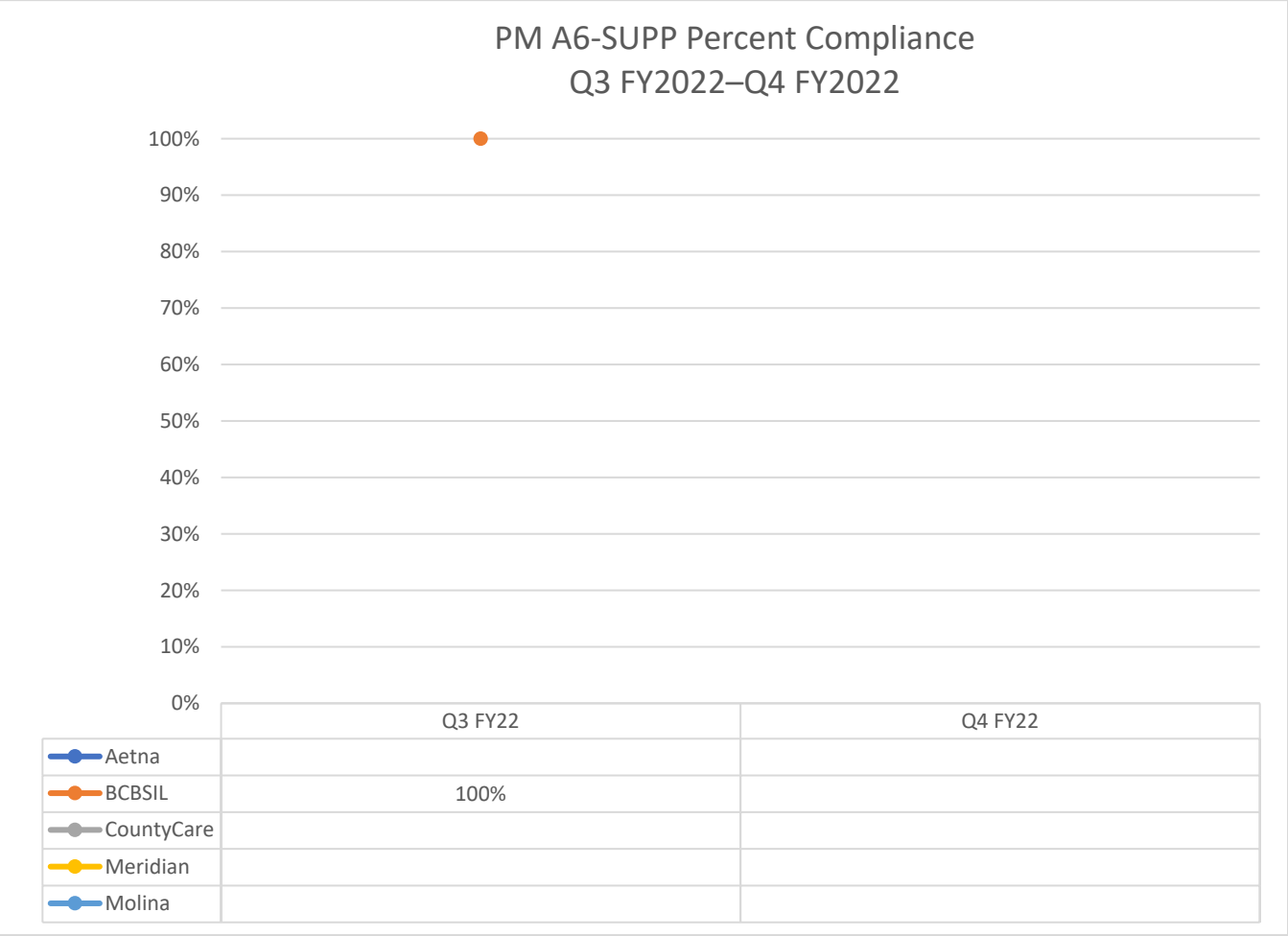


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure A6-SUPP—Did the enrollee report he/she feels supported in making decisions to remain independent? (Captured only for ELD and PD waiver enrollees receiving ADS)

This new measure is effective Q3 FY2022.

Figure B-21—Measure A6-SUPP

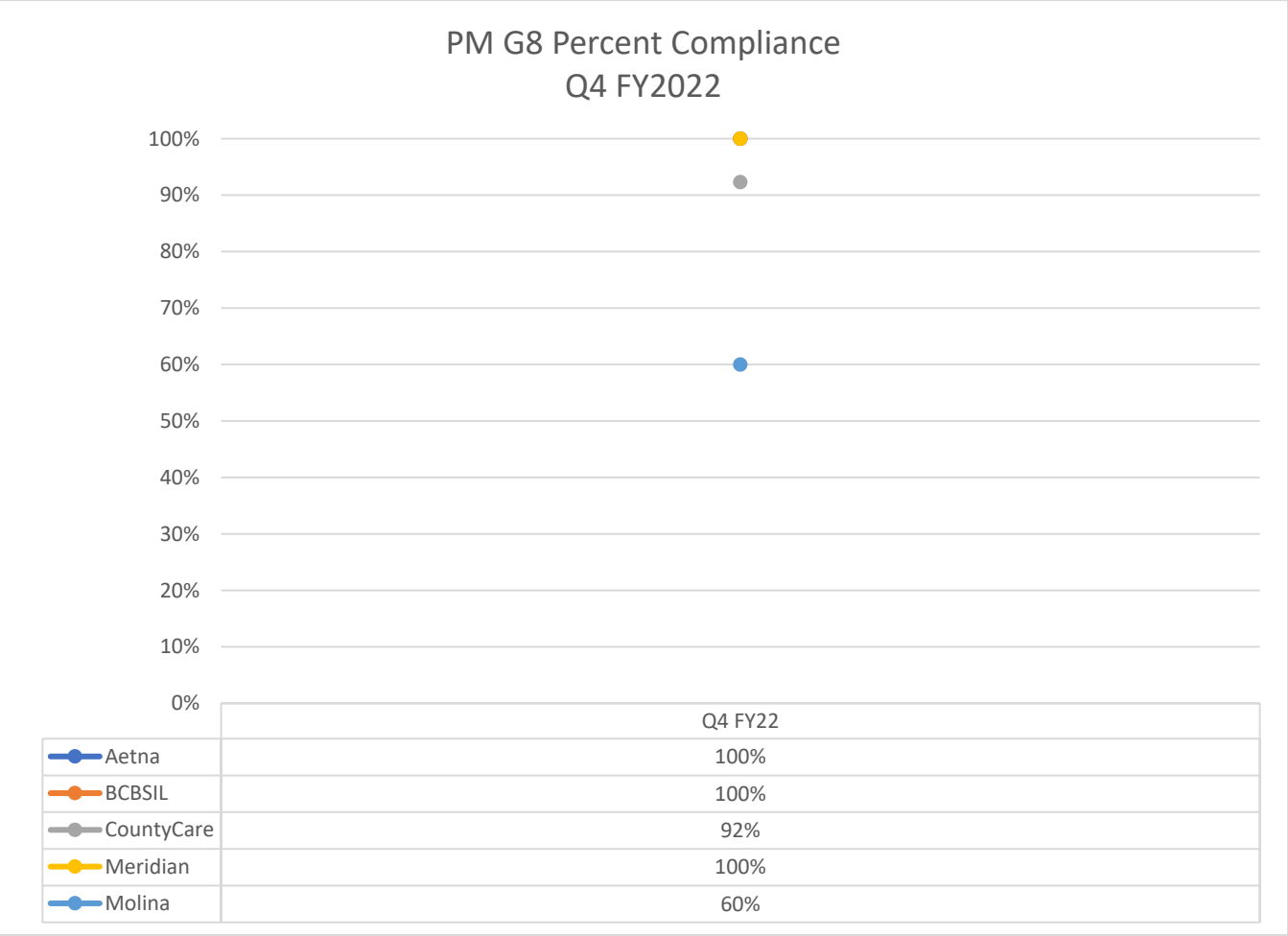


Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure G8—Does the enrollee report a visit with a doctor or practitioner and completion of a physical in the past 12 months?

This new measure is effective Q4 FY2022.

Figure B-22—Measure G8



Note: Blank cells and line breaks represent quarters in which the health plan was not reviewed or did not have eligible records.

Appendix C. Health Plan Performance, by Measure and Quarter—MMAI

Table C-1 displays health plan compliance per performance measure by quarter. Due to HFS' performance measure numbering alignment across waivers that occurred Q3 FY2022, measure numbers are listed with their updated 2022 measure number for historic tracking.

Data prior to FY2020 and for health plans previously included in MMAI are available in previous reports.

Table C-1—MMAI Performance Measure Findings Across Health Plans

Performance Measure Findings Across Health Plans—Percent Compliant by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
Aetna												
12C[4]						0%		67%		33%		
20C[2]						90%		87%		90%		93%
31D/D1		98%		100%		100%		96%		99%		99%
32D/D2		100%		97%		100%		95%		99%		99%
33D/D3		100%		100%		100%		97%		99%		97%
34D		100%		100%		100%		100%		100%		100%
35D		100%		100%		96%		86%		79%		69%
36D/D6		96%		98%		98%		96%		100%		93%
37D/D7[1]		100%		100%		100%		96%		96%		97%
38D/D8		100%		100%		85%		86%		100%		100%
39D/D9		94%		97%		91%		89%		96%		94%
40D		100%		100%		100%		100%		100%		100%

Performance Measure Findings Across Health Plans—Percent Compliant by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
41D/D10		100%		100%		96%		97%		99%		99%
42G/G1		100%		100%		96%		97%		97%		99%
44C[2]						100%		100%		100%		100%
44G/G7		100%		100%		100%		100%		100%		100%
49G/D4[1]		100%		100%		100%		100%		98%		100%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												86%
BCBSIL												
12C[4]					0%	50%	0%	10%	29%	17%		
20C[2]					88%	81%	87%	78%	73%	77%	73%	67%
31D/D1	96%	99%	99%	99%	99%	100%	99%	98%	96%	95%	97%	100%
32D/D2	95%	100%	94%	100%	98%	100%	100%	98%	95%	95%	100%	100%
33D/D3	96%	100%	97%	100%	99%	100%	100%	99%	96%	95%	100%	100%
34D	94%	98%	100%	90%	100%	100%	97%	94%	100%	100%	97%	100%
35D	94%	97%	97%	97%	99%	99%	98%	96%	90%	86%	78%	79%
36D/D6	95%	95%	93%	97%	95%	99%	91%	94%	96%	86%	69%	60%
37D/D7[1]	90%	90%	88%	94%	93%	93%	89%	83%	85%	78%	85%	80%
38D/D8	97%	89%	94%	89%	87%	95%	96%	90%	90%	64%	94%	100%

Performance Measure Findings Across Health Plans—Percent Compliant by Measure and Quarter												
	FY Quarter											
Performance Measure	**Q1 2020**	**Q2 2020**	**Q3 2020**	**Q4 2020**	**Q1 2021**	**Q2 2021**	**Q3 2021**	**Q4 2021**	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**
39D/D9	82%	84%	92%	89%	86%	96%	93%	96%	92%	90%	86%	88%
40D	94%	98%	100%	90%	97%	100%	97%	94%	100%	100%	97%	100%
41D/D10	97%	98%	99%	96%	99%	99%	99%	99%	98%	98%	100%	99%
42G/G1	97%	95%	96%	95%	97%	97%	98%	96%	95%	92%	94%	94%
44C[2]					98%	100%	100%	94%	96%	98%	100%	100%
44G/G7	100%	100%	100%	89%	100%	100%	97%	94%	100%	100%	97%	100%
49G/D4[1]	92%	98%	99%	99%	98%	100%	97%	100%	100%	96%	100%	98%
A5[3]											100%	
A5-ELD[5]												
A6-SIGN[3]											100%	
A6-SUPP[3]											100%	
G8[5]												99%
Humana												
12C[4]						0%		67%		0%		
20C[2]						67%		58%		58%		58%
31D/D1		91%		95%		92%		89%		95%		100%
32D/D2		90%		98%		92%		89%		94%		96%
33D/D3		91%		98%		92%		91%		94%		100%
34D		95%		96%		100%		100%		96%		100%
35D		91%		94%		88%		84%		68%		85%
36D/D6		87%		88%		96%		94%		97%		85%

Performance Measure Findings Across Health Plans—Percent Compliant by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
37D/D7[1]		74%		75%		74%		77%		82%		79%
38D/D8		100%		56%		33%		90%		57%		92%
39D/D9		48%		65%		61%		69%		65%		88%
40D		95%		96%		100%		100%		96%		100%
41D/D10		94%		97%		88%		88%		95%		100%
42G/G1		94%		95%		82%		72%		90%		90%
44C[2]						100%		100%		89%		100%
44G/G7		91%		96%		100%		100%		96%		100%
49G/D4[1]		96%		98%		91%		92%		92%		95%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												83%
Meridian												
12C[4]					0%	20%	0%	17%	20%	20%		
20C[2]					71%	62%	65%	87%	69%	81%	68%	91%
31D/D1	97%	95%	97%	97%	100%	100%	100%	100%	95%	98%	100%	98%
32D/D2	100%	97%	100%	100%	100%	100%	100%	99%	92%	97%	100%	98%
33D/D3	100%	100%	100%	100%	100%	100%	100%	100%	94%	98%	100%	100%
34D	100%	100%	89%	100%	89%	100%	100%	100%	100%	100%	100%	100%

Performance Measure Findings Across Health Plans—Percent Compliant by Measure and Quarter												
	FY Quarter											
Performance Measure	**Q1 2020**	**Q2 2020**	**Q3 2020**	**Q4 2020**	**Q1 2021**	**Q2 2021**	**Q3 2021**	**Q4 2021**	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**
35D	97%	92%	97%	100%	100%	89%	92%	100%	92%	88%	85%	82%
36D/D6	90%	71%	83%	81%	86%	93%	93%	88%	75%	89%	57%	69%
37D/D7[1]	84%	89%	94%	79%	84%	78%	97%	85%	80%	74%	82%	80%
38D/D8	75%	100%	100%	100%	100%	100%	100%	91%	83%	78%	100%	100%
39D/D9	62%	73%	61%	97%	86%	895	97%	91%	81%	89%	82%	84%
40D	100%	100%	89%	100%	89%	100%	100%	100%	100%	100%	100%	100%
41D/D10	95%	95%	97%	100%	100%	65%	92%	100%	95%	93%	100%	100%
42G/G1	95%	97%	97%	91%	97%	95%	89%	93%	89%	84%	88%	89%
44C[2]					100%	100%	100%	100%	100%	100%	100%	100%
44G/G7	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	100%	100%
49G/D4[1]	87%	93%	96%	100%	100%	97%	100%	97%	96%	100%	98%	100%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												98%
Molina												
12C[4]					0%	13%	0%	7%		0%		
20C[2]					44%	47%	18%	36%		41%		38%
31D/D1	100%	100%		93%	93%	98%	98%	98%		99%		97%
32D/D2	100%	100%		95%	93%	98%	98%	96%		98%		98%

Performance Measure Findings Across Health Plans—Percent Compliant by Measure and Quarter												
	FY Quarter											
Performance Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
33D/D3	100%	100%		95%	93%	98%	98%	96%		99%		97%
34D	100%	100%		100%	100%	100%	100%	100%		100%		85%
35D	100%	96%		93%	93%	91%	81%	85%		63%		62%
36D/D6	95%	88%		93%	75%	88%	86%	75%		92%		25%
37D/D7[1]	92%	96%		82%	87%	91%	74%	78%		68%		47%
38D/D8	67%	100%		100%	89%	100%	100%	50%		80%		60%
39D/D9	62%	79%		71%	79%	80%	90%	82%		82%		77%
40D	100%	100%		100%	100%	100%	100%	100%		100%		92%
41D/D10	100%	100%		95%	93%	98%	98%	93%		98%		97%
42G/G1	100%	100%		93%	93%	94%	83%	89%		76%		68%
44C[2]					87%	100%	100%	100%		93%		97%
44G/G7	100%	100%		100%	100%	100%	100%	100%		100%		100%
49G/D4[1]	100%	94%		74%	91%	91%	89%	91%		95%		93%
A5[3]												
A5-ELD[5]												
A6-SIGN[3]												
A6-SUPP[3]												
G8[5]												40%

Shaded rows/cells indicate a quarter during which a health plan was not reviewed or there were no eligible records.

[1]Revised measure effective Q1 FY2020.

[2]Measure added effective Q1 FY2021.

[3]Measure added for PD waiver effective Q3 FY2022.

[4]Measure retired effective Q3 FY2022.

[5]Measure added effective Q4 FY2022.

Appendix D. Waiver Measure Performance by Quarter—MMAI

Table D-1—MMAI Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Waivers—Percent Compliant by Measure FY2022																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	93%	89%	96%	94%	97%	94%	93%	91%	91%	95%	96%	93%	89%	87%	86%	84%	85%	81%	90%	85%
12C[1]	50%	11%	Retired		Not applicable to waiver				50%	0%	Retired		17%	9%	Retired		Not applicable to waiver			
20C	83%	79%	100%	89%	Not applicable to waiver				86%	96%	89%	82%	61%	58%	50%	53%	Not applicable to waiver			
31D/D1	100%	98%	100%	98%	98%	100%	98%	100%	100%	100%	100%	100%	98%	98%	94%	98%	87%	91%	100%	98%
32D/D2	100%	96%	100%	100%	98%	100%	100%	98%	86%	100%	100%	100%	98%	97%	100%	98%	84%	89%	100%	98%
33D/D3	96%	98%	100%	100%	98%	100%	100%	100%	95%	100%	100%	100%	98%	97%	100%	97%	87%	90%	100%	98%
34D	Not applicable to waiver				100%	99%	98%	98%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
35D	96%	86%	88%	86%	98%	86%	87%	82%	90%	94%	90%	75%	90%	82%	92%	78%	80%	53%	53%	59%
36D/D6	77%	76%	75%	80%	98%	99%	69%	63%	57%	69%	70%	81%	98%	97%	55%	55%	Not applicable to waiver			
37D/D7	92%	86%	92%	86%	89%	85%	85%	79%	90%	97%	100%	84%	79%	77%	80%	74%	73%	64%	78%	68%
38D/D8	100%	60%	100%	100%	86%	73%	100%	97%	100%	75%		100%	75%	84%	91%	89%		0%		
39D/D9	77%	84%	96%	96%	93%	76%	75%	79%	86%	91%	100%	88%	80%	81%	75%	77%	100%	99%	100%	99%
40D	Not applicable to waiver				100%	99%	98%	99%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
41D/D10	100%	98%	100%	100%	98%	100%	100%	100%	100%	100%	100%	100%	98%	99%	100%	97%	91%	90%	100%	98%
42G/G1	100%	98%	100%	96%	96%	90%	98%	92%	100%	100%	100%	100%	92%	89%	84%	83%	82%	75%	89%	82%
44C	100%	93%	100%	100%	Not applicable to waiver				100%	100%	100%	100%	95%	98%	100%	99%	Not applicable to waiver			
44G/G7	Not applicable to waiver				100%	99%	98%	100%	Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
49G/D4	96%	94%	100%	100%	100%	98%	98%	98%	100%	97%	100%	97%	98%	94%	100%	96%	Not applicable to waiver			

MMAI Performance Measure Findings Across Waivers—Percent Compliant by Measure FY2022																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3		100%		Not applicable to waiver			
A5-ELD[3]	Not applicable to waiver				Collected beginning Q4				Not applicable to waiver				Not applicable to waiver				Not applicable to waiver			
A6-SIGN[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3		100%		Not applicable to waiver			
A6-SUPP[2]	To be collected in FY2023				Collected beginning Q4				To be collected in FY2023				Collected beginning Q3		100%		Not applicable to waiver			
G8[3]	Collected beginning Q4			90%	Collected beginning Q4			92%	Collected beginning Q4			97%	Collected beginning Q4			80%	Collected beginning Q4			61%

Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.

[1]*Measure retired effective Q3 FY2022*

[2]*New measure effective Q3 FY2022*

[3]*New measure effective Q4 FY2022*

Table D-2—MMAI Waiver Performance Measure Findings: BI Waiver

MMAI Performance Measure Findings: BI Waiver—Percent Compliant by Measure FY2015–FY2021							
Performance Measure	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	89%	93%	96%	83%	86%	94%	92%
4A[1,2]				54%	35%		43%
12C[4]							22%
20C[4]							82%
26C[3]	100%	97%	99%				
31D	89%	98%	97%	96%	97%	98%	99%
32D	89%	95%	96%	99%	99%	99%	99%
33D	89%	97%	98%	99%	99%	99%	99%
34D							
35D	93%	99%	99%	100%	99%	97%	97%
36D[2]	78%	68%	73%	58%	63%	75%	74%
37D	81%	78%	97%	63%	72%	99%	91%
38D	100%	86%	100%	93%	90%	95%	90%
39D[2]	93%	99%	97%	34%	56%	82%	87%
40D							
41D	89%	98%	99%	99%	99%	99%	96%
42G	93%	100%	100%	98%	99%	97%	97%
44C[4]							99%
44G							
49G	86%	97%	100%	92%	95%	96%	97%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.*

[1]*Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.*

[2]*New measure SFY2018*

[3]*Measure retired at the end of SFY2017*

[4]*New measure SFY2021*

Table D-3—MMAI Waiver Performance Measure Findings: ELD Waiver

MMAI Performance Measure Findings: ELD Waiver—Percent Compliant by Measure FY2015–FY2021							
Performance Measure	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	87%	93%	96%	89%	91%	93%	94%
4A[1,2]				28%	23%	40%	27%
12C[4]							
20C[4]							
26C[3]							
31D	78%	93%	95%	95%	94%	98%	96%
32D	86%	88%	96%	98%	96%	98%	96%
33D	88%	93%	97%	99%	96%	99%	98%
34D				94%	99%	97%	99%
35D	81%	94%	97%	97%	97%	96%	95%
36D[2]				99%	98%	99%	98%
37D	98%	95%	97%	83%	84%	87%	88%
38D	90%	77%	77%	85%	92%	90%	88%
39D[2]	81%	96%	98%	37%	52%	68%	80%
40D				94%	98%	97%	98%
41D	93%	94%	97%	97%	97%	96%	95%
42G	92%	96%	97%	95%	96%	96%	93%
44C[4]							
44G				96%	98%	97%	99%
49G				93%	88%	98%	97%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.*

[1]*Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data not comparable.*

[2]*New measure SFY2018*

[3]*Measure retired at end of SFY2017*

[4]*New measure SFY2021*

Table D-4—MMAI Waiver Performance Measure Findings: HIV Waiver

MMAI Performance Measure Findings: HIV Waiver—Percent Compliant by Measure FY2015–FY2021							
Performance Measure	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	86%	93%	95%	88%	90%	94%	95%
4A[1,2]				40%	63%	0%	67%
12C[4]							33%
20C[4]							88%
26C[3]	100%	94%	97%				
31D	80%	93%	98%	100%	95%	98%	100%
32D	93%	91%	98%	100%	96%	98%	100%
33D	87%	91%	100%	100%	98%	99%	100%
34D							
35D	80%	98%	100%	100%	99%	98%	99%
36D[2]	93%	66%	56%	45%	58%	70%	77%
37D	93%	99%	100%	90%	92%	98%	94%
38D	100%	100%	100%	100%	90%	86%	86%
39D[2]	73%	95%	96%	54%	69%	87%	91%
40D							
41D	93%	99%	100%	98%	99%	97%	99%
42G	93%	98%	99%	98%	99%	97%	98%
44C[4]							99%
44G							
49G	64%	97%	98%	95%	95%	99%	100%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.*

[1]*Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.*

[2]*New measure SFY2018*

[3]*Measure retired at end of SFY2017*

[4]*New measure SFY2021*

Table D-5—MMAI Waiver Performance Measure Findings: PD Waiver

MMAI Performance Measure Findings: PD Waiver—Percent Compliant by Measure FY2015–FY2021							
Performance Measure	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	91%	96%	98%	90%	89%	93%	90%
4A[1,2]				26%	30%	27%	33%
12C[4]							5%
20C[4]							67%
26C[3]	100%	97%	94%				
31D	84%	96%	98%	97%	94%	98%	98%
32D	91%	93%	97%	98%	96%	98%	98%
33D	94%	95%	100%	98%	96%	98%	98%
34D							
35D	85%	96%	97%	98%	97%	98%	95%
36D[2]	99%	98%	100%	99%	98%	100%	99%
37D	98%	97%	99%	85%	83%	89%	88%
38D	100%	90%	89%	89%	84%	92%	88%
39D[2]	86%	96%	99%	43%	50%	72%	83%
40D							
41D	94%	96%	99%	96%	97%	98%	94%
42G	93%	96%	99%	96%	96%	97%	92%
44C[4]							98%
44G							
49G	86%	97%	99%	97%	92%	94%	94%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.

[2]New measure SFY2018

[3]Measure retired at end of SFY2017

[4]New measure SFY2021

Table D-6—MMAI Waiver Performance Measure Findings: SLP Waiver

MMAI Performance Measure Findings: SLP Waiver—Percent Compliant by Measure FY2015–FY2021							
Performance Measure	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
Overall[1, 2]	85%	97%	99%	96%	93%	95%	92%
4A[1,2]				35%	29%	0%	30%
12C[4]							
20C[4]							
26C[3]							
31D	73%	96%	100%	98%	93%	96%	97%
32D	71%	96%	98%	98%	94%	97%	97%
33D	78%	98%	98%	99%	95%	97%	97%
34D							
35D	85%	94%	98%	99%	98%	95%	90%
36D[2]							
37D	100%	100%	98%	90%	85%	85%	80%
38D		75%	71%	100%	25%	0%	82%
39D[2]	100%			98%	99%	100%	99%
40D							
41D	92%	98%	100%	98%	98%	97%	95%
42G	94%	97%	99%	96%	94%	95%	91%
44C[4]							
44G							
49G							

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected.*

[1]Changes in performance measure definitions and evaluation criteria effective SFY2018 and SFY2021. Historic data are not comparable.

[2]New measure SFY2018

[3]Measure retired at end of SFY2017

[4]New measure SFY2021

Appendix E. Acronyms

ACA	Affordable Care Act
ADS	Adult Day Service
AIDS	Acquired Immune Deficiency Syndrome
BI	Persons with Brain Injury Waiver
CMS	Centers for Medicare & Medicaid Services
COVID-19 PHE	Coronavirus Disease 2019 Public Health Emergency
ELD	Persons who are Elderly Waiver
EQRO	External Quality Review Organization
FHP	Family Health Plan
FY	Fiscal Year
HCBS	Home- and Community-Based Services
HCI	HealthChoice Illinois
HFS	The Illinois Department of Healthcare and Family Services
HIV	Persons with Human Immunodeficiency Virus (HIV)/AIDS Waiver
HRA	Health Risk Assessment
HSAG	Health Services Advisory Group, Inc.
ICP	Integrated Care Program
IRR	Interrater Reliability
MCP	Managed Care Plan
MLTSS	Managed Long-Term Services and Supports
MMAI	Medicare-Medicaid Alignment Initiative
N/A	Not Applicable
PA	Personal Assistant
PD	Persons with Disabilities Waiver
PM	Performance Measure
Q	Quarter
SFY	State Fiscal Year
SLP	Persons in a Supportive Living Program Waiver
VMC	Voluntary Managed Care