





HFS

Illinois Department of
Healthcare and Family Services

EXTERNAL QUALITY REVIEW ANNUAL REPORT

State Fiscal Years 2022-2023
(July 1, 2022-June 30, 2023)

Illinois Department of Healthcare
and Family Services
Division of Medical Programs

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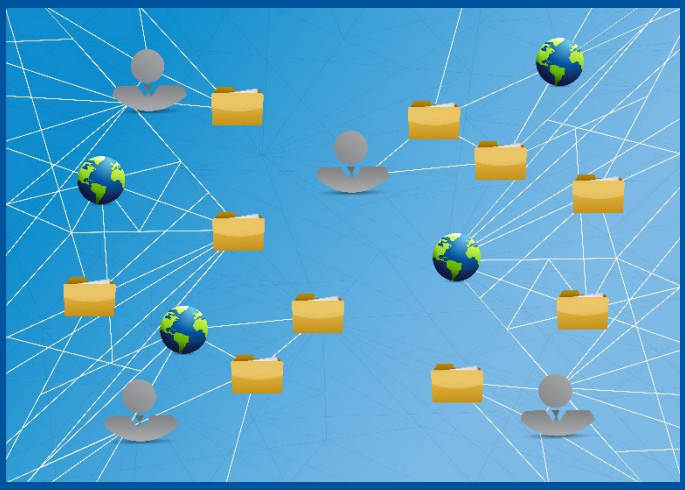
1. Executive Summary

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.



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 2023

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Community Health Plans	BCBSIL
CountyCare (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 offers additional benefits and is designed to improve access to care through active coordination and a more robust provider network. With YouthCare, DCFS youth receive additional benefits, such as trauma-informed care coordination for behavioral health needs. YouthCare provides specialized programming for adoptive families, including an adoption-competent network of therapists to support the different phases of adoption and child development.

Medicare-Medicaid Alignment Initiative (MMAI)

HFS contracted with five health plans to administer the MMAI, an ongoing partnership between HFS, CMS, and health plans, which provides coordinated care to dually eligible beneficiaries in Illinois. Table 1-2 displays the MMAI health plans.

Table 1-2—MMAI Health Plans for SFY 2023

Health Plan Name	Abbreviation
Aetna Better Health Premier Plan	Aetna
Blue Cross Community MMAI	BCBSIL
Humana Gold Plan Integrated	Humana

Health Plan Name	Abbreviation
Meridian	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 1-1.[1-1]

Figure 1-1—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://hfs.illinois.gov/content/dam/soi/en/web/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 1-2. This report provides a review of health plan performance in comparison to the Quality Strategy goals.

Figure 1-2—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 2023 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 (NAV)*	This activity includes validating data to determine whether the network standards, as defined by the state, were met.	**Protocol 4.** Validation of Network Adequacy

**Protocol 4. Validation of Network Adequacy* was released in February 2023; therefore, full implementation will occur with the 2024 NAV activities.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 2, 2024.

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 2023. 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 State Fiscal Year (SFY) 2023—Strengths

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	46 Quality Measure Indicator Rates[i]	25 Timeliness Measure Indicator Rates[ii]	30 Access Measure Indicator Rates[iii]
Strengths	Compliance	For HCI and MMAI, a total of seven standards were assessed in SFY 2023. Generally, the health plans and Medicare-Medicaid Plans (MMPs) were compliant with policies and procedures, as well as file reviews.		
	PIPs	The health plans submitted two new state-mandated PIPs for validation: *Improving Timeliness of Prenatal Care* and *Improving Transportation Services*.		
	CAHPS	Member experience survey results for *Customer Service* indicated that adult members perceived better quality of care from their health plan when they needed assistance (from 2022 to 2023) and perceived they were able to receive care when they needed it.		
	HEDIS	**90th Percentile and Above** • 1 of 46 measure rates (2.2%) ○ *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 3 of 46 measure rates (6.5%) ○ *Immunizations for Adolescents (IMA)—Combination 1* ○ *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** • 16 of 46 measure rates (34.8%) ○ *Child and Adolescent Well-Care Visits (WCV)* ○ *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)—7-Day Follow-Up—Ages 13–17,* and *7-Day Follow-Up—Ages 18–64,* and *7-Day Follow-Up—Ages 65+*	**90th Percentile and Above** • 1 of 25 measure rates (4.0%) ○ *FUM—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 1 of 25 measure rates (4.0%) ○ *FUM—30-Day Follow-Up—Ages 6–17* **Between the 50th and 74th Percentiles** • 11 of 25 measure rates (44.0%) ○ *FUI—7-Day Follow-Up—Ages 13–17,* and *7-Day Follow-Up—Ages 18–64,* and *7-Day Follow-Up—Ages 65+* ○ *FUI—30-Day Follow-Up—Ages 13–17,* and *30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *FUM—7-Day Follow-Up—Ages 18–64* and *7-Day Follow-Up—Ages 65+* ○ *FUM—30-Day Follow-Up—Ages 18–64* ○ *PPC—Timeliness of Prenatal Care* and *Postpartum Care*	**90th Percentile and Above** • 1 of 30 measure rates (3.3%) ○ *FUM—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 1 of 30 measure rates (3.3%) ○ *FUM—30-Day Follow-Up—Ages 6–17* **Between the 50th and 74th Percentiles** • 14 of 30 measure rates (46.7%) ○ *Annual Dental Visit (ADV)* ○ *FUI—7-Day Follow-Up—Ages 13–17, and 7-Day Follow-Up—Ages 18–64, and 7-Day Follow-Up—Ages 65+* ○ *FUI—30-Day Follow-Up—Ages 13–17, and 30-Day Follow-Up—Ages 18–64, and 30-Day Follow-Up—Ages 65+* ○ *FUM—7-Day Follow-Up—Ages 18–64 and 7-Day Follow-Up—Ages 65+* ○ *FUM—30-Day Follow-Up—Ages 18–64* ○ *PPC—Timeliness of Prenatal Care and Postpartum Care*

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	46 Quality Measure Indicator Rates[i]	25 Timeliness Measure Indicator Rates[ii]	30 Access Measure Indicator Rates[iii]
		○ *FUI—30-Day Follow-Up—Ages 13–17,* and *30-Day Follow-Up—Ages 18–64,* and *30-Day Follow-Up—Ages 65+* ○ *FUM—7-Day Follow-Up—Ages 18–64* and *7-Day Follow-Up—Ages 65+* ○ *FUM—30-Day Follow-Up—Ages 18–64* ○ *Hemoglobin A1c Control for Patients With Diabetes— HbA1c Control (<8.0%)* ○ *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* ○ *Statin Therapy for Patients With Diabetes—Received Statin Therapy* and *Statin Adherence 80%* ○ *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*		○ *WCV* ○ *W30—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

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 measurement year (MY) 2022. (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-three quality measure indicator rates are also included in the timeliness and access domains. Five quality measure indicator rates are also included in the access domain. One quality measure indicator rate is also included in the timeliness domain. Seventeen quality measure indicator rates are only included in the quality domain.

ii. Twenty-five timeliness measure indicator rates were compared to national Medicaid percentiles for HEDIS MY 2022; 23 of the 25 measure indicator rates are also included in the quality and access domains, one of the 25 timeliness measure rates is also included in the quality domain, and one of the 25 timeliness measure rates is also included in the access domain.

iii. Thirty access measure indicator rates were compared to national Medicaid percentiles for HEDIS MY 2022; 23 of the 30 access measure indicator rates are also included in both the quality and timeliness domains. Additionally, five of the 30 access measure rates are also included in the quality domain, one of the 30 access measure rates is also included in the timeliness domain, and one access measure indicator rate is also included in the access domain.

Table 1-5—HCI Performance Snapshot SFY 2023—Opportunities for Improvement

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	46 Quality Measures Rates	25 Timeliness Measures Rates	30 Access Measures Rates
Opportunities for Improvement 	Compliance	Compliance review file reviews demonstrated opportunities for improvement for health plans and MMPs related to processing of denials, timeliness of appeals decisions, and adherence to the HFS Readability Protocol.		
	PIPs	No overall opportunities for improvement were identified.		
	CAHPS	Adult experience survey results were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service*, which indicates that members perceive a lack of access to care, as well as an overall lack of quality of care. Child experience survey results were below the 50th percentile for every measure, which indicates that parents/caretakers of child members perceive a lack of access to and timeliness of care, as well as an overall lack of quality of care.		
	HEDIS	**Below the 25th Percentile** • 6 of 46 measure rates (13.0%) ○ *Childhood Immunization Status (CIS)—Combination 10* ○ *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Ages 18–64* ○ *FUH—30-Day Follow-Up—Ages 18–64* and *30-Day Follow-Up—Ages 65+* ○ *Pharmacotherapy for Opioid Use Disorder (POD)—Ages 65+* ○ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Body Mass Index (BMI) Percentile Documentation—Total* **Between the 25th and 49th Percentiles** • 20 of 46 measure rates (43.5%) ○ *APM—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* ○ *Blood Pressure Control for Patients with Diabetes—Blood Pressure Control (<140/90 mm Hg)*	**Below the 25th Percentile** • 4 of 25 measure rates (16.0%) ○ *FUH—7-Day Follow-Up—Ages 18–64* ○ *FUH—30-Day Follow-Up—Ages 18–64* and *30-Day Follow-Up—Ages 65+* ○ *POD—Ages 65+* **Between the 25th and 49th Percentiles** • 8 of 25 measure rates (32.0%) ○ *Adults' Access to Preventive/Ambulatory Health Services—Total* ○ *Controlling High Blood Pressure* ○ *FUH—7-Day Follow-Up—Ages 6–17* and *7-Day Follow-Up—Ages 65+* ○ *FUH—30-Day Follow-Up—Ages 6–17*	**Below the 25th Percentile** • 5 of 30 measure rates (16.7%) ○ *CIS— Combination 10* ○ *FUH—7-Day Follow-Up—Ages 18–64* ○ *FUH—30-Day Follow-Up—Ages 18–64* and *30-Day Follow-Up—Ages 65+* ○ *POD—Ages 65+* **Between the 25th and 49th Percentiles** • 9 of 30 measure rates (30.0%) ○ *Adults' Access to Preventive/Ambulatory Health Services—Total* ○ *CIS—Combination 3* ○ *FUH—7-Day Follow-Up—Ages 6–17* and *7-Day Follow-Up—Ages 65+* ○ *FUH—30-Day Follow-Up—Ages 6–17*

Table 1-5—HCI Performance Snapshot SFY 2023—Opportunities for Improvement

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	46 Quality Measures Rates	25 Timeliness Measures Rates	30 Access Measures Rates
		○ *Breast Cancer Screening (BCS)* ○ *Cervical Cancer Screening (CCS)* ○ *Chlamydia Screening in Women (CHL)* ○ *CIS—Combination 3* ○ *Controlling High Blood Pressure* ○ *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* ○ *FUH—7-Day Follow-Up—Ages 6–17* and *7-Day Follow-Up—Ages 65+* ○ *FUH—30-Day Follow-Up—Ages 6–17* ○ *FUM—30-Day Follow-Up—Ages 65+* ○ *Hemoglobin A1c Control for Patients With Diabetes— HbA1c Poor Control (>9.0%)* ○ *IMA—Combination 2* ○ *POD—Ages 16–64* and *Total (Ages 16+)* ○ *WCC—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* ○ *W30—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*	○ *FUM—30-Day Follow-Up—Ages 65+* ○ *POD—Ages 16–64* and *Total (Ages 16+)*	○ *FUM—30-Day Follow-Up—Ages 65+* ○ *POD—Ages 16–64* and *Total (Ages 16+)* ○ *W30—Well-Child Visits for Age 15 Months–30 Months—Two or More Visits*

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** • Adolescent members received the appropriate immunizations as 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, one health plan and the statewide average ranked at or above the 75th percentile, and two health plans ranked at or above the 90th percentile. • More women received preventive screenings in MY 2022 than the prior measurement year. Although the statewide average fell below the 50th percentile for the three screening measures in the Women's Health and Maternal Health domain, all five health plans and the statewide average demonstrated an increase in performance for the *Breast Cancer Screening* measure, with four health plan rates increasing by one percentile ranking. Rates for *Cervical Cancer Screening* improved with four health plans and the statewide average demonstrating increased rates. Four health plans and the statewide average also increased performance for *Chlamydia Screening in Women*. • Members with high blood pressure were receiving statin therapy, which helps reduce the risk of cardiovascular disease (all five health plans and the statewide average demonstrated performance above the 50th percentile for the *Statin Therapy for Patients with Diabetes).* • All five health plans reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update* measure, with three of the five plans reporting significantly higher rates for both the core and supplemental elements. • Member experience survey results for *Customer Service* indicated that adult members perceived better quality of care from their health plan when they needed assistance (from 2022 to 2023). • 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 HealthChoice and one MMP performed at or above 90 percent in demonstrating compliance to CMS home- and community-based services (HCBS)

Program Strengths	
	performance measures, and two of the five waiver types averaged greater than 90 percent compliance, as identified via the quarterly HCBS record reviews.
+	**Access and/or Timeliness** • Four out 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. • Member experience survey results indicated that adult members perceived they were able to receive needed care when they needed it. • Health plans 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 primary care providers (PCPs), behavioral health providers, pharmacies, hospitals, and a variety of specialty types.
	Quality, Access, and/or Timeliness • A majority of Illinois' youngest children received well-care visits which provide an opportunity for providers to assess physical, emotional, and social development (as indicated by all five health plans demonstrating an increase in performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators). • A majority of birthing persons received recommended prenatal and postpartum care (as indicated by three out of five health plans ranking at or above the 75th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure and four out of five health plans ranking at or above the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure). • Health plans were ensuring that child members seen in the ED with a mental health diagnosis were receiving timely follow-up care (as indicated by all five health plans and the statewide average ranking at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure). • The final aggregate HealthChoice compliance review score for the Access domain was 99 percent, demonstrating strengths and adherence to requirements measured in the areas of care coordination, coverage and authorization of services, and credentialing and recredentialing. • The final aggregate HealthChoice compliance review score for the Structure and Operations domain and the Measurement and Improvement domain was 100 percent, demonstrating adherence to requirements related to grievance and appeal systems; organization and governance; subcontractual relationships and delegation; and QAPI program. • The MMAI compliance review final scores ranged from 99 percent to 100 percent for all MMPs, demonstrating compliance with policies and procedures as well as file reviews. • Overall, the health plans demonstrated parity between medical and surgical services and mental, emotional, nervous, or substance use disorder or condition services (as evidenced in the mental health parity review).

Program Weaknesses	
−	**Quality** • All five health plans and the statewide average demonstrated a decrease in performance for the *Childhood Immunization Status—Combination 10* measure, and all rates ranked below the 25th percentile. Additionally, health plan and statewide performance on the *Childhood Immunization Status—Combination 3* measure ranked below the 50th percentile. • Although improvements were made from the prior year, the statewide average still fell below the 50th percentile for the three screening measures in the Women's Health and Maternal Health Domain. Three of five health plans and the statewide average for the *Cervical Cancer Screening* measure and the *Breast Cancer Screening* measure ranked below the 50th percentile, with one health plan ranking below the 25th percentile for both measures. • Room for improvement was indicated for all of the health plans on successfully transitioning Medicaid managed long-term services and supports (MLTSS) members in long-term facilities to the community. • In a review of case management staffing and training requirements, three of the five MMPs had Persons who are Elderly (ELD) waiver case managers who did not meet qualification/education requirements. • Quarterly reviews of CI records demonstrated that all health plans had 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. • The quarterly HCBS record reviews demonstrated an opportunity for HealthChoice, MLTSS, and MMAI to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*).
−	**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 all five health plans ranking below the 50th percentile for the Access to Care domain measures. Performance continued to decrease amongst all health plans for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care—ED Visits—Total* measure. • In an access and availability survey with dental providers and PCPs, HSAG was unable to reach almost 35 percent of sampled cases and was only able to obtain an appointment date with 25.4 percent of the sampled locations. • Members are experiencing wait times beyond the appointment compliance standards as only 34.4 percent of dental appointments and 12.7 percent of PCP visits met the appointment standard in the access and availability survey. • The time/distance study identified regional gaps in access to pharmacies, oral surgery specialists, and to a lesser extent allergy and immunology specialists.
−	**Quality, Access, and/or Timeliness** • All five health plans demonstrated a decrease in performance for the *Child and Adolescent Well-Care Visits—Total* measure. Additionally, three of the health plans decreased one percentile ranking. • Adult and child members who were hospitalized for mental illness were not accessing or receiving timely follow-up care for mental illness as overall performance for the *Follow-Up*

Program Weaknesses	
	After Hospitalization for Mental Illness measure remained low across all five health plans. In the Adult Behavioral Health domain, the statewide average for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+* was the only indicator to rank between the 25th and 49th percentiles, with the remainder of the measure indicators ranking below the 25th percentile. In the Child Behavioral Health domain, all but one health plan ranked below the 50th percentile for both indicators. • Adult experience survey results were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service,* which indicates that members perceive a lack of access to care, as well as an overall lack of quality of care. • Child experience survey results were below the 50th percentile for every measure, which indicates that parents/caretakers of child members perceive a lack of access to and timeliness of care, as well as an overall lack of quality of care. • Results of HealthChoice and MMAI compliance review file reviews demonstrated opportunities for improvement for health plans and MMPs related to processing of denials, timeliness of appeal decisions, and adherence to the HFS Readability Protocol. • For care coordination, opportunities were identified in the HealthChoice compliance reviews for improvement related to timely contact with enrollees, timely completion of care management activities such as health risk screenings/assessments, and sharing of the care plan. For MMAI, opportunities were identified related to timely contact with enrollees and timely completion of care management activities such as health risk screenings/assessments.

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 further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, or vaccination and to help determine why their child members are inconsistently receiving immunizations. • Require health plans to include a drill down to consider whether there are disparities and/or SDOH within their populations that contribute to lower performance in a particular stratification. • Consider efforts to address vaccine hesitancy or any other barriers impacting performance on childhood immunization rates, especially for influenza vaccine rates.	**Goal 1:** Improve population health. **Goal 4:** Improve participation in preventive care and screenings.
	Require health plans that fell below the 50th percentile to conduct further analysis of potential key drivers to determine why members are not receiving breast cancer, cervical cancer, or chlamydia screenings. • Require health plans to include a drill down to consider whether there are disparities and/or SDOH within the disproportionately impacted area (DIA) population that contribute to lower performance in a particular age or race/ethnicity stratification.	
	Require health plans to review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation. Additionally, require health plans evaluate their clinical review process for continued stay requests to look for opportunities to initiate transition planning as early as possible from a long-term institutional stay.	**Goal 3:** Increase effective coordination of care. **Goal 6:** Create consumer-centric healthcare delivery system.
	Require MMPs to review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads.	
	Require health plans to revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured and educate care managers on expectations for enrollee/authorized representative education.	
Access and/or Timeliness	Require health plans to conduct further analysis to include a drill down of disparities and/or SDOH within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification to identify why members are not accessing preventive or ambulatory visits.	**Goal 2:** Improve access to care. **Goal 4:** Improve participation in preventive care and screenings.

Domain	Program Recommendations	Quality Strategy Goal and/or Objective
	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 network validation survey to evaluate the health plans' provider directory information in addition to appointment wait times. • Review provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. • Require health plans to investigate the results of the access and availability survey to identify whether deficiencies appear to be systematic or associated with a specialty category and to review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers 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.
	To address potential opportunities to close network gaps: • Continue to collaborate with those health plans that do not meet the access standards in specific regions and help them contract with additional providers, if available, • Review provider categories for which no health plans met the access standards, with the goal of determining the cause for these failures, and identify solutions. • Continue using appointment availability surveys and incorporate encounter data for further analysis.	**Goal 2:** Improve access to care. **Goal 6:** Create consumer-centric healthcare delivery system.
Quality, Access, and/or Timeliness	Require health plans to conduct further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well-care visits.	**Goal 2:** Improve access to care. **Goal 4:** Improve participation in preventive care and screenings.
	To improve follow-up after hospitalization for mental illness: • Require health plans to conduct further analysis to consider whether there are disparities and/or SDOH within their populations that contribute to lower performance in a particular age or race/ethnicity stratification. • Require health plans to evaluate member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Lead a multidisciplinary workgroup to identify barriers/facilitators to members accessing follow-up care,	**Goal 2:** Improve access to care. **Goal 5:** Promote integration of behavioral and physical healthcare.

Domain	Program Recommendations	Quality Strategy Goal and/or Objective
	solicit best practices from other organizations within and/or outside the State, and implement appropriate interventions. • 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.	
	Encourage health plans to include information about the CAHPS survey ratings in provider communications and to solicit feedback and recommendations from their contracted providers to improve member satisfaction.	**Goal 2:** Improve access to care. **Goal 6:** Create consumer-centric healthcare delivery system.
	Continue to require the health plans and MMPs to: • Use the HFS Readability Protocol to enhance enrollee written materials and drive toward higher success rates in achieving a sixth-grade reading level. • Monitor efforts, including delegation oversight, to ensure timeliness of contract activities related to care management, denials, grievances, and appeals. • Evaluate care coordination staffing needs to ensure compliance with care coordination contractual requirements.	**Goal 3:** Increase effective coordination of 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

Introduction

Health Plans

Table 2-1 displays the HCI health plans for which performance measures were reported in SFY 2023.[2-1]

Table 2-1—HCI Health Plans for HEDIS MY 2022 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 2022 data. HFS contracted with HSAG to conduct an audit for each HCI health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 2022, Volume 6, 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 2022 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 was the first reporting year for YouthCare. SFY 2023 is the first year for YouthCare's PMV to be completed.

Table 2-2—MY 2022 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 2023. 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 MY 2022 measures is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021, 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] National Committee for Quality Assurance. HEDIS and Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Feb 26, 2024.

benchmarks are illustrated within this report using proxy displays. Since the HEDIS process is retrospective, HEDIS MY 2021 results are calculated using calendar year (CY) 2021 data and HEDIS MY 2022 results are calculated using CY 2022 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 coronavirus disease 2019 (COVID-19) pandemic impacted enrollee care during MY 2021 and MY 2022. To support the increased use of telehealth services necessitated by the pandemic and to align with telehealth guidance from the 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 2022, 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 2021 and 2022 due to health concerns and factors relating to the pandemic, which may have impacted health plans' HEDIS performance measure results.

Although pandemic restrictions continued to subside during 2022, 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 2022

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
Annual Dental Visit
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 Well-Child Visits
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child 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
Blood Pressure Control for Patients With Diabetes
Blood Pressure Control (<140/90 mm Hg)
Controlling High Blood Pressure
Controlling High Blood Pressure
Eye Exam for Patients With Diabetes
Eye Exam (Retinal) Performed
Hemoglobin A1c Control for Patients With Diabetes
HbA1c Control (<8.0%)
HbA1c Poor Control (>9.0%)
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Statin Adherence 80%
Adult Behavioral Health
Diagnosed Mental Health Disorders
Ages 18–64 Years
Ages 65+ Years
Follow-Up After Emergency Department Visit for Mental Illness
7-Day Follow-Up—Ages 18–64

Measures
7-Day Follow-Up—Ages 65+
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Follow-Up After Emergency Department Visit for Substance Use
7-Day Follow-Up—Ages 18+
30-Day Follow-Up—Ages 18+
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 Substance Use Disorder Treatment
Initiation of Substance Use Treatment—18–64 Years
Initiation of Substance Use Treatment—65+ Years
Engagement of Substance Use Treatment—18–64 Years
Engagement of Substance Use Treatment—65+ Years
Pharmacotherapy for Opioid Use Disorder
Ages 16–64
Ages 65+
Total (Ages 16+)
Child Behavioral Health
Diagnosed Mental Health Disorders
Ages 1–17 Years
Follow-Up After Emergency Department Visit for Mental Illness
7-Day Follow-Up—Ages 6–17
30-Day Follow-Up—Ages 6–17

Measures
Follow-Up After Emergency Department Visit for Substance Use
7-Day Follow-Up—Ages 13–17
30-Day Follow-Up—Ages 13–17
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 Substance Use Disorder Treatment
Initiation of Substance Use Treatment—Ages 13–17
Engagement of Substance Use Treatment—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 PCP to meet their needs. Medicaid beneficiaries should utilize their PCP to help them prevent illnesses and encourage healthy behaviors through needed services.[2-3]

Table 2-5 presents the HEDIS MY 2021 and HEDIS MY 2022 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 2021 and MY 2022 performance.

Table 2-5—Access to Care Domain Results for HEDIS MY 2021 and HEDIS MY 2022

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	MY 2021	★ 69.89%	★★ 75.90%	★ 71.44%	★★ 74.81%	★ 71.06%	★★ 73.27%
	MY 2022	★ 68.12%	★★ 73.48%	★ 69.56%	★★ 73.09%	★ 70.00%	★★ 71.43%
Ambulatory Care (per 1,000 Member Months)							
*ED Visits—Total**	MY 2021	★ 612.36	★★ 514.80	★ 576.00	★★ 543.60	★ 615.60	★★ 560.88
	MY 2022	★ 631.16	BR	★★ 594.11	★★ 581.05	★ 635.83	★★ 602.74
Outpatient Visits—Total	MY 2021	★★ 3,269.28	★★★★ 4,258.68	★★ 3,445.32	★★ 3,463.20	★★ 3,318.60	★★ 3,602.52
	MY 2022	★★ 3,322.84	BR	★★ 3,381.92	★★ 3,655.18	★★ 3,460.29	★★ 3,498.78

** Indicates this is a "lower is better" measure.*
BR indicates the health plan's rate was materially biased.

[2-3] 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: Feb 26, 2024.

Strengths	Three out of five health plans reported increases for the Ambulatory Care—Outpatient Visits—Total measure, indicating that members are starting to gradually utilize more preventive services.

Opportunities for Improvement	**Opportunity:** All five health plans ranked below the 50th percentile for the Access to Care domain measures. Performance continued to decrease amongst all health plans for the *Adults' Access to Preventive/Ambulatory Health Services* measure and amongst four out of five plans for the *Ambulatory Care—ED Visits—Total* measure. One plan, BCBSIL, reported a materially biased rate for the *Ambulatory Care* measure. **Why the Opportunity Exists:** Although the rates for three of the five health plans slightly increased for the *Ambulatory Care—Outpatient Visits—Total* measure, adult members appear to be inconsistently accessing preventive or ambulatory services that could reduce the total number of ED visits. The increase in outpatient visits in conjunction with the increase in ED visits could also indicate that acute issues are not being addressed or chronic conditions are not being managed. **Recommendation:** Results of root cause analyses completed by the health plans revealed that a high percentage of identified open care gaps involve members in DIAs; therefore, HSAG recommends that health plans consider further analysis to include a drill down of disparities and/or SDOH within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. The health plans can then consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives that can address any open care gaps identified (e.g., disseminating educational materials to empower members to advocate for health; communicating via text to secure services and provide outreach; and addressing any barriers to obtaining care such as transportation, member and provider incentives for PCP annual visits and for opting into text messaging, in-home visits, and telephone/online visits especially for members with child care or job conflicts). Health plans should prioritize verifying member demographics to ensure any interventions can be successfully completed as well as collecting demographic information from various sources if necessary. Additionally, HSAG recommends increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the State and implement appropriate interventions to increase performance related to Access to Care measures. **Opportunity:** BCBSIL's reported rates for the *Ambulatory Care—ED Visits—Total* and *Ambulatory Care—Outpatient Visits—Total* measure indicators were materially biased.

Why the Opportunity Exists: Although BCBSIL demonstrated strong performance with the *Ambulatory Care* measure in MY 2021, the reported rates in MY 2022 demonstrated a material bias greater than 5 percentage points, and the health plan was not permitted to report a rate for the measure.

Recommendation: HSAG recommends that BCBSIL determine the cause of the material bias in the *Ambulatory Care* measure. HSAG also recommends that BCBSIL consider internal validation and primary source verification (PSV) for all measures to confirm numerator compliance prior to all rate submissions. Additionally, HSAG recommends creating a document that outlines the details of the internal validation methodology to further alleviate any material bias in the future and could submit this document as evidence to the auditing team for reference.

Child Health

Illinois Medicaid provides healthcare to over 1.4 million children, nearly half of the population HFS serves.[2-4] 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.[2-5]

Table 2-6 presents the HEDIS MY 2021 and HEDIS MY 2022 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 2021 and MY 2022 performance may have been impacted for preventive care measures that required in-person visits.

Table 2-6—Child Health Domain Results for HEDIS MY 2021 and HEDIS MY 2022

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Child Health							
Annual Dental Visit							
Annual Dental Visit	MY 2021	★★ 43.31%	★★ 36.46%	★★★ 52.15%	★★★ 49.77%	★★★★ 54.47%	★★★ 46.61%
	MY 2022	★★ 45.10%	★★★ 51.91%	★★★ 55.00%	★★★ 52.00%	★★ 48.70%	★★★ 51.16%
Child and Adolescent Well-Care Visits							
Total	MY 2021	★★★ 46.07%	★★★ 52.70%	★★★★ 53.86%	★★★ 52.41%	★★★ 50.18%	★★★ 51.60%
	MY 2022	★★ 43.62%	★★★ 52.32%	★★★ 50.73%	★★★ 51.04%	★★ 47.91%	★★★ 49.99%
Childhood Immunization Status							
Combination 3	MY 2021	★ 53.77%	★ 60.34%	★ 60.10%	★ 54.74%	★ 58.88%	★ 57.15%
	MY 2022	★★ 58.64%	★★ 60.83%	★★ 60.58%	★★ 60.34%	★★ 58.39%	★★ 60.05%

[2-4] Illinois Department of Healthcare and Family Services. Annual Report, April 1, 2023. Available at: https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/2022AnnualReport.pdf. Accessed on: Feb 26, 2024.

[2-5] 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: Feb 26, 2024.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Combination 10	MY 2021	★ 22.14%	★ 31.39%	★★ 34.79%	★ 26.03%	★ 26.28%	★ 28.08%
	MY 2022	★ 20.92%	★ 27.74%	★★ 32.36%	★ 24.33%	★ 21.17%	★ 25.63%
Immunizations for Adolescents							
Combination 1 (Meningococcal, Tdap)	MY 2021	★★★★★ 89.29%	★★★★★ 90.02%	★★★ 84.67%	★★★★ 88.56%	★★★ 85.69%	★★★★ 88.12%
	MY 2022	★★★ 85.16%	★★★★★ 89.09%	★★★ 83.94%	★★★★★ 90.27%	★★★★ 86.70%	★★★★ 87.94%
Combination 2 (Meningococcal, Tdap, HPV)	MY 2021	★ 26.03%	★★ 34.79%	★★★ 40.15%	★ 27.98%	★★ 31.43%	★★ 31.50%
	MY 2022	★ 27.25%	★★★ 36.14%	★★★ 38.69%	★ 28.22%	★★ 31.24%	★★ 31.89%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile Documentation—Total	MY 2021	★ 65.94%	★★★ 77.62%	★★★★ 83.17%	★ 60.83%	★★★ 80.54%	★★ 70.85%
	MY 2022	★ 64.72%	★★ 74.21%	★★★★ 85.14%	★ 66.67%	★★ 78.10%	★ 72.16%
Counseling for Nutrition—Total	MY 2021	★★ 63.75%	★★★ 72.26%	★★★★ 81.52%	★ 53.77%	★★ 68.13%	★★ 64.97%
	MY 2022	★★ 65.21%	★★ 65.94%	★★★★ 81.08%	★★ 63.02%	★ 61.31%	★★ 66.40%
Counseling for Physical Activity—Total	MY 2021	★★ 62.77%	★★★ 68.13%	★★★★ 77.56%	★ 49.39%	★★★ 68.13%	★★ 61.62%
	MY 2022	★★ 61.07%	★★ 63.50%	★★★★ 78.72%	★ 57.91%	★★ 60.58%	★★ 62.93%
Well-Child Visits in the First 30 Months of Life							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	MY 2021	★★ 51.24%	★★ 50.15%	★★ 51.70%	★★ 50.33%	★★★ 58.51%	★★ 51.49%
	MY 2022	★★★ 58.90%	★★★★ 66.22%	★★ 54.96%	★★★ 58.64%	★★★★ 61.64%	★★★ 60.47%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	MY 2021	★ 57.82%	★ 63.31%	★ 59.49%	★ 60.53%	★ 59.84%	★ 60.48%
	MY 2022	★ 59.59%	★★★ 67.87%	★ 60.38%	★★ 64.07%	★★ 61.37%	★★ 63.59%

Strengths

- Four out 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, BCBSIL reported an increase in performance of 15.45 percentage points from the prior MY, elevating its performance to at or above the 50th percentile in MY 2022.

- 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, Molina and the statewide average ranked at or above the 75th percentile, and BCBSIL and Meridian ranked at or above the 90th percentile. These rates indicate that adolescent members are at a lower risk for contracting serious diseases that can cause difficulty breathing, heart failure, nerve damage, paralysis, brain damage, and even death.
- CountyCare continued to demonstrate strong performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, ranking at or above the 75th percentile for all three measure indicators. This performance demonstrates the health plan's commitment to monitoring weight problems of its child and adolescent members, which may lower the risk of obesity and related diseases.
- All five health plans demonstrated an increase in performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators, demonstrating a commitment to ensuring their child members are receiving the recommended well-care visits in both the first 15 months of life and the first 30 months of life. Of note, four of the five health plans ranked at or above the 50th percentile, with two of those health plans ranking at or above the 75th percentile. Additionally, three of the health plans reported MY 2022 rates that were at least 6 percentage points higher than the MY 2021 reported rates.

Opportunities for Improvement

Opportunity: Molina's performance for the *Annual Dental Visit* measure demonstrated a decline of almost 6 percentage points from the prior MY, and the percentile ranking decreased from at or above the 75th percentile to below the 50th percentile. This suggests its child members are not receiving regular dental visits. Regular preventive dental care helps keep children's teeth healthy and allows providers to address tooth decay or dental problems before they become more serious.

Why the Opportunity Exists: This decreased performance may potentially be a result of lingering effects of the COVID-19 pandemic that continued into 2022. The fear of being in a public setting without mandated mask requirements and the fear of contracting COVID-19 may have deterred individuals from seeking preventive dental care.

Recommendation: Results of root cause analyses completed by the health plans revealed that a high percentage of identified open care gaps involve members in DIAs; therefore, HSAG recommends that Molina consider additional analysis to consider whether there are disparities and/or SDOH within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Molina can then consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives (e.g., mobile services, reminders sent via mail, social media site with educational information, provider incentives, and engagement opportunities). Additionally, HSAG recommends continuous monitoring of demographic stratifications within

the measure to identify opportunities of improvement and implement appropriate interventions to improve performance related to the *Annual Dental Visit* measure.

Opportunity: All five health plans demonstrated decreased performance for the *Child and Adolescent Well-Care Visits—Total* measure. Additionally, three of the health plans decreased one percentile ranking, with Aetna and Molina decreasing from at or above the 50th percentile to below the 50th percentile, and CountyCare decreasing from at or above the 75th percentile to at or above the 50th percentile. These performance reductions indicate that children and adolescents are not receiving well-care visits, which provide an opportunity for providers to assess these members' physical, emotional, and social development.

Why the Opportunity Exists: The decreased performance may potentially be a result of lingering effects of the COVID-19 pandemic that continued into 2022. The fear of being in a public setting without mandated mask requirements and the fear of contracting COVID-19 may have deterred individuals from seeking preventive healthcare services, including well-care visits.

Recommendation: Results of root cause analyses completed by some of the health plans revealed that a high percentage of identified open care gaps involve members in DIAs; therefore, HSAG recommends that the health plans consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well-care visits. Health plans can then consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives that address any open care gaps identified (e.g., offering member incentives, disseminating educational materials, engaging members to identify barriers to members receiving the appropriate healthcare, continuously monitoring care gaps to address timely outreach, improving access and availability to allow better appointment times and locations, offering provider incentives to allow more weekend/evening availability for families with job restrictions, addressing staffing issues to increase the number of providers with more availability for appointments, offering mobile services to assist members with transportation barriers and/or those in rural areas, and using text services for member outreach and scheduling). Health plans should prioritize the verification of member demographics and potentially use other sources to collect current contact information to ensure any interventions can be successfully completed. Additionally, HSAG recommends increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the State and implement appropriate interventions to improve the performance related to well-care visits for children and adolescents.

Opportunity: All five health plans demonstrated decreased performance for the *Childhood Immunization Status—Combination 10* measure, suggesting that children are not receiving all of the recommended immunizations in accordance

with clinical recommendations, which is a critical aspect of preventable care for children.

Why the Opportunity Exists: The decreased performance may potentially be a result of lingering effects of the COVID-19 pandemic that continued into 2022. The fear of being in a public setting without mandated mask requirements and the fear of contracting COVID-19 may have deterred individuals from seeking preventive healthcare services, including immunizations.

Recommendation: Results of root cause analyses completed by the health plans revealed that a high percentage of identified open care gaps involve members in DIAs; therefore, HSAG recommends that the health plans consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, or vaccination and to help determine why their child members are inconsistently receiving immunizations. This analysis should include a drill down to consider whether there are disparities and/or SDOH within their populations that contribute to lower performance in a particular stratification. Health plans should also consider whether a particular vaccine or vaccines within the vaccine combination were missed more often than others, contributing to lower measure rates. Health plans could then investigate the rationale for these lower rates and identify a solution to increase vaccine administration, which would lead to higher performance. Upon identification of key drivers, health plans should consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives that can address any open care gaps identified (e.g., using language to focus on well-care visits where members can receive immunizations, continuous monitoring of care gap lists to ensure timely outreach to administer vaccinations within the appropriate time frame, disseminating educational materials to both members and providers to help combat hesitancy and misinformation/misconceptions about vaccinations, offering member and provider incentives/rewards, providing mobile services and/or transportation to members for whom transportation is a barrier or who live in a rural area, and promoting in-network providers and advertising hiring opportunities to help prevent staff shortages). Health plans should prioritize verifying member demographics and consider collecting contact information from other valid data sources to ensure any interventions can be successfully completed. Additionally, HSAG recommends increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the State and implement appropriate interventions to improve performance related to the *Childhood Immunization Status—Combination 10* measure indicator.

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.[2-6]

Table 2-7 presents the HEDIS MY 2021 and HEDIS MY 2022 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 2021 and MY 2022 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 2021 and HEDIS MY 2022

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Women's Health							
Breast Cancer Screening							
Breast Cancer Screening	MY 2021	★ 42.41%	★★ 50.93%	★★ 50.89%	★ 46.41%	★ 47.47%	★ 47.80%
	MY 2022	★ 43.89%	★★★ 53.11%	★★★ 53.11%	★★ 48.57%	★★ 48.06%	★★ 49.71%
Cervical Cancer Screening							
Cervical Cancer Screening	MY 2021	★ 45.50%	★★ 56.93%	★★★ 60.00%	★ 48.26%	★★ 56.69%	★★ 52.83%
	MY 2022	★ 49.64%	★★★ 59.85%	★★★ 60.51%	★★ 56.45%	★★ 55.72%	★★ 56.83%
Chlamydia Screening in Women							
Total	MY 2021	★★★ 56.80%	★★★ 55.31%	★★★ 61.37%	★ 43.89%	★★★ 56.38%	★★ 52.87%
	MY 2022	★★★ 55.32%	★★★ 56.01%	★★★★ 65.08%	★★ 46.13%	★★★ 57.21%	★★ 54.23%

[2-6] Centers for Disease Control and Prevention. Cancer Home: How to Prevent Cancer or Find It Early: Screening Tests. Available at: https://www.cdc.gov/cancer/dcpc/prevention/index.htm. Accessed on: Feb 26, 2024.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Maternal Health							
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	MY 2021	★★ 83.70%	★★★ 87.83%	★★ 82.16%	★★★ 85.89%	★★★★ 90.27%	★★★ 86.10%
	MY 2022	★★ 81.51%	★★★★ 89.78%	★★ 84.23%	★★★★ 89.29%	★★★★ 89.78%	★★★ 87.54%
Postpartum Care	MY 2021	★★ 72.02%	★★★★ 81.27%	★★★★ 79.82%	★★★★ 79.56%	★★★★ 79.56%	★★★ 78.96%
	MY 2022	★★★ 77.37%	★★★ 79.08%	★★ 76.70%	★★★★ 81.51%	★★★ 77.86%	★★★ 79.09%

Strengths

- All five health plans and the statewide average demonstrated an increase in performance for the *Breast Cancer Screening* measure. Of note, four of the five health plan rates increased by one percentile ranking, with Meridian and Molina increasing to at above the 25th percentile, and BCBSIL and CountyCare increasing to at or above the 50th percentile.
- Three of the five health plans ranked at or above the 75th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure, with the statewide average ranking at or above the 50th percentile. Four of the five health plans and the statewide average ranked at or above the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure, with Meridian ranking at or above the 75th percentile.

Opportunities for Improvement

Opportunity: Three of the five health plans and the statewide average for the *Cervical Cancer Screening* measure ranked below the 50th percentile, with one health plan ranking below the 25th percentile.

Why the Opportunity Exists: Women are not receiving timely access to cervical cancer screenings. Early screening and detection of cervical pre-cancers have led to a significant reduction in the death rate.

Recommendation: HSAG recommends that Aetna, Meridian, and Molina consider further analysis of potential key drivers that may contribute to the observed low performance. This analysis should include a drill down to consider whether there are disparities and/or SDOH within the DIA population that contribute to lower performance in a particular age or race/ethnicity stratification. Upon identification of a key driver, the health plans should consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives that can address any open care gaps identified (e.g., providing educational opportunities regarding proper documentation of a medical record to assist in medical record review and compliance, offering provider and member incentives, providing transportation to members with transportation barriers, and improving access and availability of appointments for members with barriers related to work or child care). Health plans should prioritize the verification of member demographics to ensure any interventions can be successfully completed.

Additionally, HSAG recommends increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the State and 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.[2-7]

Table 2-8 presents the HEDIS MY 2021 and HEDIS MY 2022 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 2021 and MY 2022 performance may have been impacted.

Table 2-8—Living With Illness Domain Results for HEDIS MY 2021 and HEDIS MY 2022

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Living With Illness							
Blood Pressure Control for Patients With Diabetes							
Blood Pressure Control (<140/90 mm Hg)	MY 2021	★★ 54.74%	★★★ 64.72%	★ 52.07%	★ 46.96%	★★★ 60.34%	★★ 54.73%
	MY 2022	★ 49.88%	★★★ 63.75%	★★ 58.15%	★★★ 61.80%	★★★ 61.56%	★★ 59.79%
Controlling High Blood Pressure							
Controlling High Blood Pressure	MY 2021	★ 49.88%	★★★ 57.66%	★ 45.50%	★ 43.80%	★★★ 60.10%	★ 50.03%
	MY 2022	★ 53.77%	★★★ 61.56%	★ 53.53%	★★ 58.39%	★★★ 61.31%	★★ 57.96%
Eye Exam for Patients With Diabetes							
Eye Exam (Retinal) Performed	MY 2021	★★★ 51.58%	★★ 48.18%	★★ 50.85%	★ 41.61%	★ 42.82%	★★ 46.43%
	MY 2022	★★ 46.47%	★★ 45.01%	★★★ 52.31%	★★★ 51.09%	★ 44.28%	★★ 48.29%

[2-7] 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: Feb 26, 2024.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Hemoglobin A1c Control for Patients With Diabetes							
HbA1c Control (<8.0%)	MY 2021	★★ 42.34%	★★★ 47.69%	★★ 40.39%	★ 35.28%	★★ 42.34%	★★ 40.98%
	MY 2022	★★★★ 57.18%	★★★ 51.58%	★★ 48.91%	★★ 49.64%	★★ 44.04%	★★★ 50.55%
*HbA1c Poor Control (>9.0%)**	MY 2021	★★ 50.61%	★★★ 40.39%	★★ 50.85%	★ 58.64%	★★ 47.45%	★★ 50.47%
	MY 2022	★★★★ 34.31%	★★ 42.09%	★★ 44.77%	★★ 40.88%	★★ 46.47%	★★ 41.51%
Statin Therapy for Patients With Diabetes							
Received Statin Therapy	MY 2021	★★★ 67.87%	★★★★ 71.74%	★★★★ 71.27%	★★★ 69.26%	★★★ 68.28%	★★★★ 69.95%
	MY 2022	★★★ 66.88%	★★★★ 70.06%	★★★★ 70.34%	★★★ 67.14%	★★★ 66.77%	★★★ 68.42%
Statin Adherence 80%	MY 2021	★★★ 69.15%	★★ 67.55%	★★★ 73.17%	★★ 67.79%	★★ 65.57%	★★★ 68.84%
	MY 2022	★★★ 70.14%	★★★ 66.77%	★★★ 71.56%	★★★ 67.45%	★★★★★ 87.52%	★★★ 70.38%

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

Strengths

- Meridian demonstrated an increase of more than 10 percentage points in MY 2022 for the *Blood Pressure Control for Patients with Diabetes,* and *Controlling High Blood Pressure* measures and the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)* measure indicator. Of note, Meridian improved performance for the *Controlling High Blood Pressure* measure and the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control for Patients With Diabetes* measure from below the 25th percentile to below the 50th percentile. Meridian also improved performance for the *Blood Pressure Control for Patients With Diabetes* and *Eye Exam for Patients With Diabetes* measures from below the 25th percentile to at or above the 50th percentile.
- Aetna demonstrated significant improvement in the *Hemoglobin A1c Control for Patients With Diabetes* measure, reporting a 14.84 percentage point increase in the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)* measure indicator and a 16.3 percentage point decrease (lower is better) in the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* measure indicator. Of note, Aetna increased from below the 50th percentile for both indicators to at or above the 75th percentile for both indicators.
- All five health plans and the statewide average demonstrated performance increases for the *Controlling High Blood Pressure* measure, with the statewide average increasing nearly 8 percentage points. The statewide

average also improved from below the 25th percentile to below the 50th percentile.

- All five health plans and the statewide average demonstrated performance at or above the 50th percentile for the *Statin Therapy for Patients With Diabetes* measure indicators. Of note, BCBSIL and CountyCare ranked at or above the 75th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator, and Molina improved its rate by almost 22 percentage points and ranked at or above the 90th percentile for the *Statin Therapy for Patients with Diabetes—Statin Adherence 80%* measure indicator. This performance indicates members are receiving and adhering to statin therapy, which helps reduce the risk of cardiovascular disease that is elevated for people with diabetes.

Opportunities for Improvement

Opportunity: Aetna demonstrated a rate decrease of nearly 5 percentage points for the *Blood Pressure Control for Patients With Diabetes* measure and slightly more than 5 percentage points for the *Eye Exam for Patients With Diabetes* measure. Of note, both measure rates also fell by one percentile ranking, with the *Blood Pressure Control for Patients With Diabetes* measure falling below the 25th percentile and the *Eye Exam for Patients With Diabetes* measure falling below the 50th percentile.

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

Recommendation: Results of root cause analyses completed by the health plans related to other diabetes care measures revealed a high percentage of open care gaps identified for members in the African-American population; therefore, HSAG recommends that Aetna consider further analysis of potential key drivers that includes a drill down to consider whether there are disparities and/or SDOH within its African-American population that contribute to lower performance in a particular age stratification. Upon identification of key drivers, Aetna should consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives (e.g., disseminating educational material on healthy eating/diet habits and managing current conditions, offering provider education on accurate coding, providing transportation to those with transportation barriers, offering incentives for blood pressure monitoring, engaging members for self-management, and improving supplemental data quality control mechanisms). Additionally, HSAG recommends increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the State and implement appropriate interventions to improve performance related to the *Blood Pressure Control for Patients With Diabetes* and *Eye Exam for Patients With Diabetes* measures.

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.[2-8]

Table 2-9 and Table 2-10 present the HEDIS MY 2021 and HEDIS MY 2022 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 2021 and MY 2022 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 2021 and HEDIS MY 2022

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Adult Behavioral Health							
Diagnosed Mental Health Disorders[1]							
Ages 18–64 Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 28.76%	NC 25.48%	NC 20.74%	NC 28.43%	NC 28.69%	NC 26.56%
Ages 65+ Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 31.29%	NC 27.69%	NC 26.87%	NC 28.49%	NC 35.11%	NC 29.12%
Follow-Up After Emergency Department Visit for Mental Illness							
7-Day Follow-Up—Ages 18–64	MY 2021	★★★★ 46.61%	★★★ 43.01%	★★★ 34.65%	★★★★ 46.26%	★★★★ 49.72%	★★★ 45.10%
	MY 2022	★★★ 45.79%	★★★ 43.72%	★★ 33.18%	★★★★ 47.38%	★★★ 44.71%	★★★ 44.15%

[2-8] U.S. Department of Health and Human Services. Healthy People 2030 Objectives and Data: Mental Health and Mental Disorders. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders. Accessed on: Mar 5, 2024.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
7-Day Follow-Up—Ages 65+	MY 2021	NA	NA	NA	★★ 31.94%	NA	★★ 31.50%
	MY 2022	NA	NA	NA	NA	NA	★★★ 36.36%
30-Day Follow-Up—Ages 18–64	MY 2021	★★★ 56.20%	★★★ 53.98%	★★ 44.14%	★★★ 55.96%	★★★★ 60.54%	★★★ 55.20%
	MY 2022	★★★ 56.12%	★★★ 54.01%	★★ 43.23%	★★★ 56.48%	★★★ 55.62%	★★★ 54.13%
30-Day Follow-Up—Ages 65+	MY 2021	NA	NA	NA	★★ 45.83%	NA	★★ 43.31%
	MY 2022	NA	NA	NA	NA	NA	★★ 42.42%
Follow-Up After Emergency Department Visit for Substance Use							
7-Day Follow-Up—Ages 18+	MY 2021	—	—	—	—	—	—
	MY 2022	NC 24.62%	NC 27.72%	NC 19.20%	NC 26.92%	NC 28.64%	NC 25.63%
30-Day Follow-Up—Ages 18+	MY 2021	—	—	—	—	—	—
	MY 2022	NC 34.83%	NC 38.02%	NC 27.11%	NC 37.31%	NC 41.16%	NC 35.86%
Follow-Up After High-Intensity Care for Substance Use Disorder							
7-Day Follow-Up—Ages 18–64	MY 2021	★★★ 38.03%	★★★ 39.49%	★★★ 39.27%	★★★ 39.77%	★★★ 39.75%	★★★ 39.28%
	MY 2022	★★★ 38.44%	★★★ 37.55%	★★★ 38.58%	★★★ 37.74%	★★★★ 40.19%	★★★ 38.28%
7-Day Follow-Up—Ages 65+	MY 2021	NA	NA	★★★★ 42.86%	★★★★ 40.63%	NA	★★★★ 36.89%
	MY 2022	NA	NA	★★★ 26.32%	★★★ 22.58%	NA	★★★ 28.46%
30-Day Follow-Up—Ages 18–64	MY 2021	★★ 53.71%	★★★ 56.31%	★★ 54.37%	★★★ 55.27%	★★★ 55.68%	★★★ 55.04%
	MY 2022	★★★ 55.34%	★★★ 53.68%	★★★ 54.04%	★★★ 55.43%	★★★ 57.54%	★★★ 55.03%
30-Day Follow-Up—Ages 65+	MY 2021	NA	NA	★★★★ 52.38%	★★★ 46.88%	NA	★★★ 48.36%
	MY 2022	NA	NA	★★ 38.60%	★★ 38.71%	NA	★★★ 39.84%
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Ages 18–64	MY 2021	★★ 26.67%	★ 25.69%	★ 18.52%	★ 21.26%	★ 24.26%	★ 23.24%
	MY 2022	★★ 27.69%	★ 23.99%	★ 18.93%	★ 25.50%	★ 24.48%	★ 24.45%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
7-Day Follow-Up—Ages 65+	MY 2021	NA	★★★ 26.47%	★ 15.38%	★ 5.45%	NA	★ 16.46%
	MY 2022	NA	★★ 19.35%	★★ 19.57%	★ 12.96%	NA	★★ 15.85%
30-Day Follow-Up—Ages 18–64	MY 2021	★★ 45.27%	★★ 45.79%	★ 34.72%	★ 37.24%	★★ 45.75%	★ 41.34%
	MY 2022	★★ 46.99%	★ 42.18%	★ 34.17%	★ 44.55%	★★ 46.16%	★ 43.12%
30-Day Follow-Up—Ages 65+	MY 2021	NA	★ 38.24%	★ 28.21%	★ 23.64%	NA	★ 32.91%
	MY 2022	NA	★ 35.48%	★ 36.96%	★ 37.04%	NA	★ 33.54%
Initiation and Engagement of Substance Use Treatment							
Initiation of Substance Use Treatment—18–64 Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 39.91%	NC 48.30%	NC 39.03%	NC 43.86%	NC 46.60%	NC 43.57%
Initiation of Substance Use Treatment—65+ Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 37.99%	NC 49.78%	NC 33.88%	NC 47.84%	NC 41.00%	NC 41.61%
Engagement of Substance Use Treatment—18–64 Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 14.11%	NC 14.40%	NC 10.50%	NC 13.34%	NC 12.99%	NC 13.21%
Engagement of Substance Use Treatment—65+ Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 6.12%	NC 7.56%	NC 6.83%	NC 6.64%	NC 9.00%	NC 6.96%
Pharmacotherapy for Opioid Use Disorder							
Ages 16–64	MY 2021	★★ 25.77%	★★ 24.98%	★★ 23.54%	★★ 25.64%	★ 7.91%	★ 21.80%
	MY 2022	★★ 27.26%	★★ 24.92%	★★ 22.11%	★★ 26.07%	★ 7.68%	★★ 21.75%
Ages 65+	MY 2021	★★ 29.23%	★★ 35.44%	★★ 33.04%	★★ 34.94%	★ 2.86%	★★ 30.50%
	MY 2022	★★★ 35.85%	★ 26.79%	★★★ 36.99%	★ 18.06%	★ 1.82%	★ 27.38%
Total (Ages 16+)	MY 2021	★★ 25.86%	★★ 25.31%	★★ 23.92%	★★ 25.85%	★ 7.84%	★ 22.04%
	MY 2022	★★ 27.46%	★★ 24.96%	★★ 22.91%	★★ 25.91%	★ 7.56%	★★ 21.91%

[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 2022.

— *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 2021 and HEDIS MY 2022

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Child Behavioral Health							
Diagnosed Mental Health Disorders[1]							
Ages 1–17 Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 21.27%	NC 19.63%	NC 20.77%	NC 21.79%	NC 17.52%	NC 20.55%
Follow-Up After Emergency Department Visit for Mental Illness							
7-Day Follow-Up—Ages 6–17	MY 2021	★★★★ 75.23%	★★★★★ 75.85%	★★★★ 66.03%	★★★★★ 77.88%	★★★★★ 76.12%	★★★★★ 75.98%
	MY 2022	★★★★★ 77.45%	★★★★ 71.91%	★★★★ 70.93%	★★★★★ 77.94%	★★★★★ 79.68%	★★★★★ 76.06%
30-Day Follow-Up—Ages 6–17	MY 2021	★★★★ 81.75%	★★★★★ 84.15%	★★★ 71.29%	★★★★ 83.18%	★★★★★ 85.04%	★★★★ 82.58%
	MY 2022	★★★★ 83.33%	★★★★ 80.39%	★★★★ 77.00%	★★★★ 83.56%	★★★★★ 87.90%	★★★★ 82.75%
Follow-Up After Emergency Department Visit for Substance Use							
7-Day Follow-Up—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 13.68%	NC 17.30%	NC 12.22%	NC 25.56%	NC 22.99%	NC 19.92%
30-Day Follow-Up—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 20.00%	NC 27.03%	NC 16.67%	NC 34.96%	NC 34.48%	NC 28.63%
Follow-Up After High-Intensity Care for Substance Use Disorder							
7-Day Follow-Up—Ages 13–17	MY 2021	NA	NA	NA	NA	NA	★ 6.67%
	MY 2022	NA	NA	NA	NA	NA	★★★ 25.00%
30-Day Follow-Up—Ages 13–17	MY 2021	NA	NA	NA	NA	NA	★ 10.00%
	MY 2022	NA	NA	NA	NA	NA	★★★ 43.18%
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Ages 6–17	MY 2021	★★ 42.34%	★★ 48.92%	★★ 43.49%	★★ 42.05%	★★ 47.23%	★★ 44.46%
	MY 2022	★★ 46.27%	★★★ 48.42%	★ 37.74%	★★ 42.28%	★★ 43.27%	★★ 43.99%
30-Day Follow-Up—Ages 6–17	MY 2021	★★ 69.82%	★★★ 73.32%	★★ 67.71%	★★ 64.84%	★★★ 74.94%	★★ 69.08%
	MY 2022	★★ 70.58%	★★★ 74.46%	★ 62.37%	★★ 68.65%	★★ 69.54%	★★ 69.71%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Initiation and Engagement of Substance Use Treatment							
Initiation of Substance Use Treatment—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 47.81%	NC 50.00%	NC 46.20%	NC 49.22%	NC 49.51%	NC 48.77%
Engagement of Substance Use Treatment—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 9.63%	NC 13.84%	NC 10.33%	NC 13.06%	NC 6.55%	NC 11.58%
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose Testing—Total	MY 2021	★★★★ 61.25%	★★★★★ 62.80%	★★★★★ 62.73%	★★★★ 59.90%	★★★★ 56.85%	★★★★ 60.56%
	MY 2022	★★★★ 62.35%	★★★★ 64.90%	★★★ 58.28%	★★★ 59.32%	★★★ 58.15%	★★★★ 60.79%
Cholesterol Testing—Total	MY 2021	★★ 31.11%	★★★★ 40.69%	★★★ 38.48%	★★★ 33.26%	★★ 28.56%	★★★ 34.32%
	MY 2022	★★ 32.46%	★★★ 39.78%	★★ 34.70%	★★ 32.29%	★★ 31.01%	★★ 34.04%
Blood Glucose and Cholesterol Testing—Total	MY 2021	★★ 30.54%	★★★★ 39.21%	★★★★ 37.58%	★★★ 32.67%	★★ 28.03%	★★★ 33.52%
	MY 2022	★★ 31.76%	★★★ 38.75%	★★ 33.51%	★★ 31.51%	★★ 30.34%	★★ 33.19%

[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 2022.

— *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 Adult Behavioral Health domain, Aetna demonstrated an increase of more than 5 percentage points for the *Pharmacotherapy for Opioid Use Disorder—Age 65+* measure indicator, and Aetna was one of only two plans to meet or exceed the 50th percentile for this measure indicator.
- 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* measure indicator rates. Three of the five health plans ranked at or above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator, and one of the five health plans ranked at or above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator.

Opportunities for Improvement	
	Opportunity: In the Adult Behavioral Health domain, overall performance for the *Follow-Up After Hospitalization for Mental Illness* measure remained low across all five health plans. The statewide average for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+* was the only indicator to rank between the 25th and 49th percentile, with the remainder of the measure indicators ranking below the 25th percentile. **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. **Recommendation:** Although the health plans completed a root cause analysis as suggested in the prior year's recommendations, HSAG recommends that the health plans consider further analysis to consider whether there are disparities and/or SDOH within their populations that contribute to lower performance in a particular age or race/ethnicity stratification. Upon identification of key drivers, the health plans should consider reassessing, evaluating, and expanding current and/or new member outreach and engagement initiatives (e.g., improving access and availability for appointments to combat barriers such as school, work, or family obligations; increasing telehealth options; offering provider incentives to promote staffing; continued education of the importance of follow-up appointments in the treatment of mental illness;, improving monitoring of members to ensure timely scheduling; increasing utilization of case managers after an ED visit or hospital discharge to schedule follow-up care appointments and develop plans for ongoing follow-up care; and increasing collaboration with behavioral health facilities to help members get the care that is needed). Additionally, HSAG recommends increasing the frequency of internal- and external-facing multidisciplinary workgroups designed to solicit best practices from other organizations within and/or outside the State and implement appropriate interventions to improve performance related to the *Follow-Up After Hospitalization for Mental Illness* measure.

PMV—Pay-for-Reporting

HFS directed HSAG to conduct PMV for the Pay-for-Reporting (P4R) program to validate data reported for MY 2022. 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 Hospitalizations for Children and Adolescents	HFS Custom
Inpatient Utilization—Behavioral Health 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	HFS Custom
Prescription of HIV Antiretroviral Therapy	HFS Custom
Pillar: Improving Community Placement	
Managed Long-Term Services and Supports (MLTSS) Comprehensive Care Plan and Update	CMS MLTSS
LTSS Successful Transition After Long-Term Facility 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.*

Methodology and Technical Methods of Data Collection

Validation of Performance Measures

For the HealthChoice Illinois managed care organizations (MCOs), HSAG conducted the validation activities as outlined in CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023[2-9] (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, 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 each validation finding on how significant the errors were in each measure's evaluation elements, not by

[2-9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 26, 2024.

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 all five MCOs' information systems and processes were compliant with IS standards and that the performance indicators calculated by the five MCOs had a status of *Reportable* based on the reporting requirements for MY 2022 PMV.

Performance Measure Results

For MY 2022, the MCOs calculated and reported 16 performance indicators. MY 2020–MY 2022 results for HEDIS measures were compared to NCQA's Quality Compass benchmarking data, and MY 2020–MY 2022 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 for the *Follow-Up After High-Intensity Care for Substance Use Disorder—7-Day Follow-Up* measure indicator, with four of the five health plans reporting rates above the national Medicaid 50th percentile for the *Follow-Up After High-Intensity Care for Substance Use Disorder—30-Day Follow-Up* measure indicator. However, the rates of members with diagnosed opioid use disorder receiving consistent pharmacotherapy continued to decline, with three out of five health plans reporting rates below the national Medicaid 25th percentile.

Child Behavioral Health

This pillar contains the *Inpatient Utilization—Behavioral Health 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 Behavioral Health Hospitalizations for Children and Adolescents* measures. Mobile crisis services and ED visits that result in hospital admission remained flat between MY 2021 and MY 2022, but they were reduced in comparison to the MY 2020 rates (lower is better). Behavioral health hospitalizations also demonstrated rate reductions in comparison to the MY 2020 and MY 2021 rates (lower is better). However, repeat admissions increased slightly over time, indicating worse performance. Additionally, there was a high degree of variability between HealthChoice plans on mobile crisis response services and ED visits that result in hospital admission.

Maternal and 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. The *Well-Child Visits in the First 30 Months of Life* measure, specifically for visits occurring within the first 15 months, demonstrated rates above the national Medicaid 50th percentile for four of the five health plans, with one of those health plans reporting rates above the national Medicaid 75th percentile. The *Well-Child Visits in the First 30 Months of Life* measure, specifically for visits occurring within the first 15–30 months of life, demonstrated rates between the national Medicaid 50th and 75th percentile for three health plans, with the remaining two health plans reporting rates below the national Medicaid 25th percentile. The rates for *Child and Adolescent Well-Care Visits* were consistent, with a difference of only 7 percentage points between HealthChoice plans; however, there was evidence of a downward trend between MY 2021 and MY 2022 that is likely due to the COVID-19 pandemic. Dental visits showed an overall rate improvement, with four out of five plans demonstrating rate increases and a difference of only 10 percentage points being noted between plans. The statewide average for immunizations demonstrated a slight rate increase between MY 2021 and MY 2022; however, all plans reported rates that remained below the national Medicaid 25th percentile.

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 at approximately 89 percent on average, with a slight decrease noted in MY 2021 likely due to the COVID-19 pandemic. Gaps in medical visits continued to decrease over time (lower is better). Viral load suppression significantly increased in comparison to the MY 2020 and MY 2021 rates; however, there was a high degree of variability between HealthChoice plans on the *HIV Viral Load Suppression* measure.

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 improved significantly between MY 2021 and MY 2022, with the statewide average increasing nearly 20 percent. The statewide average for successful transitions to the community

after long-term care was at approximately 18 percent while the expected transition rate averaged approximately 70 percent, indicating significant room for improvement.

Performance measure rates submitted by the five HealthChoice Illinois plans for MY 2020–MY 2022 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)					
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%
Q3 2021	7-Day Follow-Up—Ages 18-64	37.88%	38.50%	36.02%	30.20%	37.94%
Q4 2021	7-Day Follow-Up—Ages 18-64	37.59%	39.01%	38.69%	30.71%	39.56%
Q1 2022	7-Day Follow-Up—Ages 18-64	38.91%	25.87%	36.73%	21.32%	36.40%
Q2 2022	7-Day Follow-Up—Ages 18-64	37.24%	32.21%	37.35%	38.06%	38.73%
Q3 2022	7-Day Follow-Up—Ages 18-64	38.51%	32.83%	36.59%	38.00%	39.34%
Q4 2022	7-Day Follow-Up—Ages 18-64	38.40%	35.23%	38.75%	37.74%	39.98%
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
Q3 2021	7-Day Follow-Up—Ages 65+	NA	NA	NA	26.67%	NA
Q4 2021	7-Day Follow-Up—Ages 65+	NA	NA	39.53%	25.93%	NA
Q1 2022	7-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
Q2 2022	7-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
Q3 2022	7-Day Follow-Up—Ages 65+	NA	NA	20.45%	NA	NA
Q4 2022	7-Day Follow-Up—Ages 65+	NA	NA	26.32%	22.58%	NA
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%
Q3 2021	7-Day Follow-Up—Total	37.74%	38.45%	35.99%	30.15%	37.94%
Q4 2021	7-Day Follow-Up—Total	37.46%	38.97%	38.70%	30.64%	39.52%
Q1 2022	7-Day Follow-Up—Total	39.10%	26.19%	36.26%	21.20%	36.40%
Q2 2022	7-Day Follow-Up—Total	37.21%	32.19%	36.76%	37.91%	38.80%
Q3 2022	7-Day Follow-Up—Total	38.34%	32.88%	36.15%	37.86%	39.36%
Q4 2022	7-Day Follow-Up—Total	38.25%	35.33%	38.41%	37.59%	40.00%
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%
Q3 2021	30-Day Follow-Up—Ages 18-64	52.42%	55.45%	49.82%	47.94%	53.36%
Q4 2021	30-Day Follow-Up—Ages 18-64	53.03%	55.77%	53.98%	49.32%	55.06%
Q1 2022	30-Day Follow-Up—Ages 18-64	55.95%	40.80%	50.50%	34.61%	50.20%
Q2 2022	30-Day Follow-Up—Ages 18-64	55.80%	48.10%	50.60%	55.90%	56.70%
Q3 2022	30-Day Follow-Up—Ages 18-64	55.76%	48.89%	50.77%	55.31%	56.15%
Q4 2022	30-Day Follow-Up—Ages 18-64	55.40%	51.10%	54.15%	55.26%	57.57%
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
Q3 2021	30-Day Follow-Up—Ages 65+	NA	NA	NA	33.33%	NA
Q4 2021	30-Day Follow-Up—Ages 65+	NA	NA	48.84%	33.33%	NA
Q1 2022	30-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
Q2 2022	30-Day Follow-Up—Ages 65+	NA	NA	NA	NA	NA
Q3 2022	30-Day Follow-Up—Ages 65+	NA	NA	34.09%	NA	NA
Q4 2022	30-Day Follow-Up—Ages 65+	NA	NA	38.60%	38.71%	NA
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%
Q3 2021	30-Day Follow-Up—Total	52.28%	55.36%	49.65%	47.73%	53.34%
Q4 2021	30-Day Follow-Up—Total	52.95%	55.71%	53.88%	49.08%	54.99%
Q1 2022	30-Day Follow-Up—Total	56.09%	41.01%	50.10%	34.46%	50.20%
Q2 2022	30-Day Follow-Up—Total	55.76%	48.06%	49.85%	55.73%	56.74%
Q3 2022	30-Day Follow-Up—Total	55.53%	48.89%	50.31%	55.14%	56.14%
Q4 2022	30-Day Follow-Up—Total	55.15%	51.12%	53.72%	55.09%	57.56%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Adult Behavioral Health						
2	Pharmacotherapy for Opioid Use Disorder (POD)					
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%
Q3 2021	Ages 16-64	25.27%	25.66%	25.83%	17.55%	7.27%
Q4 2021	Ages 16-64	25.44%	29.32%	22.65%	21.13%	7.91%
Q1 2022	Ages 16-64	26.80%	30.25%	6.37%	24.21%	6.10%
Q2 2022	Ages 16-64	19.76%	27.22%	29.79%	18.01%	6.12%
Q3 2022	Ages 16-64	20.18%	27.81%	11.21%	20.38%	7.57%
Q4 2022	Ages 16-64	19.05%	23.58%	21.42%	16.90%	7.69%
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%
Q3 2021	Ages 65+	26.87%	35.80%	37.76%	26.88%	1.45%
Q4 2021	Ages 65+	26.15%	41.54%	33.33%	30.43%	2.86%
Q1 2022	Ages 65+	29.69%	38.46%	4.65%	29.41%	NA
Q2 2022	Ages 65+	27.91%	38.10%	41.43%	13.70%	1.82%
Q3 2022	Ages 65+	31.25%	36.73%	21.31%	15.63%	1.89%
Q4 2022	Ages 65+	28.57%	25.00%	35.84%	12.90%	1.85%
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%
Q3 2021	Total	25.32%	26.03%	26.42%	17.78%	7.19%
Q4 2021	Total	25.46%	29.70%	23.07%	21.36%	7.84%
Q1 2022	Total	26.88%	30.45%	6.31%	24.37%	6.00%
Q2 2022	Total	19.92%	27.45%	30.36%	17.93%	6.04%
Q3 2022	Total	20.42%	28.02%	11.78%	20.30%	7.46%
Q4 2022	Total	19.24%	23.61%	22.19%	16.83%	7.57%

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) (Lower is better)					
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
Q3 2021	Ages 0-5	NA	19.44%	NA	NA	NA
Q4 2021	Ages 0-5	15.63%	17.24%	NA	6.98%	NA
Q1 2022	Ages 0-5	NA	NA	NA	NA	NA
Q2 2022	Ages 0-5	NA	NA	NA	0.00%	NA
Q3 2022	Ages 0-5	12.12%	11.43%	NA	6.78%	NA
Q4 2022	Ages 0-5	NA	7.69%	4.65%	4.81%	NA
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%
Q3 2021	Ages 6-11	29.31%	33.19%	NA	11.97%	10.96%
Q4 2021	Ages 6-11	24.71%	27.56%	16.18%	11.43%	12.43%
Q1 2022	Ages 6-11	17.74%	21.28%	8.57%	10.04%	10.74%
Q2 2022	Ages 6-11	22.39%	19.78%	9.15%	9.55%	8.73%
Q3 2022	Ages 6-11	15.23%	23.73%	11.35%	17.48%	9.48%
Q4 2022	Ages 6-11	14.23%	24.36%	9.53%	17.20%	10.59%
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%
Q3 2021	Ages 12-17	44.87%	50.21%	28.19%	18.29%	19.37%
Q4 2021	Ages 12-17	37.77%	48.69%	22.99%	17.43%	18.88%
Q1 2022	Ages 12-17	26.44%	46.30%	36.80%	13.64%	11.86%
Q2 2022	Ages 12-17	34.87%	41.21%	30.63%	14.37%	12.72%
Q3 2022	Ages 12-17	25.57%	45.18%	29.18%	26.38%	12.93%
Q4 2022	Ages 12-17	24.66%	44.48%	27.56%	26.41%	14.59%
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%
Q3 2021	Ages 18-20	50.92%	57.22%	56.41%	15.16%	20.90%
Q4 2021	Ages 18-20	45.26%	60.88%	NA	16.45%	21.55%
Q1 2022	Ages 18-20	31.76%	64.62%	NA	7.61%	10.75%
Q2 2022	Ages 18-20	41.53%	57.09%	46.48%	13.23%	8.99%
Q3 2022	Ages 18-20	30.28%	60.44%	49.52%	36.95%	10.92%
Q4 2022	Ages 18-20	40.59%	59.45%	44.32%	36.52%	13.87%
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%
Q3 2021	Total	42.71%	48.61%	30.41%	16.70%	18.00%
Q4 2021	Total	36.19%	46.56%	22.97%	16.15%	17.88%
Q1 2022	Total	25.12%	42.31%	31.84%	12.01%	11.37%
Q2 2022	Total	32.59%	38.23%	26.41%	12.94%	11.11%
Q3 2022	Total	23.65%	42.34%	26.49%	25.58%	11.69%
Q4 2022	Total	23.48%	41.80%	23.77%	25.22%	13.42%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Child Behavioral Health						
4	Emergency Department (ED) Visits that Result in an Inpatient Admission for Children and Adolescents (BIA) (Lower is better)					
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%
Q3 2021	Ages 0-5	1.18%	NA	0.00%	0.90%	0.00%
Q4 2021	Ages 0-5	2.38%	NA	0.00%	0.88%	0.69%
Q1 2022	Ages 0-5	1.92%	NA	0.00%	0.00%	0.00%
Q2 2022	Ages 0-5	3.09%	NA	0.00%	0.00%	0.00%
Q3 2022	Ages 0-5	NA	NA	0.00%	NA	0.00%
Q4 2022	Ages 0-5	0.00%	NA	0.40%	2.50%	0.00%
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%
Q3 2021	Ages 6-11	18.77%	37.69%	2.67%	10.66%	13.49%
Q4 2021	Ages 6-11	17.36%	36.73%	3.61%	10.14%	12.21%
Q1 2022	Ages 6-11	15.83%	37.88%	5.95%	7.25%	15.75%
Q2 2022	Ages 6-11	21.07%	34.68%	7.26%	8.21%	14.19%
Q3 2022	Ages 6-11	28.37%	34.88%	6.95%	16.71%	14.39%
Q4 2022	Ages 6-11	14.66%	34.73%	6.79%	16.94%	12.82%
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%
Q3 2021	Ages 12-17	31.74%	45.37%	12.20%	24.99%	24.54%
Q4 2021	Ages 12-17	27.22%	44.44%	16.28%	23.15%	22.22%
Q1 2022	Ages 12-17	21.43%	47.70%	18.88%	14.10%	12.64%
Q2 2022	Ages 12-17	25.81%	43.49%	17.55%	13.38%	14.92%
Q3 2022	Ages 12-17	23.30%	46.00%	16.41%	18.28%	14.85%
Q4 2022	Ages 12-17	20.07%	46.51%	16.69%	18.13%	15.10%
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%
Q3 2021	Ages 18-20	23.28%	50.63%	14.80%	17.77%	17.01%
Q4 2021	Ages 18-20	21.47%	52.65%	18.18%	17.61%	17.20%
Q1 2022	Ages 18-20	18.64%	55.64%	19.69%	16.81%	18.47%
Q2 2022	Ages 18-20	29.68%	56.41%	21.35%	18.16%	18.94%
Q3 2022	Ages 18-20	37.31%	59.56%	21.78%	30.63%	18.79%
Q4 2022	Ages 18-20	19.43%	58.04%	21.43%	30.97%	18.82%
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%
Q3 2021	Total	26.25%	46.04%	10.91%	20.05%	19.42%
Q4 2021	Total	23.08%	45.78%	13.75%	18.74%	17.89%
Q1 2022	Total	18.44%	48.32%	15.01%	12.19%	13.83%
Q2 2022	Total	24.54%	45.73%	14.90%	12.62%	14.65%
Q3 2022	Total	27.41%	48.25%	14.45%	21.35%	14.77%
Q4 2022	Total	17.41%	48.11%	14.24%	21.37%	14.49%

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) (Lower is better)					
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
Q3 2021	Inpatient BH Utilization—Ages 0-5	11.03	0.01	0.00	0.01	0.01
Q4 2021	Inpatient BH Utilization—Ages 0-5	11.60	0.01	0.00	0.01	0.01
Q1 2022	Inpatient BH Utilization—Ages 0-5	11.44	0.01	0.01	0.00	0.01
Q2 2022	Inpatient BH Utilization—Ages 0-5	11.61	0.01	0.01	0.00	0.01
Q3 2022	Inpatient BH Utilization—Ages 0-5	0.04	0.01	0.01	0.00	0.01
Q4 2022	Inpatient BH Utilization—Ages 0-5	0.59	0.01	0.01	0.01	0.01
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
Q3 2021	Inpatient BH Utilization—Ages 6-11	0.96	0.26	0.07	0.24	0.25
Q4 2021	Inpatient BH Utilization—Ages 6-11	1.02	0.28	0.19	0.24	0.29
Q1 2022	Inpatient BH Utilization—Ages 6-11	0.92	0.29	0.17	0.19	0.42
Q2 2022	Inpatient BH Utilization—Ages 6-11	0.99	0.27	0.22	0.11	0.40
Q3 2022	Inpatient BH Utilization—Ages 6-11	0.00	0.27	0.20	0.18	0.36
Q4 2022	Inpatient BH Utilization—Ages 6-11	0.14	0.29	0.21	0.23	0.35
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
Q3 2021	Inpatient BH Utilization—Ages 12-17	3.03	1.52	0.62	1.30	1.44
Q4 2021	Inpatient BH Utilization—Ages 12-17	3.04	1.64	1.02	1.30	1.50
Q1 2022	Inpatient BH Utilization—Ages 12-17	2.57	1.69	1.27	0.96	1.25
Q2 2022	Inpatient BH Utilization—Ages 12-17	2.89	1.48	1.24	0.65	1.25
Q3 2022	Inpatient BH Utilization—Ages 12-17	0.00	1.53	1.03	0.98	1.22
Q4 2022	Inpatient BH Utilization—Ages 12-17	0.53	1.60	1.04	1.04	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
Q3 2021	Inpatient BH Utilization—Ages 18-20	6.00	1.41	0.73	1.01	1.17
Q4 2021	Inpatient BH Utilization—Ages 18-20	6.11	1.47	1.06	0.96	1.12
Q1 2022	Inpatient BH Utilization—Ages 18-20	5.57	1.17	0.79	0.64	1.13
Q2 2022	Inpatient BH Utilization—Ages 18-20	5.57	1.15	0.90	0.61	1.03
Q3 2022	Inpatient BH Utilization—Ages 18-20	0.02	1.25	0.85	0.92	1.07
Q4 2022	Inpatient BH Utilization—Ages 18-20	0.53	1.25	0.87	0.87	1.07
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
Q3 2021	Inpatient BH Utilization—Total	5.03	0.70	0.29	0.57	0.63
Q4 2021	Inpatient BH Utilization—Total	5.22	0.75	0.49	0.56	0.65
Q1 2022	Inpatient BH Utilization—Total	4.94	0.73	0.53	0.42	0.62
Q2 2022	Inpatient BH Utilization—Total	5.10	0.66	0.55	0.31	0.61
Q3 2022	Inpatient BH Utilization—Total	0.02	0.69	0.48	0.47	0.59
Q4 2022	Inpatient BH Utilization—Total	0.43	0.72	0.49	0.50	0.61

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) (Lower is better)					
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
Q3 2021	Average Length of Stay—Ages 0–5	3.79	NA	NA	NA	NA
Q4 2021	Average Length of Stay—Ages 0–5	3.91	NA	NA	NA	NA
Q1 2022	Average Length of Stay—Ages 0–5	4.08	NA	NA	NA	NA
Q2 2022	Average Length of Stay—Ages 0–5	4.54	NA	NA	NA	NA
Q3 2022	Average Length of Stay—Ages 0–5	NA	NA	NA	NA	NA
Q4 2022	Average Length of Stay—Ages 0–5	6.04	NA	NA	NA	NA
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
Q3 2021	Average Length of Stay—Ages 6–11	6.77	9.25	NA	9.61	8.97
Q4 2021	Average Length of Stay—Ages 6–11	6.61	8.98	8.09	9.58	9.25
Q1 2022	Average Length of Stay—Ages 6–11	6.04	7.90	NA	9.83	9.56
Q2 2022	Average Length of Stay—Ages 6–11	7.09	8.24	8.70	9.39	9.56
Q3 2022	Average Length of Stay—Ages 6–11	NA	8.26	8.96	9.12	9.75
Q4 2022	Average Length of Stay—Ages 6–11	8.33	8.44	10.23	9.34	9.79
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
Q3 2021	Average Length of Stay—Ages 12–17	6.78	8.69	9.06	8.68	9.17
Q4 2021	Average Length of Stay—Ages 12–17	6.89	8.66	8.85	8.77	9.13
Q1 2022	Average Length of Stay—Ages 12–17	7.06	8.31	8.79	9.08	9.66
Q2 2022	Average Length of Stay—Ages 12–17	7.10	8.34	9.16	9.14	9.71
Q3 2022	Average Length of Stay—Ages 12–17	NA	8.41	9.59	8.88	9.72
Q4 2022	Average Length of Stay—Ages 12–17	8.33	8.45	9.80	8.99	9.97
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
Q3 2021	Average Length of Stay—Ages 18–20	4.55	6.97	6.96	7.13	6.84
Q4 2021	Average Length of Stay—Ages 18–20	4.59	7.23	5.82	7.15	6.86
Q1 2022	Average Length of Stay—Ages 18–20	4.96	6.84	6.85	7.85	6.90
Q2 2022	Average Length of Stay—Ages 18–20	4.92	6.85	6.55	8.24	7.01
Q3 2022	Average Length of Stay—Ages 18–20	NA	7.08	6.82	7.96	7.16
Q4 2022	Average Length of Stay—Ages 18–20	5.90	7.11	6.71	7.59	7.33
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
Q3 2021	Average Length of Stay—Total	4.61	8.35	8.56	8.50	8.65
Q4 2021	Average Length of Stay—Total	4.68	8.36	7.97	8.58	8.69
Q1 2022	Average Length of Stay—Total	4.78	7.97	8.44	8.96	9.06
Q2 2022	Average Length of Stay—Total	5.17	8.00	8.57	8.94	9.14
Q3 2022	Average Length of Stay—Total	NA	8.10	8.89	8.68	9.18
Q4 2022	Average Length of Stay—Total	7.08	8.16	9.14	8.73	9.39

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Child Behavioral Health						
6	Repeat BH Hospitalizations for Children and Adolescents (RBH) (Lower is better)					
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
Q3 2021	Repeat BH Hospitalizations–Ages 0-5	61.00	0.00	0.00	0.00	0.00
Q4 2021	Repeat BH Hospitalizations–Ages 0-5	60.00	1.00	0.00	1.00	0.00
Q1 2022	Repeat BH Hospitalizations–Ages 0-5	107.00	1.00	0.00	1.00	0.00
Q2 2022	Repeat BH Hospitalizations–Ages 0-5	128.00	0.00	0.00	1.00	0.00
Q3 2022	Repeat BH Hospitalizations–Ages 0-5	0.00	0.00	0.00	3.00	0.00
Q4 2022	Repeat BH Hospitalizations–Ages 0-5	32.00	0.00	0.00	0.00	0.00
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
Q3 2021	Repeat BH Hospitalizations–Ages 6-11	76.00	53.00	6.00	56.00	21.00
Q4 2021	Repeat BH Hospitalizations–Ages 6-11	111.00	45.00	11.00	59.00	34.00
Q1 2022	Repeat BH Hospitalizations–Ages 6-11	112.00	48.00	9.00	57.00	41.00
Q2 2022	Repeat BH Hospitalizations–Ages 6-11	127.00	45.00	20.00	162.00	31.00
Q3 2022	Repeat BH Hospitalizations–Ages 6-11	0.00	54.00	23.00	261.00	28.00
Q4 2022	Repeat BH Hospitalizations–Ages 6-11	11.00	51.00	23.00	62.00	22.00
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
Q3 2021	Repeat BH Hospitalizations–Ages 12-17	261.00	452.00	74.00	433.00	183.00
Q4 2021	Repeat BH Hospitalizations–Ages 12-17	338.00	475.00	154.00	400.00	166.00
Q1 2022	Repeat BH Hospitalizations–Ages 12-17	346.00	443.00	157.00	367.00	131.00
Q2 2022	Repeat BH Hospitalizations–Ages 12-17	394.00	339.00	162.00	1046.00	137.00
Q3 2022	Repeat BH Hospitalizations–Ages 12-17	0.00	421.00	136.00	1541.00	136.00
Q4 2022	Repeat BH Hospitalizations–Ages 12-17	46.00	473.00	141.00	375.00	150.00
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
Q3 2021	Repeat BH Hospitalizations–Ages 18-20	89.00	150.00	12.00	140.00	50.00
Q4 2021	Repeat BH Hospitalizations–Ages 18-20	94.00	170.00	45.00	121.00	44.00
Q1 2022	Repeat BH Hospitalizations–Ages 18-20	108.00	172.00	29.00	160.00	39.00
Q2 2022	Repeat BH Hospitalizations–Ages 18-20	118.00	138.00	47.00	386.00	46.00
Q3 2022	Repeat BH Hospitalizations–Ages 18-20	3.00	123.00	49.00	534.00	58.00
Q4 2022	Repeat BH Hospitalizations–Ages 18-20	15.00	139.00	45.00	121.00	66.00
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
Q3 2021	Repeat BH Hospitalizations–Total	487.00	655.00	92.00	629.00	254.00
Q4 2021	Repeat BH Hospitalizations–Total	603.00	691.00	210.00	581.00	244.00
Q1 2022	Repeat BH Hospitalizations–Total	673.00	664.00	195.00	585.00	211.00
Q2 2022	Repeat BH Hospitalizations–Total	767.00	522.00	229.00	1595.00	214.00
Q3 2022	Repeat BH Hospitalizations–Total	3.00	598.00	208.00	2339.00	222.00
Q4 2022	Repeat BH Hospitalizations–Total	104.00	663.00	209.00	558.00	238.00

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Child Behavioral Health						
6	Repeat BH Hospitalizations for Children and Adolescents (RBH) (Lower is better)					
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
Q3 2021	Percent of Members with Repeat BH Hospitalization–Ages 0-5	16.34%	NA	NA	NA	NA
Q4 2021	Percent of Members with Repeat BH Hospitalization–Ages 0-5	18.39%	NA	NA	NA	NA
Q1 2022	Percent of Members with Repeat BH Hospitalization–Ages 0-5	18.73%	NA	NA	NA	NA
Q2 2022	Percent of Members with Repeat BH Hospitalization–Ages 0-5	19.15%	NA	NA	NA	NA
Q3 2022	Percent of Members with Repeat BH Hospitalization–Ages 0-5	NA	NA	NA	NA	NA
Q4 2022	Percent of Members with Repeat BH Hospitalization–Ages 0-5	24.72%	NA	NA	NA	NA
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%
Q3 2021	Percent of Members with Repeat BH Hospitalization–Ages 6-11	22.50%	23.81%	19.35%	17.62%	25.81%
Q4 2021	Percent of Members with Repeat BH Hospitalization–Ages 6-11	22.35%	18.59%	20.00%	15.02%	23.46%
Q1 2022	Percent of Members with Repeat BH Hospitalization–Ages 6-11	22.86%	19.14%	12.70%	16.50%	22.11%
Q2 2022	Percent of Members with Repeat BH Hospitalization–Ages 6-11	23.27%	19.50%	19.74%	14.71%	19.79%
Q3 2022	Percent of Members with Repeat BH Hospitalization–Ages 6-11	NA	22.09%	21.05%	18.84%	18.29%
Q4 2022	Percent of Members with Repeat BH Hospitalization–Ages 6-11	12.00%	19.23%	19.48%	17.65%	17.20%
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%
Q3 2021	Percent of Members with Repeat BH Hospitalization–Ages 12-17	18.21%	26.00%	18.96%	16.04%	21.67%
Q4 2021	Percent of Members with Repeat BH Hospitalization–Ages 12-17	18.85%	24.04%	20.05%	14.55%	19.17%
Q1 2022	Percent of Members with Repeat BH Hospitalization–Ages 12-17	18.17%	21.34%	18.85%	16.13%	17.84%
Q2 2022	Percent of Members with Repeat BH Hospitalization–Ages 12-17	19.42%	18.51%	17.86%	18.39%	18.24%
Q3 2022	Percent of Members with Repeat BH Hospitalization–Ages 12-17	NA	20.79%	17.27%	19.78%	17.30%
Q4 2022	Percent of Members with Repeat BH Hospitalization–Ages 12-17	12.76%	22.98%	16.35%	21.02%	19.63%
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%
Q3 2021	Percent of Members with Repeat BH Hospitalization–Ages 18-20	14.29%	20.90%	8.40%	13.41%	19.18%
Q4 2021	Percent of Members with Repeat BH Hospitalization–Ages 18-20	14.72%	21.80%	18.97%	14.29%	17.11%
Q1 2022	Percent of Members with Repeat BH Hospitalization–Ages 18-20	15.64%	20.24%	11.40%	14.22%	14.56%
Q2 2022	Percent of Members with Repeat BH Hospitalization–Ages 18-20	15.82%	20.76%	15.76%	13.97%	17.01%
Q3 2022	Percent of Members with Repeat BH Hospitalization–Ages 18-20	NA	19.26%	17.68%	18.54%	19.23%
Q4 2022	Percent of Members with Repeat BH Hospitalization–Ages 18-20	12.04%	20.86%	17.39%	14.71%	19.46%
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%	10.54%	21.29%
Q2 2021	Percent of Members with Repeat BH Hospitalization–Total	16.73%	25.16%	17.25%	16.51%	21.27%
Q3 2021	Percent of Members with Repeat BH Hospitalization–Total	17.60%	24.46%	15.99%	15.44%	21.36%
Q4 2021	Percent of Members with Repeat BH Hospitalization–Total	18.43%	23.04%	19.76%	14.44%	19.16%
Q1 2022	Percent of Members with Repeat BH Hospitalization–Total	18.33%	20.91%	16.43%	15.55%	17.69%
Q2 2022	Percent of Members with Repeat BH Hospitalization–Total	19.20%	19.08%	17.45%	16.90%	18.14%
Q3 2022	Percent of Members with Repeat BH Hospitalization–Total	NA	20.54%	17.71%	19.36%	17.77%
Q4 2022	Percent of Members with Repeat BH Hospitalization–Total	14.41%	22.09%	16.86%	19.09%	19.23%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Child Behavioral Health						
6	Repeat BH Hospitalizations for Children and Adolescents (RBH) (Lower is better)					
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
Q3 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 0-5	0.30	NA	NA	NA	NA
Q4 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 0-5	0.34	NA	NA	NA	NA
Q1 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 0-5	0.36	NA	NA	NA	NA
Q2 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 0-5	0.39	NA	NA	NA	NA
Q3 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 0-5	NA	NA	NA	NA	NA
Q4 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 0-5	0.36	NA	NA	NA	NA
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
Q3 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 6-11	0.38	0.42	0.19	0.23	0.34
Q4 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 6-11	0.42	0.29	0.20	0.22	0.42
Q1 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 6-11	0.40	0.30	0.14	0.29	0.43
Q2 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 6-11	0.40	0.28	0.26	1.19	0.32
Q3 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 6-11	NA	0.31	0.30	1.26	0.34
Q4 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 6-11	0.15	0.28	0.30	0.28	0.24
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
Q3 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 12-17	0.30	0.46	0.28	0.24	0.44
Q4 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 12-17	0.33	0.41	0.35	0.22	0.35
Q1 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 12-17	0.31	0.35	0.30	0.25	0.27
Q2 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 12-17	0.34	0.29	0.28	1.26	0.29
Q3 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 12-17	NA	0.33	0.26	1.29	0.27
Q4 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 12-17	0.16	0.39	0.27	0.31	0.31
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
Q3 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 18-20	0.24	0.40	0.10	0.23	0.34
Q4 2021	Average Number of Repeat BH Hospitalizations Per Member–Ages 18-20	0.24	0.43	0.26	0.22	0.29
Q1 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 18-20	0.24	0.41	0.15	0.24	0.25
Q2 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 18-20	0.26	0.35	0.23	1.23	0.31
Q3 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 18-20	NA	0.30	0.25	1.30	0.37
Q4 2022	Average Number of Repeat BH Hospitalizations Per Member–Ages 18-20	0.14	0.33	0.24	0.28	0.44
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
Q3 2021	Average Number of Repeat BH Hospitalizations Per Member–Total	0.29	0.44	0.22	0.23	0.40
Q4 2021	Average Number of Repeat BH Hospitalizations Per Member–Total	0.32	0.41	0.32	0.22	0.34
Q1 2022	Average Number of Repeat BH Hospitalizations Per Member–Total	0.31	0.36	0.25	0.25	0.29
Q2 2022	Average Number of Repeat BH Hospitalizations Per Member–Total	0.34	0.30	0.27	1.24	0.30
Q3 2022	Average Number of Repeat BH Hospitalizations Per Member–Total	NA	0.32	0.26	1.29	0.30
Q4 2022	Average Number of Repeat BH Hospitalizations Per Member–Total	0.19	0.37	0.26	0.30	0.33

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)					
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%
Q3 2021	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	47.67%	47.48%	47.93%	47.90%	57.95%
Q4 2021	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	51.21%	49.93%	51.73%	49.02%	58.49%
Q1 2022	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	46.38%	29.53%	31.16%	31.96%	49.06%
Q2 2022	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	55.19%	47.34%	42.46%	47.58%	59.18%
Q3 2022	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.56%	62.96%	50.99%	56.56%	52.15%
Q4 2022	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.91%	56.42%	54.93%	57.82%	61.64%
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%
Q3 2021	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	56.54%	62.34%	57.70%	59.36%	59.51%
Q4 2021	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	57.82%	63.26%	59.53%	59.82%	59.83%
Q1 2022	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	55.61%	53.97%	50.74%	54.44%	57.11%
Q2 2022	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	58.54%	61.95%	55.35%	61.23%	60.51%
Q3 2022	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	59.44%	66.63%	58.93%	63.11%	61.23%
Q4 2022	Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	59.59%	63.27%	60.37%	63.74%	61.36%
8	Child and Adolescent Well-Care Visits (WCV)					
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%
Q3 2021	Ages 3-11	36.12%	42.52%	42.03%	45.19%	51.31%
Q4 2021	Ages 3-11	51.34%	56.80%	60.69%	56.94%	55.26%
Q1 2022	Ages 3-11	8.33%	9.17%	10.50%	9.98%	18.05%
Q2 2022	Ages 3-11	18.85%	21.96%	20.92%	23.23%	40.96%
Q3 2022	Ages 3-11	40.53%	44.12%	42.78%	46.04%	52.11%
Q4 2022	Ages 3-11	49.51%	49.82%	57.71%	56.51%	53.45%
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%
Q3 2021	Ages 12-17	35.11%	41.52%	39.02%	44.00%	50.93%
Q4 2021	Ages 12-17	50.92%	55.32%	57.07%	55.92%	54.68%
Q1 2022	Ages 12-17	6.82%	7.12%	8.59%	7.48%	12.96%
Q2 2022	Ages 12-17	14.44%	17.32%	17.14%	18.24%	38.21%
Q3 2022	Ages 12-17	35.34%	42.02%	38.92%	42.97%	49.87%
Q4 2022	Ages 12-17	47.71%	47.54%	53.44%	54.94%	51.22%
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%
Q3 2021	Ages 18-21	15.82%	21.61%	18.93%	20.99%	21.97%
Q4 2021	Ages 18-21	21.95%	27.65%	26.99%	26.32%	23.93%
Q1 2022	Ages 18-21	6.63%	5.23%	5.45%	5.48%	8.74%
Q2 2022	Ages 18-21	12.10%	11.51%	9.98%	NA	17.01%
Q3 2022	Ages 18-21	16.42%	20.65%	17.68%	22.05%	22.26%
Q4 2022	Ages 18-21	20.26%	22.39%	25.78%	26.34%	23.15%
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%
Q3 2021	Total	32.13%	38.55%	37.21%	41.09%	46.53%
Q4 2021	Total	45.98%	51.30%	53.88%	51.91%	50.10%
Q1 2022	Total	7.50%	7.75%	8.97%	8.38%	14.78%
Q2 2022	Total	16.09%	18.47%	17.71%	21.23%	36.06%
Q3 2022	Total	34.31%	39.13%	37.07%	40.98%	46.48%
Q4 2022	Total	43.56%	44.10%	50.68%	50.98%	47.75%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Maternal and Child Health						
9	Annual Dental Visits (ADV)					
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%
Q3 2021	Ages 2-3	17.69%	13.92%	31.45%	22.52%	33.37%
Q4 2021	Ages 2-3	23.68%	13.97%	39.36%	27.79%	36.41%
Q1 2022	Ages 2-3	5.89%	4.79%	12.25%	6.85%	21.82%
Q2 2022	Ages 2-3	12.64%	9.52%	21.17%	16.06%	23.02%
Q3 2022	Ages 2-3	19.30%	22.20%	32.62%	24.08%	27.65%
Q4 2022	Ages 2-3	24.22%	25.50%	39.85%	29.34%	32.10%
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%
Q3 2021	Ages 4-6	39.07%	31.21%	48.37%	45.63%	49.29%
Q4 2021	Ages 4-6	48.97%	31.40%	58.99%	52.83%	54.37%
Q1 2022	Ages 4-6	15.44%	11.93%	20.93%	16.94%	30.80%
Q2 2022	Ages 4-6	30.39%	24.18%	34.55%	36.27%	39.99%
Q3 2022	Ages 4-6	42.86%	48.29%	50.78%	49.47%	49.45%
Q4 2022	Ages 4-6	50.55%	52.95%	61.48%	56.53%	53.95%
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%
Q3 2021	Ages 7-10	42.17%	36.01%	46.83%	50.34%	51.08%
Q4 2021	Ages 7-10	51.60%	36.19%	58.53%	57.42%	56.92%
Q1 2022	Ages 7-10	21.37%	15.46%	22.61%	22.90%	35.83%
Q2 2022	Ages 7-10	37.71%	30.30%	37.54%	44.39%	45.84%
Q3 2022	Ages 7-10	48.53%	54.64%	53.59%	55.51%	54.06%
Q4 2022	Ages 7-10	56.40%	59.23%	65.41%	62.15%	58.14%
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%
Q3 2021	Ages 11-14	41.02%	35.11%	45.95%	48.76%	49.43%
Q4 2021	Ages 11-14	49.05%	35.28%	55.93%	54.78%	53.77%
Q1 2022	Ages 11-14	18.56%	14.95%	20.20%	21.07%	32.09%
Q2 2022	Ages 11-14	33.94%	29.26%	33.85%	41.50%	43.14%
Q3 2022	Ages 11-14	45.55%	53.80%	50.45%	53.66%	50.03%
Q4 2022	Ages 11-14	51.74%	57.96%	61.26%	59.08%	54.29%
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%
Q3 2021	Ages 15-18	35.25%	32.17%	40.43%	41.85%	43.66%
Q4 2021	Ages 15-18	41.23%	32.37%	49.25%	46.47%	46.65%
Q1 2022	Ages 15-18	15.74%	13.23%	15.70%	18.13%	27.21%
Q2 2022	Ages 15-18	27.50%	25.43%	26.14%	34.23%	34.91%
Q3 2022	Ages 15-18	36.07%	45.10%	39.90%	43.81%	39.55%
Q4 2022	Ages 15-18	40.97%	48.73%	49.51%	48.40%	43.98%
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%
Q3 2021	Ages 19-20	22.57%	21.31%	25.76%	28.18%	31.10%
Q4 2021	Ages 19-20	26.64%	21.61%	33.29%	31.65%	33.22%
Q1 2022	Ages 19-20	9.83%	9.02%	9.89%	11.55%	19.11%
Q2 2022	Ages 19-20	17.51%	17.00%	16.68%	22.20%	22.49%
Q3 2022	Ages 19-20	22.92%	29.58%	26.09%	28.58%	25.24%
Q4 2022	Ages 19-20	26.52%	32.02%	33.07%	32.25%	29.26%
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%
Q3 2021	Total	35.64%	30.69%	42.23%	42.76%	45.49%
Q4 2021	Total	43.29%	30.90%	51.98%	48.65%	49.71%
Q1 2022	Total	15.93%	12.56%	18.17%	17.97%	29.51%
Q2 2022	Total	29.06%	24.60%	30.31%	35.65%	37.70%
Q3 2022	Total	38.94%	45.67%	44.99%	46.30%	44.32%
Q4 2022	Total	45.09%	49.67%	55.00%	51.97%	48.62%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Maternal and Child Health						
10	Childhood Immunization Status (CIS)—Combination 10					
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%
Q3 2021	Total	20.55%	20.22%	29.98%	15.25%	23.38%
Q4 2021	Total	22.66%	20.69%	30.76%	15.43%	23.80%
Q1 2022	Total	19.23%	21.88%	26.31%	17.50%	19.06%
Q2 2022	Total	19.68%	24.82%	26.38%	21.08%	20.09%
Q3 2022	Total	19.93%	25.89%	27.20%	21.55%	20.92%
Q4 2022	Total	20.01%	26.44%	27.93%	21.75%	21.27%
Pillar: Equity						
11	HIV Viral Load Suppression (HVL-AD)					
2020	Percent Members Viral Load <200 - Ages 18-64	8.56%	20.55%	12.22%	NR	17.73%
Q1 2021	Percent Members Viral Load <200 - Ages 18-64	9.18%	17.60%	12.67%	NR	17.23%
Q2 2021	Percent Members Viral Load <200 - Ages 18-64	14.54%	17.55%	12.62%	NR	18.39%
Q3 2021	Percent Members Viral Load <200 - Ages 18-64	16.60%	27.93%	11.54%	10.94%	17.42%
Q4 2021	Percent Members Viral Load <200 - Ages 18-64	15.38%	28.67%	11.06%	16.81%	16.89%
Q1 2022	Percent Members Viral Load <200 - Ages 18-64	7.42%	24.72%	27.26%	15.52%	9.36%
Q2 2022	Percent Members Viral Load <200 - Ages 18-64	13.61%	46.00%	27.09%	40.17%	48.35%
Q3 2022	Percent Members Viral Load <200 - Ages 18-64	12.12%	50.24%	24.83%	39.52%	56.62%
Q4 2022	Percent Members Viral Load <200 - Ages 18-64	14.39%	49.84%	23.81%	40.38%	58.23%
2020	Percent Members Viral Load <200 - Ages 65+	13.79%	5.56%	11.81%	NR	NA
Q1 2021	Percent Members Viral Load <200 - Ages 65+	NA	7.89%	12.77%	NR	NA
Q2 2021	Percent Members Viral Load <200 - Ages 65+	12.50%	5.00%	13.64%	NR	NA
Q3 2021	Percent Members Viral Load <200 - Ages 65+	16.22%	12.94%	10.24%	4.76%	NA
Q4 2021	Percent Members Viral Load <200 - Ages 65+	12.70%	16.84%	9.20%	6.93%	NA
Q1 2022	Percent Members Viral Load <200 - Ages 65+	8.82%	15.00%	20.73%	4.88%	NA
Q2 2022	Percent Members Viral Load <200 - Ages 65+	9.38%	36.36%	26.39%	37.04%	NA
Q3 2022	Percent Members Viral Load <200 - Ages 65+	8.57%	49.02%	20.81%	36.36%	NA
Q4 2022	Percent Members Viral Load <200 - Ages 65+	11.29%	50.47%	21.43%	35.29%	NA
2020	Percent Members Viral Load <200 - Total	8.79%	20.04%	12.21%	NR	17.84%
Q1 2021	Percent Members Viral Load <200 - Total	9.27%	17.30%	12.67%	NR	17.42%
Q2 2021	Percent Members Viral Load <200 - Total	14.46%	17.11%	12.66%	NR	18.49%
Q3 2021	Percent Members Viral Load <200 - Total	16.59%	27.32%	11.48%	10.68%	17.45%
Q4 2021	Percent Members Viral Load <200 - Total	15.26%	28.16%	10.97%	16.38%	16.84%
Q1 2022	Percent Members Viral Load <200 - Total	7.49%	24.30%	26.99%	15.06%	9.15%
Q2 2022	Percent Members Viral Load <200 - Total	13.38%	45.52%	27.06%	40.06%	48.31%
Q3 2022	Percent Members Viral Load <200 - Total	11.91%	50.19%	24.62%	39.44%	56.32%
Q4 2022	Percent Members Viral Load <200 - Total	14.79%	49.86%	23.68%	40.23%	58.03%
2020	Percent Members Lab Result Available - Ages 18-64	NR	NR	NR	NR	NR
Q1 2021	Percent Members Lab Result Available - Ages 18-64	NR	NR	NR	NR	NR
Q2 2021	Percent Members Lab Result Available - Ages 18-64	NR	NR	NR	NR	NR
Q3 2021	Percent Members Lab Result Available - Ages 18-64	NR	NR	NR	NR	NR
Q4 2021	Percent Members Lab Result Available - Ages 18-64	NR	NR	NR	NR	NR
Q1 2022	Percent Members Lab Result Available - Ages 18-64	31.75%	26.91%	30.89%	28.05%	12.77%
Q2 2022	Percent Members Lab Result Available - Ages 18-64	42.08%	52.49%	31.67%	43.69%	52.07%
Q3 2022	Percent Members Lab Result Available - Ages 18-64	40.93%	57.34%	29.85%	43.01%	61.14%
Q4 2022	Percent Members Lab Result Available - Ages 18-64	42.60%	57.99%	29.12%	43.76%	62.76%
2020	Percent Members Lab Result Available - Ages 65+	NR	NR	NR	NR	NR
Q1 2021	Percent Members Lab Result Available - Ages 65+	NR	NR	NR	NR	NR
Q2 2021	Percent Members Lab Result Available - Ages 65+	NR	NR	NR	NR	NR
Q3 2021	Percent Members Lab Result Available - Ages 65+	NR	NR	NR	NR	NR
Q4 2021	Percent Members Lab Result Available - Ages 65+	NR	NR	NR	NR	NR
Q1 2022	Percent Members Lab Result Available - Ages 65+	20.59%	15.00%	21.95%	19.51%	NA
Q2 2022	Percent Members Lab Result Available - Ages 65+	31.25%	40.91%	27.08%	37.04%	NA
Q3 2022	Percent Members Lab Result Available - Ages 65+	18.57%	52.94%	22.84%	36.36%	NA
Q4 2022	Percent Members Lab Result Available - Ages 65+	17.74%	56.07%	23.66%	35.29%	NA
2020	Percent Members Lab Result Available - Total	NR	NR	NR	NR	NR
Q1 2021	Percent Members Lab Result Available - Total	NR	NR	NR	NR	NR
Q2 2021	Percent Members Lab Result Available - Total	NR	NR	NR	NR	NR
Q3 2021	Percent Members Lab Result Available - Total	NR	NR	NR	NR	NR
Q4 2021	Percent Members Lab Result Available - Total	NR	NR	NR	NR	NR
Q1 2022	Percent Members Lab Result Available - Total	31.21%	26.39%	30.52%	27.68%	12.47%
Q2 2022	Percent Members Lab Result Available - Total	41.50%	51.92%	31.46%	43.47%	51.97%
Q3 2022	Percent Members Lab Result Available - Total	39.59%	57.15%	29.48%	42.84%	60.77%
Q4 2022	Percent Members Lab Result Available - Total	41.26%	57.91%	28.82%	43.52%	62.47%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Equity						
11	HIV Viral Load Suppression (HVL-AD)					
2020	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	NR	NR	NR	NR	NR
Q1 2021	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	NR	NR	NR	NR	NR
Q2 2021	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	NR	NR	NR	NR	NR
Q3 2021	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	NR	NR	NR	NR	NR
Q4 2021	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	NR	NR	NR	NR	NR
Q1 2022	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	23.36%	91.85%	88.25%	55.34%	73.33%
Q2 2022	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	32.35%	87.63%	85.54%	91.94%	92.86%
Q3 2022	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	29.62%	87.63%	83.18%	91.88%	92.59%
Q4 2022	Percent Members w/ Lab Result <200copies/mL - Ages 18-64	35.19%	85.95%	81.78%	92.28%	92.78%
2020	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NR	NR	NR	NR	NR
Q1 2021	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NR	NR	NR	NR	NR
Q2 2021	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NR	NR	NR	NR	NR
Q3 2021	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NR	NR	NR	NR	NR
Q4 2021	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NR	NR	NR	NR	NR
Q1 2022	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NA	NA	NA	NA	NA
Q2 2022	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NA	NA	97.44%	NA	NA
Q3 2022	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NA	92.59%	91.11%	NA	NA
Q4 2022	Percent Members w/ Lab Result <200copies/mL - Ages 65+	NA	90.00%	90.57%	NA	NA
2020	Percent Members w/ Lab Result <200copies/mL - Total	NR	NR	NR	NR	NR
Q1 2021	Percent Members w/ Lab Result <200copies/mL - Total	NR	NR	NR	NR	NR
Q2 2021	Percent Members w/ Lab Result <200copies/mL - Total	NR	NR	NR	NR	NR
Q3 2021	Percent Members w/ Lab Result <200copies/mL - Total	NR	NR	NR	NR	NR
Q4 2021	Percent Members w/ Lab Result <200copies/mL - Total	NR	NR	NR	NR	NR
Q1 2022	Percent Members w/ Lab Result <200copies/mL - Total	23.98%	92.05%	88.43%	54.41%	73.33%
Q2 2022	Percent Members w/ Lab Result <200copies/mL - Total	32.25%	87.68%	86.02%	92.17%	92.97%
Q3 2022	Percent Members w/ Lab Result <200copies/mL - Total	30.09%	87.82%	83.50%	92.06%	92.68%
Q4 2022	Percent Members w/ Lab Result <200copies/mL - Total	35.85%	86.11%	82.17%	92.46%	92.88%
12	Gap in Human Immunodeficiency Virus (HIV) Medical Visits (HGM) (lower is better)					
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
Q3 2021	Ages 0-17	NA	22.86%	NA	NA	NA
Q4 2021	Ages 0-17	NA	NA	NA	NA	NA
Q1 2022	Ages 0-17	NA	25.00%	NA	25.00%	NA
Q2 2022	Ages 0-17	NA	35.29%	NA	NA	NA
Q3 2022	Ages 0-17	NA	NA	NA	NA	NA
Q4 2022	Ages 0-17	NA	NA	NA	NA	NA
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%
Q3 2021	Ages 18-64	35.26%	22.95%	30.64%	39.85%	13.96%
Q4 2021	Ages 18-64	29.28%	26.00%	22.93%	32.91%	10.45%
Q1 2022	Ages 18-64	27.07%	24.41%	22.32%	35.10%	10.16%
Q2 2022	Ages 18-64	24.01%	24.10%	22.04%	44.13%	10.97%
Q3 2022	Ages 18-64	18.94%	25.86%	27.13%	19.46%	12.52%
Q4 2022	Ages 18-64	20.92%	24.83%	29.79%	20.65%	13.25%
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
Q3 2021	Ages 65+	50.00%	24.68%	35.19%	48.15%	NA
Q4 2021	Ages 65+	37.14%	20.51%	20.00%	40.32%	NA
Q1 2022	Ages 65+	38.46%	23.08%	21.14%	41.18%	NA
Q2 2022	Ages 65+	24.00%	29.52%	20.44%	33.90%	NA
Q3 2022	Ages 65+	21.92%	31.07%	19.73%	16.39%	NA
Q4 2022	Ages 65+	22.54%	25.81%	23.87%	17.31%	NA
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%
Q3 2021	Total	35.68%	23.02%	31.12%	40.09%	14.43%
Q4 2021	Total	29.41%	25.66%	22.75%	32.84%	11.08%
Q1 2022	Total	27.71%	24.36%	22.34%	35.15%	11.05%
Q2 2022	Total	23.98%	24.56%	21.99%	43.73%	11.62%
Q3 2022	Total	19.09%	25.91%	26.68%	19.22%	12.99%
Q4 2022	Total	21.06%	24.77%	29.50%	20.43%	13.61%

Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
Pillar: Equity						
13	Prescription of HIV Antiretroviral Therapy (HAT)					
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
Q3 2021	Ages 0-17	NA	NA	NA	NA	NA
Q4 2021	Ages 0-17	NA	NA	NA	NA	NA
Q1 2022	Ages 0-17	NA	NA	NA	NA	NA
Q2 2022	Ages 0-17	NA	NA	NA	NA	NA
Q3 2022	Ages 0-17	NA	NA	NA	NA	NA
Q4 2022	Ages 0-17	NA	NA	NA	NA	NA
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%
Q3 2021	Ages 18-64	88.98%	87.45%	91.80%	80.07%	90.99%
Q4 2021	Ages 18-64	88.10%	92.46%	90.47%	15.14%	91.11%
Q1 2022	Ages 18-64	88.49%	93.39%	90.50%	88.48%	93.63%
Q2 2022	Ages 18-64	88.74%	93.68%	90.03%	87.52%	92.85%
Q3 2022	Ages 18-64	87.83%	92.36%	87.41%	89.07%	91.94%
Q4 2022	Ages 18-64	88.36%	91.31%	88.53%	89.11%	92.42%
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
Q3 2021	Ages 65+	NA	88.46%	95.40%	85.29%	NA
Q4 2021	Ages 65+	NA	95.00%	86.00%	22.50%	NA
Q1 2022	Ages 65+	NA	95.59%	81.82%	85.37%	NA
Q2 2022	Ages 65+	90.32%	90.28%	80.58%	NA	NA
Q3 2022	Ages 65+	91.07%	87.32%	76.82%	91.11%	NA
Q4 2022	Ages 65+	84.91%	87.67%	81.88%	94.74%	NA
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%
Q3 2021	Total	89.24%	87.41%	91.97%	80.48%	90.77%
Q4 2021	Total	88.11%	92.44%	90.23%	15.22%	90.92%
Q1 2022	Total	88.39%	93.41%	89.90%	88.49%	93.18%
Q2 2022	Total	88.71%	93.35%	89.41%	87.31%	92.43%
Q3 2022	Total	87.88%	91.93%	86.72%	88.86%	91.55%
Q4 2022	Total	88.10%	90.90%	88.02%	89.04%	92.02%

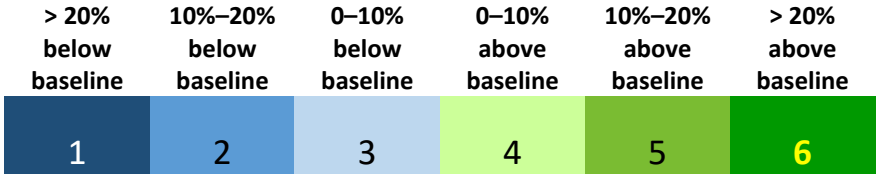
Period	Measure/Data Element	Aetna	BCBS	CountyCare	Meridian	Molina
	Pillar: Improving Community Placement					
14	Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update (LTSS-CCP)					
2020	Care Plan with Core Elements	67.88%	26.03%	14.84%	18.00%	29.50%
Q1 2021	Care Plan with Core Elements	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%
Q3 2021	Care Plan with Core Elements	68.37%	43.80%	19.95%	74.94%	43.17%
Q4 2021	Care Plan with Core Elements	65.69%	48.18%	38.69%	52.55%	42.21%
Q1 2022	Care Plan with Core Elements	86.46%	14.58%	67.71%	47.92%	62.50%
Q2 2022	Care Plan with Core Elements	78.13%	44.79%	64.58%	53.13%	87.50%
Q3 2022	Care Plan with Core Elements	90.63%	50.00%	57.29%	56.25%	81.25%
Q4 2022	Care Plan with Core Elements	94.79%	53.13%	53.13%	56.25%	88.54%
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%
Q3 2021	Care Plan with Supplemental Elements	68.13%	43.80%	19.95%	74.70%	42.95%
Q4 2021	Care Plan with Supplemental Elements	65.69%	48.18%	37.23%	52.55%	41.76%
Q1 2022	Care Plan with Supplemental Elements	86.46%	14.58%	67.71%	47.92%	61.46%
Q2 2022	Care Plan with Supplemental Elements	78.13%	44.79%	64.58%	53.13%	87.50%
Q3 2022	Care Plan with Supplemental Elements	90.63%	50.00%	57.29%	56.25%	81.25%
Q4 2022	Care Plan with Supplemental Elements	94.79%	53.13%	53.13%	56.25%	88.54%
15	LTSS Successful Transition After Long-Term Institution Stay (LTSS-TRAN)					
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%
Q3 2021	Observed Transition Rate - Total	NA	13.47%	24.30%	47.49%	4.45%
Q4 2021	Observed Transition Rate - Total	NA	15.04%	23.42%	NA	4.13%
Q1 2022	Observed Transition Rate - Total	NA	23.05%	12.30%	25.82%	12.88%
Q2 2022	Observed Transition Rate - Total	NA	19.11%	12.07%	26.13%	14.97%
Q3 2022	Observed Transition Rate - Total	NA	20.01%	12.15%	11.94%	4.89%
Q4 2022	Observed Transition Rate - Total	NA	20.33%	12.18%	12.71%	22.03%
2020	Expected Transition Rate - Total	NA	75.23%	69.46%	59.56%	60.12%
Q1 2021	Expected Transition Rate - Total	NA	73.66%	69.25%	60.13%	58.02%
Q2 2021	Expected Transition Rate - Total	43.93%	74.48%	70.01%	60.55%	54.35%
Q3 2021	Expected Transition Rate - Total	NA	76.48%	69.78%	48.60%	53.37%
Q4 2021	Expected Transition Rate - Total	NA	75.99%	68.82%	NA	52.83%
Q1 2022	Expected Transition Rate - Total	NA	74.40%	69.81%	58.21%	65.28%
Q2 2022	Expected Transition Rate - Total	NA	74.64%	69.28%	47.86%	65.64%
Q3 2022	Expected Transition Rate - Total	NA	74.50%	68.67%	46.94%	63.97%
Q4 2022	Expected Transition Rate - Total	NA	74.46%	69.19%	46.72%	54.88%
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	1.05	0.24	0.28	0.24	0.09
Q3 2021	Observed/Expected Ratio - Total	NA	0.18	0.35	0.98	0.08
Q4 2021	Observed/Expected Ratio - Total	NA	0.20	0.34	NA	0.08
Q1 2022	Observed/Expected Ratio - Total	NA	0.31	0.18	0.44	0.20
Q2 2022	Observed/Expected Ratio - Total	NA	0.26	0.17	0.55	0.23
Q3 2022	Observed/Expected Ratio - Total	NA	0.27	0.18	0.25	0.08
Q4 2022	Observed/Expected Ratio - Total	NA	0.27	0.18	0.27	0.40

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 to the Q4 rates for each respective reporting period.

- # = 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 the Q4 rates for each respective reporting period to provide a comparison of the MCO's current rate to the prior year's statewide average.



Strengths

- Aetna and Meridian were both able to identify and correct source code errors for the state-specific child behavioral health measures for the MY 2022 reporting period.
- All five health plans reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update* measure, with three of the five plans reporting significantly higher rates for both the core and supplemental elements.

Opportunities for Improvement

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

Why the Opportunity Exists: The health plans 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 they may not be including Medicare institutional facility claims received in FFS historical claim files for MMP opt-out members in the identification of the eligible population or calculation of observed discharges for the measure.

Recommendation: HSAG recommends that the health plans review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation. Additionally, HSAG recommends that the health plans 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.

Opportunity: Aetna's rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure were too small to calculate a valid rate.

Why the Opportunity Exists: Aetna confirmed that it provided a copy of the MY 2022 P4R Reporting Guidance document to its measure calculation vendor, which indicated that long-term institutional stays that were billed using Illinois-specific billing codes should be included in the denominator. However, the eligible population identified by Aetna was less than 30 for the entire measurement year, which does not align with the count reported by all other Illinois health plans.

Recommendation: HSAG recommends that Aetna review claims data extracts provided to its measure calculation vendor to ensure that all claims for long-term intuitional stays were provided in the extracts, including those with Illinois-specific billing codes as outlined in the MY 2022 P4R Reporting Guidance document. The extract sent to the vendor should also include Medicare claims provided to Aetna by HFS within the Care Coordination Claims Data (CCCD) files as noted in the reporting guidance. A documented process of oversight and validation would also help assist with identifying any discrepancies prior to reporting.

Illinois MCO Performance Reporting

Introduction

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures. HFS selected four measures for validation from the HFS MCO Performance Reporting (MPR)/Quarterly Business Review (QBR) reporting requirements:

- *New Enrollee Screening and Assessments*
- *Enrollee Engagement: Care Assessment and Individualized Plan of Care*
- *Enrollee Engagement: Reassessments Every 12 Months*
- *Enrollee Engagement: Contact Frequency*

MCOs

Table 2-20 displays the MCOs for which the measures were reported in SFY 2023.

Table 2-14—HealthChoice Illinois Plans for Performance Measure Validation

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

Methodology

HSAG validated the data collection and reporting processes used by the MCOs to report the performance measure data for July 1, 2021–December 31, 2021, in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019[2-10] (CMS Protocol 2). Additional details about the methodology are in Appendix B.

[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: Nov 3, 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).

Table 2-15 presents the PMV findings HSAG used for its review of the MPR measures audited during this activity.

Table 2-15—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 MCO was not required to report the measure
NR = Not reported	Measure was not reported because the MMP did not offer the required benefit

Table 2-16 to Table 2-19 display HSAG's validation finding for all MCOs.

Table 2-16—Validation Findings for New Enrollee Screening and Assessments

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	*Reportable*	*Reportable*	*Reportable*	*Reportable*

Table 2-17—Validation Findings for Care Assessment and Individualized Plan of Care

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	*Reportable*	*Reportable*	*Reportable*	*Reportable*

Table 2-18—Validation Findings for Reassessments Every 12 Months

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	*Reportable*	*Reportable*	*Reportable*	*Reportable*

Table 2-19—Validation Findings for Contact Frequency

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	*Reportable*	*Reportable*	*Reportable*	*Reportable*

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 2-20 displays the MMPs for which IL 3.6 was reported in SFY 2023.

Table 2-20—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 8 (January 1, 2022, through December 31, 2022) in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[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*, February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 27, 2024.

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 2-21 displays HSAG's validation finding for all MMPs.

Table 2-21—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.

MMAI PMV—Humana

Introduction

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures. HFS selected two measures for validation for the MMAI program. Table 2-22 presents the performance measures selected by HFS, the specifications the MMAI plans were required to use for each of the measures, and the method of data collection selected by HFS.

Table 2-22—Performance Measures for Humana

Performance Measure	Specifications	Method
Adults' Access to Preventive/Ambulatory Health Services	HEDIS	Admin
Initiation and Engagement of Substance Use Disorder Treatment	HEDIS	Admin

MMPs

Table 2-23 displays the MMP for which PMV was conducted. The remaining four MMPs received PMV of the measures displayed in Table 2-22, as described earlier in this report.

Table 2-23—MMAI Health Plans for PMV

Health Plan Name	Abbreviation
Humana Gold Plan Integrated	Humana

Methodology

HSAG validated the data collection and reporting processes used by Humana to report the performance measure data for MY 2022 (January 1, 2022, through December 31, 2022) in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[2-12] (CMS Protocol 2). Additional details about the methodology are in Appendix B.

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 2-24 displays HSAG's validation finding for Humana.

Table 2-24—Validation Findings for Humana

Performance Measure	Measure Designation
Adults' Access to Preventive/Ambulatory Health Services	*Reportable*
Initiation and Engagement of Substance Use Disorder Treatment	*Reportable*

An MMP-specific report was delivered to HFS and Humana and is available on request.

[2-12] Ibid.

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.

Introduction

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 2023, 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 by evaluating a subset of standards selected by HFS for the health plans serving HCI and the Medicare-MMPs serving the Medicare-Medicaid Alignment Initiative MMAI.

Objectives

The Compliance Review assessed each health plan's and MMP's compliance with the federal standards and the State contract requirements found in HFS Model Contract 2018-24-001, the MMAI three-way contract, the YouthCare contract, and the subsequent amendments to all three contracts. In SFY 2024, the Compliance Review will cover the remaining standards, thereby completing the required evaluation of the administrative and compliance process once in a three-year period.

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.

Compliance Review Process: Technical Methods of Data Collection and Analysis

The Compliance Review was conducted in two overall phases: initial review and remediation. In the initial review, HSAG completed a desk review of documents submitted by the health plan and conducted file and program description (PD) reviews. A webinar review was then conducted with the health plan to clarify desk review, file review, and PD review results. During the webinar, HSAG also assessed whether health plan staff were knowledgeable about the requirements, policies, and procedures. Following the initial review, HSAG produced a health plan-specific initial Compliance Review Report of Findings, which listed each element for which HSAG assigned a score *Not Met*, as well as the associated findings and recommendations to bring the health plan's performance into full compliance with the requirement. HFS required the health plans to remediate each element for which HSAG assigned a score of *Not Met*. The health plans had a 30-day remediation period in which to submit additional documentation or implement policies and procedures that met requirements. HSAG then assessed all remediation elements to determine if compliance with requirements had been met and assigned a final score, which is included in this final Compliance Review report.

For any elements that remained out of compliance following remediation, the health plan is required to submit a corrective action plan (CAP) to HFS. HFS and HSAG will monitor each health plan's progress toward correcting deficiencies.

Standards

The SFY 2023 Compliance Review included a subset of requirements that address federal Medicaid managed care regulations and State standards. For HCI and MMAI, a total of seven standards were assessed in SFY 2023, and the remaining standards will be covered in SFY 2024, thereby completing the required evaluation of the administrative and compliance process once in a three-year period. Table 3-1 displays the standards reviewed for each health plan in the three-year cycle.

Table 3-1—Review Standards for the Three-Year Period: SFY 2023–SFY 2025

			All HCI and MMAI Health Plans		
#	CFR	Standard Name	SFY 2023	SFY 2024	SFY 2025
I	438.206	Availability of Services[3-1]		✓	
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	✓		
VIII[3-2]	438.100	Enrollee Information/Enrollee Rights		✓	
IX	438.224	Confidentiality		✓	
X	438.56	Enrollment and Disenrollment		✓	
XI	438.228	Grievance and Appeal Systems	✓		
XII	N/A	Organization and Governance	✓		
XIII	N/A	Fraud, Waste, and Abuse		✓	
XIV	438.242	Health Information Systems		✓	

[3-1] Standard I included Emergency and Poststabilization Services.

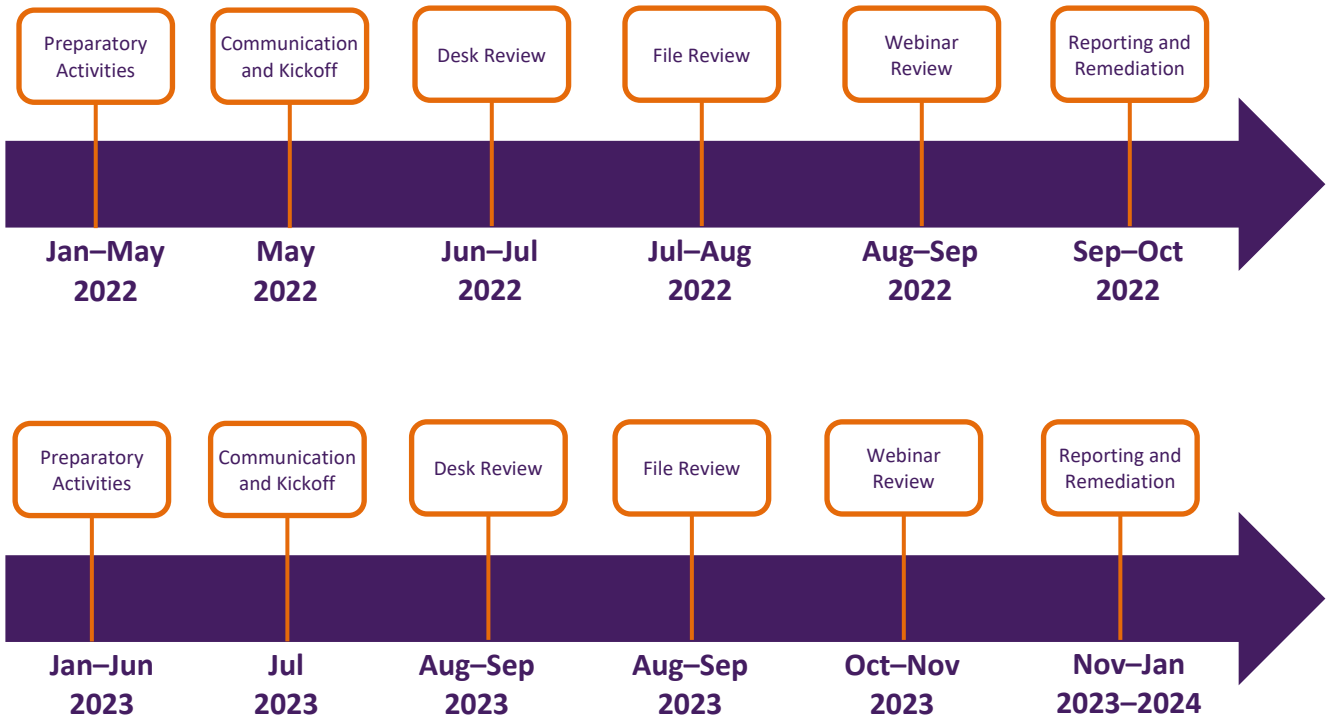
[3-2] In previous compliance review cycles, HSAG and HFS designated Standard VI for children's behavioral health (CBH) and Standard VII for YouthCare. In SFY 2023, standards VI and VII were removed because YouthCare-specific review tools were created to ensure evaluation of specific contact requirements. In SFY 2024, HSAG will conduct a CBH post-implementation review to follow up on previous findings; therefore, it is not included in this cycle's standard set.

			All HCI and MMAI Health Plans		
#	CFR	Standard Name	SFY 2023	SFY 2024	SFY 2025
XV	438.230	Subcontractual Relationships and Delegation	✓		
XVI	N/A	Critical Incidents		✓	
XVII	438.236	Practice Guidelines and Minimum Standards of Care		✓	
XVIII	438.330	QAPI Program	✓		

Timeline

Figure 3-1 displays the timeline for the three-year review period.

Figure 3-1—Review Standards for the Three-Year Period: SFY 2023–SFY 2025



Health Plans

The Compliance Review was conducted for six HCI health plans and five MMPs as shown in Table 3-2.

Table 3-2—HCI Health Plans and MMPs

Health Plan Name	Abbreviation
HCI	
Aetna Better Health	Aetna
Blue Cross Community Health Plans	BCBSIL
CountyCare Health Plan	CountyCare
Meridian	Meridian
Molina Healthcare of Illinois	Molina
YouthCare Specialty Plan	YouthCare
MMP	
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

For details about the methodology for the Compliance Review, see Appendix F.

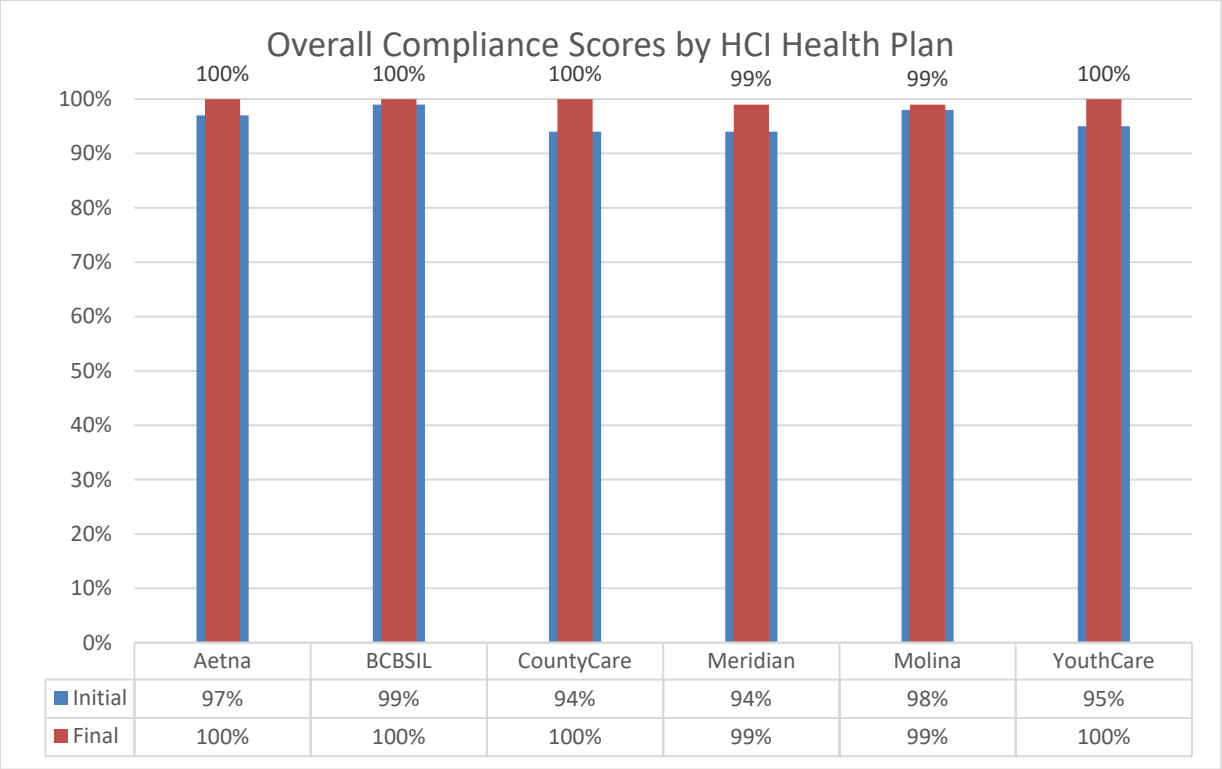
HCI Findings

This report details aggregated Compliance Review results, displaying the initial and final scores achieved after remediation. The health plans' final scores may not always reflect 100 percent compliance. Final scores which did not achieve 100 percent compliance were reviewed with HFS to determine the criticality of the requirement and recommendations for additional follow-up.

Overall Compliance

Figure 3-2 displays the overall initial and final health plan-specific compliance scores for all seven standards reviewed during the Compliance Review.

Figure 3-2—Overall Compliance Ratings by HCI Health Plan



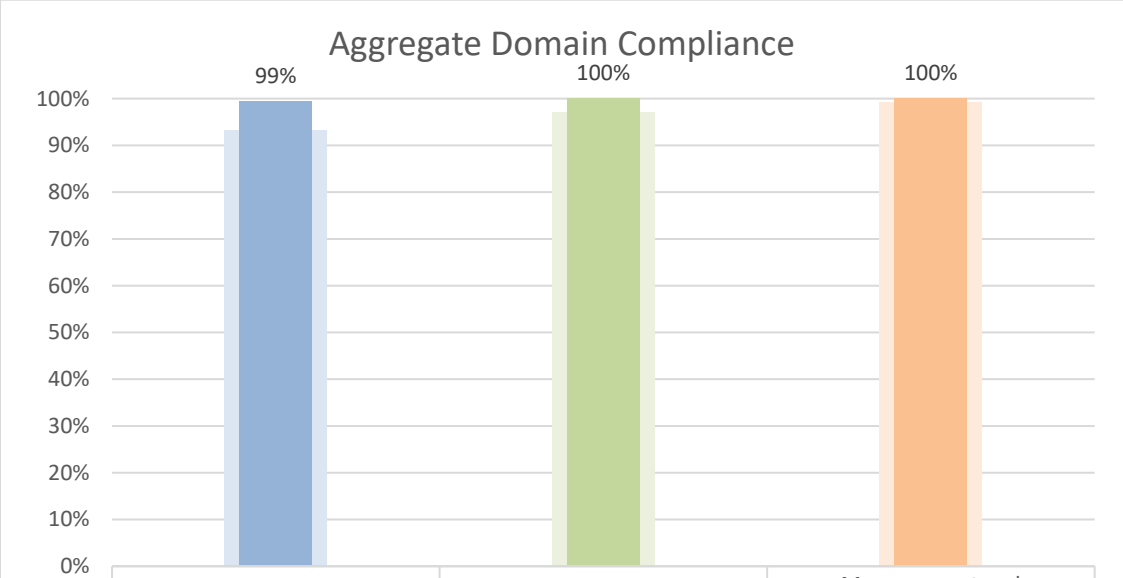
	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Initial	97%	99%	94%	94%	98%	95%
Final	100%	100%	100%	99%	99%	100%

As shown in Figure 3-2, all HCI health plans achieved an initial overall compliance score at or between 94 percent and 99 percent. Generally, the health plans were compliant with policies and procedures, as well as file reviews. However, opportunities for improvement were identified for several file reviews as detailed later in this report. Health plans were provided an opportunity to remediate elements for each standard that did not achieve 100 percent on initial review; final scores ranged from 99 percent to 100 percent for all health plans.

Domain Compliance

HSAG's Compliance Review assessed standards in three domains: Access, Structure and Operations, and Measurement and Improvement. Figure 3-3 displays the initial and final aggregate compliance scores for each domain.

Figure 3-3—Aggregate HCI Compliance Ratings by Domain



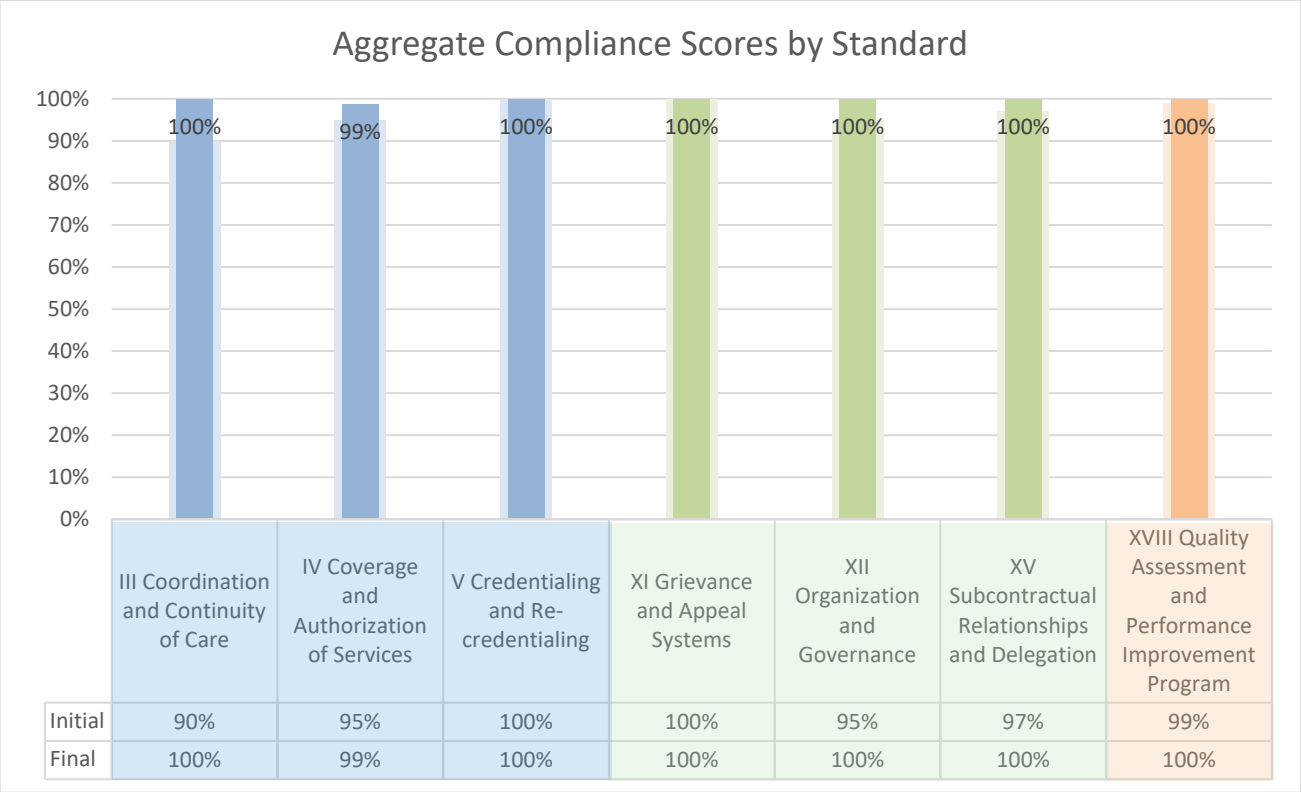
	Access	Structure and Operations	Measurement and Improvement
Initial	93%	97%	99%
Final	99%	100%	100%

As shown in Figure 3-3, the health plans achieved an initial compliance score greater than 90 percent in all three domains. Upon completion of health plan remediation, final scores ranged from 99 percent to 100 percent for all three domains. Performance on the standards included in each domain is described below.

Compliance With Standards

Figure 3-4 displays the initial and final aggregate Compliance Review scores for all HCI health plans for each standard.

Figure 3-4—Aggregate HCI Compliance Ratings by Standard



	III Coordination and Continuity of Care	IV Coverage and Authorization of Services	V Credentialing and Re-credentialing	XI Grievance and Appeal Systems	XII Organization and Governance	XV Subcontractual Relationships and Delegation	XVIII Quality Assessment and Performance Improvement Program
Initial	90%	95%	100%	100%	95%	97%	99%
Final	100%	99%	100%	100%	100%	100%	100%

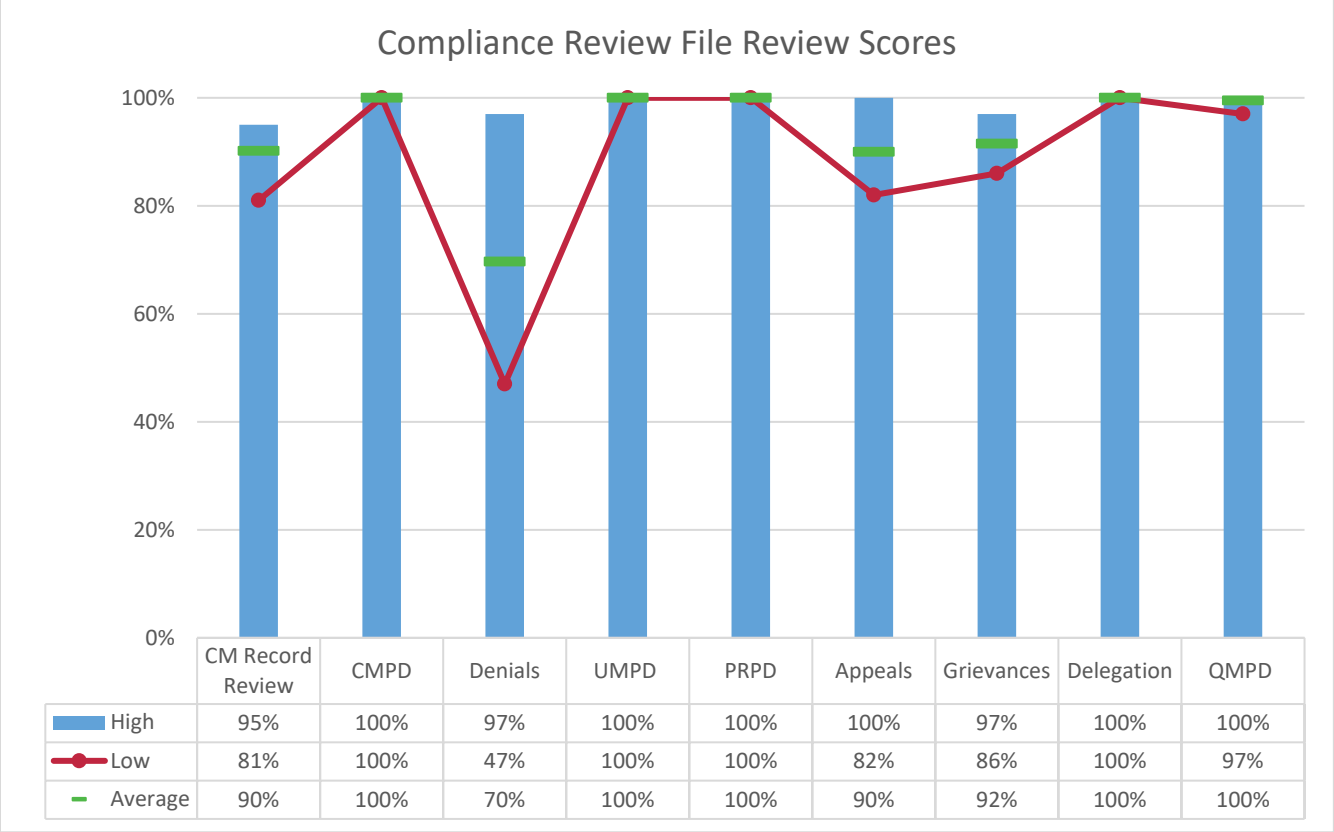
As shown in Figure 3-4, six of the seven standards initially scored at or above 95 percent. Health plans demonstrated the greatest opportunity for improvement in the Coordination and Continuity of Care standard, which was impacted by the results of case management file reviews.

Health plans were provided an opportunity to remediate elements for each standard that did not achieve 100 percent on initial review; final scores ranged from 99 percent to 100 percent when aggregated.

Compliance With File Reviews

Nine file reviews were conducted to assess the health plans' compliance with elements of selected standards. Figure 3-5 displays the high and low file review scores across the HCI health plans.

Figure 3-5—HCI File Review Scores*



	CM Record Review	CMPD	Denials	UMPD	PRPD	Appeals	Grievances	Delegation	QMPD
High	95%	100%	97%	100%	100%	100%	97%	100%	100%
Low	81%	100%	47%	100%	100%	82%	86%	100%	97%
Average	90%	100%	70%	100%	100%	90%	92%	100%	100%

*CM=case management; CMPD=case management program description; UMPD=utilization management program description; PRPD=peer review program description; QMPD=quality management program description.

As displayed in Figure 3-5, the health plans demonstrated the widest range of compliance in the denials file review, with an average score of 70 percent compliance, and demonstrated an average score of 90 percent compliance in the appeals file review. For both file reviews, HSAG identified opportunities for improvement related to timeliness of decisions and adherence to the HFS Readability Protocol.

The health plans averaged 90 percent compliance in the CM record review. HSAG identified opportunities for improvement related to timely contact with enrollees, timely completion of CM activities such as health risk screenings and assessments, and sharing of the care plan.

Additional Compliance Review Findings

Status of Special Needs Children (SNC) Post-Implementation Review Remediation

As part of the Compliance Review, HSAG followed up on the health plans' progress in correcting deficiencies identified in the CY 2021 SNC post-implementation review. The following summary documents the results of this review:

- HSAG conducted interviews with health plan staff to ensure implementation of oversight and monitoring of SNC care coordination requirements. All health plans demonstrated oversight and monitoring processes for care coordination requirements using reporting and audits.
- HSAG conducted CM record reviews of SNC waiver enrollees. The record reviews included elements to ensure timely completion of initial health risk screening and assessment, reassessment, care plan, and enrollee contacts. The file review results and findings were included as part of the Compliance Review scores.

Overall Findings and Conclusions

Access Domain

- Three of the six health plans (Aetna, BCBSIL, and Molina) initially achieved compliance scores at or above 95 percent in the three standards reviewed under the Access domain. The final aggregate score for the domain was 99 percent, demonstrating strengths and adherence to requirements measured in the areas of care coordination, coverage and authorization of services, and credentialing and recredentialing.
- All six health plans achieved 100 percent compliance with the CMPD, UMPD, and PRPD reviews, indicating the health plans included all requirements in their PDs.
- Results of file reviews demonstrated opportunities for improvement for health plans related to CM and processing of denials.

Structure and Operations Domain

- All six health plans achieved 95 percent or greater compliance in the Structure and Operations domain. One health plan, Molina, achieved full compliance scores in the three standards reviewed under this domain. The final aggregate score for this domain was 100 percent, demonstrating strengths and adherence to all requirements measured in the domain.
- All six health plans achieved full compliance with requirements for the delegation file review.
- Four of the six health plans (CountyCare, Meridian, Molina, and YouthCare) demonstrated compliance scores below 90 percent in the Appeals file review. HSAG identified opportunities for improvement related to timeliness of decisions and adherence to the HFS Readability Protocol.

Measurement and Improvement Domain

- All six HCI health plans scored above 95 percent in the one standard reviewed under the Measurement and Improvement domain. The final aggregate score for this domain was 100 percent, demonstrating strengths and adherence to all requirements measured in this domain.
- Five of the six health plans achieved full compliance with the QMPD review. One health plan, BCBSIL, achieved full compliance upon remediation of omitted documentation in its PD.

Conclusions

The Compliance Review findings suggest that HCI health plans developed the necessary policies and procedures and operationalized most of the required elements of the HealthChoice contract. Further, interviews with key health plan staff demonstrated that staff members were generally knowledgeable about the requirements of the contract and the policies and procedures that the health plans employed to meet contractual requirements. File review results provided evidence to support that health plans had implemented effective systems to capture and document required activities.

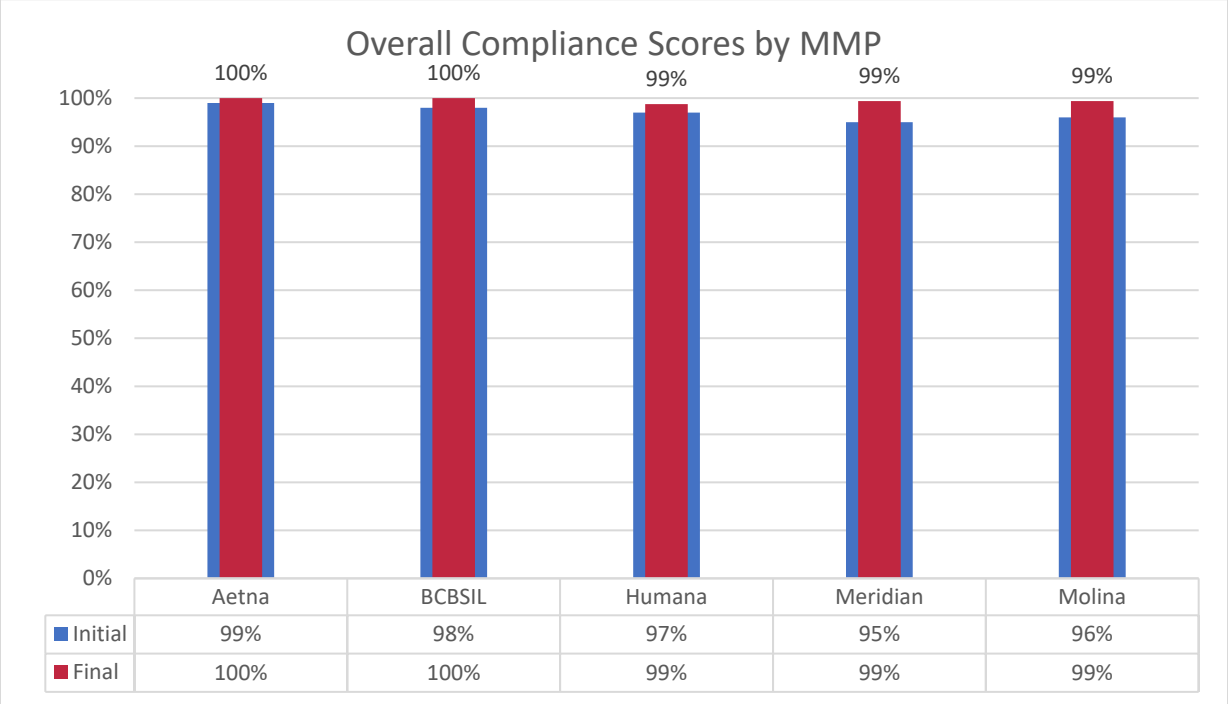
MMAI Findings

This report details aggregated Compliance Review results, displaying the initial and final scores achieved after remediation. The MMPs' final scores may not always reflect 100 percent compliance. Final scores which did not achieve 100 percent compliance were reviewed with HFS to determine the criticality of the requirement and recommendations for additional follow-up.

Overall Compliance

Figure 3-6 details the overall MMP-specific compliance score for all seven standards reviewed during the Compliance Review.

Figure 3-6—Overall Compliance Ratings by MMP



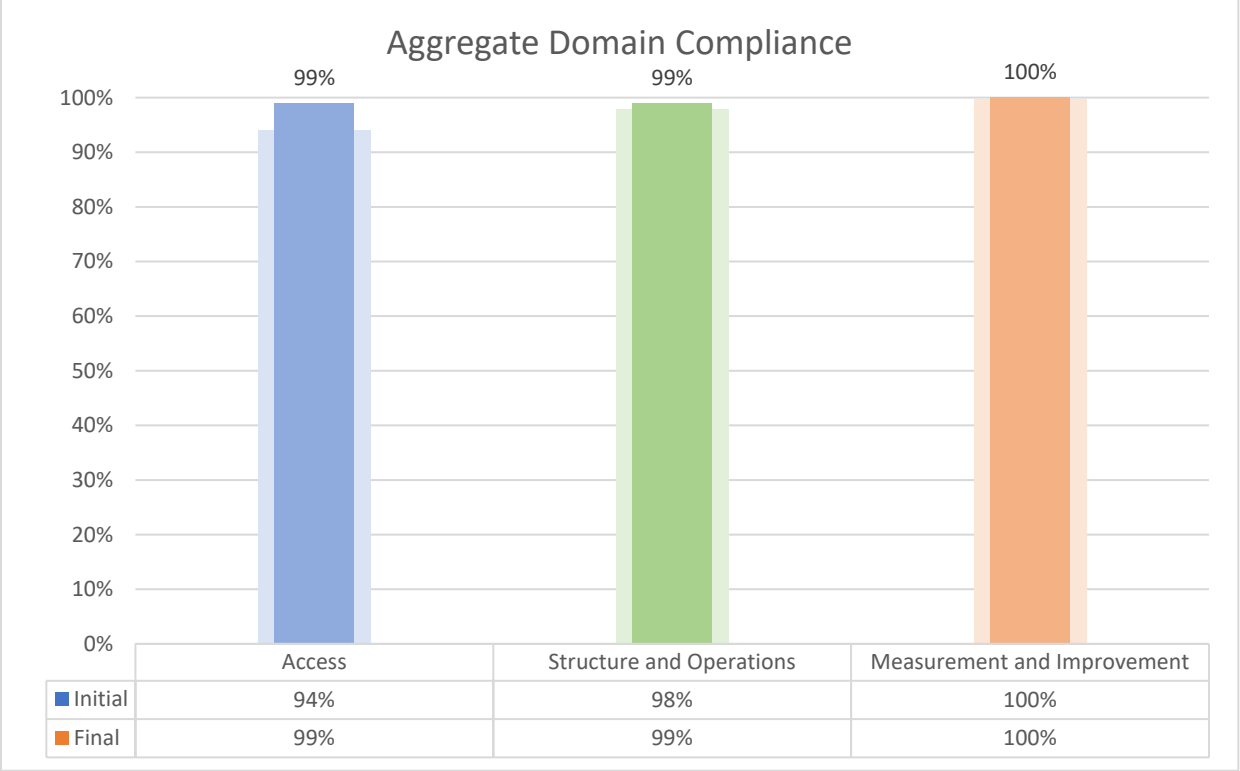
	Aetna	BCBSIL	Humana	Meridian	Molina
Initial	99%	98%	97%	95%	96%
Final	100%	100%	99%	99%	99%

As shown in Figure 3-6, all MMPs achieved an initial overall compliance score at or between 95 percent and 99 percent. Generally, the MMPs were compliant with policies and procedures, as well as file reviews. However, opportunities for improvement were identified for several file reviews as detailed later in this report. The MMPs were provided an opportunity to remediate elements for each standard that did not achieve 100 percent on initial review; final scores ranged from 99 percent to 100 percent for all MMPs.

Domain Compliance

HSAG's Compliance Review assessed standards in three domains: Access, Structure and Operations, and Measurement and Improvement. Figure 3-7 details the aggregate initial and final compliance scores for each domain.

Figure 3-7—Aggregate MMP Compliance Ratings by Domain



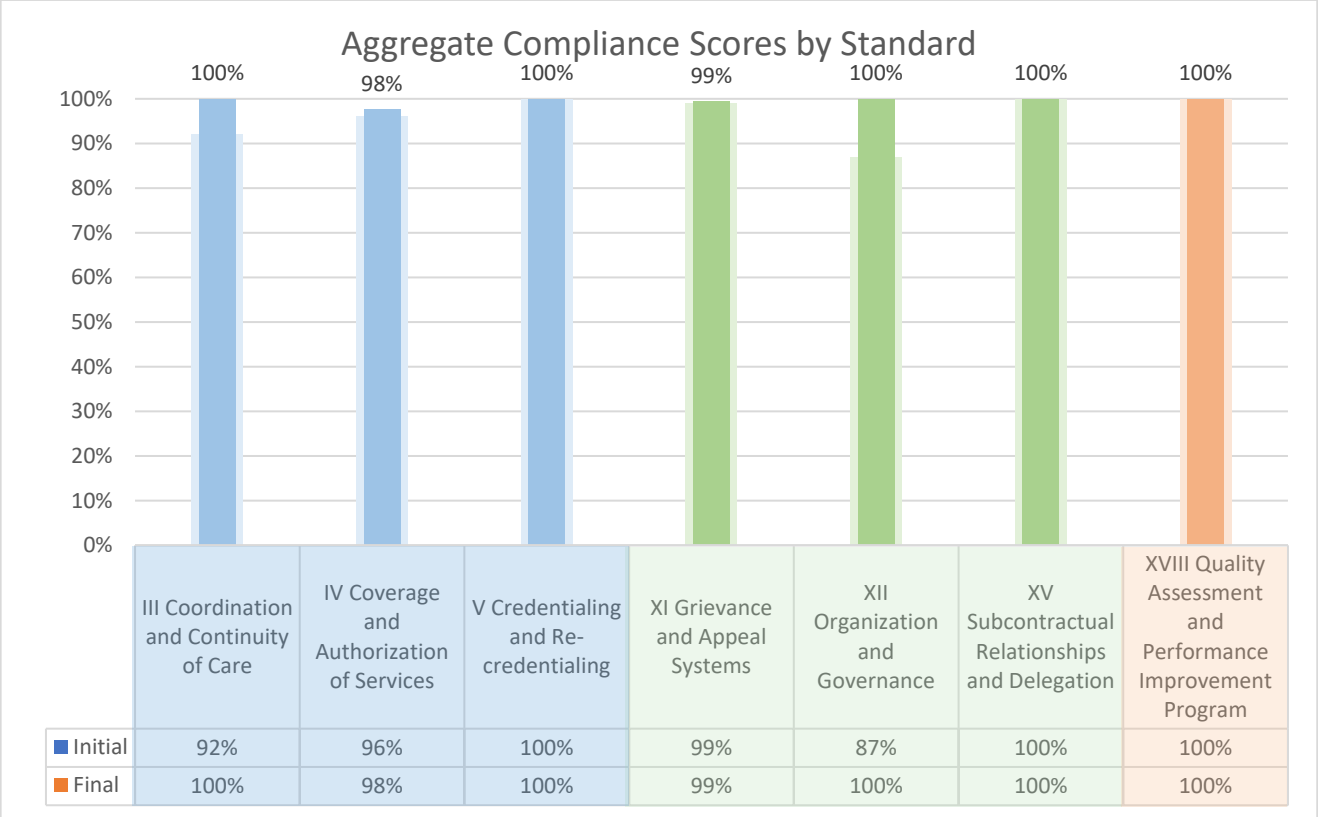
	Access	Structure and Operations	Measurement and Improvement
Initial	94%	98%	100%
Final	99%	99%	100%

As shown in Figure 3-7, the MMPs achieved an initial compliance score greater than 90 percent in all three domains. Upon completion of health plan remediation, final scores ranged from 99 percent to 100 percent for all three domains. Performance on the standards included in each domain is described below.

Compliance With Standards

Figure 3-8 displays the aggregate initial and final Compliance Review scores for all MMPs for each standard.

Figure 3-8—Aggregate MMP Compliance Ratings by Standard



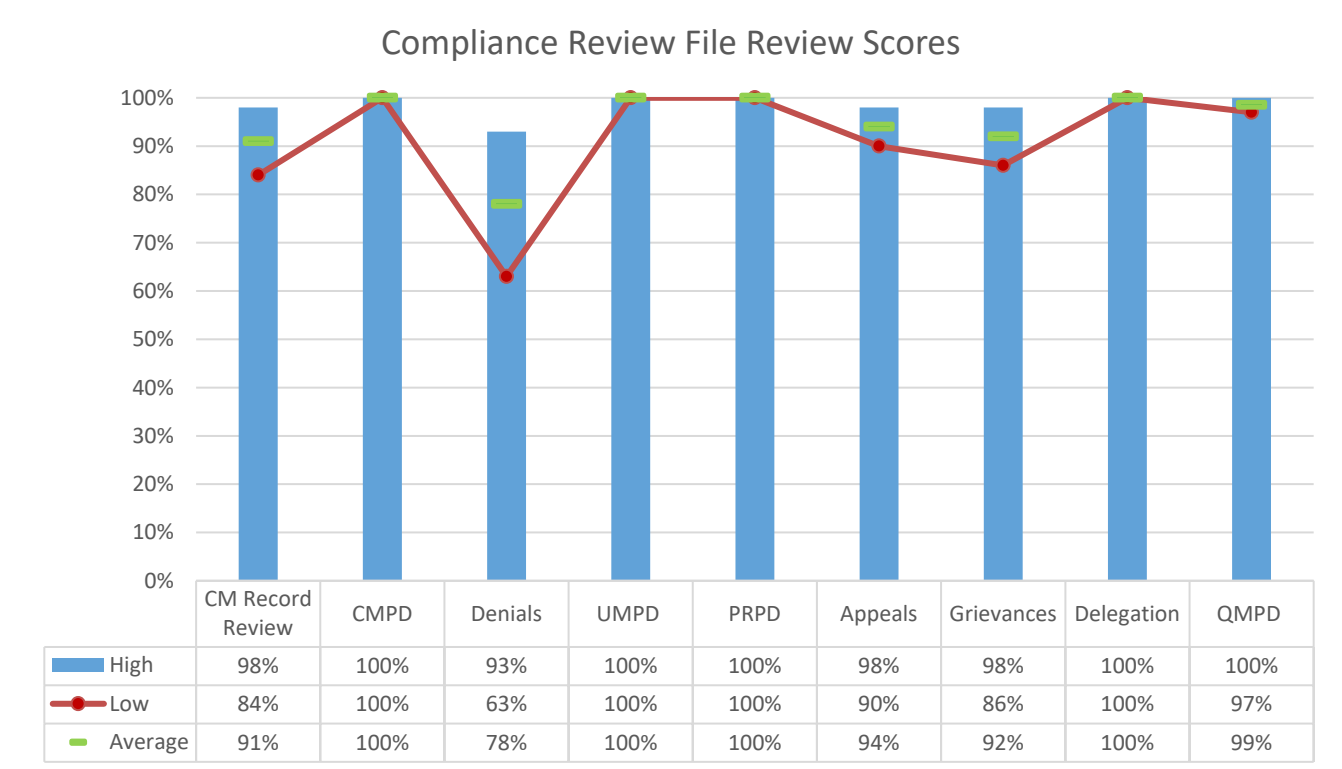
As shown in Figure 3-8, six of the seven standards initially scored above 90 percent. The MMPs demonstrated the greatest opportunity for improvement in the Organization and Governance standard.

The MMPs were provided an opportunity to remediate elements for each standard that did not achieve 100 percent on initial review; final scores ranged from 98 percent to 100 percent when aggregated.

Compliance With File Reviews

Nine file reviews were conducted to assess the health plans' compliance with elements of selected standards. Figure 3-9 displays the high and low file review scores across the MMPs.

Figure 3-9—MMAI File Review Scores*



	CM Record Review	CMPD	Denials	UMPD	PRPD	Appeals	Grievances	Delegation	QMPD
High	98%	100%	93%	100%	100%	98%	98%	100%	100%
Low	84%	100%	63%	100%	100%	90%	86%	100%	97%
Average	91%	100%	78%	100%	100%	94%	92%	100%	99%

*CM=case management; CMPD=case management program description; UMPD=utilization management program description; PRPD=peer review program description; QMPD=quality management program description.

As displayed in Figure 3-9, the MMPs demonstrated the widest range of compliance in the denials file review, with an average score of 78 percent compliance, and demonstrated an average of 94 percent compliance in the appeals file review. For both file reviews, HSAG identified opportunities for improvement related to timeliness of decisions. The grievances file review demonstrated an average compliance rate of 92 percent. For the denials, appeals, and grievances file reviews, the MMPs had an opportunity for improvement related to adherence to the HFS Readability Protocol.

The MMPs averaged 91 percent compliance in the CM record review. HSAG identified opportunities for improvement related to timely contact with enrollees and timely completion of CM activities such as health risk screenings and assessments.

Additional Compliance Review Findings

Status of Post-Implementation Review Remediation

As part of the Compliance Review, HSAG conducted a post-implementation review to assess continued compliance of the statewide MMAI expansion. The following summary provides the results of the post-implementation review:

- HSAG conducted interviews with MMP staff, who provided an overview of challenges and successes experienced during the implementation of statewide expansion. The MMPs demonstrated their efforts for continuous monitoring of key metrics and processes to ensure compliance with requirements for structural and operational areas.
- HSAG conducted CM, UM, and grievances and appeals file reviews for members enrolled during the statewide expansion. The file reviews were used to demonstrate the MMPs' compliance with requirements, and the results were included as part of the overall Compliance Review scores.

Overall MMAI Findings and Conclusions

Access Domain

- Two of the five MMPs (Aetna and BCBSIL) initially achieved compliance scores at or above 95 percent in the three standards reviewed under the Access domain. The final aggregate score for the domain was 99 percent, demonstrating strengths and adherence to all requirements measured in the areas of care coordination, coverage and authorization of services, and credentialing and recredentialing.
- All five MMPs achieved 100 percent compliance with the CMPD, UMPD, and PRPD reviews, indicating the MMPs included all requirements in their PDs.
- Results of file reviews demonstrated opportunities for improvement for MMPs related to CM and processing of denials.

Structure and Operations Domain

- All five MMPs achieved 95 percent or greater compliance in the Structure and Operations domain. One MMP, Molina, achieved full compliance scores in the three standards reviewed under this domain. The final aggregate score for this domain was 99 percent, demonstrating strengths and adherence to all requirements measured in the domain.
- All five MMPs achieved full compliance with requirements for the delegation file review.
- Results of the appeals and grievances file reviews demonstrated opportunities for improvement related to timeliness of decisions and adherence to the HFS Readability Protocol.

Measurement and Improvement Domain

- All five MMPs scored above 95 percent in the one standard reviewed under the Measurement and Improvement domain. The final aggregate score for this domain was 100 percent, demonstrating strengths and adherence to all requirements measured in this domain.
- Five of the six health plans achieved full compliance with the QMPD review. One health plan, BCBSIL, achieved full compliance upon remediation of omitted documentation in its PD.

Conclusions

The Compliance Review findings suggest that the MMPs developed the necessary policies and procedures and operationalized most of the required elements of the MMAI contract. Further, interviews with key MMP staff demonstrated that staff members were generally knowledgeable about the requirements of the contract and the policies and procedures that the MMPs followed to meet contractual requirements. File review results provided evidence to support that the MMPs had implemented effective systems to capture and document required activities.

Health Plan and MMP Recommendations

HSAG assessed individual and aggregate HCI health plan and MMP findings and remediation actions to determine system recommendations. Although not all HCI health plans and MMPs achieved final Compliance Review scores of 100 percent, there were no critical findings requiring corrective action.

HFS, the HCI health plans, and the MMPs should use the Compliance Review results to support continuous quality improvement. Based on the Compliance Review findings, HSAG offered the following recommendations.

Access Domain

- All health plans and MMPs should continue to evaluate care coordination staffing needs to ensure compliance with care coordination contractual requirements.
- The health plans and MMPs should continue to use the HFS Readability Protocol to enhance enrollee written materials and drive toward higher success rates in achieving a sixth-grade reading level. Molina should ensure internal distribution of the protocol to assist health plan staff with making needed changes.
- The health plans and MMPs should continue monitoring efforts, including delegation oversight, to ensure timeliness of contract activities related to CM and denials.
- HFS should direct a follow-up system demonstration to determine whether Molina's remediation action to update its CM system to display enrollee initial risk stratification has been effectively implemented. HFS directed HSAG to conduct the follow-up review.

Structure and Operations Domain

- The health plans and MMPs should continue to use the HFS Readability Protocol to enhance enrollee written materials and drive toward higher success rates in achieving a sixth-grade reading level. Molina should ensure internal distribution of the protocol to assist staff with making needed changes.
- The health plans and MMPs should continue monitoring efforts, including delegation oversight, to ensure timeliness of contract activities related to grievances and appeals.

Measurement and Improvement Domain

- The health plans and MMPs demonstrated substantial compliance in this domain. HSAG did not identify any recommendations for improvement.

Post-Implementation Review

- The results of the SNC post-implementation review provided evidence of compliance for all health plans. HFS may consider future file reviews to ensure continued compliance with CM requirements for this population.
- The MMAI post-implementation review did not reveal any critical findings. HFS should continue to use results from other EQRO activities, including biannual staffing and training reviews, to determine opportunities for improvement.

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

PIP activities are conducted across a calendar year. The health plans submitted two state-mandated PIPs for validation: *Improving Timeliness of Prenatal Care* and *Improving Transportation Services*. Final validation for the *Improving Transportation Services* PIP was completed in October 2022, and final validation for the *Improving Timeliness of Prenatal Care* and *Improving Transportation Services* was completed in March 2023. Due to the timing of the publication of the EQR technical report, the SFY 2022 report included the results for both PIP validations. PIP validations for CY 2023 were being completed at the time of this SFY 2023 EQR technical report; therefore, this PIP section contains information from last year's report. CY 2023 PIP activities will be updated in the SFY 2024 EQR technical report.

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, 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.

[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.

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.

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

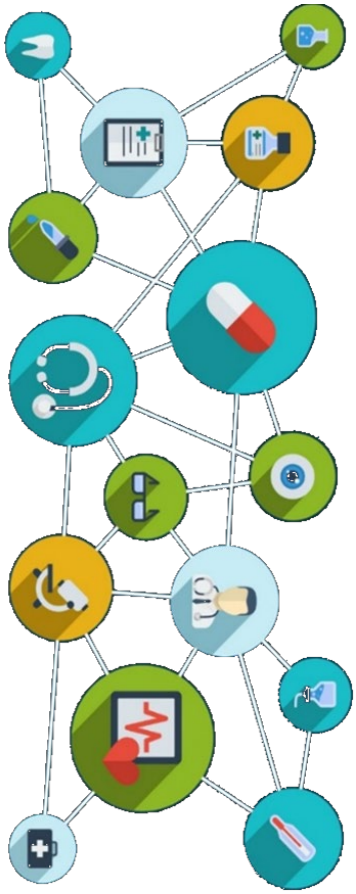
Strengths	• Designed a methodologically sound QIP. • Achieved all validation criteria for Steps 1 through 6 (QIP Design).
Opportunities for Improvement	**Opportunity:** No opportunities for improvement were identified.

5. Network Adequacy Validation

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CFR §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. CMS Protocol 4 was issued in February 2023. 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 analyses of data of the number of 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.

Analyses and monitoring of the HealthChoice Illinois provider network throughout SFY 2023 verified that the health plans contracted with a sufficient number of required provider types within each service region. SFY 2023 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 population.

Results

The analyses 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 data analyses of the number of 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 three-way 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.

Analyses and monitoring of the MMAI provider network throughout SFY 2023 verified that the health plans contracted with a sufficient number of required provider types within each service region. SFY 2023 biannual provider network reports are available upon request.

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 to evaluate the accuracy of provider information and appointment availability for Illinois Medicaid enrollees with a dental provider or PCP. To support HFS' goal to identify and prioritize reducing health disparities, the focus of the study was on providers in DIAs.[5-1] DIAs are defined as ZIP Codes that meet the following criteria:[5-2]

- Severely affected by COVID-19 based on positive case per capita rates
- One of the following poverty-related criteria was relatively higher than other ZIP Codes in that region:
  - Share of population consisting of children 6 to 17 years old in households with income less than 125 percent of the federal poverty level (FPL)
  - Share of population consisting of adults older than 64 years of age in households with income less than 200 percent of the FPL
  - Share of population in household with income less than 150 percent of the FPL
  - Share of population consisting of children ages 5 years and under in households with income less than 185 percent of the FPL

According to the managed care plans' contracts with HFS, each health plan is required to maintain provider network capacity to ensure that non-symptomatic office visit appointments (i.e., routine and preventive care) are available within five weeks. Specific survey objectives included the following:

- Determine whether provider locations accept patients enrolled with a Medicaid health plan.
- Determine whether provider locations accept new patients.
- Determine appointment availability with the sampled specialty locations for routine dental and primary care services.

[5-1] The list of DIA ZIP Codes can be found at the following Illinois Department of Commerce & Economic Opportunity website: https://www.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: Jan 23, 2024.

[5-2] Illinois WorkNet Center. QCT – DIA Map. Available at: https://www.illinoisworknet.com/qctdiamap. Accessed on: Jan 23, 2024.

Methodology

To address the study objectives described above, HSAG used an HFS-approved methodology (Appendix B) and script (Appendix C) to conduct a non-secret (i.e., "revealed caller") telephone survey of PCP and dental providers' offices to collect information on enrollees' access to providers. The health plans assessed in this analysis included the following:

- Aetna Better Health of Illinois (Aetna)
- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare (available only in Cook County)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare Specialty Plan (YouthCare)[5-3]

Study Limitations

Due to the nature of the survey, there were limitations that should be considered when generalizing survey results across all providers contracted with the health plans to serve Medicaid enrollees. More details are available in the full report in Appendix D2.

Key Findings

Overall, the provider information maintained and provided by the plans is poor, which impacts access to care due to the ability of members to find a provider that delivers the requested services. Table 5-1 below provides a summary of the findings from the study.

Table 5-1—Summary of Findings

Concerns	Findings
A substantial percentage of telephone numbers were inaccurate.	Approximately 15 percent of sampled providers' phone numbers were bad phone numbers, which included reaching a disconnected number, fax number, or a personal number or non-medical facility. 17 percent of phone numbers could not be used by an enrollee to make an appointment.
The providers' locations were wrong.	10 percent of the sampled providers were located at the wrong address.

[5-3] YouthCare serves Illinois Department of Children & Family Services (DCFS), Youth In Care (YIC), and Former Youth In Care (FYIC) enrollees only.

Concerns	Findings
Data issues seem to be higher for PCPs compared to dental providers.	Compared to the dental providers, fewer PCP locations confirmed the address, specialty, and insurance information noted in the health plan data.
The ability to make an appointment is limited by the accuracy of provider information.	An appointment was offered in only 40.9 percent of sampled dental cases and 16.8 percent of sampled PCP cases. This is due to inaccurate data which prevent the survey from continuing or reaching the provider office.
Members are having to wait for an appointment beyond the appointment compliance standards.	For those surveys wherein an appointment was offered, only 34 percent of dental appointments and 13 percent of PCP visits met the appointment standard.

If the surveyors were able to reach the correct provider location, overall accuracy of acceptance of the health plan, Medicaid, and new patients, and of offering the service was high. However, concerns with data accuracy need to be addressed as this is preventing most callers from reaching a provider office or appointment line.

When compared to the 2022 statewide Access and Availability Survey of specialty providers,[5-4] the DIA group performed worse than the specialty provider population for most study indicators. The poor quality of the provider information contributed to these findings and resulted in a decreased ability for enrollees in DIAs to access dental and primary care services. Additionally, when compared to similar studies in other states, the DIA response rates were lower across comparable surveys. Moreover, the DIA population experienced a higher number of bad phone numbers or offices that were unable to be reached than callers have experienced when conducting similar surveys. Overall, the poor quality of the provider data found in the DIA population is generally worse than in other surveys.

Recommendations

Based on the survey results presented in this report and the accompanying case-level analytic data files, HSAG offers the following recommendations to evaluate and address potential health plan provider data quality and/or access to care concerns:

- **The provider's contact information provided by the plans was incorrect—**HSAG was unable to reach 34.5 percent of sampled cases across all health plans. Of all surveyed cases, 16.8 percent indicated the telephone number did not connect to a patient scheduling line, and 10.0 percent indicated the address was incorrect.
  - 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

[5-4] The 2022 Access and Availability Survey evaluated appointment availability for routine appointments with the following provider specialties: cardiologists, pulmonologists, allergy and immunologists, neurologists, and licensed professional counselors.

each health plan will address provider data deficiencies identified during the survey calls (e.g., disconnected telephone numbers or telephone numbers and addresses that do not correspond to the sampled provider location).

  - To further evaluate data inconsistencies, HFS could consider conducting a network validation survey (NVS) to evaluate the health plans' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the health plans' provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the plan-submitted data and the online provider directory, a call would be placed to the provider location to verbally confirm the directory information and request appointment availability.

- **Members are experiencing limited appointment availability—**HSAG was only able to obtain an appointment date with 25.4 percent of the sampled locations, with 50.5 percent of respondents offering a new patient appointment and 54.7 percent offering an existing patient appointment. For new and existing patient appointments, across all plans, dental appointments were more readily available than primary care appointments. The survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling and the schedule/calendar being unavailable. 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 enrollee's ability to schedule an appointment.
- **Members are experiencing wait times beyond the appointment compliance standards—** Appointment availability compliance rates were low, with 34.4 percent of dental appointments and 12.7 percent of PCP visits meeting the appointment standard.
  - The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
  - 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.
  - 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 D2.

Time/Distance Analysis

Introduction

As part of its provider network adequacy monitoring activities, HFS requested its EQRO, HSAG, to conduct an analysis of the travel time or distance between enrollees and providers in the health plans' networks. Specifically, the SFY 2023 Time/Distance Analysis examined the geographical distribution of each health plan's provider network in relation to its enrollees. The study calculated the percentage of each health plan's enrollees who have a provider located within the required access standards.[5-5]

This kind of study is called a network adequacy validation (NAV) and is required by the CMS rule §438.358(b)(1)(iv).[5-6]

The health plans assessed in this report are:

- Aetna Better Health of Illinois (Aetna)
- Blue Cross Community Health Plan (BCBSIL)
- CountyCare (available only in Cook County)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare HealthChoice Illinois (YouthCare)

Methodology

HFS has set access standards that define the minimum time and distance enrollees should have to travel to obtain care. These access standards are incorporated in the health plan contracts, and they require that at least 90 percent of a health plan's enrollees in each county have the necessary number of providers within the time and distance standards. Providers covered by the standards include PCPs, obstetricians and gynecologists (OB/GYNs), BH providers, pediatric dentists, hospitals, and several necessary specialists. For this year's analysis, HFS requested an analysis of adult and pediatric specialists in six provider categories: allergy/immunology, audiology, endocrinology,

[5-5] Standards can be found 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.

[5-6] CMS issued its External Quality Review (EQR) Protocols in February 2023. The activities described in the protocol must be implemented beginning in February 2024 and validated in EQRO Technical Reports due in April 2025. This report does not apply the new protocols.

neurosurgery, oral surgery, and pulmonology. In addition, 100 percent of enrollees must have access to a pharmacy within access standards.

Study Limitations

These results provide one indication of access to care but do not take into account other important factors such as whether an enrollee depends on public transportation to visit a provider, or whether the nearest provider is accepting new HealthChoice patients. These factors must be considered in context with other available information. Study limitations include:

- Time/distance results only highlight the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations. These 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. They do not take into consideration whether providers are contracted with multiple health plans.
- 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.
- 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.

Additional details about the methodology for the time/distance analysis can be found in the SFY 2023 Provider Network Time/Distance Analysis in Appendix D3.

Key Findings

- Statewide: For the majority of provider types, all health plans met or exceeded HFS' access standards. Overall, 99 percent to 100 percent of HealthChoice enrollees had providers located within the required time and distance from their residence.
- Health Equity: There was little indication of disparities in access for enrollees related to race, ethnicity, age, sex, and DIA status. Deficits in access were similar across urbanicity, age, sex, race, and ethnicity. Enrollees residing in DIA ZIP Codes were more likely to have access to care within standards than those residing in non-DIA ZIP Codes, but this may be due to a correspondence between DIA status and urbanicity, and may or may not be a function of disparity.
- Pharmacies: Access to pharmacies is held to a higher standard than other provider categories, requiring that 100 percent of urban enrollees have access within 15 minutes or miles and rural residents have access within 60 minutes or miles from their residence. All statewide health plans met this standard in rural counties, but some health plans did not meet the standard in all urban counties.

While there was some variation in findings, no statewide health plan met the time and distance standard for pharmacies in DeKalb, McLean, or Vermilion counties. Two health plans, Aetna and Molina, showed improvement from last year by meeting the pharmacy standard in one additional county.

- Oral Surgeons: All statewide health plans failed to provide the required access to oral surgeons for adult and pediatric enrollees in some areas, predominantly in rural counties located in regions 1, 2, or 3. Based on prior studies, the health plans have attributed the noncompliance for oral surgery to the lack of provider availability across the State and/or provider unwillingness to accept Medicaid rates.
- No statewide health plan met the time and distance standard for Oral Surgery, Adult in any of the following counties: Franklin, Hamilton, Johnson, Massac, Pope, Pulaski, Saline, Union, White, and Williamson.
- No statewide health plan met the time and distance standard for Oral Surgery, Pediatric in any of the following counties: Franklin, Gallatin, Hamilton, Hardin, Johnson, Massac, Pope, Pulaski, Saline, Union, White, and Williamson.
- YouthCare showed improvement since last year by meeting the standard for oral surgeons for adults in two additional counties, and for children in one additional county.
- BCBSIL's access results were worse than last year, meeting the standard for oral surgeons for adults in three fewer counties, and for children in two fewer counties.
- Allergy and Immunology: Two health plans did not provide the required access to allergy and immunology providers in some areas, especially for pediatric populations.
- One of those health plans, BCBSIL, met the standards for Allergy and Immunology, Adult and Pediatric, in two additional counties compared to last year's results.
- The other health plan, Molina, met the standard for Allergy and Immunology, Pediatric, in 12 fewer counties this year compared to last year.
- Audiology: One health plan, BCBSIL, failed to meet the access standards for Audiology, Adult and Pediatric in one county. All others met or exceeded HFS' access standards.
- Endocrinology: One health plan, BCBSIL corrected its failure to meet standards in a single county last year for Endocrinology, Adult providers, meeting standards in all counties this year.
- Neurosurgery: One health plan, BCBSIL, improved its performance in several counties compared to last year for adult and pediatric neurosurgery providers, adding four and five counties, respectively, to those that met standards.
- Pulmonology: All health plans met or exceeded HFS' access standards for Pulmonology, Adult and Pediatric.

Successes

Overall, each of the six health plans have contracted with a broad network of providers with offices that are located reasonably close to the enrollees they serve. Figure 5-1 presents the standards that were met by all health plans. For most provider categories, and across most parts of the State, health plan performance exceeded HFS' expectation that 90 percent of enrollees have access within these standards. In fact, with the exception of a limited number of provider categories discussed below, 99 percent to 100 percent of HealthChoice enrollees had providers located within the required time and distance from their residence.

Figure 5-1—Access Standards Met by All Health Plans

At least 90% of Urban Residents Could Reach	At least 90% of Rural Residents Could Reach
Within 30 minutes or miles: • 2 PCPs/Pediatricians • 2 Behavioral Health Providers • 2 OB/GYNs • 1 Pediatric Dentist • 1 Hospital	***Within 60 minutes or miles***: • 1 PCP/Pediatrician • 1 Behavioral Health Provider • 1 OB/GYN • 1 Pediatric Dentist • 1 Hospital
Within 60 minutes or miles: Specialist, Adult and Pediatric • Audiology • Endocrinology • Neurosurgery • Pulmonology	***Within 90 minutes or miles:*** Specialist, Adult and Pediatric • Audiology • Endocrinology • Neurosurgery • Pulmonology

Compared to last year's results, some health plans improved the number of passing standards, including addressing a lack of neurosurgery specialists. The SFY 2023 findings also demonstrated widespread access to specialists in two new categories analyzed this year, audiology, and pulmonology. However, there are opportunities for improving access to pharmacies, oral surgery specialists, and to a lesser extent allergy and immunology specialists.

Opportunities for Improvement

The results that fell short of standards were found in three key areas, all of which were identified in prior years. For pharmacy, all health plans met access standards for residents in rural counties. In urban counties, some enrollees in some health plans did not have a pharmacy within the required 15 minutes or miles. For oral surgeons, no health plans met access standards for adult and pediatric populations in several counties. These counties are predominantly, but not exclusively, rural. The deficits in access to oral surgeons were most serious in Region 3, the southern portion of the State, where all statewide health plans provided access to between 70.4 percent and 84.2 percent of enrollees. This does not mean that health plans failed to meet standards in all counties. There were also issues with access to allergy and immunology specialists, but these were limited primarily to two health plans. On a regional level, service regions with the most rural counties (i.e., regions 1, 2, and 3) had more noncompliant findings than areas with more urban counties (i.e., regions 4 and 5).

Particular deficits that impacted a relatively large percentage of counties included the following:

- In Region 2, Molina provided the required access to pediatric allergy and immunology specialists for enrollees residing in 62.9 percent of counties in this region.
- In Region 3, Molina provided the required access to pediatric allergy/immunology specialists in less than half of the counties in this region (47.1 percent).
- Also in Region 3, none of the statewide health plans provided enrollees with the required access to oral surgery specialists for adults or children. Their results ranged from a low of 41.2 percentage of counties meetings access standards for adults and children (Molina), to a high of 62.5 percent of counties meeting access standards for adults and 55.9 percent of counties meeting access standards for children (YouthCare).

Stratified Findings

When HSAG analyzed the data by race, ethnicity, age, sex, and DIA ZIP Codes,[5-7] there was no clear evidence of inequities in access within the constraints of this study. Few access issues were discovered for population subgroups outside of those discovered from analysis of the full population at the regional level; deficits in access were similar across urbanicity, age, sex, race, and ethnicity. Enrollees residing in DIA ZIP Codes were more likely to have access to care within standards than those residing in non-DIA ZIP Codes, but this is likely due to the correspondence between DIA status and urbanicity, and may or may not be a function of disparity.

[5-7] Illinois Department of Commerce & Economic Opportunity. Zip Codes that Qualify as Disproportionately Impacted Areas for the Illinois Back to Business (B2B) Grant Program. Available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: Jan 23, 2024.

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' access to healthcare services within reasonable limits of time and distance:

- While most health plans are meeting the contract standards for most provider categories and showed improvement over last year's results, HFS should continue to collaborate with the health plans to monitor the status of access standards for all provider categories.
- HFS should continue to collaborate with those health plans that do not meet the access standards in specific regions and help them contract with additional providers, if available. Provider categories of concern include pharmacy, allergy and immunology, and oral surgery. For provider categories wherein health plans are not meeting access standards, HSAG has provided lists of providers with which the health plans are not currently contracted. HFS and the health plans should review these lists as part of their contracting outreach efforts.
- HFS should continue to review provider categories for which no health plans met the access standards, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
- While a time/distance analysis can give an approximation of the level of difficulty enrollees face in traveling to a physician office, hospital, or pharmacy, it does not indicate whether enrollees can get an appointment to see a healthcare provider when they need one. HFS should continue using appointment availability surveys to evaluate providers' appointment 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 actively delivering services to enrollees still meets the defined access standards.
- HFS could consider conducting analyses of the extent to which the health plans are using telehealth services to address access issues.
- HFS may consider collaborating with HSAG to design and implement a focus study to investigate selected topics regarding access to care among enrollees by geographic region. Study topics could include how factors such as health disparities or access to public transportation are impacting access to care.

Additional details about the methodology for the time/distance analysis are in the SFY 2023 Provider Network Time/Distance Analysis in Appendix D3.

MMAI Provider Network Post-Implementation Reviews

Introduction

The prior SFY 2022 technical report detailed HFS' request that HSAG monitor continued health plan compliance with provider network adequacy requirements following the statewide implementation for the MMAI program. As part of the network monitoring conducted by the EQRO, the health plans were required to follow the standardized PFL submission process to complete and submit provider network data quarterly. HFS required the health plans to remain contracted with BH providers in at least 80 percent of the Illinois counties following the MMAI statewide implementation on July 1, 2021. HSAG conducted a thorough analysis of the health plan provider data file submissions, and HSAG 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 BH network if the health plans failed to maintain compliance with the HFS requirement.

During the last quarter of SFY 2022, HSAG's review identified that one health plan was noncompliant with the HFS requirement to maintain contracted BH providers in at least 80 percent of the counties. Review of the health plan's provider data identified 79 percent of counties with contracted BH providers. As required by HFS, HSAG notified the health plan in July 2022 of its noncompliance, and it was placed on a CAP to monitor the health plan's progress to comply with the HFS requirement. The health plan was required to respond with a process to achieve compliance and remediate the network gap.

Compliance

HSAG reviewed PFLs submitted by the health plan and worked with the health plan to ensure resubmissions when incomplete data or discrepancies were noted. Based on the review of multiple submissions, the health plan demonstrated compliance with 82 percent of counties identified with one or more contracted BH providers. The CAP was continued to ensure that the health plan would demonstrate continued BH network compliance in the next quarterly provider data file submission. HSAG used the provider data file submission to verify the accuracy and completeness of the provider data. The analysis identified contracted BH providers in 83 percent of the Illinois counties, which demonstrated compliance for two consecutive submissions, and provided additional information regarding the health plan's efforts to contract with BH providers in additional counties.

HFS directed HSAG to close the CAP for the BH network, as the health plan demonstrated continued compliance with the HFS requirement.

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 2023 in response to HFS provider network requests are listed below.

- Memorial Health Contracted Health Plans: Following the provider termination notice between Aetna and Memorial Health, HFS requested that HSAG conduct an analysis to identify all the HCI health plans contracted with Memorial Health including Memorial associated providers.
- CMS Network Adequacy and Access Assurance Reporting Template (CMS NAAAR template): HSAG assisted HFS with completing the CMS network template.
- CountyCare Marketing Campaign Approval: HFS requested that HSAG validate the provider network information utilized by CountyCare in its marketing campaign prior to health plan distribution to enrollees.
- Hematology Providers: HSAG assisted HFS with a request to review contracted pediatric hematology providers.
- Provider Network Audit Request for Documentation: HSAG assisted HFS with compiling documentation for an audit review.
- Quantitative Network Adequacy Standards for OB/GYN Providers: HSAG provided HFS with language to address network adequacy questions including contract citations for network standards related to time and distance, and access and availability specific to OB/GYN providers.
- Springfield Clinic: HFS requested that HSAG identify all contracted health plans with Springfield Clinic as of the date of the HFS request.
- Breast Cancer Legislation: HFS requested that HSAG conduct a review to determine compliance with the breast cancer legislation known as "The Best Act." HSAG reviewed the HCI health plans' networks to validate contracting with facilities designated as Breast Imaging Centers of Excellence and the American College of Surgeons Commission on Cancer.
- CMS Annual Managed Care Program Report: HSAG assisted HFS with the completion of the annual managed care program report template.
- CMS Managed Care Program Integrity Audit: HFS requested that HSAG validate the provider network counts for three health plans as part of a CMS Program Integrity Audit.
- Freedom of Information Act (FOIA) Request: HSAG assisted HFS with compiling documentation in response to a FOIA request.

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 2023. 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 2023.

Table 6-1—HealthChoice Illinois Health Plans for 2023 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 2023 top-box scores to the corresponding 2022 top-box scores. Top-box score results that were statistically significantly higher in 2023 than in 2022 are noted with upward (▲) triangles. Top-box scores that were statistically significantly lower in 2023 than in 2022 are noted with downward (▼) triangles. Top-box scores in 2023 that were not statistically significantly higher or lower than scores in 2022 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

	2022	2023	Trending Results (2022–2023)
Composite Measures			
Getting Needed Care	82.3% ★★	81.4% ★★	—
Getting Care Quickly	78.8% ★	81.0% ★★★	—
How Well Doctors Communicate	93.8% ★★★	91.7% ★★	—
Customer Service	88.2% ★★	90.2% ★★★	—
Global Ratings			
Rating of All Health Care	54.3% ★	55.9% ★★	—
Rating of Personal Doctor	67.7% ★★	66.8% ★★	—
Rating of Specialist Seen Most Often	67.0% ★★	64.3% ★	—
Rating of Health Plan	59.3% ★★	58.0% ★	—

▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
— Indicates the 2023 score is not statistically significantly higher or lower than the 2022 score.

Strengths	None of the experience survey results showed a statistically significant improvement from the prior year; however, experience survey results for *Getting Care Quickly* and *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles. This indicates that members perceived better timeliness of care from and interaction with their health plan when they needed assistance from 2022 to 2023.
Opportunities for Improvement	**Opportunity:** Experience survey results were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service,* which indicates that members perceive a lack of access to care, as well as an overall lack of quality of care. **Why the Opportunity Exists:** Members may have difficulty obtaining the care, tests, or treatments they need. Additionally, providers and specialists may not be spending enough quality time with members or not satisfactorily communicating and addressing members' needs. **Recommendation:** HSAG recommends that the HealthChoice Illinois health plans consider including information about the ratings from the CAHPS survey in provider communications during the year. HealthChoice Illinois health plans could include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Additionally, HSAG recommends that the HealthChoice Illinois health plans consider obtaining feedback from patients on their recent office visit, such as a follow-up call or email, to gather more information concerning areas for improvement.

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)

	2022	2023	Trending Results (2022–2023)
Composite Measures			
Getting Needed Care	79.4% ★	80.4% ★	—
Getting Care Quickly	82.4% ★	83.1% ★	—
How Well Doctors Communicate	93.5% ★★	93.5% ★★	—
Customer Service	90.1% ★★★	86.3% ★★	—
Global Ratings			
Rating of All Health Care	67.6% ★	68.4% ★★	—
Rating of Personal Doctor	77.1% ★★	75.2% ★★	—
Rating of Specialist Seen Most Often	67.1% ★	70.4% ★★	—
Rating of Health Plan	69.0% ★★	69.5% ★★	—

▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
— Indicates the 2023 score is not statistically significantly higher or lower than the 2022 score.

Strengths	HSAG did not identify any strengths for the child CAHPS survey.
Opportunities for Improvement	**Opportunity:** Experience survey results were below the 50th percentile for every measure, which indicates that parents/caretakers of child 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:** Parents/caretakers of child members may have difficulty obtaining access to the care or treatment their child needs, 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. 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 HealthChoice Illinois health plans prioritize improving parents/caretakers' overall experiences with their child's personal doctor and determine a root cause for the poorer performance. As part of this analysis, HealthChoice Illinois health plans could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. Additionally, HSAG recommends that HealthChoice Illinois health plans continue promoting the results of member experiences with its contracted providers and staff members, and soliciting feedback and recommendations to improve parents'/caretakers' overall satisfaction with both HealthChoice Illinois health plans and contracted providers.

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. The 2023 administration of the child CAHPS survey for children with special needs was not yet complete during the reporting cycle; therefore, results will be provided in the SFY 2024 technical report.

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

	2022	2023	Trending Results (2022–2023)
Composite Measures			
Getting Needed Care	78.5% ★	81.5% ★★	—
Getting Care Quickly	79.5% ★	82.4% ★	—
How Well Doctors Communicate	93.6% ★★	94.7% ★★★	—
Customer Service	79.2% ★	86.9% ★★	▲
Global Ratings			
Rating of All Health Care	66.3% ★	67.1% ★	—
Rating of Personal Doctor	74.6% ★	74.6% ★	—
Rating of Specialist Seen Most Often	64.4% ★	75.4% ★★★	▲
Rating of Health Plan	59.0% ★	62.4% ★	—

▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
— Indicates the 2023 score is not statistically significantly higher or lower than the 2022 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).

Experience With Care

Child Statewide

Strengths	Experience survey results show a statistically significant improvement for *Customer Service* and *Rating of Specialist Seen Most Often* measures, which indicates that members perceived better quality of care from their health plan when they needed assistance and better care received from specialists from 2022 to 2023.
Opportunities for Improvement	**Opportunity:** Experience survey results were below the 50th percentile for every measure except *How Well Doctors Communicate* and *Rating of Specialist Seen Most Often*, which indicates that parents/caretakers of child 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:** 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 of child members may feel they are not getting the time they need with their child's provider to obtain and understand needed information or are not being provided with adequate materials that offer further understanding of their child's care. **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

	2022	2023	Trending Results (2022–2023)
Composite Measures			
Getting Needed Care	78.3% ★	82.3% ★	—
Getting Care Quickly	84.4% ★	88.0% ★★	—
How Well Doctors Communicate	91.5% ★	95.1% ★★★	▲
Customer Service	81.1%+ ★+	86.3%+ NA	—
Global Ratings			
Rating of All Health Care	61.8% ★	63.5% ★★	—
Rating of Personal Doctor	70.5% ★	74.0% ★★	—
Rating of Specialist Seen Most Often	64.4% ★	75.7% ★★★	▲
Rating of Health Plan	52.5% ★	55.3% ★	—
CCC Composites and Items			
Access to Specialized Services	58.2% ★	65.3%+ ★+	—
FCC: Personal Doctor Who Knows Child	89.5% ★	90.8% ★	—
Coordination of Care for Children with Chronic Conditions	73.8% ★	81.6%+ ★★★★★+	—
Access to Prescription Medicines	87.2% ★	95.0% ★★★★★	—
FCC: Getting Needed Information	87.1% ★	91.8% ★★★	▲

\+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA indicates that NCQA's 2022 Quality Compass Benchmark and Compare Quality Data were not available; therefore, star results are not available.

▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
— Indicates the 2023 score is not statistically significantly higher or lower than the 2022 score.

Experience With Care

Child Statewide

Strengths	Experience survey results show a statistically significant improvement from last year for *How Well Doctors Communicate*, *Rating of Specialist Seen Most Often*, and *FCC: Getting Needed Information* measures, which indicates that members perceived better quality in how their provider satisfactorily communicated and addressed their needs, including answers to their questions and regarding the care received from specialists from 2022 to 2023.
Opportunities for Improvement	**Opportunity:** Experience survey results were below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Specialized Services*, and *FCC: Personal Doctor Who Knows Child* measures. This indicates that parents/caretakers of child 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:** Parents/caretakers of child members may 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, providers may not be spending enough quality time with members or not understanding how the child's medical, behavioral, or other health conditions are impacting the child's and family's day-to-day life. **Recommendation:** HSAG recommends that Illinois Medicaid and All Kids programs conduct secret shopper calls to a variety of provider specialties to determine if timeliness is an issue within certain provider specialty types. Additionally, HSAG recommends reviewing member-to-provider ratios within access requirements to determine if there are enough in-network providers available to allow for timely appointment scheduling. Furthermore, the Illinois Medicaid and All Kids programs could consider conducting root cause analyses or focus studies to further explore members' perceptions regarding the quality of, timeliness of, and access to care and services they received to determine what could be driving scores to fall below the national averages and implement appropriate interventions to improve performance related to the care members need.

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 2023, 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, identified as important to consumers.[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 if members with behavioral health conditions received appropriate follow-up after hospitalization, ED visit, or high intensity care, as well as measures that assess pharmacotherapy for opioid use disorder and the initiation and engagement of SUD 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 2023 (CY 2022) Report Card based on a number of factors, such as measures that best approximate the reporting categories that are useful to consumers; using data that are available; and using nationally recognized, standardized measures of Medicaid and/or managed care. Fifty-two measures were chosen: 11 CAHPS and 41 HEDIS. 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 compared to the 2022 Quality Compass national Medicaid benchmarks. In addition, HSAG provided consumers with 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 MCOs' average rating in each category improved, declined, or stayed the same from 2022 to 2023 based on comparisons to national Medicaid benchmarks. HSAG computed six reporting category summary scores for each MCO. 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

Due to program changes, such as incorporating SNC 1915(b) waiver populations in HealthChoice Illinois and the statewide expansion of the MLTSS 1915(b) waiver, HFS revised its *Comprehensive Medical Programs Quality Strategy* (Quality Strategy), published in March 2021.

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 and SFY 2024, HSAG will assist HFS with its Quality Strategy evaluation in accordance with CMS' *Quality Strategy Toolkit for States*.[7-2] In addition to addressing the evaluation findings, HFS recognized the need to update its Quality Strategy to incorporate departmental strategic directions. Therefore, HFS worked throughout SFY 2023 to revise its Quality Strategy, scheduled for publication in 2024.

[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. HFS requires that case managers meet certain staffing and training requirements listed in the health plans' contracts.

HSAG reviewed the qualifications and related experience, caseload assignments, general training completion, and waiver-specific training completion for CM staff members. Staffing data were evaluated for non-waiver and HCBS CM requirements. Data were also evaluated for the MLTSS and SNC 1915(b) waivers.

HSAG analyzed contractually required elements of CM 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 2022 biannual staffing and training reviews.

The first biannual review of 2023 included an assessment of internal health plan staff as well as any delegated entities performing CM services,[7-3] and included health plan data for staff members with hire dates on or before April 1, 2023. 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.

[7-3] A delegate is an entity that provides case management on behalf of the health plan. Delegates are separate companies from the health plan, but the health plan is responsible for making sure that they meet the same requirements as the health plan's own employees.

Findings

HealthChoice Illinois

HSAG analyzed health plan compliance with 11 contractually required elements of CM staffing and training in the HealthChoice Illinois contract. YouthCare Specialty Plan's compliance with eight contractually required elements of CM staffing was analyzed. The health plan-specific strengths, opportunities for improvement, and recommendations are described below.

Strengths	• All five HealthChoice health plans (Aetna, BCBSIL, CountyCare, Meridian, and Molina) met all contract requirements related to caseloads. • All of the HealthChoice health plans met qualification/education requirements for case managers with Persons with HIV [human immunodeficiency virus]/AIDS [acquired immune deficiency syndrome] (HIV) waiver caseloads. • Three HealthChoice health plans (BCBSIL, Meridian, and Molina) met qualification/education requirements for case managers with all waiver caseload types. • YouthCare achieved 100 percent compliance for case management supervisor qualifications and credentials.
Opportunities for Improvement	**Opportunity:** Some HealthChoice health plans did not meet the following qualification/education requirements: • Aetna and CountyCare for case managers with Persons with Brain Injury (BI) Waiver or Persons with Disabilities (PD) waiver caseloads. • Aetna for case managers with Persons who are Elderly (ELD) waiver caseloads. **Recommendation:** The health plans should review the qualification/education requirements for the BI, ELD, and/or PD waivers to ensure that only staff with those qualifications are assigned waiver caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those waiver cases reassigned to qualified staff.
	Opportunity: YouthCare was noncompliant with low risk caseload requirements. **Recommendation:** The health plan should develop a plan to reassign caseloads to those case managers not meeting low risk caseload limits.
	Opportunity: YouthCare was noncompliant with case manager credentials requirements. **Recommendation:** The health plan should review the qualification/education requirements to ensure that only staff members with those qualifications are

	assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to caseload assignment. Staff members without the appropriate qualifications should have those cases reassigned to qualified staff members. The health plan may consider submitting exemption requests to HFS for consideration.
	Opportunity: Two health plans (Aetna's delegate PCCE and Molina) had HIV waiver case managers who did not meet related experience requirements. **Recommendation:** The health plans should review the required related experience for the HIV waiver to ensure that only staff members with experience in all five required areas are assigned HIV waiver caseloads and develop a plan to ensure that experience is reviewed prior to waiver caseload assignment. Staff members without the appropriate related experience should have those waiver cases reassigned to qualified staff members.
	Opportunity: Aetna, BCBSIL, CountyCare, and YouthCare had an opportunity to ensure that case managers receive all required trainings. **Recommendation:** The health plans should review their oversight processes to ensure that they are tracking and completing all required trainings prior to the end of each calendar year.

MMAI

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

Strengths	• All MMPs except Molina 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:** Three of the five MMPs (BCBSIL, Meridian, and Molina) had ELD waiver case managers who did not meet qualification/education requirements. **Recommendation:** The MMPs 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 MMPs 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 MMPs may also consider submitting exemption requests to HFS for consideration.

Opportunity: Molina was noncompliant with MMAI weighted and low risk caseload requirements. **Recommendation:** The health plan should develop a plan to reassign caseloads to those case managers not meeting caseload limits.
Opportunity: Molina was noncompliant with HIV case manager related experience requirements. **Recommendation:** The health plan should review the required related experience for the Persons with HIV waiver to ensure that only staff members with experience in all five required areas are assigned HIV waiver caseloads and develop a plan to ensure that experience is reviewed prior to waiver caseload assignment. Staff members without the appropriate related experience should have those waiver cases reassigned to qualified staff members.
Opportunity: BCBSIL had an opportunity to ensure that case managers receive all required trainings. **Recommendation:** The health plan should review its oversight processes to ensure that it is tracking and completing all required trainings prior to the end of each calendar year.

Remediation

Health plans are required to remediate all findings from the first biannual review, which are to be assessed during the 2023 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 may consider requesting additional information from health plans with repeat findings to validate the health plan's progress on redistribution of caseloads or compliance with education/qualification requirements.
- HFS should review the qualification/education requirements for the BI and 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 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.

The health plans that were included in the FY 2023 review are shown in Table 7-1.

Table 7-1—Health Plans in CI Monitoring Review

Health Plan	Population(s) Reviewed
Aetna	HealthChoice, MMAI
BCBSIL	HealthChoice, MMAI
CountyCare	HealthChoice
Humana	MMAI
Meridian	HealthChoice, MMAI
Molina	HealthChoice, MMAI

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. 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 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

HSAG also reviewed the following information to assess the health plans' CI system effectiveness:

- Remediation of recommendations from quarterly reviews.
- Coordination of CI processes between transition of care (TOC) and case management teams.
- Communication with the Adult Protective Services (APS) case worker after receipt of the APS Report of Substantiation (ROS) form.
- CI reporting for falls with and without injury.
- Barriers to utilization of the APS ROS process policy.
- Implementation of internal policy and procedure updates.
- Unable to reach (UTR) process for CIs.

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. • All six health plans demonstrated consistent utilization of processes for communicating with the investigating authority after an initial CI report is made. • All six health plans remediated all CI review findings. • All six health plans demonstrated processes to ensure coordination of CI follow-up TOC and case management teams.
Opportunities for Improvement	**Opportunity:** The six health plans did not uniformly report CIs as a result of an injury from a fall for waiver and non-waiver enrollees. **Why the Opportunity Exists:** The health plans demonstrated varied interpretations of CI categorizations and associated definitions within the April 2022 *HFS Critical Incident Guide*. **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: Aetna, Humana, and Molina demonstrated opportunity for improvement in utilization of their UTR processes prior to closure of the CI.

Why the Opportunity Exists: The health plan staff members demonstrated inconsistent utilization of their CI closure processes, which requires application of the UTR process.

Recommendation: The health plans should evaluate their current oversight processes 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: BCBSIL, CountyCare, Humana, and Meridian demonstrated an opportunity for improvement in timely internal reporting of the CI from the date of CI identification.

Why the Opportunity Exists: Recommendation: The health plan staff members demonstrated inconsistent utilization of processes to create a CI report within one business day from notification of the CI event.

Recommendation: The health plans should reeducate staff members on the expectations for timely internal reporting of CIs from the date of CI identification.

Opportunity: BCBSIL, Humana, and Molina demonstrated an opportunity for improvement in compliance with the APS ROS process policy.

Why the Opportunity Exists: The health plans did not consistently apply their internal procedures to comply with the APS ROS process policy.

Recommendation: The health plans should provide training to staff members on their processes for conducting follow up with the APS case worker and enrollees post receipt of the APS ROS form.

Opportunity: Aetna and Molina demonstrated lack of thorough documentation within the CI report.

Why the Opportunity Exists: The health plan staff members demonstrated inconsistent documentation of the CI event.

Recommendation: The health plans should continue routine training on documentation requirements. The health plans should ensure the training includes who identified the CI event, who reported the CI event, when the CI was identified, where the CI occurred, a thorough narrative of the CI event, and specific information on reporting to the investigating authority.

Opportunity: CountyCare demonstrated lack of timely follow-up with enrollees after identification of the CI.

Why the Opportunity Exists: The health plan identified a gap in continuity between identification of a CI event from the utilization management team and assignment for follow-up from the care coordination team, resulting in a delay of more than two weeks to conduct follow up with the enrollee.

Recommendation: The health plan should continue its implementation of oversight and monitoring of timely CI case assignment and follow-up contact with enrollee after CI identification.

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 2023 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 were provided in quarterly and annual reports that are available upon request.

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 7-2 displays the five HealthChoice Illinois health plans reviewed in SFY 2023.

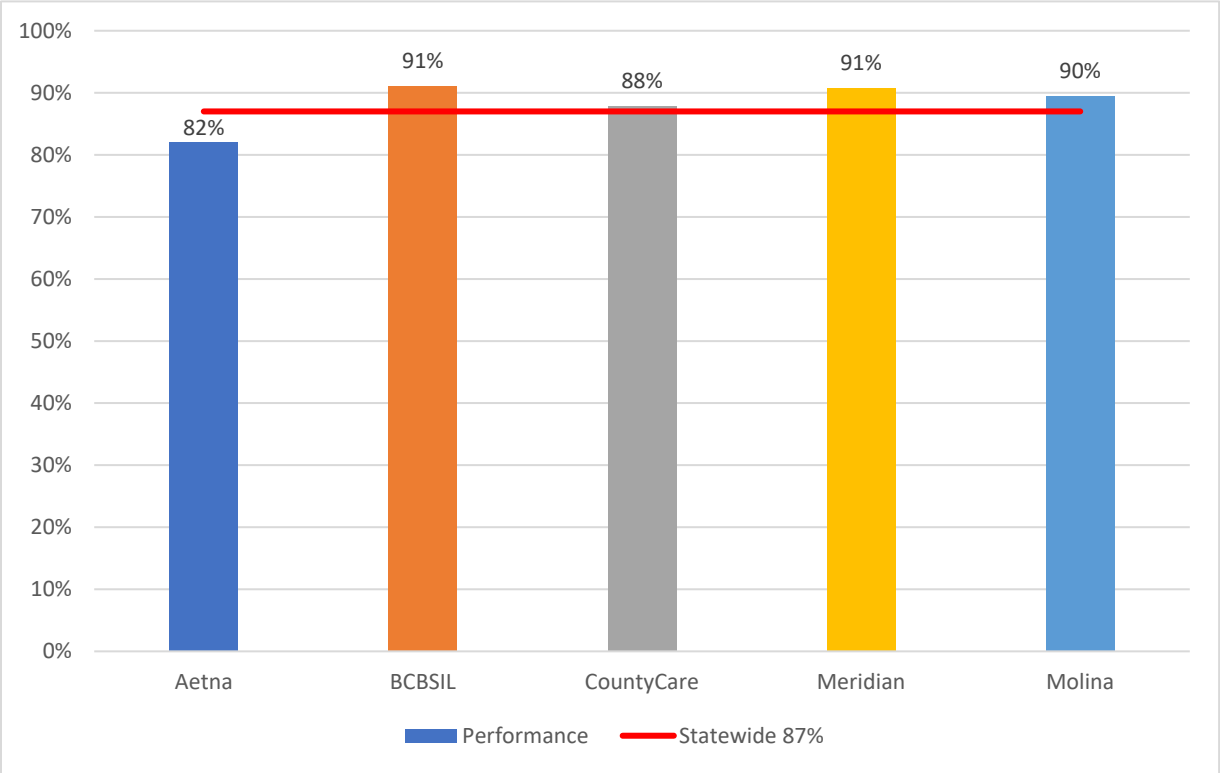
Table 7-2—HealthChoice Illinois Plans Reviewed in SFY 2023

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 2023, 1,498 HealthChoice and 1,546 MLTSS[7-4] records were reviewed using HSAG's web-based data collection tool. As a result, 2,229 HealthChoice and 2,475 MLTSS findings of noncompliance were identified.

Figure 7-1 displays a computed average of the total performance achieved by each health plan on the 21[7-5] 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 2023. There was a 9-percentage-point difference (82 percent to 91 percent) among health plans.

Figure 7-1—Overall HealthChoice Compliance



SFY 2023 represented the sixth year of review for the HealthChoice population, and several successes were identified as well as opportunities for improvement.

7-4 MLTSS enrollees are managed through HealthChoice and included in HealthChoice results. MLTSS-specific results are available upon request.

7-5 The table reflects comparisons across all 21 performance measures reviewed throughout the SFY. At the end of SFY 2023, a total of 18 performance measures were reviewed due to changes in waiver requirements. Comparisons in total reflect the health plans' performance for the entire SFY.

Strengths	• Sixteen of the 21 CMS performance measures averaged 90 percent or greater compliance. • Five performance measures achieved a statistically significant increase in performance when compared to the prior year. • The measures averaging 90 percent or greater compliance indicate that the health plans demonstrated strengths in documenting enrollee risks, needs, goals, and backup plans in service plans; that updates to service plans are being completed when enrollees' needs change; that health plans are ensuring enrollees' choice is honored and documented when selecting services; and that enrollees reported satisfaction with personal services. • Four health plans achieved overall compliance rates higher than the statewide average. • Two of the five waivers averaged greater than 90 percent compliance.
Opportunities for Improvement	**Opportunity:** Aetna performed at a statistically significantly lower rate than all other health plans. **Recommendation:** Aetna should consider reviewing its oversight processes to identify improvements to impact performance.
	Opportunity: All health plans had an opportunity to improve performance on Measure D6 (*the case manager made timely contact with the enrollee or there is valid justification in the record*), which averaged 66 percent compliance. **Recommendation:** • 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. • Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts 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.
	Opportunity: All health plans had an opportunity to improve performance on Measure D7 (*the most recent service plan is in the record and completed in a timely manner*), which averaged 82 percent compliance. **Recommendation:** • 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 expectations and time frames for completion of the annual service plan or valid justification for the delay.

Opportunity: All health plans had an opportunity to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*), which averaged 35 percent compliance.

Recommendation:

- Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured.
- Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.

Opportunity: Aetna, BCSBIL, CountyCare, and Molina also had opportunity to focus efforts on 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 84 percent compliance.

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 HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).

MMAI Record Reviews

Table 7-3 displays the five MMAI health plans reviewed during SFY 2023.

Table 7-3—MMAI Health Plans Reviewed in SFY 2023

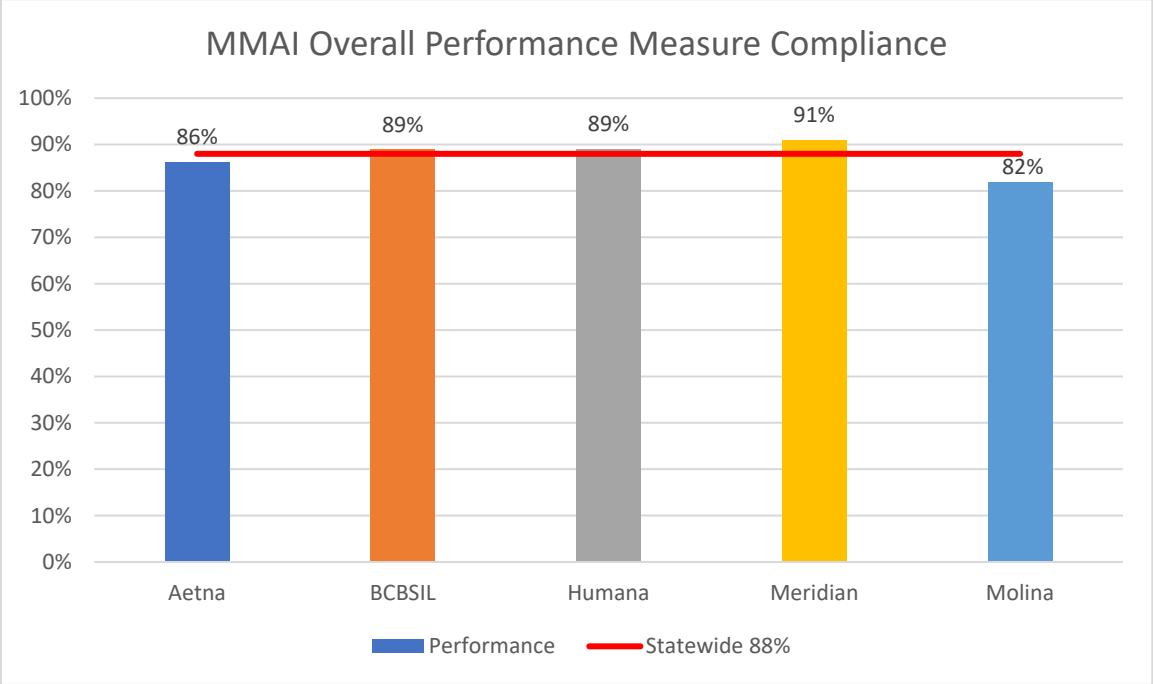
Health Plan Name	Abbreviation
Aetna Better Health Premier Plan	Aetna
Blue Cross Community MMAI	BCBSIL
Humana Gold Plan Integrated	Humana
Meridian	Meridian
Molina Dual Options Medicare-Medicaid Plan	Molina

During SFY 2023, 1,280 records were reviewed using HSAG's web-based data collection tool. As a result, 1,913 findings of noncompliance were identified.

Figure 7-2 displays a computed average of the total performance achieved by each health plan on the 21[7-6] 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. Of the five health plans, only Meridian averaged greater than 90 percent overall compliance in SFY 2023. There was a 16-percentage-point difference (82 percent to 91 percent) among health plans.

[7-6] The table reflects comparisons across all 21 performance measures reviewed throughout the SFY. At the end of SFY 2023, a total of 18 performance measures were reviewed due to changes in waiver requirements. Comparisons in total reflect the health plans' performance for the entire SFY.

Figure 7-2—Overall MMAI Compliance



SFY 2023 represented the ninth 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 performance measures achieved a statistically significant increase in performance when compared to the prior year.
- The measures averaging 90 percent or greater compliance indicate that the health plans demonstrated strengths in documenting enrollee risks, needs, goals, and backup plans in service plans; that updates to service plans are being completed when enrollees' needs change; that health plans are ensuring enrollees' choice is honored and documented when selecting services; and that enrollees reported satisfaction with personal services.
- Three health plans achieved overall compliance rates higher than the statewide average.
- Meridian performed at a statistically significantly higher rate than all other health plans.
- The health plans achieved significant increases in performance for measures impacted by COVID-19 public health emergency (PHE) restrictions, including service plan updates and enrollee signatures.
- Two waivers averaged greater than 90 percent compliance.

Opportunities for Improvement	
	Opportunity: All health plans had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment,* which averaged a 39 percent compliance rate. **Recommendation:** • Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. • Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
	Opportunity: Aetna, BCBSIL, Meridian, and Molina also had an opportunity to focus efforts on 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. **Recommendation:** • 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. • Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required. • Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.
	Opportunity: BCBSIL and Molina had opportunity to focus efforts on Measure D7, *the most recent service plan is in the record and completed in a timely manner,* which averaged an 83 percent compliance rate. **Recommendation:** • 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 expectations and time frames for completion of the annual service plan or valid justification for the delay.

Opportunity: Molina performed at a statistically significantly lower rate than all other health plans.

Recommendation: Molina should consider reviewing its oversight processes to identify improvements to impact performance.

Opportunity: Aetna, BCBSIL, Humana, and Molina had opportunity to focus efforts on 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 83 percent.

Recommendation:

- 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 HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).

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 2023 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.

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*
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 summary for Mobile Crisis Response (MCR) activities including activities, including utilization, outcomes, and hospitalization rates? *Special Needs Children (SNC populations including subsets DCFS Youth in Care and Former Youth in Care)* *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*
12. 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*
13. 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*

Standard
14. 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*
15. 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*
16. 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*
17. 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*
18. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*
19. 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*
20. 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*
21. 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*
22. 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*
23. 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*
24. 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*

General Requirements

HSAG assessed each health plan's FY 2023 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?
- Does the report address the MLTSS and SNC 1915(b) waiver populations, if applicable?
- 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 2023, HEDIS and CAHPS measurement year 2022)?

- Does the report include an evaluation of the efficacy of strategies and interventions to address measures identified as Low and Lowest Performance on the HealthChoice Report Card? *HealthChoice only*
- Does the report include discussion of analysis, initiatives, and opportunities to address health equity, including analysis of geography, disproportionately impacted areas, etc.?
- Does the report include discussion of implementation of the Health Equity Plan? *HealthChoice only*
- Does the report reference MPR statistic reports for all applicable areas (i.e., discussion of care coordination elements/metrics should include references to performance/efforts for MPR measures)? *HealthChoice only*

Qualitative Assessment

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.

For this review, HSAG considered the following criteria as outlined by HFS:

- Did the health plan use appropriate metrics/data to determine successful or unsuccessful outcomes?
- Do the metrics align with the health plan's and HFS' strategies?
- Did the health plan identify metrics that addressed appropriate focus and priority areas?
- Are the actions or goals appropriate to the findings and demonstrate meaningful goals and sufficient opportunity for improvements?
- Did the health plan demonstrate conclusions to fully represent the population served, using all data available?
- Did the health plan correlate internal data to other outcomes/results or opportunities for improvement?
- Did the health plan acknowledge CAPs as appropriate?
- Did the health plan correlate operational area data to other outcomes/results or opportunities for improvement?
- Did the health plan demonstrate effective oversight of delegates?
- Did the health plan demonstrate an effective process for provider network analysis?

Findings and Recommendations

Contract Requirements

Review of the health plans' annual reports identified that all seven health plans achieved a performance score greater than 90 percent; five achieved a performance score of 100 percent. There were no health plans with critical findings that required resubmission of the QA/UR/PR report. Findings included the following:

- Aetna's report included an analysis of quality improvement and work plan monitoring for the HealthChoice population. However, the work plan documentation submitted for the MMAI population was incomplete.
- Humana's report failed to include a robust analysis of the impact of cultural competency trainings and a detailed discussion of process improvements.

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	23	1	0	96% (23/24)
BCBSIL	24	0	0	100% (24/24)
CountyCare	21	0	3	100% (21/21)
Humana	17	1	5	95% (18/19)
Meridian	24	0	0	100% (24/24)
Molina	24	0	0	100% (24/24)
YouthCare	21	0	3	100% (21/21)

General Requirements

Five of the seven health plans demonstrated full compliance with the general requirements. Molina had findings that would be resolved in future reports by ensuring inclusion of evaluation for efficacy of strategies and interventions to address the lowest performance on the HealthChoice report card. CountyCare had a finding that would be resolved in future reports by inclusion of MPR statistic reports for all applicable areas.

Qualitative Assessment

HSAG noted that the health plans' reports demonstrated different maturity and sophistication levels of providing narrative information, drawing conclusions, or assessing data to determine the success of their QA/UR/PR programs. Three of the seven health plans received an assessment score of *Effective*; BCBSIL, CountyCare, Meridian, and YouthCare received a score of *Mature* based on the level of detail and process improvements identified from the prior year.

Recommendations

HSAG offered the following overall recommendations to HFS:

1. 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 2024.

Remediation

As directed by HFS, remediation of findings will be expected to be addressed in the health plans' FY 2024 reports.

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 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 42 CFR Parts 438, 440, and 457; and 45 CFR Part 146.136) and Illinois statute 215 ILCS 5/370c.1,[7-7] HFS and the 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, 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 2022–2023 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 CMS: *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[7-8]

[7-7] 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.

[7-8] 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 June 30, 2022, and addressed HFS' Phase II parity reporting for:
  - Concurrent Review.
  - Retrospective Review.
  - Outlier Management.
  - Failure to Complete.
  - Blanket Exclusions of Services.
  - Exclusions for Court-Ordered Treatment or Involuntary Holds.
  - Provider Type Exclusions.
  - Out-Of-Network Coverage Standards.
  - Geographic Restrictions.
- Review of the health plans' utilization management (UM) documents and information.
- Analysis of M/S and MH/SUD PA denial data, which are self-reported to HFS.
- File review of prior authorization (PA) requests and health plans' decisions, encompassing both M/S and MH/SUD requests.

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.

Overall, the health plans demonstrated parity in policies and procedures across M/S and MH/SUD services and implementation of those policies and procedures. HSAG's observations included the following:

- All health plans used nationally recognized utilization review criteria.
- All health plans' policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that all health plans followed decision-making guidelines. The documentation within the files demonstrated that in all cases, the individual who made the determination possessed the required credentials and expertise to do so.
- All health plans followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions.
- The health plans demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.

Recommendations

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

- HSAG noted that, although all health plans had processes to monitor and analyze MHP, ongoing review to determine enhancements to data stratification may inform areas of focus or opportunities for improvement.
- HFS should monitor CMS Final Rules to determine if changes to focus or assessment areas are applicable to the Medicaid population.
- HFS should develop and select special investigation topics for future single-year analyses. Qualitative assessments and frameworks should be incorporated alongside quantitative assessments as necessary and appropriate for MHP evaluation.

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 2023.

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…."[7-9] 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 accreditation.

[7-9] 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.

HSAG developed the Illinois Managed Care Program NCQA Medicaid Healthcare Maintenance Organization Accreditation status sheet (status sheet), which succinctly displays each health plan's accreditation 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.

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 developing 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.

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 2023, 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://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mapofmanagedcare06012023.pdf?wcmmode=disabled.

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.	2
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.	5
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.	16-18; 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.**	102, 113
4b	• **Objectives.**	96, 108
4c	• **Technical methods of data collection and analysis.**	Appendix C
4d	• **Description of data obtained.**	97, 108–109
4e	• **Conclusions drawn from the data.**	98–101, 103–107, 110–112, 114–116, 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.**	21–22, 29–30, 32–35, 37–38, 40–41, 46–47, 67–68
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.**	76, Appendix F
6b	• **Technical methods of data collection and analysis.**	76, Appendix F
6c	• **Description of data obtained.**	76, Appendix F
6d	• **Conclusions drawn from the data.**	85, 91, 92–93
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–D3 and E1–E2
7b	• **Technical methods of data collection and analysis.**	Section 7, Appendices D1–D3 and E1–E2
7c	• **Description of data obtained.**	Section 7, Appendices D1–D3 and E1–E2
7d	• **Conclusions drawn from the data.**	Section 7, Appendices D1–D3 and E1–E2

Performance Measure Domains

Table A1-2 shows HSAG's assignment of the HEDIS measurement year (MY) 2022 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—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 and *Combination 2*	✓		
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 and *Well-Child Visits for Age 15 Months–30 Months*	✓		✓
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			
Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)	✓		
Controlling High Blood Pressure	✓	✓	
Eye Exam for Patients with Diabetes—Eye Exam (Retinal) Performed	✓		

Performance Measure	Quality	Timeliness	Access
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) and *HbA1c Poor Control (>9.0%)*	✓		
Statin Therapy for People With Diabetes—Received Statin Therapy and *Statin Adherence 80%*	✓		
Adult Behavioral Health			
Diagnosed Mental Health Disorders—Ages 18–64 Years and *Ages 65 and Older*	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 18–64 Years, 7-Day Follow-Up—Ages 65 and Older, 30-Day Follow-Up—Ages 18–64 Years, and *30-Day Follow-Up—Ages 65 and Older*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 18 and Older and *30-Day Follow-Up—Ages 18 and Older*	✓	✓	✓
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 18–64 Years, 7-Day Follow-Up—Ages 65 and Older, 30-Day Follow-Up—Ages 18–64 Years, and *30-Day Follow-Up—Ages 65 and Older*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18–64 Years, 7-Day Follow-Up—Ages 65 and Older, 30-Day Follow-Up—Ages 18–64 Years and *30-Day Follow-Up—Ages 65 and Older*	✓	✓	✓
Initiation and Engagement of Substance Use Disorder Treatment—Initiation of Substance Use Treatment—Ages 18–64 Years, Initiation of Substance Use Treatment—Ages 65 and Older and *Engagement of Substance Use Treatment—Ages 18–64 Years, Engagement of Substance Use Treatment—Ages 65 and Older*	✓	✓	✓
Pharmacotherapy for Opioid Use Disorder—Ages 18–64 Years, Ages 65 and Older, and *Total*	✓	✓	✓
Child Behavioral Health			
Diagnosed Mental Health Disorders—Ages 1–17 Years	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6–17 Years and *30-Day Follow-Up—Ages 6–17 Years*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 13–17 Years and *30-Day Follow-Up—Ages 13–17 Years*	✓	✓	✓
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 13–17 Years and *30-Day Follow-Up—Ages 13–17 Years*	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6–17 Years and *30-Day Follow-Up—Ages 6–17 Years*	✓	✓	✓
Initiation and Engagement of Substance Use Disorder Treatment—Initiation of Substance Use Treatment—Ages 13–17 Years and *Engagement of Substance Use Treatment—Ages 13–17 Years*	✓	✓	✓
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 or a diagnosed prevalence 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
Aetna did not accurately document the data collection process or report the correct baseline performance percentage based on the numerator and denominator documented. HSAG recommended the following: • Address HSAG's PIP validation feedback, references the PIP Completion Instructions, and seek technical assistance for any questions or needed guidance.
Response
a. Describe why this weakness exists: - In the Timeliness of Prenatal Care (TOPC) PIP baseline submission completed in February 2022, HSAG PIP validation feedback was provided the Data Collection Procedures (Step 6) and Data Analysis (Step 7). The data collection process step included information related to manual data and medical record abstraction. Validation feedback stated this information should be removed. In the data analysis section, the numerator digits were transposed (clerical error). While the reported percentage was accurate, the calculation using the stated numerator and denominator did not align.
b. Describe initiatives implemented based on recommendations: • A technical assistance call with HSAG was completed on September 22, 2022. Required changes based on PIP validation feedback and PIP Completion Instructions were implemented as recommended and resubmitted in Remeasurement Year 1 TOPC PIP in January 2023. In the data collection process, the information related to manual data and medical record abstraction was removed. In the data analysis section, the numerator was corrected, and the calculation matched the reported percentage.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Remeasurement Year 1 TOPC PIP received a 100% validation score.
d. Identify any barriers to implementing initiatives: • There were no identified barriers to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • Not Applicable.
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 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. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Organizational: Complex healthcare navigation support, access to providers, overwhelming number of communications. Transportation: Lack of transportation in urban and rural areas, lack of facilities and providers in rural areas Educational: Lack of education/understanding of why wellness checks is important Socio-economic: Lack of time -Work/Kids scheduling & balance, lack of cell phone access. There are 23,387 members that have established with care in their primary practice, yet they have not closed the AAP care gap
b. Describe initiatives implemented based on recommendations: • Targeted Member Outreach for Members assigned to Region 5 low performing providers. Provider Engagement Optimization (Quality Practice Advisors reinforcing and reviewing tip sheets, claims gap reporting review, monthly performance reviews to identify trends and actionable recommendations). MyOwnDoc member outreach; schedule AAP telemedicine visit. Member Enablement Strategies mPulse (IVR & SMS) & Member/Provider Incentives. Pyx: Targeted member outreach AAP Women >50 with a BCS and CCS GiC(10/1/2023).
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Most of the initiatives were implemented in the past six months and we have not yet seen improvement in the measures.
d. Identify any barriers to implementing initiatives: • No barriers identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue Member Enablement Interventions. Coordinate pre-visit planning with providers to convert acute care visits to well care visits. Implement a comprehensive mass marketing campaign in which all member-facing roles actively promote the importance of annual preventive care to members.
HSAG Assessment


Recommendation
HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • Conducted a focus study to determine why Aetna Better Health of Illinois (ABHIL) child members were not receiving the well-child visit as recommended. Data showed that around 94% of the non-compliant membership lived in DIA zip code areas.
b. Describe initiatives implemented based on recommendations: • Implemented a pediatric push member outreach initiative from August to October of 2022, which consisted in partnering with the top pediatricians and PCPs with the most assigned membership with open well child visit HEDIS care gaps prioritizing members living in DIA zip code areas. In addition, HC was included in the 2023 Early Childhood Medicaid Next Best Action (NBA) educational campaign which encourages members to take their children to recommended well-child visits and stay on schedule for recommended vaccinations and screenings thru direct mailer (DM) emails with a link to the campaign landing page or call pod, depending on the member's permissions for the different channels of communication.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • About 3,100 members were outreached during the time of the Pediatric Push intervention for well-child visits. There was a total measure rate increase of 1.79% by the end of the intervention. Overall, the Well-Child Visit HEDIS rate has shown a year-over-year improvement of 2.38% percentage points.
d. Identify any barriers to implementing initiatives: • There were no identified barriers to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to finetune and create member-centered interventions to promote health and wellness for children, improve HEDIS gap closure rates, and help members meet the Bright Future's periodicity schedule and EPSDT's recommended screening services during well-child visits.
HSAG Assessment


Recommendation
HSAG recommended the following: • 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 performance.
Response
a. Describe why this weakness exists: • Conducted a root cause analysis to determine why Aetna child members were not receiving all the recommended vaccines. Data showed that the causes are multifaceted and interconnected. Lack of awareness and education, vaccine hesitancy and misinformation, cultural and religious beliefs are the leading reasons for non-compliance. Internal data showed that the vaccines that were missed the most were Influenza, DTap, and Pneumococcal Conjugate which contribute to lower rates within the Childhood Immunization Status measure.
b. Describe initiatives implemented based on recommendations: • Implemented a pediatric push member outreach initiative, which consisted in partnering with the top pediatricians and PCPs with the most assigned membership with open well child visit HEDIS care gaps, embedded were included non-compliant members for Childhood Immunization Status who were approaching 2 years of age in the upcoming months and had a chance of becoming compliant before their second birthdays. Members with the earlier birthdays were prioritized to ensure compliance. In addition, HC participated in an Aetna National Team Call Pod Pilot to increase vaccine compliance in members 2 years and younger. Aetna HC is also participating in the Pfizer Vaccine Adherence in Kids (VAK) program which provides general education regarding vaccine adherence thru postcards.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • About 1,325 members were outreached during the Pediatric Push intervention who were non-compliant for Childhood Immunization Status and approaching 2 years of age. There was a total measure rate improvement of 1.63% by the end of the intervention. In addition, 372 members were outreached for the NBA call pod campaign which showed an increase in measure rate of 0.57%. Overall, the Childhood Immunization Status HEDIS rate has shown year-over-year improvement 2.74% percentage points.
d. Identify any barriers to implementing initiatives: • There were no identified barriers to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to finetune and create member-centered interventions to promote education around vaccine adherence in children, improve HEDIS gap closure rates, and help members meet the Bright Future's periodicity schedule and EPSDT's recommended preventive services.

HSAG Assessment

Recommendation
HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • To address the root causes of low breast cancer screenings, the root cause analysis found three primary reasons on why the weakness exists; many members avoid breast cancer screenings due to the perceptions that the process is painful and uncomfortable, the fear of receiving a cancer diagnosis deters members from getting screened and members wrongly assume they are not at risk for breast cancer because the lack family history of breast cancer.
b. Describe initiatives implemented based on recommendations: • An intervention strategy was deployed focusing on educating members to address their top concerns and barriers. The strategy included: a. Enhance Provider Education to address evidenced based talking points to increase breast cancer screenings for PCP members b. Grow member awareness and understanding of the facts and myths of breast cancer screening through the Aetna Member Enablement Programs (Health Tags, mPulse SMS/IVR campaigns and Member Incentive Programs, Flyers at Community Events) c. Targeted educational mailers (Mother's Day) d. Member Outreach Campaigns (goal to educate, schedule appointments & arrange transportation) and d. Implement the Pamper Me Pink Program.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The targeted interventions produced the following improved results: 45 care gaps were addressed through the Liberty Creative Solutions Program and 584 were resolved with the Mother's Day Mailer initiative (largest care gaps closed in Region 4).
d. Identify any barriers to implementing initiatives: • Barriers include: a. 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) b. appointment availability and wait times at imaging facilitates c. Transportation timeliness (pick-up, drop-off) & transportation no shows (member & provider) and d. Effectively addressing the challenge of changing members perception of the mammogram process as painful and not necessary due to family history

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

- The continued improvement interventions and strategies include: a. Assess Member Access to Care Barriers (focus groups, outreach campaigns, Member Service assistance). b. Implement new Pyx (vendor) intervention that targets member outreach to women with an AAP open care gap >50 and with BCS and CCS open care gaps. c. Targeted member outreach for provider mammogram event. d. Implement a Pink Hotline assisting members with scheduling mammograms. e. Explore quality vendor Finity program with a targeted member incentive mailer. f. Implement member enablement strategy HealthTags (Oct 1-Dec 31) and g. Utilize year round medical records reviews to discover coding and billing improvement opportunities.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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

Response

a. Describe why this weakness exists:

- Root cause analysis (fishbone method) was performed by a cross-functional workgroup and identified that timely follow-up performance was due to members lacking access to cell phones as well as their homelessness status. Increasing collaborative partnership with behavioral health facilities was also seen as an opportunity to improve follow-up post hospitalizations.

b. Describe initiatives implemented based on recommendations:

- The cross-functional workgroup determined that a member and provider educational initiative about the free cell phone service (LifeLine) should be developed and implemented. The health plan is in the development phase of the materials to be distributed. Once the materials are ready, they will be disseminated through multiple channels by end of Q3 2023 (e.g., face-to-face when feasible at discharge facility, member newsletters, quality provider meetings, member welcome packet, and others). In addition, provider education and incentives program to document Z59 codes are in development to capture homelessness status in order to better inform our strategies and planning. To enhance communication and collaboration with hospitals, the plan's health services team implemented a care manager on-site program with select facilities (5 hospitals, currently, additional partnerships are being explored) in Q1 2023 to collaborate with discharging facility team (e.g., to educate members, assist with appointment scheduling, strengthen partnership with provider).

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

- Currently developing educational content for as access to cell phone initiative. For the on-site staff initiative, follow-up rates for members at the facilities with on-site staff improved from Q1 2023 to Q2 2023 (average rate of members that followed-up at those facilities in Q1 = 34.52% vs Q2 = 48.38%), and was higher than the average rate of members that follow-up after discharge from facilities without an on-site staff member (44.95%), as well as the overall health plan follow-up rate of 45.47% through Q2 2023. Impact on monthly HEDIS rates (FUH) will continue to be analyzed for positive rate improvements (compared to month-over-month, and year over year).

d. Identify any barriers to implementing initiatives:

- No current significant barriers to implementing have been identified.

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

- The data post implementation of free cell phone education initiative will be gathered and analyzed for usage and compared to FUH rates. In addition, future care management on-site partnerships with behavioral health facilities will be included in the quarterly evaluation of follow-up rates for members discharged from those facilities, with opportunities and challenges to be raised during cross-functional workgroup sessions.

HSAG Assessment

Recommendation

HSAG recommended the following:

For the HIV Viral Load Suppression measure, many health plans reported difficulty obtaining viral load data which may be leading to underreporting of performance. HSAG recommended the following:

- Monitor 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.

Response

a. Describe why this weakness exists:

- ABHIL was able to confirm that for the data sharing agreement currently in place lab data is being received from lab vendors

b. Describe why this weakness exists:

- The current status in addition to the data sharing files there is also EMR access with lab vendors to pull lab results.

c. Describe initiatives implemented based on recommendations:

- Our quarter over quarter rates have continuously improved

d. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None
e. Identify any barriers to implementing initiatives: • The plan is to continue to utilize EMR access to confirm that accurate lab values are being captured.
HSAG Assessment

Recommendation
HSAG recommended the following: For the LTSS Comprehensive Care Plan and Update measure, 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. HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • Aetna HC noted limited ability to report from text/narrative fields to determine compliance on a scalable level.
b. Describe initiatives implemented based on recommendations: • Aetna HC completed multiple retrainings with staff to improve documentation to allow for increased reporting. Additionally, Aetna HC worked to develop enhanced reporting through scanning text fields for appropriate documentation to identify opportunities or gaps.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Aetna HC has observed some improvement in scores with the Care Plan and Update measure – waiver cases at 79% and LTC cases at 95%.
d. Identify any barriers to implementing initiatives: • Ongoing hiring of staff requires ongoing re-education to ensure Aetna HC maintains compliance.
e. Identify strategy for continued improvement or overcoming identified barriers: • Aetna HC will continue trainings to ensure compliance with care plan completion to maintain improved performance in this measure. Additionally, Aetna HC continues to modify the oversight report to allow timely identification of gaps in documentation.

HSAG Assessment

Recommendation
HSAG recommended the following: For the LTSS—Successful Transition After Long-Term Institutional Stay measure, the health plans may not be including all enrolled MLTSS members in the eligible population for this measure due to states 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 Opt-Out members in the identification of the eligible population or calculation of observed discharges for the measure. HSAG recommended the following: • Review the process for identifying the eligible population and their data sources for institutional facility claims. • Evaluate clinical review processes 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.
Response
a. Describe why this weakness exists: • Opportunities for increased leadership oversight to ensure clinical reviews are occurring timely to divert long-term nursing facility stays and/or transition of members that are agreeable and able to live independently in a community setting of their choice.
b. Describe initiatives implemented based on recommendations: • Aetna HC has worked closely with Collective Medical to identify new admissions in nursing facilities in Cook County. The intent of this monitoring is to identify and contact members at day 30 or 60 of their nursing home stay to discuss and facilitate transition to the community.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Aetna HC has exceeded annual targets for Community Transition Initiative (CTI) for Colbert members with 25 successfully transitioned before Q4, 2023. Aetna HC is also on track to meet the annual target for Williams members transitions with 5 members already transitioned before Q4, 2023.
d. Identify any barriers to implementing initiatives: • The CTI is limited to Cook County, Aetna HC continues to see issues with data transparency in other regions across the state.
e. Identify strategy for continued improvement or overcoming identified barriers: • Aetna HC is exploring methods to expand reporting to state-wide for increased scope outside the Colbert and Williams Decree members.

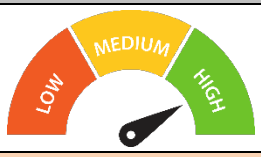
HSAG Assessment

Recommendation
HSAG recommended the following: For the LTSS Successful Transition After Long-Term Institutional Stay measure, Patient Level Detail files were missing a significant number of ZIP Codes, and Aetna reported no data 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. HSAG recommended the following: • Research the historical enrollment data migrated into the data warehouse against the historical raw 83 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. • 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.
Response
a. Describe why this weakness exists: • Aetna reported no data for the LTSS Successful Transition After Long-Term Institutional Stay measure in MY 2018 and eligible populations for MY 2019, MY 2020, and Q1 2021 that were too small to calculate a rate for the measure.
b. Describe initiatives implemented based on recommendations: • Process and system improvements continue to be investigated to clearly identify LTSS members in denominator
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Collaboration from Growth Partners and ABHIL LTSS SMEs to solution system and/or process improvements to integrate LTSS and waiver members' activity from legacy sources into a system we can query.
d. Identify any barriers to implementing initiatives: • No barriers
e. Identify strategy for continued improvement or overcoming identified barriers: • Collaboration from Growth Partners and Aetna HC LTSS SMEs to solution system and/or process improvements to integrate LTSS and waiver members' activity from legacy sources into a system we can query.
HSAG Assessment


3. Prior Year Recommendations for Network Adequacy
Recommendation
In regard to the Access and Availability Telephone Survey, 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. HSAG recommended the following: • Work with HFS to obtain the case-level survey data files to address provider data deficiencies identified during the survey. • Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Additionally, 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.
Response
a. Describe why this weakness exists: • Turnover in staff and/or remote workforce is believed to be the primary cause for the described weakness. In addition, reduction in office staff and/or combining job responsibilities during the PHE is also believed to be a contributing factor. In these instances, education is required for front and back-office staff. Issues with reaching provider offices is generally due to inaccurate or aged provider data within the health plan systems which can result from a lack of supplied accurate/timely information from providers or incorrectly implemented roster loads on the part of the plan.
b. Describe initiatives implemented based on recommendations: • The form is available for use by cross-functional departments to request provider outreach and education where applicable. The Access standards are intentionally shared during the bi-weekly New Provider Orientations/Provider Onboarding and annual trainings. Leverage all provider interactions to help reinforce the need for accurate & consistent rosters on a set cadence to keep internal provider data in-sync with any external changes in the provider environment.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
d. Identify any barriers to implementing initiatives: • No internal barriers to report.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Provider Relations team will include the link to the Access Standards in their email signature for all outbound provider email communications. Ensure all meeting agendas and meeting recaps include Access Standards. The health plan will be disseminating mouse pads for front desk and scheduling staff to allow ease of access to the appointment availability standards moving forward Continue to monitor member complaint/grievances, call center data, and directory audit findings to identify potential areas of improvement for phone number and address accuracy. Reinforce reminder that providers are contractually bound to adhering to appointment availability (Article II section 2.01 subsections a-c of provider agreement). PR staff will also be

establishing a reminder in each provider newsletter as additional visibility to the network. Newsletter communication is shared with providers on a quarterly basis.

HSAG Assessment



Recommendation

In regard to the Access and Availability Telephone Survey, compliance with appointment availability standards was low, especially in the areas of allergy and immunology, pulmonology, and neurology. HSAG recommended the following:

- 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.

Response

a. Describe initiatives implemented based on recommendations:

- Aetna identified appointment availability access for specialist providers in particular as a weakness due to a variety of factors including a higher percentage of closed panels (compared to PCP/BH providers), an influx of membership looking for appointments following PHE restrictions loosening, and educational gaps for providers as it relates to appointment availability standards

b. Describe initiatives implemented based on recommendations:

- The Plan will obtain and review case-level survey data to correct specific deficiencies identified and determine whether there's systemic issues or other root causes contributing to failed outreach outcomes. This information will be reviewed in conjunction with internal appointment availability data provided through a partnership with SPH analytics to highlight any shared trends, areas of concern, and root causes driving 'fails' in this area. Continue to partner with providers on both a local and national level on opportunities to offer telehealth alternatives to in-office visits to give members additional options for timely treatment and counseling. Representatives from the provider experience team reach out to provider offices directly when an appointment availability issue is identified via the call center, G&A team, or other external facing avenues to directly engage & educate the provider on appointment availability standards. The provider experience team leverages provider summits, new provider orientations, and routine visits with providers to share and stress the importance of the availability & access standards as well as revisiting groups' panel statuses in cases where the provider previously indicated they should be closed

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

- Aetna continues to see increased engagement from the provider community with the summits that are offered including larger health systems with numerous specialists on staff. Since the access & availability standards are incorporated into those sessions the wider audience helps

ensure that message is reaching a broader swath of providers. The health plan has seen year over year increases in the number of providers offering telehealth appointments/availability

d. Identify any barriers to implementing initiatives:

- One barrier for improving appointment availability is proactive identification of which providers are communicating to members appointment times beyond the compliance standards. While outreach is made to address once identified, that's still a step removed from preventing the issue, and the subsequent impact to members, in the first place.

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

- Continue to leverage interactions with providers from the provider experience end to educate/reinforce the importance of adhering to the access & availability standards and use other outreach related to directory accuracy to also identify potential appointment access issues preemptively. The health plan will be disseminating mouse pads for front desk and scheduling staff to allow ease of access to the appointment availability standards moving forward to solve for education gaps in that regard

HSAG Assessment

Recommendation

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. HSAG recommended the following:

- 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. 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.

Response

a. Describe why this weakness exists:

- 56 Counties in the state of Illinois have no identifiable oral surgery resources. The existing Oral Surgeons in rural counties of need are moving away from accepting insurance programs all together and are changing their business model to cash payments paid up front.
  For Pharmacy, Aetna HC has identified 6 counties (Champaign, Dekalb, Kankakee, McLean, Sangamon, and Vermilion Counties) which have less than 100% pharmacy coverage. All 6 counties contain an urban city center with a large portion of the county being geographically rural. Given this dynamic, a large majority of the brick-and-mortar pharmacies in these counties are located in the urban centers, with very few pharmacies located in the rural areas. Additionally, despite being largely rural by geography, these counties are entirely categorized as "urban". This categorization extends the urban geo-access pharmacy standard to the rural areas.

Several geographically rural areas within these 6 counties have no physical pharmacy locations, leaving Aetna no options for network solicitation. This becomes an additional reporting issue when an urban time/distance metric standard is applied to these largely rural areas.

b. Describe initiatives implemented based on recommendations:
• Initiatives Implemented:
  • Member Treatment: DentaQuest has a Member Placement team who works with a group of out of network oral surgeons to complete treatment for members in need. This is conducted through our Single Case Agreement process.
  • Aetna offers member transportation services to members who may need to travel farther.
  • OS Recruitment: DentaQuest has been conducting a large on-going recruitment project for OS in the state of IL. In addition, the DentaQuest Provider Engagement team has started the process of recruiting OS providers in boarder states. Pharmacy Initiatives: Aetna HC has continued to monitor pharmacy availability in the rural parts of the 6 counties, which includes identifying new chain, independently owned, or clinic-based pharmacy locations. Any identified pharmacy is outreached for inclusion into Aetna's pharmacy network. Due to the lack of new pharmacy locations in these counties, Aetna HC offers members additional ways to obtain medication, including mail order and delivery of medication directly to the members' home. Additionally, many pharmacy programs that help members with medication adherence and pharmacy counseling are made available telephonically and/or electronically.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Members who require the assistance from our Member Placement team typically receive an Oral Surgeon able to complete the required procedures in under a week. For Pharmacy, performance improvement is directly tied to new brick-and-mortar pharmacy locations in the affected areas, of which there have been none to date. Aetna HC continues to monitor pharmacy availability for changes.
d. Identify any barriers to implementing initiatives: • DentaQuest has made over 300+ calls to active Oral Surgeons. Oral Surgeons in the state of Illinois have requested our recruitment team stop reaching out. Since the majority of Oral Surgeons request an upfront Cash Payment be made, a state program is unable to comply with these requests. For Pharmacy, no new brick-and-mortar pharmacies have been opened in the affected areas to date.
e. Identify strategy for continued improvement or overcoming identified barriers: • DentaQuest will continue to use the existing Single Case Agreement process to assist with members OS needs. While doing so, we will continue our out of state recruitment project which has seen some success. For Pharmacy, Aetna HC will continue to monitor new pharmacy availability and closures, promptly adding pharmacies to the Aetna IL network when gaps are identified. In areas where pharmacy availability is continually challenged, Aetna HC will provide alternative ways to obtain medication, and help members take advantage of pharmacy programs.

HSAG Assessment

4. Prior Year Recommendations for CAHPS:
Recommendation
HSAG recommended the following for adult CAHPS: • Conduct a root cause analyses or focus studies to that include health plan enrollees to address results of adult CAHPS experience surveys.
Response
a. Describe why this weakness exists: • A. Rating of Personal Doctor: Much of patient dissatisfaction stems from a lack of effective physician communication (listening, respect, spending enough time) and Practitioners for different service types are located far from one another. B. Getting Needed Care: Improving Health Plan Provider Network Availability of BH, Licensed Clinical Professional Counselors, Dental Providers, Member perception of appointment availability challenges and options such as Telehealth (engage Physical and Behavioral Health Care), Healthcare navigation challenges and/or lack of knowledge regarding plan level services, benefits, incentives and providers, Transportation timeliness (pick-up, drop-off) & transportation no shows (member & provider). C. Customer Service: Potential inconsistency in services & communication provided by Member Facing staff.
b. Describe initiatives implemented based on recommendations: • Initiatives include: Conduct Member Research Quantitative and Qualitative Study (Understand the human dimensions of members – their needs, barriers to care, experiences, expectations, and perceptions, Administer Member Satisfaction Off Cycle Surveys, Administer Member PCP Engagement Off Cycle Surveys, Implement CAHPS Member Facing Staff Training (Implement 5 Solution Starters) & Training Reinforcement Strategies, Conduct Member Barrier Analysis Survey (Feedback & observations from member facing staff), Implement CAHPS Outreach Interventions, Enhance and implement CAHPS Provider Education, Increase Member participation in the CAHPS survey – oversampling strategy, Implement Cross Functional Member & Provider Satisfaction Work Group (includes members and providers),Increase member participation in Member Committees, Increase Member Education on PCP engagement, appointment standards, incentives and benefits and Conduct Monthly Member Services Call Calibrations (identify member engagement improvement opportunities).
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Getting Needed Care (% Always or Usually) improved measure performance by 1.25% (3 star rating), Rating of Personal Doctor (% 9 or 10) improve measure performance by .90% and Improved CAHPS Survey response rate by .94 for 2023 over 2022 | 2023 response rate of 14.27% and 2022 response rate of 13.33%

d. Identify any barriers to implementing initiatives:

- Barriers include: 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), Research Study finding: Members in DIA zip codes do not feel the quality of their physician pool is good and Member confidence in the Transportation Services.

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

- A. Enhance Provider CAHPS education forums (Orientation, ongoing training and evidenced based member engagement resources), B. Implement the 5 Solution Starters (AIDET Model, Meaningful Messaging, Overcoming Belief Bias, Empathetic Listening and Service Recovery) with every member engagement to transform the member experience with Member Services, Care Management, Grievances & Appeals, Quality Management and the Community Outreach staff, C. Increase off cycle surveys to monitor PCP & Specialist engagement with members, D. Execute Member Contact Platform for improved connection to members through SMS/Text, IVR, Live Call, Mailing and Email, E. Install a Voice of the Customer Program (regular quantitative and qualitative feedback from members and providers), F. Implement strategies to Help Patients Communicate with their PCP & Specialists and G. Implement comprehensive Marketing campaign to elevate Member understanding and preparation for the 2024 CAHPS survey

HSAG Assessment

Recommendation

HSAG recommended the following for child CAHPS:

- Conduct a root cause analyses or focus studies to that include health plan enrollees to address results of child CAHPS experience surveys.
- Evaluate child member access and 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 why this weakness exists:

- A. Rating of Personal Doctor: Much of patient dissatisfaction stems from a lack of effective physician communication (listening, respect, spending enough time) and Practitioners for different service types are located far from one another. B. Getting Needed Care: Improving Health Plan Provider Network | Availability of BH, Licensed Clinical Professional Counselors, Dental Providers, Member perception of appointment availability challenges and options such as Telehealth (engage Physical and Behavioral Health Care), Healthcare navigation challenges and/or lack of knowledge regarding plan level services, benefits, incentives and providers, Transportation timeliness (pick-up, drop-off) & transportation no shows (member & provider).

C. Customer Service: Potential inconsistency in services & communication provided by Member Facing staff
b. Describe initiatives implemented based on recommendations: • Initiatives include: Conduct Member Research Quantitative and Qualitative Study (Understand the human dimensions of members – their needs, barriers to care, experiences, expectations, and perceptions, Administer Member Satisfaction Off Cycle Surveys, Administer Member PCP Engagement Off Cycle Surveys, Implement CAHPS Member Facing Staff Training (Implement 5 Solution Starters) & Training Reinforcement Strategies, Conduct Member Barrier Analysis Survey (Feedback & observations from member facing staff), Implement CAHPS Outreach Interventions, Enhance and implement CAHPS Provider Education, Increase Member participation in the CAHPS survey – oversampling strategy, Implement Cross Functional Member & Provider Satisfaction Work Group (includes members and providers),Increase member participation in Member Committees, Increase Member Education on PCP engagement, appointment standards, incentives and benefits and Conduct Monthly Member Services Call Calibrations (identify member engagement improvement opportunities).
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Rating of Personal Doctor (% 9 or 10) improved measure performance by .77% , Rating of Health Plan (% 9 or 10) improved measure performance by .95%, Coordination of Care (% Always or Usually) improved measure by 3.28% and Improved CAHPS Survey response rate by 1.02% for 2023 over 2022 | 2023 response rate of 16.55% and 2022 response rate of 15.53%
d. Identify any barriers to implementing initiatives: • Barriers include: 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), Research Study finding: Members in DIA zip codes do not feel the quality of their physician pool is good and Member confidence in the Transportation Services.
e. Identify strategy for continued improvement or overcoming identified barriers: • A. Enhance Provider CAHPS education forums (Orientation, ongoing training and evidenced based member engagement resources), B. Implement the 5 Solution Starters (AIDET Model, Meaningful Messaging, Overcoming Belief Bias, Empathetic Listening and Service Recovery) with every member engagement to transform the member experience with Member Services, Care Management, Grievances & Appeals, Quality Management and the Community Outreach staff, C. Increase off cycle surveys to monitor PCP & Specialist engagement with members, D. Execute Member Contact Platform for improved connection to members through SMS/Text, IVR, Live Call, Mailing and Email, E. Install a Voice of the Customer Program (regular quantitative and qualitative feedback from members and providers), F. Implement strategies to Help Patients Communicate with their PCP & Specialists and G. Implement comprehensive Marketing campaign to elevate Member understanding and preparation for the 2024 CAHPS survey

HSAG Assessment

5. Prior Year Recommendation for Care Management Staffing

Recommendation

HSAG recommended the following for HealthChoice:

- 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.

Response

a. Describe why this weakness exists:

- Challenges with leadership oversight and execution to ensure compliance with contractual requirements.

b. Describe initiatives implemented based on recommendations:

- Effective January 2023, Aetna HC made significant organizational changes in an effort to increase and improve leadership oversight, compliance, and accountability. Initiatives include: hiring a new LTSS director, dedicating leadership staff to support trends noted by HSAG and HFS, and increased reporting and leadership meetings to ensure clarity and transparency in areas of opportunities. Aetna HC completed a deep-dive review of all findings from the latest staffing workbook feedback and is working to reconcile identified gaps.

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

- Aetna HC has made strides in overall compliance with Care Coordination assignment, timeliness of care coordination activities and follow-up to ensure timely and appropriate assignment of enrollee cases to staff. Of the 14 staff listed HC has identified the following: One (1) is no longer employed with Aetna. Five (5) meet the qualifications under 1.1.3.3 and 1.1.2.8. Eight (8) are under review to determine if the workbook did not include sufficient information or if the caseload assignments should be adjusted.

d. Identify any barriers to implementing initiatives:

- Challenges with incumbent staff noncompliance remains a challenge. Additionally, workforce challenges remain an issue in some geographic areas that Aetna HC continues to work on resolving.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Aetna HC will share findings of deep-dive with HSAG and HFS to review staff that Aetna HC believes met the contractual requirements versus staff that require an exemption request for consideration.

HSAG Assessment

6. Prior Year Recommendations for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Limited oversight and automation in critical incident reporting and tracking prevents Aetna HC leaders from reviewing adherence to critical incident processes prior to closure for all incidents. This requires a significant number of manual reviews.

b. Describe initiatives implemented based on recommendations:
- HC has dedicated leaders on the LTSS waiver and long term care (LTC) teams to oversee and audit critical incidents to ensure compliance with processes prior to closure. Additionally, Aetna HC has developed a suite of reports to aid monitoring of critical incident follow-ups and timely resolution prior to closure. Aetna HC has completed ongoing trainings with staff to re-educate care coordinators on the end-to-end process and expectations when documenting and following up on a critical incident.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Aetna HC has observed improvements in timely follow-up and documentation in reviews. In the recent HSAG critical incident quarterly audit, Aetna HC scored 100%.

d. Identify any barriers to implementing initiatives:
- Ongoing barriers identified include performance management with lower performing staff that demonstrate non-compliance with internal processes. Additionally, Aetna HC has observed that documentation of details related to a critical incident remains in a text narrative format, making it challenging for reporting oversight.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Aetna HC is exploring the creation of a form that lives within the clinical system for critical incident reporting. The form would include reportable fields for information related to the

critical incident such as who reported the incident, the type of incident, etc. In these fields, staff will include if members are residing in a facility and if the facility was contacted. This form will allow care coordinators to document unlimited details related to the critical incident and allow for reporting on the incident to decrease manual oversight and auditing and increase the ability for leaders to monitor.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Hiring to fill large staffing gap in 2022 created training opportunities for appropriate follow-up including related to follow-up with investigating authorities after an initial CI report has been made.

b. Describe initiatives implemented based on recommendations:
- Aetna HC has implemented trainings related to critical incident reporting, documentation, and follow-up for care coordination staff. Included in this training is guidance regarding how and when to follow-up with investigating authorities such as Adult Protective Services (APS). Training was completed on 5/11/2023. Job aids were also updated and distributed to staff.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Aetna HC scored 100% on the most recent HSAG critical incident quarterly audit. HC feels this score reflects the impacts of improvements made to critical incident documentation.

d. Identify any barriers to implementing initiatives:
- Care Coordination staff attrition increases risk of noncompliance with workflows and processes as new staff join the team.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Aetna HC has training planned in October 2023 to ensure all care coordination staff have regular refreshers around critical incident documentation standards and follow-up requirements.

HSAG Assessment

7. Prior Year Recommendations for HCBS Waiver Performance Measures (HealthChoice and MLTSS):
Recommendation
Aetna demonstrated a statistically significant decrease in five performance measures (35D, D6, D7, D8, and G1) in SFY 2022 when compared to SFY 2021. HSAG recommended the following: • Focus improvement efforts on measures 35D, D6, D7, D8, and G1. Strengthen internal audit processes to focus on the remediation findings that result from each quarterly review.
Response
a. Describe why this weakness exists: • Insufficient leadership oversight, significant staffing challenges and lack of transparency in reporting and monitoring resulted in decreases in the five (5) performance measures listed above (35D, D6, D7, D8, and G1).
b. Describe initiatives implemented based on recommendations: • HC has dedicated leaders on the LTSS waiver and long term care (LTC) teams to oversee and audit critical incidents to ensure compliance with processes prior to closure. Additionally, Aetna HC has developed a suite of reports to aid monitoring of critical incident follow-ups and timely resolution prior to closure. Aetna HC has completed ongoing trainings with staff to re-educate care coordinators on the end-to-end process and expectations when documenting and following up on a critical incident.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • A key metric in the suite of monitoring reports is tracking enrollee contact compliance. Ongoing quarterly audits evidence improvement in D6, directly relating to enrollee contact. Similarly, Aetna HC saw a slight improvement in 35D, a topic covered in multiple trainings. Despite a slight decline, Aetna HC maintained performance over 90% in D8. Aetna HC continues to work to improve our performance in measures D7 and G1.
d. Identify any barriers to implementing initiatives: • Return to face-to-face visits has slowed momentum and productivity slightly as travel time has increased. This may impact timeliness performance measures such as D7. With the improvements in oversight and monitoring made, performance management efforts have also increased. This has resulted in some attrition, impacting compliance with timeliness of care coordination activities in some areas.
e. Identify strategy for continued improvement or overcoming identified barriers: • Aetna HC is continuing to improve reports to increase oversight and improve compliance with care coordination activities. Additionally, Aetna HC is reviewing clinical system enhancements to create efficiencies for care coordination documentation. In Q4 2023, Aetna HC will focus small-group care coordination trainings on the opportunities identified through chart reviews, including performance measure gaps.

HSAG Assessment

Recommendation
HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*: • 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).
Response
a. Describe why this weakness exists: • Insufficient leadership oversight, significant staffing challenges and lack of transparency in reporting and monitoring resulted in lower performance for measure 35D.
b. Describe initiatives implemented based on recommendations: • In Q4 2023, Aetna HC developed a suite of monitoring reports to improve tracking and transparency across multiple performance measures. Aetna HC demonstrated the use of these reports by all levels of leadership for HFS and HSAG in January 2023 and March 2023. The reports assist care coordination staff with planning for upcoming visits. In addition to report enhancements, Aetna HC set up care coordination small-group trainings to re-educate staff on care coordination requirements, documentation standards, and answer questions. In Q2 2023, Aetna HC worked closely with the enterprise audit teams to implement and updated monthly audit tool that audits for all care coordination elements including the above performance measures. 110 audits are completed monthly and the scores are shared with the care coordinator who was audited and their supervisor. Included in these audits are reviews focused on timely service plan updates, verbal consent documentation and specific documentation guidelines during the PHE and the post-PHE unwinding.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Aetna HC has shown significant improvement in timely contact and care coordination efforts over the past nine (9) months. Overall, timely contact has improved from 70% in October 2022 to 88% in June 2023. Aetna HC's last quarterly audit showed compliance scores of 71% HCI and 66% MLTSS. Despite the improvement in timeliness, Aetna HC sees challenges with scoring 90% or higher in this performance measure.

d. Identify any barriers to implementing initiatives:
- Return to 100% face-to-face visits has slowed momentum and productivity slightly as travel time has increased. This may impact timeliness performance measures including 35D. With the improvements in oversight and monitoring made, performance management efforts have also increased. This has resulted in some attrition, impacting compliance with timeliness of care coordination activities in some areas. Additionally, there continues to be manual review required, creating a risk of incomplete oversight/monitoring.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Aetna HC is exploring the development of a reportable mechanism to enter service delivery information in a reportable form. This would allow increased oversight and tracking.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D6, the case manager made timely contact with the enrollee or there is valid justification in the record:
- 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.

Response

a. Describe why this weakness exists:
- Insufficient leadership oversight, significant staffing challenges, and lack of transparency in reporting/monitoring resulted in low performance for Measure D6 and delayed timely contact with enrollees.

b. Describe initiatives implemented based on recommendations:
- In Q4 2022, Aetna HC developed a suite of monitoring reports to improve tracking and transparency across multiple performance measures. Aetna HC demonstrated the use of these reports by all levels of leadership for HFS and HSAG in January 2023 and March 2023. The

reports assist care coordination staff with planning for upcoming visits and monitors timely contact with enrollees. The report also captures caseloads by Care Coordinator for monitoring workload and compliance with HIV and BI waivers. In addition to reporting, Aetna HC set up care coordination small-group trainings to re-educate staff on care coordination requirements, documentation standards, and answer questions. In Q2 2023, Aetna HC worked closely with enterprise audit teams to implement an updated monthly audit tool that audits for all care coordination elements, including the above performance measures. 110 audits are completed monthly. Scores are shared with the Care Coordinator audited and supervisor. Included in these audits are reviews focused on contractual elements, including timely contact with enrollees.

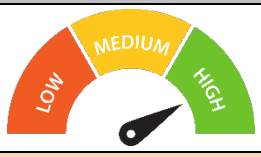
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Significant progress has been made with D6 as evidenced via quarterly audits and ongoing reporting. Aetna HC reports improvement in timely contact from 70% in October 2022 to 88% in June 2023. Aetna HC has been able to maintain 85% compliance and higher since March 2023.

d. Identify any barriers to implementing initiatives:

- Return to 100% face-to-face visits has slowed momentum/productivity slightly as travel time has increased. This may impact timeliness performance measures, including 35D. With the improvements in oversight and monitoring made, performance management efforts have also increased. This has resulted in minimal attrition, impacting compliance with timeliness of care coordination activities in some areas. When partnered with workforce challenges in certain areas of the State, compliance may be impacted.

HSAG Assessment



Recommendation

HSAG recommended the following for Measure D7, *the most recent service plan is in the record and completed in a timely manner*:

- 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.

Response

a. Describe why this weakness exists:

- Insufficient leadership oversight, significant staffing challenges, and lack of transparency in reporting/monitoring resulted in low performance for Measure D6 and delayed timely contact with enrollees.

b. Describe initiatives implemented based on recommendations:

- In Q4 2022, Aetna HC developed a suite of monitoring reports to improve tracking and transparency across multiple performance measures. Aetna HC demonstrated the use of these reports by all levels of leadership for HFS and HSAG in January 2023 and March 2023. The reports assist care coordination staff with planning for upcoming visits, care plan/service plans, and monitors timely contact with enrollees. In addition to reporting, Aetna HC set up care coordination small-group trainings to re-educate staff on care coordination requirements, documentation standards, and answer questions. In Q2 2023, Aetna HC worked closely with enterprise audit teams to implement an updated monthly audit tool that audits for all care coordination elements, including the above performance measures. 110 audits are completed monthly. Scores are shared with the Care Coordinator audited and supervisor. Included in these audits are reviews focused on contractual elements, including timely contact with enrollees.

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

- Aetna HC has seen improvement with overall timeliness in care coordination compliance, including service planning. Overall care planning/service planning compliance has increased to above 80%. July 2023 and August 2023 audits show ongoing opportunities for improvement with quality of service plans.

d. Identify any barriers to implementing initiatives:

- Audit methodology issues were identified with the audit parameters that resulted in inflated non-compliance in internal audits. Aetna HC has reviewed the concern with the performance optimization/audit teams for corrections going forward.

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

- Audit results show slightly improvement in September 2023 audits to date. Performance of timeliness and quality of charts increased from 56% to 69% in two months. Aetna HC is internally reviewing opportunities to improve the overall format of the service plan (and will share with HFS for approval prior to operationalizing). Trainings and 1:1 reviews to improve compliance and quality will continue.

HSAG Assessment

8. Prior Year Recommendations for HCBS Waiver Performance Measures (MMAI):

Recommendation

HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*:

- 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.
Response
a. Describe why this weakness exists: • The health plan experienced heightened staff turnover, which greatly contributed to overdue service plans identified in our HCBS waiver audits. The Case management staff were also allowing members a choice of having a witness on the call during telephonic service plan coordination instead of requiring a documented verbal consent witness.
b. Describe initiatives implemented based on recommendations: • The health plan addressed case manager attrition by offering sign on bonuses, increasing case management salaries, providing overtime to current staff to manage open caseloads, hiring temporary case management staff, adjusting/updating new hire trainings, and implementing a new hire mentoring program and curriculum. The health plan has improved processes related to Measure 35D through re-educating case management staff to require a documented verbal consent witness on the weeks of 1/2/23 and 6/5/23. Workflow documents have since been updated to reflect the required verbal consent witness. Prior to the update to the workflows, MMAI case management staff presented the verbal consent witness as optional to the member during telephonic review of service plans. Case management staff have returned to the field for HCBS as of 7/3/2023 and are now obtaining physical signatures at face-to-face visits. HSAG recommended MMAI and Aetna HC alignment to improve oversight, which occurred. The following implementation has taken place since recommendations were received: A weekly CM Dashboard report sent to staff and reviewed by leadership to track compliance and get ahead of service plans going overdue, weekly and monthly CM Productivity Snapshot review by supervisors to ensure productivity meets expectations, and a Daily 15-Day Report was implemented to ensure 15-Day members have service plans and authorizations in place by the 15th day of enrollment. Staff have on demand access the CM Dashboard to track and monitor due dates for contractual due dates independently and their direct manager reviews barriers to timeliness during one on one meetings with case management staff at least monthly.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We anticipate marked performance improvement by the next HSAG audit scheduled for 12/2023. HSAG provided remediation feedback during the remediation call held 3/14/23, which will correspond with the upcoming lookback period.
d. Identify any barriers to implementing initiatives: • There were no identified barriers with implementing initiatives, which are all currently in place.
e. Identify strategy for continued improvement or overcoming identified barriers: • The health plan is consistently monitoring metrics including Measure 35D through reporting, the CM Dashboard, and staff one on one discussions involving metrics oversight. The current barrier continues to be staffing, which has improved since the HSAG audit that occurred in May 2023.

HSAG Assessment

9. Prior Year Recommendations for QA/UR/PR Annual Report:
Recommendation
HSAG recommended the following: • Include a detailed analysis of access and utilization of dental services.
Response
a. Describe why this weakness exists: • Offices slowly opening back up from COVID shutdowns with the IL State of Emergency still in effect. Dentaquest limitations with only being able to contract providers who are IMPACT credentialed.
b. Describe initiatives implemented based on recommendations: • Statewide Provider Engagement Recruitment Project: Enhanced recruitment and utilization reporting provided.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Provider Recruitment
d. Identify any barriers to implementing initiatives: • Low IL fee schedule and providers moving to a non-insurance business model. Decline in the dental workforce which is impacting capacity at many clinics.
e. Identify strategy for continued improvement or overcoming identified barriers: • Single Case Agreements and utilization of out of state providers. Partnering with State of IL on the workforce grant that has planned recruitment and education for the IL Dental workforce in 2024.
HSAG Assessment

10. Prior Year Recommendations for Mental Health Parity Review:
Recommendation
HSAG recommended the following: • Review the systems and processes responsible for denial 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.
Response
a. Describe why this weakness exists: • Unanticipated staff turnover, which leads to new staff being hired and requiring ongoing education and training during new hire orientation periods
b. Describe initiatives implemented based on recommendations: • HealthChoice received the readability protocol on February 17, 2022. It was immediately distributed to all necessary team members. HealthChoice currently utilizes the Spelling & Grammar feature within Microsoft Word to calculate the Flesch-Kincaid Grade Level as listed in the protocol. This process is monitored by the Internal Audit team during quarterly audits. Spot audits by all Utilization Management Managers also occur periodically outside of the formal audit process, in the context of reviewing charts as part of supervision, medical necessity consultations, TAT management and other regular business reviews; any issues with readability would be addressed at this time. In addition, as HealthChoice is currently in the NCQA look-back period (08/2022-08/2023), mock audits with the Quality team are occurring on a regular basis
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From August 2022 through June 2023, the Quality Department has conducted monthly mock audits with the Utilization Management teams in preparation of the 2023 NCQA survey. All mock audits included monitoring of appropriate member reading levels being used. No files reviewed during mock audits identified concerns with readability.
d. Identify any barriers to implementing initiatives: • Anticipated barriers include unplanned staff turnover and unanticipated systems issues.
e. Identify strategy for continued improvement or overcoming identified barriers: • HealthChoice continues to engage in regular auditing and ongoing training opportunities for all staff involved in using and assessing the use of appropriate member readability compliance.
HSAG Assessment

Recommendation
HSAG recommended the following: • Ensure and demonstrate that adverse benefit determination decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).
Response
a. Describe why this weakness exists: • Unanticipated staff turnover and intermittent systems issues.

b. Describe initiatives implemented based on recommendations: • All Managers within the HealthChoice Utilization Management Department monitor timeliness of decisions twice per day through real-time reporting updated every 15 minutes. In addition, HealthChoice is currently in the NCQA look-back period which includes additional auditing of all denials through the Quality department to ensure written notifications are timely. Reporting monitoring has been developed specifically to enhance the ability to monitor that decision notifications occur within required timeframes.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Monthly mock audits conducted by the HealthChoice Quality Department over the last 12 months have resulted in 100% timeliness compliance for all but one authorization reviewed, with development of enhancements to report monitoring occurring since that time. HealthChoice Utilization Management Managers continue to monitor timeliness at a minimum of twice per day with reports refreshing every 15 minutes, resulting in continued notification of decision occurring within expected timeframes.
d. Identify any barriers to implementing initiatives: • Barriers include unanticipated staff turnover leading to increased caseloads, as well as intermittent systems issues that are identified within timeframes that do not allow for timely processing.
e. Identify strategy for continued improvement or overcoming identified barriers: • HealthChoice continues to proactively monitor system functioning to anticipate any barriers that could lead to untimely notification, as well as opportunities for continued development of reporting to enhance ability to monitor timeliness.
HSAG Assessment


Blue Cross Blue Shield of Illinois

1. Prior Year Recommendation for Performance Measures:
Recommendation
HSAG recommended the following: • 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. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • The root cause analysis to determine why members are not consistently accessing preventive and ambulatory services reveals that 58% of members who live in disproportionately impacted areas have open care gaps related to accessing preventive and ambulatory services. Disproportionately Impacted Areas (DIA) are likely to report lower levels of health literacy. The health disparities are amplified in DIA zip codes in Chicago Metro area and rural IL, where there is a lack of community infrastructure allowing access to services and programs promoting wellness. 55% of members residing in DIA zip codes in the Chicago Metro area and 63% of members residing in DIA zip codes in rural IL have preventive and ambulatory services care gaps.

b. Describe initiatives implemented based on recommendations:
• To address barriers of health literacy and improving access to wellness promotions, the following initiatives were implemented:
  • Partnered with HealConnect to send text messages to members who have open care gaps for the HEDIS® Adult's Access to Preventive/Ambulatory Health Services (AAP) measure was sent in April 2023
  • Collaborated with providers Howard Brown Health Center and Southern Illinois Healthcare Foundation (SIHF) in SFY 2023, and Medimore Unity Point starting June 2023. Howard Brown Health Center serves the Chicago metro area, and SIHF and Medimore Unity Point serve rural Illinois. These providers serve a large population of members who reside in DIA zip codes. Providers are asked to outreach members who have open care gaps and are provided member educational materials to empower members to be health advocates, as well as SDoH resource information to remove barriers that prevent members from attending their preventive care appointments.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HealConnect text initiative has shown an 11-percentage point increase in the number of AAP care gap closures since its launch in April 2023 until the end of the state fiscal year in June 2023. • Collaborating with provider partners has shown improvement in the number of AAP care gaps closed. Howard Brown Health Center closed an average of 71% of their open care gaps. This is 7-percentage points higher than their SFY2022 rates. SIHF closed 56% of their open care gaps in

SFY2023, which is a 13-percentage point increase from their SFY 2022 rates. Being that partnership with Medimore Unity Point has just started June 2023, future data analysis of care gap closure improvements will be conducted as it becomes available.

d. Identify any barriers to implementing initiatives:

- Members could not be outreached due to outdated member contact information, which was a barrier for the text and provider partner outreach.
- Lack of text consent has been the prevalent barrier to sending members the text outreach.

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

- To overcome the barrier of outdated member contact information Unable-to-Reach (UTR) letters are mailed to members who were unreachable by text or phone call, with instructions on how to contact BCBSIL to update their contact information.
- To address the lack of text consent, the HealConnect team is contacting members via phone call to obtain text consent.
- Continued care gap closure rate monitoring and analysis will be conducted to identify areas with high open care-gaps and determine the most appropriate interventions to address barriers based on analysis findings.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- Based on root cause analysis conducted, it was determined that members who live in Disproportionately Impacted Areas (DIA) zip codes had the highest amount of non-compliance for dental visits. A total of 39.25% of members who are non-compliant for annual dental visits live in DIA zip codes based on our analysis.

b. Describe initiatives implemented based on recommendations:

To improve compliance with annual dental visits, several initiatives were implemented:

- Smiling Stork Campaign: Flyer sent to members who are pregnant via mail to remind them of dental services. Educational flyer: Quick Guide to your child's Oral Health" sent to mothers and mothers to be. Educational webpage focus on pregnant women and children. Number of mailers sent Feb 2022- November 2022: 10,541, Number of mailers Jan-June 2023: 3,917. This Campaign was implemented 2/8/2022, and will continue in SFY 2023

- Dental Home Campaign: Dental home is a behavior modification program for the provider and child member. For the provider they are incentivizing providers who do well will be sent more members and vice versa providers who do not perform well will have members taken away. For the members, they have a provider much like a primary care provider. Number of mailers sent in May-December 2022: 802,090 (this is combined BCCHP and MMAI), Number of mailers Jan-June 2023: 87,537 (this is combined BCCHP and MMAI). This Campaign was implemented 5/1/2022, and will continue in SFY 2023
- Dental Outreach Campaign: Focused Campaign – Kids Preventative Dental Health Post: Social media post focused population - Members 6 and under with low to no utilization who live in DIA (implemented November 4, 2022)- Campaign Outcomes: Total campaign sizes: adult 166,330, child 3,990 ,69.87k Impressions = the number of times any content from your Page or about your Page entered a person's screen. 16.58k Video Views = the number of times any content from your Page or about your Page entered a person's screen. 17.59k Engagements – the number of clicks, shared it or liked it ex: thumbs up A focused social media/email campaign towards membership with low to no utilization who live in DIA zip codes. This Campaign was implemented 11/4/2022, and will continue in SFY 2023
- Dental Van: Increase Access to Dental care, community resources and education. This Campaign was implemented SFY2023 QTR 1
- Provider Network engagement: Provider education on dental plan benefits and resources for the members QTR1 2023: 29 providers engaged. This Campaign was implemented SFY2023 QTR 1

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

- The Smiling Stork Campaign conducted monthly and implemented SFY 2022 Q1, and the Dental Home Campaign conducted monthly and implemented in SFY 2022 Q2. As a result of the above campaigns SFY2022 Q3 noted a 14.15%-point increase in utilization, SFY2022 Q4 noted a 33.82%-point increase in utilization.
- The Dental Home Campaign conducted quarterly and implemented SFY 2022 Q4. As a result of the above campaign SFY2023-Q1 noted a 14.29%-point increase in utilization
- The Dental Van Campaign conducted monthly and implemented SFY 2023 Q1, and the Provider Network Engagement Campaign conducted quarterly and implemented in SFY 2023 Q1. As a result of the above campaigns SFY2023-Q2 noted a 10.94% increase in utilization
- Current Rate MY2023-40.84%

d. Identify any barriers to implementing initiatives:

- There were no smiling stork mailers for the month of December 2022 due to a system issue

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

- Monitor performance and internally evaluate for areas for continued improvement

HSAG Assessment

Recommendation
HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • Root cause analysis to determine why child members are not receiving the recommended well-child visits revealed that 52% of members residing in Disproportionately Impacted Areas (DIA) zip codes have open care gaps for well child visits and 58% of the members who live in DIA zip codes in rural IL have open care gaps for well child visits. Health literacy is lower and Social Determinants of Health (SDoH) barriers are higher in areas that have been disproportionately affected. DIA zip codes in rural Illinois, where there is a lack of community infrastructure allowing access to services and initiatives promoting wellness, are particularly affected by these disparities.
b. Describe initiatives implemented based on recommendations: • To address health literacy and SDoH needs of members, the following initiatives have been implemented: • Partnered with Healthmine to provide $30 gift cards to BCBSIL Medicaid members 0-15 months that complete 6 well child visits. Members with SDoH barriers have their focus on their personal day-to-day needs. When paired with health education, member incentives are powerful tools for motivating members to invest in their healthcare needs. • Partnered with vendor to conduct outbound telephonically campaign to engage with members with well-child visit care gaps, by assisting with provider appointment set-ups, providing educational materials, conducting SDoH assessments, and provide resources and solutions to health care barriers. Member engagement started in October 2022 • Collaborated with providers' Southern Illinois Healthcare Foundation (SIHF) and Medimore Unity Point in SFY2023. Both providers serve rural IL and have a large population of members that reside in DIA zip codes. To remove obstacles preventing members from attending their well-child visits, providers are asked to reach out to members who have open care gaps and inform them of BCBSIL initiatives, member educational materials, and useful resources that will enable them to become their family's health advocates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • By the end of SFY2023, process improvement was noted with the Healthmine initiative. An average of 50% of the members completed 6 visits for well-child visits 0-15 years old. • Between October 2022 and June 2023, HCDI closed 3% of HEDIS® Well-Child 0-30 months of age (W30) care gaps. Of the SDoH barriers identified during member engagement to close care

gaps across multiple HEDIS® measures, including W30, 43% of the barriers identified from member engagements were provided referrals for barrier resolution.

- Collaborating with provider partners has shown an overall improvement in the number of W30 care gaps closed in SFY 2023. SIHF's SFY2023 average W30 0-14 closure rate, is 46% which is 8-percentage points higher than their SFY2022 rate, and W30 15-30 achieved a closure rate of 54% for SFY2023, which is 3% higher than their SFY2022 rate. Medimore Unity Point's average closure rate for SFY 2023 W30 0-14 is 52% and W30 15-30 is 58%. Compared to SFY2022, their SFY2023 rate for W30 0-14 is 11-percentage point higher, and W30 15-30 is 2-percentage point higher.

d. Identify any barriers to implementing initiatives:

- HCDI noted that there is engagement hesitancy with members and providers. Outdated contact information for both providers and members has also been a barrier to being able to engage members and contact providers to assist with appointment set-ups.

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

- To address the member and provider hesitancy in engaging with HCDI, BCBSIL will include information regarding HCDI to provider and member communications to increase awareness and establish the legitimacy of the vendor partnership.
- Member and/or provider inaccurate or outdated contact information findings by HCDI will be communicated to BCBSIL to track down accurate contact information.
- A Back-to-school text campaign targeting members residing in DIA zip codes is planned in SFY2024 to educate and encourage members to complete their well-child visits.
- Ongoing monitoring and analysis of care gap closure rates will be carried out to identify regions with a high number of open care caps and determine the most effective interventions to resolve barriers.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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 performance.

Response
a. Describe why this weakness exists: • Data analysis performed and identified the root cause why children members are not receiving all recommended vaccines which is 50.25% of members for Childhood immunization (CIS (Childhood Immunization Status) Combo 3, 50.86% of members for Combo 10 and 59.74% members for Adolescent Immunization (IMA) Combo 2 are residing in Disproportionately Impacted Areas (DIA) zip codes having open care gaps. DIA zip codes are considered to report lower levels of health literacy and children living in DIA zip codes are less likely to get their childhood and adolescent immunizations.
b. Describe initiatives implemented based on recommendations: • Partnered with HealConnect to send text messages to parents/guardians for CIS Combo 3 who have open care gaps w. Text messages were sent in April 2023. • Collaborated with provider groups, Medimore Unity Point and Memorial Health Partners in SFY2023 and John H Stroger Jr Hospital Cook County started in June 2023. Chicago Family Health Center partnership started in July 2022 and continued till December 2022. Medimore Unity Point and Memorial Health Partners serve rural Illinois and Chicago Family Health and John H Stroger Jr Hospital Cook County serves the Chicago metro area. These providers serve large numbers of members living in DIA zip codes. BCBSIL shares monthly care gap reports, provides members educational materials to the providers to share with their members and encourages them to outreach their members who have open care gaps for immunizations. • During SFY2023, BCBSIL is sponsoring a webinar series for providers about vaccine confidence and strategies. Merck & Co leads these webinars, and the focus is on Human Papillomavirus (HPV) vaccine and building confidence and addressing vaccine hesitancy. It is presented by the Regional Medical Director of Merck with expertise in the topics.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • By the end of SFY2023, HealConnect rate shows an increase of 5.34% points in the prospective rate of CIS Combo 3. • Collaborating with provider partner rate has shown an overall improvement of CIS Combo 3 care gap closure. By December 2022, Chicago Family Health Center shown improvement in all immunization rates. Their CIS Combo 3 increased 0.97% % points, CIS Combo 10 increased by 1.43% points and IMA Combo 2 rate increased 1.21% points. As of June 2023, Medimore Unity Point rate for CIS Combo 3 increased by 4.27% points, for CIS Combo 10 increased by 1.40% points and IMA Combo 2 slight decline by 0.71% points. As of June 2023, Memorial Health Partners rate for CIS Combo 3 increased by 2.07% points but on the other hand CIS Combo 10 rate decreased by 4.94% points and IMA Combo 2 increased by 2.32% points. Collaboration with John H Stroger Jr Hospital started in June 2023, future data analysis of care gap closure will monitor as it become available.
d. Identify any barriers to implementing initiatives: • Members could not be outreached due to outdated member contact information, which was a barrier for the text campaign and provider outreach.

- Still noticed decline in rates for CIS 10 for Memorial Health Partner and IMA Combo 2 for Medimore Unity Point due to misconception with the HPV and flu vaccination.

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

- Continued care gap closure rate monitoring and sharing with the partnered provider groups. Also, conduct analysis to identify areas with high open care-gaps and address barriers based on analysis findings.
- Member and/or provider inaccurate or outdated contact information findings by HCDI will be communicated to BCBSIL to track down accurate contact information.
- Will continue to encourage the provider groups to attend webinar series for providers about vaccine confidence and strategies.
- Will continue to provide CareVan schedule to provider groups so they can collaborate with their members to attend CareVan events for immunizations and get benefit from it.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- Based on the root cause analysis conducted to determine why female members are not receiving timely screenings for breast cancer, it was determined that multiple barriers existed. According to the National Institute of Health, those barriers consist of low socioeconomic status and lack of knowledge about preventative breast cancer screenings. Additionally, those who had access problems to transportation were 26.4% less likely to complete screenings. Due to these barriers, members are not aware of the necessity of screening as well as rewards and resources available to them.
- Based on our population analysis utilizing Population Analytics and Research Tool Zip Explorer, we identified zip codes 60617, 60628, and 60629 as areas with the most care gaps in 2022. Within 60629, African American Women had the lowest compliance rate (43.2%) in 2022. According to 2022 Indices data, out of all zip codes, 60628 had the 4th highest population of African American Women and ranks 6th on the list of most open care gaps within the BCS measure. Zip code 60617 came in at 6th in highest African American Female population and has the 10th most care gaps for

that demographic in Cook County. BCBSIL is currently partnered with a FQHC located within these zip codes.
b. Describe initiatives implemented based on recommendations: • Four Federally Qualified Health Centers (FQHC's) along with our Clinical Practice Consultant team to provide a drill down analysis on data with a focus on Disproportionately Impacted Areas (DIA) in the Chicago Area, which have a high rate of non-compliance in breast cancer screenings. The FQHC's are provided with monthly care gap reports for their non-compliant members and conduct outreach in an effort to close care gaps. • HealthMine, a health reward and engagement company, to help target member engagement for BCS • HCDI to conduct outreach to members with open care gaps as well as provide education on screening status, assess social determinants of health (SDoH) barriers, and identify the need for additional resources. • HealConnect to launch a text messaging campaign to help target member engagement for members who have not completed their mammogram
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Overall, the BCS measure increased by 1.73 percentage points from MY2021 to MY 2022 and met the 50th percentile QC benchmark. • By utilizing the HealthMine partnership, the average gap closure rate as of June 2023, is 48.47% • Provider partnerships within DIA zip codes have led to: (July 1st, 2022-December 31st, 2022) - Near-North Health Services Corporation: 4.78 percentage point increase - Crusader Central Clinic Association: 3.23 percentage point increase - Lawndale Christian Health Center: 4.66 percentage point increase (Jan 1st, 2023-Jun 30th, 2023) - Chicago Family Health Center: 5.05 percentage point increase • By utilizing HCDI's outreach, 7,661 BCS members were contacted over the span of 6 months and screened for SDoH barriers. With 11 of those members completing a mammogram since its launch in 2022 and more insight has been provided on barriers members are currently facing. • By partnering with HealConnect, we were able to successfully reach out to 8,513 members which lead to 737 members completing a mammogram after texts were sent out in October 2022. Another text campaign is planned for this fall.
d. Identify any barriers to implementing initiatives: • Incorrect member details, such as phone number or address which inhibits outreach. • Lack of knowledge of BCBSIL benefits • Members may be focusing on other urgent medical ailments which delays the timeliness of screenings completed.

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

- Collaborating with provider groups and vendors to encourage members to voice concerns about barriers they are facing as well as provide updated contact information.
- Continue to identify social determinants of health barriers and provide resources to members in order to increase awareness of breast cancer prevention/screening and remind members of BCBSIL benefits.
- BCBSL is completing analysis focused on member population and demographics such as race, ethnicity, and DIA zip codes. Our analysis identified the top DIA zip codes with the highest member non-compliance within Cook County. We are currently working with FQHC's located in those areas to effectively target and assess vulnerable communities.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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

Response

a. Describe why this weakness exists:

- A root cause analysis shows a variety of factors contributing to a lack of follow-up. Members possibly not attending follow-up appointments due to them having family, school, and employment obligations and being unable to take additional time to attend follow-up appointments. Another factor for lack of follow-up could be staffing shortages and long wait times at agencies for follow-up appointments. Lack of financial resources and transportation could be additional barriers to attending follow-up appointments. Members may also feel better after an inpatient admission and may think that they do not need additional behavioral health treatment or understand the importance of continuing their treatment. There could also be stigma around the need for continued behavioral health treatment. There may be a lack of coordination of care among providers to ensure that follow-up appointments are scheduled and occur in a timely manner.

b. Describe initiatives implemented based on recommendations:

- Initiatives implemented to improve follow-up rates included four provider education webinars that offered Continuing Medical Education (CME) and Continuing Education Unit (CEU) credits and stressed the importance of receiving appropriate follow up care for both mental health and substance use issues, distribution of member education videos on the importance of follow-up

care for mental health and the importance of seeking professional substance abuse treatment, a Reserved Appointment Program with a community provider, and member outreach using a BEP vendor to assist with securing follow-up appointments.

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

- A total of 2,063 IL providers attended the four webinars and received information about the importance of follow-up care. Follow-up rates have improved especially for members aged 65 and older (33.33% for the 30-day follow-up and 22.22% for the 7-day follow-up) when compared to the prior year (16.67% for 30-day follow-up and 8.33% for 7-day follow-up%) but remain below goal. Interventions will continue and follow-up rates will continue to be monitored.

d. Identify any barriers to implementing initiatives:

- In February 2023, the outpatient provider that was part of the Reserved Appointment Program at the Blue Door Neighborhood Center was unable to continue participation in the program due to staffing issues and the program had to be paused until a new community provider could be identified leading to an unforeseen barrier. Another barrier has been unable to reach members, which has impacted the ability to assist with accessing follow-up care.

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

- A new community partner has been identified and the Reserved Appointment Program at the Blue Door Neighborhood Center has resumed in order to improve access to timely follow-up appointments.

HSAG Assessment

Recommendation

For the HIV Viral Load Suppression measure, many health plans reported difficulty obtaining viral load data which may be leading to underreporting of performance. HSAG recommended the following:

- Monitor 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.

Response

a. Describe why this weakness exists:

- We currently do not have agreements with all lab companies who provide lab results for Enrollees.
- The current CCCD includes only a subset of our Enrollees HIV lab tests results.
- Each weakness results in under reporting and identification of Enrollees whose lab results are either normal or abnormal.

b. Describe initiatives implemented based on recommendations:

- Currently partnering with our Medicaid Operations team to help us identify which lab companies we currently do not receive results for our Enrollees with HIV to then pursue agreements.

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

- Since the implementation of the Care Coordination model focusing on African American Enrollees ages 18-64 who live in DIA and whose viral load was >=200, started at 0% decrease (improvement) in VL <200 and is currently at 50% decrease (improvement).

d. Identify any barriers to implementing initiatives:

- Lab results and compliance varies as members in target groups may not have been due for a test result which impacted overall decrease (improvement) of Enrollees who VL<200.
- Did not receive lab results for Enrollees consistently quarter over quarter unless the source was from the CCCD file and lab companies we have agreements with.
- Enrollees opted out of care coordination as they were directly working with their PCP for ongoing needs and management.

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

- Will continue to identify opportunities to re-engage members who declined.
- Partnering with Medicaid Operations to identify other lab vendors we do not have agreements with but where Enrollees labs were drawn to determine outreach and support needed for management.

HSAG Assessment

Recommendation

For the LTSS Comprehensive Care Plan and Update measure, 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. HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- Complexity in data management and system limitations: Care plan core and supplemental elements are in different sections of the Care Management System which are often in narrative or free text form or in fields which are not systematically reportable.
- Change in reporting period in 2022 to point in time which impacts quarter over quarter performance.
- BCBSIL did realize an increase performance measure from Q2-2021 to Q4 2021 to 44.48% from 23.60%, and in Q4- 2022 is at 50.95%.

b. Describe initiatives implemented based on recommendations:

- BCBSIL completed process and system analysis on how to capture all core and supplemental elements of the Comprehensive Care Plan.
- Care coordination training was provided on comprehensive care planning development requirements and documentation to more effectively evidence core and supplemental elements.
- Data analysis and logic updates were made to capture each core and supplemental element in order to remove need for manual review of several of the lower performer elements.
- May 2023 BCBSIL initiated the development of an LTSS comprehensive assessment. This project includes assessment questions tailored to the LTSS population and will more clearly capture identified needs or no needs related to core and supplemental elements along with member preference for goals to be included to the person-centered care plan. It is anticipated that historically low performing specific elements such as cognitive needs, emergency plan, behavioral health needs, social and community integration needs will realize performance improvement along with several additional elements as a result of this assessment enhancement. The LTSS Health Risk Assessment has a targeted roll out of Q1 2024.
- The LTSS Health Risk Assessment project also includes system enhancements to care plan goal categories which align to core and supplemental elements, making it easier to systematically capture reportable fields to demonstrate specific met elements.

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

- Year over year improvement:
  - CY 2021 showed an increase to 44.48% from CY2020 of 26.03%
  - CY 2022 showed an increase to 50.95% from CY2021 of 44.48%

d. Identify any barriers to implementing initiatives:

- Complexity of the number of care plan elements related to data management and system update needs.
- Clinical systems do not frequently capture LTSS specific care planning requirements. Enhancements often take time to develop, integrate and implement. It would be anticipated that year over year performance continues to improve as system enhancements are fully implemented.

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

- IT, Data and Clinical Operations workgroup to for continual process improvement opportunities and planning for ongoing system enhancements, when appropriate.
- Inclusion of clinical trainers and specialty staff in system enhancements/logic updates to increase expertise to support ongoing improved knowledge base and user adoptability by clinical staff.

HSAG Assessment

Recommendation
For the LTSS—Successful Transition After Long-Term Institutional Stay measure, the health plans may not be including all enrolled MLTSS members in the eligible population for this measure due to states 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 Opt-Out members in the identification of the eligible population or calculation of observed discharges for the measure. HSAG recommended the following: • Review the process for identifying the eligible population and their data sources for institutional facility claims. • Evaluate clinical review processes 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.
Response
a. Describe why this weakness exists: • Lack of tracking mechanism to evaluate members who are in the facility for short term stay and evaluate their transition probability. • Lack of timely notification of LTC/SNF admissions and internal UM notification • LTSS TRAN report specifications include home health revenue codes from the CMS Value set which identifies non-institutionalized members in the dataset.
b. Describe initiatives implemented based on recommendations: • BCBSIL completed analysis to exclude home health rev codes and analyzed LOS, age, and facility location which allowed for targeted member engagement and more effective use of staff resources. • Workgroup developed to target members for early outreach who are in NF for short stay or have expressed desire to transition back to community. • Leveraged ADT data through real time monitoring, outreach and engagement for SNF admissions. • Implemented clinical transition screening targeting Cook County members. • Adding several care coordinators to community transition team who focus exclusively on transitions to community settings. Team consists of 10 care coordinators with a dedicated Manager.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Demonstrated 5% percent increase in performance from CY2021- CY2022 from (15% to 20%)
d. Identify any barriers to implementing initiatives: • Considering Members' average length of stay in the facility and age are found to be the barriers for successful transition. • Limitations with the report specifications related to value set continue to be a barrier.

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

- Continued use of dedicated community transition team specialty trained in assessing, transition planning and community resources, including HCBS.
- Ongoing monitoring and oversight of ADT data to inform staff of new member SNF admissions.
- Collaboration with State, State agencies and facilities to remove transition barriers.

HSAG Assessment

2. Prior Year Recommendations for Network Adequacy

Recommendation

In regard to the Access and Availability Telephone Survey, 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. HSAG recommended the following:

- Work with HFS to obtain the case-level survey data files to address provider data deficiencies identified during the survey.
- Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Additionally, 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.

Response

a. Describe why this weakness exists:

- Primary factors impacting the ability to perform the access and availability survey include:
  - provider data information for phone/contact information and address
  - provider specialty type data
  - provider office staff awareness of BCBSIL Medicaid contracted network status with provider

Additionally, while the HSAG's Access and Availability Telephone Survey provided valuable insights into opportunities, an important consideration for this type of survey approach is that providers require callers to be able to provide some level of personal information, ID number, clinical information, etc. prior to offering an appointment time. This is standard practice and in many cases, required per HIPAA and/or state/federal regs. These should not necessarily be considered a limitation for enrollees' ability to access care. BCBSIL experiences the same situations while performing its telephone / 'secret shopper' surveys for appointment availability checks.

b. Describe initiatives implemented based on recommendations:

- Given higher levels of changes/attrition for providers' office staff due to COVID, BCBSIL has continued to provide (re) education for all our providers to ensure contracted providers' staff understand that the provider does accept BCBSIL Medicaid program coverage. We also provide

ongoing education/information about what covered Medicaid benefits are expected of the provider, and the required access/availability timeframe standards by specialty type and need for the provider.

- BCBSIL has a continuous improvement process in place to review provider directory/provider demographic information (contact number, office address, etc.) and data to ensure accuracy.

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

- Performance improvement initiatives are ongoing

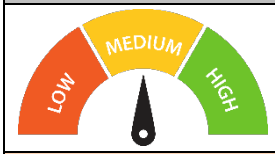
d. Identify any barriers to implementing initiatives:

- No barriers identified to-date

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

- Ongoing review of provider demographic data accuracy and provider education is an important ongoing part of our continuous performance improvement approach
- BCBSIL will continue to focus efforts in these two areas as part of our ongoing access to care strategy

HSAG Assessment



Recommendation

In regard to the Access and Availability Telephone Survey, compliance with appointment availability standards was low, especially in the areas of allergy and immunology, pulmonology, and neurology. HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- BCBSIL analyzed the results of the Access and Availability Telephone Survey, with particular focus on provider specialties of: allergy and immunology, pulmonology, and neurology.
- For these specialty types, BCBSIL has a fully adequate network (in terms of time/distance standards) for all counties and specialty types – with the exception of Allergy and Immunology specific to Rock Island county only. Therefore, results do not appear to be localized to specific geographic areas.

b. Describe initiatives implemented based on recommendations:

- Given higher levels of changes/attrition for providers' office staff due to COVID, BCBSIL has continued to provide (re) education for all our providers to ensure contracted providers' staff understand that the provider does accept BCBSIL Medicaid program coverage. BCBSIL also provides ongoing education/information about what covered Medicaid benefits are expected of the provider, and the required access/availability timeframe standards. BCBSIL will continue to

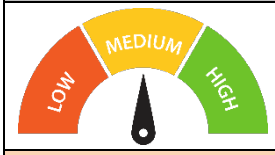
focus these education efforts for the provider specialties: Allergy and Immunology, Pulmonology, and Neurology

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Performance improvement initiatives are ongoing

d. Identify any barriers to implementing initiatives:
- No barriers identified to-date

e. Identify strategy for continued improvement or overcoming identified barriers:
- Ongoing review of provider demographic data accuracy and provider education - targeted for the identified specialty types – will continue to be a critical part of our continuous performance improvement approach

HSAG Assessment



Recommendation

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. HSAG recommended the following:

- 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. 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.

Response

a. Describe why this weakness exists:
- The failure to meet the time/distance network access standard(s) resulted from a lack of providers and the inability to contract with providers within the geographic area.

b. Describe initiatives implemented based on recommendations:
- We prepare and review a monthly adequacy report created using the time distance standards. The templates used to create past reporting where reviewed and data issue has been addressed in those templates. Every gap identified from the reporting is assigned a contractor to perform outreach to all targets of the gap.
- A monthly Government Products Advisory Board is help reporting all gaps and remediation efforts to leadership.
- Quarterly at the Quality Assurance Committee meeting adequacy and remediation efforts are reported.

- Quarterly at the Contracts Requirement Committee reporting of all gaps and remediation efforts is presented to leadership.
- Monthly the entire Network Contracting team meets with Executive Director of Network Contracting to review each gap and remediation efforts.

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

- At the start of this reporting period there were 125 identified gaps. At the end of this reporting period there are 33 gaps identified. Please note 30 of those gaps are Oral Surgery in rural areas.

d. Identify any barriers to implementing initiatives:

- There are counties in IL with limited oral surgeons (one or none) which makes contracting with them very difficult.

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

- Our dental vendor who is responsible to contract with oral surgeons has been put on an action plan to help create ways to recruit oral surgeons who potentially can be contracted for Medicaid services in the future.

HSAG Assessment

3. Prior Year Recommendations for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct a root cause analysis 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. Consider whether there are disparities within populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the care members need.

Response

a. Describe why this weakness exists:

- A quantitative and qualitative analysis was conducted by reviewing member appeals and grievances receive in 2022. Based on our findings, it was revealed that the top grievances/complaints from the members were related to transportation services and dissatisfaction in the communication with Primary Care Physician (PCP) office staff.
- Furthermore, BCBSIL conduced in-depth analysis of the Adult CAHPS® survey results based on Race and Ethnicity for the composite measures, "Getting Needed Care" and Getting Care Quickly" and noted the following findings: Of the eligible adult members who had completed the CAHPS® survey, Asian members scored 23% lower compared to Hispanic members for the response of "Getting Needed Care" followed by African American at 14.8% and White at 5% lower than Hispanic members. For "Getting Care Quickly," Asian scored 15.6% lower compared to African American members followed by White members at 5.5% lower and Hispanic members

at 4.8% lower than African American members. A geography analysis revealed members residing in the City of Chicago scored 19.4% lower compared to Chicago West for the response of "Getting Needed Care" followed by Chicago South/Southwest area scored 8.1% lower than Chicago West. For "Getting Care Quickly," Chicago South/Southwest scored 16.9% lower than City of Chicago followed by Chicago West at 5.6%.

CAHPS Adult				
CAHPS Survey Response based on Race	White	African American	Hispanic	Asian
Getting Needed Care (% Always/Usually)	80.00%	70.20%	85.00%	62.00%
Getting Care Quickly (% Always/Usually)	76.80%	82.30%	77.50%	66.70%
CAHPS Survey Response based on Geography	City of Chicago*	Chicago South/Southwest*	Chicago West*	
Getting Needed Care (% Always/Usually)	71.50%	82.80%	90.90%	
Getting Care Quickly (% Always/Usually)	80.00%	63.10%	74.40%	

*Top 10 DIA Zip Codes for City of Chicago for CAHPS: 60620, 60621, 60624,60619, 60623, 60626, 60628, 60617, 60827 and 60649
*Top 10 DIA Zip Codes Chicago South/Southwest for CAHPS: 60425, 60429, 60432, 60433, 60436, 60458, 60438, 60428, 60827 and 60472
* DIA Zip Codes for Chicago West for CAHPS:60505, 60506, 60139, 60133, 60545 and 60185.

b. Describe initiatives implemented based on recommendations:

- BCBSIL's implemented a CAHPS® Workgroup, which continued meeting quarterly throughout SFY 2023. The CAHPS® workgroup includes internal partners from key departments such as Provider Network, Care Coordination, Appeals and Grievance, Pharmacy and Utilization Management to develop initiatives based on root cause analysis.
- BCBSIL members have a Transportation vendor available to schedule health care visits and medical trips. Members are informed about this availability on various platforms including Member Handbook and member website. Additionally, this information is shared with our providers so they can educate their patients on available transportation facilities and how to utilize it.
- Provider Network Consultants (PNC) conduct ongoing provider education on Access and Availability standards during provider meetings, orientations, and educational webinars. Additionally, the providers are mandated to complete Cultural Competency training and regularly educated on how to treat members with respect and dignity.
- Members also have the option to change their PCP at any given time. Members can contact Member Services at 1-877-860-2837. The call is toll free. Members can also use Blue Access for Members (BAM) to change their PCP.
- BCBSIL Members also have access to a 24/7 Nurse Line where members can talk to a private nurse about their immediate health care needs.
- The Clinical Practice Consultants (CPCs) review provider group specific CAHPS® results that include member demographic information including race and ethnicity and identify areas of improvement. CAHPS Tip Sheets are available for providers during provider engagement meetings.

- The Network Adequacy Team completes network adequacy analysis reports monthly, which are monitored quarterly at the Quality Assurance Committee (QAC) Meetings. However, no gaps in adult specialty care providers have been identified based on our network adequacy reports in SFY 2023.
- BCBSIL implemented a process change within the Call Center. All call center quality review calls are insourced.
- Opened a Plan of Action (POA) with ModivCare for on-time performance on 6/30/2021. This plan of action remains open as ModivCare continues remediation efforts.
- Comprehensive training was developed and deployed to address and educate ModivCare drivers on BCBSIL expectations when interacting BCBSIL members. The training included modules on professional boundaries, trauma informed care, emotional intelligence, and mini medical training. Training also included basic details on different medical conditions. The training serves to help drivers understand the vital role they play in service delivery and the members' health.
- Developed a VIP program to assisted members with requesting services, selecting preferred provider, and arranging transportation for upcoming scheduled appointments. The program was designed to assist members that have experienced multiple services failures.
- Integrated education opportunities into the telephonic member engagement. Members were educated on their rights as BCBSIL members, and the process they should follow if they feel unsafe. Additionally, Members were educated in the following areas: preferred provider selection, Ride share opportunities, Care Coordination services, and grievance procedures for ModivCare and BCSBIL. Lastly, a social media campaign was launched to help education members about their transportation benefits.

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

Analyzing the CAHPS® survey results year over year showed:

- Improvement in "Getting Needed Care" measure rating at 78.3% in 2023 compared to 77.6% in 2022.
- Improvement in "Customer Service" measure rating at 89.2% in 2023 compared to 86% in 2022.
- Decline in "Getting Care Quickly" measure rating at 75.3% in 2023 compared to 77.9% in 2022.
- Decline in "How Well Doctors Communicate" measure rating at 91.9% in 2023 compared to 94.1% in 2022.
- Improvement in Overall Rating of Health plan at 78.9% in 2023 compared to 76.3% in 2022.
- Improvement of Overall Rating of Specialist at 83% in 2023 compared to 77.88% in 2022.
- Decline in Overall Rating of Health Care at 79% in 2023 compared to 79.89% in 2022.
- Decline in Overall Rating of Personal Doctor at 86.10% in 2023 compared to 86.73% in 2022.
- Increase in First Call Resolution within the Call Center indicating a better member experience for callers.

d. Identify any barriers to implementing initiatives:

- A barrier to note is that the CAHPS® reporting does not provide analysis by location making it challenging to determine if results are related to provider shortage in a specific area.

- Another barrier identified could be that provider offices are experiencing continued staffing shortages.

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

- We will continue to evaluate Geo-Access to assess geographical distribution of PCP's and Specialists.
- An article is posted in the Provider Newsletter to educate providers on overall CAHPS® results and provide them with tips to improve their access to care and overall satisfaction for our members.
- An article is posted on the BCBSIL member website to encourage members to complete the survey. Additionally, members are encouraged to complete the survey during Member Advisory Board (MAB) Meetings and in Family Leadership Council (FLC) meetings.
- BCBSIL will continue all initiatives mentioned in section 3B.

HSAG Assessment

Recommendation

HSAG recommended the following for child CAHPS:

- Conduct root cause analysis 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, 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 specialists in the area or if specialists are unwilling to contract with the health plan.

Response

a. Describe why this weakness exists:

- A quantitative and qualitative analysis was conducted by reviewing member appeals and grievances received in 2022. Based on our findings, it was revealed that the top grievances/complaints from the members were related to transportation services and dissatisfaction in the communication with Primary Care Physician (PCP) office staff.
- Furthermore, BCBSIL conduced in-depth analysis of the Child CAHPS® survey results based on Race and Ethnicity for the composite measures, "Getting Needed Care" and Getting Care Quickly" and noted the following findings: Of the eligible child members who had completed the CAHPS® survey, Asian members scored 24.8% lower compared to Hispanic members for the response of "Getting Needed Care" followed by African American at 9.5% lower and White members at 3.7% lower than Hispanic members. For the response of "Getting Care Quickly", Asian members scored 48.8% lower compared to White members followed by African American members scored 18.5% lower and Hispanic member scored 4.1% lower than White members. A geography analysis revealed members residing in Chicago Near West scored 31.1 % lower

compared to Chicago West for the response of "Getting Needed Care" followed by Chicago Southwest scored 7.1% lower and City of Chicago scored 3.7% lower than Chicago West. For the response of "Getting Care Quickly", Chicago West scored 9% lower than Chicago South/Southwest followed by City of Chicago scored 3.1% lower and Chicago Near West scored 0.7% lower than Chicago South/Southwest.

CAHPS Child				
CAHPS Survey Response based on Race	White	African American	Hispanic	Asian
Getting Needed Care (% Always/Usually)	72.50%	66.70%	76.20%	51.40%
Getting Care Quickly (% Always/Usually)	85.30%	66.80%	81.20%	36.50%
CAHPS Survey Response based on Geography	City of Chicago*	Chicago South/Southwest*	Chicago West*	Chicago Near West*
Getting Needed Care (% Always/Usually)	73.80%	70.40%	77.50%	46.40%
Getting Care Quickly (% Always/Usually)	77.40%	80.50%	71.50%	79.80%

*Top 10 DIA Zip Codes for City of Chicago for CAHPS: 60620, 60621, 60624,60619, 60623, 60626, 60628, 60617, 60827 and 60649
*Top 10 DIA Zip Codes Chicago South/Southwest for CAHPS: 60425, 60429, 60432, 60433, 60436, 60458, 60438, 60428, 60827 and 60472
* DIA Zip Codes for Chicago West for CAHPS:60505, 60506, 60139, 60133, 60545 and 60185.
* Top 10 DIA Zip Codes for Chicago Near West:60101, 60104, 60106, 60402, 60155, 60804, 60141, 60534, 60153, 60160 and 60164.

To note: BCBSIL's monthly adequacy reports shows no gaps for child providers within the network.

b. Describe initiatives implemented based on recommendations:

- BCBSIL's implemented a CAHPS® Workgroup, which continued meeting quarterly throughout SFY 2023. The CAHPS® workgroup includes internal partners from key departments such as Provider Network, Care Coordination, Appeals and Grievance, Pharmacy and Utilization Management to develop initiatives based on root cause analysis.
- BCBSIL members have a Transportation vendor available to schedule health care visits and medical trips. Members are informed about this availability on various platforms including Member Handbook and member website. Additionally, this information is shared with our providers so they can educate their patients on available transportation facilities and how to utilize it.
- Provider Network Consultants (PNC) conduct ongoing provider education on Access and Availability standards during provider meetings, orientations, and educational webinars. Additionally, the providers are mandated to complete Cultural Competency training and regularly educated on how to treat members with respect and dignity.
- Members also have the option to change their PCP at any given time. Members can contact Member Services at 1-877-860-2837. The call is toll free. Members can also use Blue Access for Members (BAM) to change their PCP.
- BCBSIL Members also have access to a 24/7 Nurse Line where members can talk to a private nurse about their immediate health care needs.
- The Clinical Practice Consultants (CPCs) review provider group specific CAHPS® results that include member demographic information including race and ethnicity and identify areas of

improvement. CAHPS Tip Sheets are available for providers during provider engagement meetings.

- The Network Adequacy Team completes network adequacy analysis reports monthly, which are monitored quarterly at the Quality Assurance Committee (QAC) Meetings. However, no gaps in child specialty care providers have been identified based on our network adequacy reports in SFY 2023.
- BCBSIL implemented a process change within the Call Center. All call center quality review calls are insourced.

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

Analyzing the Child CAHPS® survey results year over year showed:

- Improvement in "Getting Care Quickly" measure rating at 79.00% in 2023 compared to 78.62% in 2022
- Decline in "Getting Needed Care" measure rating at 73.10% in 2023 compared to 77.87% in 2022.
- Decline in "Customer Service" measure rating at 87.70% in 2023 compared to 90.22% in 2022.
- Decline in "How Well Doctors Communicate" measure rating at 92.60% in 2023 compared to 94.41% in 2022.
- Improvement in Overall Rating of Health plan at 89.10% in 2023 compared to 86.98% in 2022.
- Decline in Overall Rating of Health Care at 83.50% in 2023 compared to 89.83% in 2022.
- Decline in Overall Rating of Personal Doctor at 88.90% in 2023 compared to 91.15% in 2022.
- Decline in Overall Rating of Specialist at 76.10% in 2023 compared to 83.10% in 2022.
- Increase in First Call Resolution within the Call Center indicating a better member experience for callers.

d. Identify any barriers to implementing initiatives:

- A barrier to note is that the CAHPS® reporting does not provide analysis by location making it challenging to determine if results are related to provider shortage in a specific area.
- Another barrier identified could be that provider offices are experiencing continued staffing shortages.

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

- We will continue to evaluate Geo-Access to assess geographical distribution of PCP's and Specialists.
- An article is posted in the Provider Newsletter to educate providers on overall CAHPS® results and provide them with tips to improve their access to care and overall satisfaction for our members.
- An article is posted on the BCBSIL member website to encourage members to complete the survey. Additionally, members are encouraged to complete the survey during Member Advisory Board (MAB) Meetings and in Family Leadership Council (FLC) meetings.

- We will continue all initiatives mentioned in section 3B.

HSAG Assessment

4. Prior Year Recommendation for Care Management Staffing:

Recommendation

HSAG recommended the following for HealthChoice and MMAI:

- 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.

Response

a. Describe why this weakness exists:
   - For the SFY 2022 Staffing and Training workbook, the book was submitted with three Care Coordinators shown to manage a PD (Physically Disabled) waiver case, when in fact they were not qualified to manage the PD waiver. The members did get assigned in error and then reassigned to the proper staff.

b. Describe initiatives implemented based on recommendations:
   - The Unit Manager oversight process was increased for continuous monitoring of the caseloads that each staff member is assigned.
   - Created an oversight team that encompasses subject matter experts by Line of Business, Waiver type along with Physical Health and/or Behavioral Health. This group meets monthly to discuss staffing, training, caseloads, and to identify any patterns or discrepancies.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Currently waiting on the SFY 2023 final Staffing and Training workbook along with final reports.

d. Identify any barriers to implementing initiatives:
   - For a short period, the state was sending us members with the incorrect (code) waiver type listed. With our automated systems, these members must be manually scrubbed, assigned, and monitored.

e. Identify strategy for continued improvement or overcoming identified barriers:
   - Unit Managers and Care Coordination staff to have continuous communication on caseloads, and waiver type assignment.
   - Continuous communication from our subject matter experts across all teams.

HSAG Assessment

5. Prior Year Recommendation for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Newly hired staff's ability to fully understand CI process and reporting requirements

b. Describe initiatives implemented based on recommendations:
- The LTC/SLP team has a regular cadence of CI Trainings, which occurred on the following dates: 3/14/2023, 6/22/2023, 6/27/2023
- Newly hired staff also participate in training and have CI SME's, including managers, available for support
- Given the PHE ended, the UTR process was updated to include unscheduled face to face visits to ensure appropriate member follow up
- The Team has a designated CI specialist who provides training, quality reviews and process oversight.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- One of the strengths noted during the Q3 CI audit was the high level of communication with providers, members, POAs and informal support with our LTC members.

d. Identify any barriers to implementing initiatives:
- Potential barriers may include facilities that are currently experiencing Covid outbreaks, as CI's that warrant a face to face, may be delayed.

e. Identify strategy for continued improvement or overcoming identified barriers:
- We continue to provide intensive training with potential barriers and/or improvements being reviewed quarterly.

HSAG Assessment

Recommendation
HSAG recommended the following: • Revise 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.
Response
a. Describe why this weakness exists: • BCBSIL received 100% compliance reporting to the investigating authority in all HSAG audits. During the Q3 audit, BCBSIL received 100% compliance with following the policies of the investigating authority.
b. Describe initiatives implemented based on recommendations: • After our process was updated to align with the external entity's communication requirements, all teams were trained on these updates in March 2023. Additionally, the Critical Incident Process Manual and Critical Incident Job Aid were updated with these changes.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During the Q3 audit, BCBS received 100% compliance in following the policies of the investigative authority
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Critical Incident team provides annual CI training to all staff, initial CI training for all new hires and provides CI refresher training quarterly or as needed to teams based on gaps identified by managers and the Critical Incident Team.
HSAG Assessment

6. Prior Year Recommendations for HCBS Waiver Performance Measures (HealthChoice and MLTSS):
Recommendation
HSAG recommended the following: • Focus efforts on measures 35D. HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*: • 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).

Response

a. Describe why this weakness exists:
   - A weakness was identified within our care management platform system.

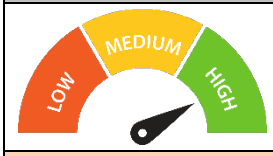
b. Describe initiatives implemented based on recommendations:
   - System enhancement to our Care Management platform to include the alert of any upcoming due Service Plan, initial or annual.
   - System enhancement with the recent implementation of the electronic member Service Plan into Guiding Care, our Care Management platform.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - SFY 2022, HealthChoice ended with an annual total compliance rate of 88% with Performance Measure 35D.
   - SFY 2023, HealthChoice ended with an annual total compliance rate of 91% with Performance Measure 35D.

d. Identify any barriers to implementing initiatives:
   - System enhancements and implementations are time consuming.

e. Identify strategy for continued improvement or overcoming identified barriers:
   - A future implementation will be the use of the member voice signature.
   - Continued training opportunities for our Care Coordination staff on streamlined processes.
   - Projecting to see a decrease with this measure due to the return of in-person member visits.

HSAG Assessment



Recommendation

HSAG recommended the following:

- Focus efforts on measures D6. HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*:
  - 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.
Response
a. Describe why this weakness exists: • During the PHE, the Care Coordination staff was adjusting to the telephonic process and member engagement during this time.
b. Describe initiatives implemented based on recommendations: • System enhancement was implemented into Guiding Care, to include a required activity code that alerts staff when a member's visit is coming due. • A Unit Manager oversight process was developed to include in-depth review of the Care Coordination reports. This includes strategies on how to identify upcoming system contact activities. Unit Managers also monitor this report for any late activity. • The staff was trained in the use of the new system activity codes during our monthly Care Coordination clinics. This meeting is required for all Care Coordination staff along with the required completion of attestation. • Quarterly staff training is held after each HCBS waiver audit to re-educate staff on the contractual requirements of our waiver population. This training also includes the use of valid justification, when to use it and why.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • SFY 2022, HealthChoice ended with an annual total compliance rate of 67% with Performance Measure D6. • SFY 2023, HealthChoice ended with an annual total compliance rate of 81% with Performance Measure D6.
d. Identify any barriers to implementing initiatives: • System enhancements and implementations are time consuming. • Staff might not be as familiar with the new process and revert to old habits in the workflow.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Unit Managers have a one-on-one coaching session with any Care Coordination staff showing signs of low performance within the required activities. Along with the additional and continuous oversight and monitoring of the weekly caseload report by Management. • Continued education for the Care Coordination staff on the contractual requirements of our members.

HSAG Assessment

7. Prior Year Recommendations for HCBS Waiver Performance Measures (MMAI):

Recommendation

HSAG recommended the following:

- Focus efforts on measures 35D and D6 and benefit from implementing the performance measure-specific recommendations provided by HSAG.

Recommendation

HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*:

- 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.

Response

a. Describe why this weakness exists:
   - A weakness was identified within our care management platform system.

b. Describe initiatives implemented based on recommendations:
   - System enhancement to our Care Management platform to include the alert of any upcoming due Service Plan, initial or annual.
   - System enhancement with the recent implementation of the electronic member Service Plan into Guiding Care, our Care Management platform.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - SFY 2022, MMAI ended with an annual total compliance rate of 79% with Performance Measure 35D.
   - SFY 2023, MMAI ended with an annual total compliance rate of 90% with Performance Measure 35D.

d. Identify any barriers to implementing initiatives:
   - System enhancements can be time consuming with the implementation process. Staff may be under utilizing the new activities within the Guiding care system.

e. Identify strategy for continued improvement or overcoming identified barriers:
- A future implementation will be the use of the member voice signature.
- Continued training opportunities for our Care Coordination staff on streamlined processes.
- Projecting to see a decrease with this measure due to the return of in-person member visits.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- 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.

Response

a. Describe why this weakness exists:
- During the PHE, the Care Coordination staff was adjusting to the telephonic process and member engagement during this time.

b. Describe initiatives implemented based on recommendations:
- System enhancement was implemented into Guiding Care, to include a required activity code that alerts staff when a member's visit is coming due.
- A Unit Manager oversight process was developed to include in-depth review of the Care Coordination reports. This includes strategies on how to identify upcoming system contact activities. Unit Managers also monitor this report for any late activity.
- The staff was trained in the use of the new system activity codes during our monthly Care Coordination clinics. This meeting is required for all Care Coordination staff along with the required completion of attestation.
- Quarterly staff training is held after each HCBS waiver audit to re-educate staff on the contractual requirements of our waiver population. This training also includes the use of valid justification, when to use it and why.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- SFY 2022, MMAI ended with an annual total compliance rate of 49% with Performance Measure D6.
- SFY 2023, MMAI ended with an annual total compliance rate of 76% with Performance Measure D6.

d. Identify any barriers to implementing initiatives:
- System enhancements can be time consuming with the implementation process. Staff may be under utilizing the new activities within the Guiding Care system.

e. Identify strategy for continued improvement or overcoming identified barriers:
- The Unit Managers have a one-on-one coaching session with any Care Coordination staff showing signs of low performance within the required activities. Along with the additional and continuous oversight and monitoring of the weekly caseload report by Management.
- Continued education for the Care Coordination staff on the contractual requirements of our members.

HSAG Assessment

8. Prior Year Recommendations for QA/UR/PR Annual Report

Recommendation

HSAG recommended the following:
- Include a detailed analysis of access and utilization of dental services.
- Include a detailed analysis of cultural competency.

Response

a. Describe why this weakness exists:
- For dental utilization, identifying the appropriate business owners and assigning responsibility to track and monitor access and utilization efforts of dental services across all populations
- For cultural competency, defining ownership of cultural competency monitoring

b. Describe initiatives implemented based on recommendations:
- Dental utilization has been added to the QA/UR/PR Annual Report. The utilization includes all active members for BCCHP and MMAI with a breakdown analysis of age, race, and geographical location (including DIA zip code analysis)
- BCBSIL has added how we address Cultural Competency within the QA/UR/PR Annual Report. For Cultural Competency, a Cultural Competency plan was finalized in May 2023.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

d. Identify any barriers to implementing initiatives:
- N/A

e. Identify strategy for continued improvement or overcoming identified barriers:
- As of SFY2022, BCBSIL has remediated previous findings related to monitoring and analysis of access/utilization of dental services across all populations and analysis, and also implemented interventions and programs to address cultural competency within the QA/UR/PR report.
- Moving forward, BCBSIL will continue to include access and utilization for dental services along with Cultural Competency initiatives in the QA/UR/PR Annual Report.

HSAG Assessment

9. Prior Year Recommendations for Mental Health Parity Review

Recommendation

HSAG recommended the following:

- Review the systems and processes responsible for denial 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.

Response

a. Describe why this weakness exists:

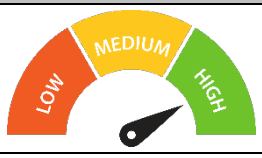
- Disease states, diagnosis, and anatomical names for parts of the body may be required on occasion to appropriately explain unique conditions/treatments within the denial rational driving up the FK scoring.

b. Describe initiatives implemented based on recommendations:

- Beginning March 2021 BCBSIL updated oversight processes surrounding the monitoring of written notifications to members of Service Authorizations for both internal departments and delegates. BCBSIL performs oversight to ensure decisions and written notices are reviewed for timeliness of decision, readability, clinical appropriateness, and notification against applicable contract, regulatory and/or accreditation standards.

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

- 2022 BCCHP PH Utilization Management Review of Member Letter Appropriateness = 99.5%
- 2022 MMAI PH Utilization Management Review of Member Letter Appropriateness = 99.7%
- 2022 BCCHP BH Utilization Management Review of Member Letter Appropriateness = 100%
- 2022 MMAI BH Utilization Management Review of Member Letter Appropriateness = 100%
- 2022 BCCHP Del. Utilization Management Review of Member Letter Appropriateness = 98.9%
- 2022 MMAI Del. Utilization Management Review of Member Letter Appropriateness = 99.4%
- 2023 Q1 BCCHP PH Utilization Management Review of Member Letter Appropriateness = 100%
- 2023 Q1 MMAI PH Utilization Management Review of Member Letter Appropriateness = 100%
- 2023 Q1 BCCHP BH Utilization Management Review of Member Letter Appropriateness = 100%
- 2023 Q1 MMAI BH Utilization Management Review of Member Letter Appropriateness = 100%

• 2023 Q1 BCCHP Del. Utilization Management Review of Member Letter Appropriateness = 99.9% • 2023 Q1 MMAI Del. Utilization Management Review of Member Letter Appropriateness = 99.9%
d. Identify any barriers to implementing initiatives: • No known barriers.
e. Identify strategy for continued improvement or overcoming identified barriers: • Frequent monitoring of operational reporting and systems of control to identify requests that are approaching decision timeframe expiration (ongoing) • Continue random monthly and quarterly audits to identify root cause for (ongoing)
HSAG Assessment


CountyCare

1. Prior Year Recommendations for Performance Measures:
Recommendation
HSAG recommended the following: • 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. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • CountyCare missed the 75th percentile by 11.3% in MY2022. Root cause analysis revealed that low performance was due to occasional mis-matches in member empanelment with some members empaneled to a primary care provider (PCP) or medical home where they were not engaged. Additionally, inaccurate contact information for members, and changes in health behaviors, especially in younger member populations were common barriers to the completion of annual preventive health visits, contributing to lower performance for this measure.
b. Describe initiatives implemented based on recommendations: • CountyCare developed reporting to track the percentage of empaneled members within each provider supergroup who had a visit with their empaneled PCP in the calendar year. CountyCare shared this reporting quarterly with large provider networks (supergroups) and used this to re-assign members based on the group where the member was actually engaged in care. To improve the completeness and accuracy of member demographic information, CountyCare implemented solutions to collect demographic information from a variety of sources and also implemented a technology solution to validate demographic data collected. Additionally, CountyCare implemented a Member Engagement text message campaign series. The multi-text campaign provided reminders to members about the importance of preventive care, assisted members with locating care, and helped to address any barriers to care identified (like transportation needs, for example). This text campaign series has been highly effective in engaging members, educating them on the importance of preventive care and addressing barriers that exist.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The MY2022 rate for Adults' Access to Preventive/Ambulatory Health Services (AAP) was 69.56%, which was a 1.88% decrease from MY2021. To date, CountyCare's initiatives have shown improvement with this measure for MY2023. CountyCare has trended above MY2022 performance when comparing each month's performance to the same month in the prior year.
d. Identify any barriers to implementing initiatives: • Analysis shows that young members (ages 20-44) have been the most difficult to engage in care. Lack of understanding about the importance of annual preventive health visits, along with other barriers like work schedules, social determinants of health, or transportation have a significant impact in this age group.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare began working with its delegated care management entities (CMEs) to develop individualized strategies to impact members who have a care gap for this measure. CountyCare continues to offer member incentives for annual PCP visit and the member incentive increased in 2023 based on results in FY22. In addition to member incentives, CountyCare continues to work to develop provider incentives and value-based agreements to incentivize excellent performance on this measure. Continued text messaging campaigns are planned to promote the completion of preventive services. 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 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.

Response

a. Describe why this weakness exists:
- Segmented data analysis has been completed for both the Well-Child Visits in the First 30 Months of Life (W30) sub-measures and for the Child and Adolescent Well-Care Visits (WCV) measure. Analysis shows that African-American/Black members have lower rates of well-visit completion, than do members in other race groups. African-American/Black members residing in a Disproportionately Impacted Area (DIA) zip codes have the same rate of service completion as compared to members in this race group not residing in a DIA. In addition to this identified disparity, CountyCare's root cause analysis indicated that health behaviors that changed during the pandemic persisted in FY2023. Members are less likely to complete timely preventive services due to competing priorities, lack of convenient appointment modalities and options, and due to lack of understanding about the importance and purpose of early childhood well-visits.

b. Describe initiatives implemented based on recommendations:
- CountyCare continues to promote its Brighter Beginnings program, supporting families with educational resources, tools, benefits and rewards. The Brighter Beginnings webpage provides members easy access to these educational materials and tools. Member rewards continue to incentivize members to complete early childhood well-visits. CountyCare executed a Brighter Beginnings text message campaign sending a series of messages that provided education on well-visits, immunizations, and information about benefits and rewards specific to this population. Additionally, CountyCare distributes care gaps lists routinely, at minimum on a quarterly basis, to facilitate real-time care gaps outreach by provider groups and CME staff.

CountyCare also continues to assess and improve access and availability in its network to ensure members are able to access timely care in close proximity to the area where they reside.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The performance for W30-First 15 Months improved by 3.26% from MY2021-MY2022, but still was 6.23% below the 75th percentile. The performance for W30-15-30 Months improved by nearly 1% from the prior year and was 11.86% below the 75th percentile. WCV declined by over 3% from MY2021 and was 6.71% below the 75th percentile.

d. Identify any barriers to implementing initiatives:
- CountyCare has observed ongoing access issues with providers in the network with impact on both routine and urgent appointments due to regional staffing shortages, continued high staff turnover, and limited evening/weekend appointments continues to impact members' ability to access preventive care and well-visits in a timely manner.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare has planned more targeted outreach to the population experiencing disparities with both the W30 and WCV measures. Additionally, CountyCare established a Quality-focused CME workgroup to continue to work through additional root-cause analysis, discussion of barriers and evaluation of interventions to ensure that care gaps are effectively closed and target populations are reached. Modified text messaging campaigns could be considered as an alternative engagement strategy for the target population; this strategy has been successful with other measures.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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 performance.

Response

a. Describe why this weakness exists:
- Similar to the findings of root-cause analysis completed for early childhood well-visits, CountyCare's causal analysis for childhood immunizations indicated that health behaviors that changed during the pandemic persisted in FY2023. Members were still observed to have increased vaccine hesitancy, were less likely to complete timely preventive services due to competing priorities, lack knowledge about where immunizations can be received, and may not have complete understanding of the complete recommended immunization schedule. Segmented

data analysis has been completed for the Childhood Immunization Status (CIS) measure. Consistent with the analysis for well-visits, analysis shows that African-American/Black members have lower rates of timely immunization completion, as compared to members in other race groups. African-American/Black members residing in a Disproportionately Impacted Area (DIA) zip codes have a very similar rate of services completion as compared to members in this race group not residing in a DIA.

b. Describe initiatives implemented based on recommendations:
- CountyCare continues to promote its Brighter Beginnings program, supporting families with educational resources, tools, benefits and rewards, including rewards for completion of childhood immunizations. CountyCare distributes care gaps lists routinely, at minimum on a quarterly basis, to facilitate real-time care gaps outreach by provider groups and CME staff. Additionally, CountyCare continues to assess and improve access and availability in its network to ensure members are able to access timely care in close proximity to the area they reside.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Performance for CIS-Combo 3 improved slightly (0.48%) from MY2021 to MY2022. CIS-Combo 10 declined by 2.43% from MY2021 to MY2022. Both rates in MY2022 were at the 25th percentile, missing the target of the 75th percentile.

d. Identify any barriers to implementing initiatives:
- CountyCare has observed ongoing access issues with providers in the network with impact on both routine and urgent appointments due to regional staffing shortages, continued high staff turnover, and limited evening/weekend appointments continues to impact members' ability to access preventive care and well-visits in a timely manner. Additionally, the COVID-19 pandemic significantly impacted health behaviors and attitudes related to immunizations/vaccines. Ongoing hesitancy related to immunization and vaccines continues to be observed.

e. Identify strategy for continued improvement or overcoming identified barriers:
- In addition to targeted outreach to the target populations for these measures, regular distribution of care gaps lists to providers and CMEs, collaboration with CME staff through a quality-focused workgroup, and promotion of the Brighter Beginnings program, CountyCare is exploring ways to partner with external groups, like Chicago Public Schools, to support improvement with immunization completion and more effective data exchange. CountyCare recognizes that many families served by the health plan have one or more students enrolled in Chicago Public Schools.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.
Response
a. Describe why this weakness exists: • CountyCare missed the 75th percentile by 3.41% in MY2022. Segmented data analysis showed a slightly lower rate of breast cancer screening completion for the African-American/Black race group compared to the Caucasian/White and Other race groups. There was no distinguishable difference in service completion for African-American/Black members residing in DIA zip codes versus those residing in non-disproportionately impacted areas. Root cause analysis showed that mammography facilities and timely appointment access may be a barrier for this population; social determinants of health may impact this population more significantly than other race groups.
b. Describe initiatives implemented based on recommendations: • To aid members in locating facilities offering mammography services, 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 also worked with a vendor to execute a care gaps text message campaign for members overdue for breast cancer screening. In 2022, CountyCare hosted a Women's Health Fair at Provident Hospital for members in the target population to offer an alternative option for receiving preventive care services, including breast cancer screening. CountyCare also supports improvement with this measure by implementing provider incentives for this measure and providing regular care gaps lists to provider and CME groups to support care gap closure.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance for Breast Cancer Screening improved from MY2021 to MY2022 by 2.22%. CountyCare's rate of 53.11% was at the 50th percentile, 3.41% away from the 75th percentile.
d. Identify any barriers to implementing initiatives: • Provider groups and members continue to juggle many acute health needs and competing priorities as many members continue to manage chronic conditions, including mental health needs. Preventive services are sometimes a lower priority as members work with their care team to address their chronic and acute health needs. Additionally, some members may not understand the recommended timeframe for completing this screening service.
e. Identify strategy for continued improvement or overcoming identified barriers: • CountyCare will continue initiatives as outlined above including updating the breast cancer screening resource annually, planning annual Women's Health fairs in partnership with Provident Hospital, and continuing to expand provider incentives/value-based contracts prioritizing performance on this measure. Text messaging campaigns focused on education and closure of this care gap will also continue. Care management teams will be engaged to execute targeted outreach to the key population with disparate outcomes; this will help assess and mitigate barriers members in this population are experiencing.

HSAG Assessment

Recommendation
HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • CountyCare missed the 75th percentile by 5.35% in MY2022. CountyCare observed low performance due to lower member engagement in primary care overall as the pandemic and public health emergency wound down in FY2023. Social determinants of health also caused lower control of chronic conditions including transportation barriers, lack of consistent access to healthy food, increased incidence of homelessness or insecure housing, low health literacy, and lack of financial resources. Additionally, segmented data analysis showed a slightly lower rate of blood sugar control in the African-American/Black member population as compared to other race groups. There was minimal difference in rates of control when looking at performance by DIA vs. non-DIA populations.
b. Describe initiatives implemented based on recommendations: • 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). In addition to the self management program, CountyCare also works with Canary Telehealth to provide in-home diabetic services to members with care gaps, including measurement of HbA1c. Members in target populations have been prioritized for these programs. Other initiatives include: increasing provider incentives/value-based contracts focused on this measure, inclusion of diabetes services into the member rewards program, distribution of care gaps lists to provider/CME groups, working to improve the quantity and quality of supplemental data, and health fairs at Provident Hospital.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In 2022, CountyCare increased performance for Hemoglobin A1c control for Patients with Diabetes <8% by 8.52%.
d. Identify any barriers to implementing initiatives: • Provider groups and members continue to juggle many acute health needs and competing priorities. Many members continue to manage chronic conditions, including mental health needs. Social determinants of health heavily impact chronic disease control, as transportation, health literacy, healthy diet, and the ability to lead a healthy lifestyle, are common barriers for CountyCare's members. Additionally, gaps in data continue to impact this measure, with few

providers coding HbA1c results when submitting claims. CountyCare heavily relies on specific and accurate coding, as well as supplemental data, for this measure.

e. 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 will continue to offer member incentives for Hemoglobin A1c monitoring to support member engagement with self-management of chronic conditions. Text messaging outreach is planned 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. CountyCare will access and address supplemental data more proactively.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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

Response

a. Describe why this weakness exists:
- CountyCare declined very slightly in the 7-day and 30-day follow-up completion for the Follow-up After Hospitalization for Mental Illness (FUH) sub-measures. 7-day follow-up declined by 0.31% in MY2022 as compared to the prior year, with a rate of 23.10% in MY2022 (< 25th percentile). 30-day follow-up declined by 0.71% in MY2022 as compared to the prior year, with a rate of 40.44% in MY2022 (< 25th percentile). Through analysis, CountyCare found that a significant numbers its members struggle with severe mental illness, causing many members to have multiple acute behavioral health events in one year. Additionally, CountyCare observed that many members experiencing acute mental illness events have co-morbid substance use disorders in addition to their behavioral health condition(s). Social and structural factors also contributing to low performance include transportation barriers, increased incidence of homelessness or insecure housing, low health literacy, and lack of support. Segmented data analysis showed a slightly lower rate of blood sugar control in the African American/Black member population as compared to other race groups. There was minimal difference in rates of control when looking at performance by DIA vs. non-DIA populations.

b. Describe initiatives implemented based on recommendations: • Performance Improvement Workgroups (PIWs) continued work 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 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 developed partnerships with organizations to expand access and coordination of mental health services. CountyCare worked to collaborate with high-volume facilities to allow for co-location of care management staff with the goal of improving engagement with members experiencing acute mental health needs in these facilities. CountyCare also continues to work to improve workflow for high volume facilities in DIA areas with CME partners.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Current MY2023 performance for this measure is trending above last year's performance with a year over-year comparison as monthly HEDIS refreshes occur. No performance improvement from MY2021-MY2022 was observed.
d. Identify any barriers to implementing initiatives: • Due to the highly confidential nature of Behavioral Health (BH) 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. The HealthChoice Illinois ADT, through PointClickCare, has been incomplete with many of CountyCare's high-volume facilities submitting partial or no ADT alerts through this platform. CountyCare has worked collaboratively to address the gaps in data and continues to analyze opportunities for improvement. 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.
e. Identify strategy for continued improvement or overcoming identified barriers: • CountyCare implemented a comprehensive Behavioral Health Initiative recently to put forth focused performance-improvement efforts to improve timely connection to follow-up care after an acute behavioral health episode. The scope of this initiative is comprehensive and includes workflow modifications, data improvements, collaboration with external organizations, providers, and partners, and the development of a dedicated team within the health plan to outreach to members recently discharged after a mental health admission. All of this work will support continued improvement regarding CountyCare's ability to identify members in a timely manner, engage members effectively, and coordinate follow-up care.

HSAG Assessment

Recommendation
For the HIV Viral Load Suppression measure, many health plans reported difficulty obtaining viral load data which may be leading to underreporting of performance. HSAG recommended the following: • Monitor 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.
Response
a. Describe why this weakness exists: • This weakness may exist due to the extra care surrounding the sharing of HIV data and the hesitancy to share the information with MCOs. The sensitivity of the HIV data can make it difficult to obtain a comprehensive look on the HIV population due confidentiality, privacy and heightened protections surrounding the data.
b. Describe initiatives implemented based on recommendations: • Developed lab sharing agreement with LapCorp to obtain HIV lab data and provide broader scope of the HIV population. Enhanced reporting methods to highlight gaps and trends in HIV data and improve outreach and engagement methods across the plan. Investigated ICD-10 codes (B20 & Z21) and CPT-87536 to determine which members had a viral load lab test completed and billed. Receive a monthly file from the State of IL that identifies members with detectable levels of HIV. County Care Coordinators use claims data, Utilization Management data, and direct communication with members to determine validity of data received from the State of IL. Upon confirmation the identified members are enrolled in Care Coordination that focuses on connection of the member with a PCP, medication acquisition, and any removal of any barriers to members being able to acquire anti-retroviral therapy/medications, or PCP linkage.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For Q4 2022 the percentage of members with a valid viral load lab result was 28.82% which was an improvement from the Q4 2021 percentage total of 10.97%. Due to the targeted outreach of members who are not virally suppressed and living in disproportionately impacted areas many members have been reengaged in HIV care. Members have been reconnected with the PCP and assisted with acquisition of anti-retroviral medications. The engagement rate is at 41% with dedicated staff/Care Coordinators outreaching members identified by the State of IL and confirmed by the Health Plan.
d. Identify any barriers to implementing initiatives: • Correct phone numbers, and member engagement due to telephonic scams that cause some members to distrust phone calls from County Care coordinator. Other barriers that teams have run into but are not limited to are members that are identified as unable/hard to reach and members opting out of care, or some members being incarcerated.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Leverage other projects that are already in play in the health plan other teams' and other resources in the health plan, such as our new ADT vendor Point Click Care, to ensure accurate and alternative phone numbers are available. Cultivate relationships with reputable and accredited HIV organizations within Chicago to optimize already implemented practices and methods that could be used on our members with HIV. Do a deeper exploration into HCPCS G Codes (G9424 & G92943) to investigate the valid viral load results and look more into the data that we need to incorporate at the Health Plan. Letters with the health plan/County Care letterhead being sent to member's homes to add credibility to the phone calls, thereby increasing engagement.

HSAG Assessment

Recommendation

For the LTSS Comprehensive Care Plan and Update measure, 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. HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:
- The health plan developed and transitioned to a new care management documentation platform (CMIS) on 1/31/2022. Many requests and priorities for enhancements and adjustments to the new system were in play including updates to the care plan.

b. Describe initiatives implemented based on recommendations:
- The health plan updated its documentation template in Q4 2022 to capture additional core/supplemental elements in a uniform manner. The health plan is also performing routine audits and tracking of care plan completion, providing real time feedback to staff and management regarding any findings. Refresher trainings occur quarterly.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The health plan has identified increased compliance with timeliness of care plan completion and elements due to the initiatives described above. For example per the state Enrollee Engagement Report, average timely completion of the Care Plan for new waiver members to the plan improved by 18 percentage points between 2022 and to current 2023.

d. Identify any barriers to implementing initiatives:
- Competing priorities for enhancements to the care management system.

e. Identify strategy for continued improvement or overcoming identified barriers:
- The health plan will continue to utilize routine audits and internal tracking of care plan completion and address any findings via training. We will continue our care coordinator hiring efforts to adequately cover all cases and reduce caseload size. The health plan will continue to work with the CMIS team to implement enhancements as prioritized.

HSAG Assessment

Recommendation

For the LTSS—Successful Transition After Long-Term Institutional Stay measure, the health plans may not be including all enrolled MLTSS members in the eligible population for this measure due to states 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 Opt-Out members in the identification of the eligible population or calculation of observed discharges for the measure. HSAG recommended the following:

- Review the process for identifying the eligible population and their data sources for institutional facility claims.
- Evaluate clinical review processes 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.

Response

a. Describe why this weakness exists:
- The CCCD Medicare claims only applied to the dual plans.

b. Describe initiatives implemented based on recommendations:
- CountyCare reviewed and ensured that the SAS codes used for LTSS TRAN P4R measure are in line with the specs from the state to incorporate additional LTC claims. CountyCare also reviewed its processes for identifying members earlier in the process for potential discharge opportunities. We are now utilizing a length of stay report to help identify members earlier in the process and improve our discharge rate. In addition, we are identifying and tracking waiver members who go into nursing facilities for rehab, short-term, or other reasons to ensure they successfully discharge back home with waiver services restarted.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- For the Community Transitions Initiative annual targets, CountyCare has already surpassed the number of transitions we completed in CY 2022 with another quarter still remaining in CY 2023.

d. Identify any barriers to implementing initiatives:
- We continue to work through individual member level barriers to transition including lack of income, identification, housing, and external support.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare is committed to increasing our transitions from nursing home to community. We are reviewing our org chart and staffing plans for the CTI program and will be making adjustments

and adding additional resources (i.e., housing coordinator, BH focused clinicians, additional transition care coordinators)

HSAG Assessment

2. Prior Year Recommendations for Network Adequacy

Recommendation

In regard to the Access and Availability Telephone Survey, HSAG was unable to almost 34.5 percent of sampled cases and was only able to obtain an appointment date with 13.2 percent of the sampled locations. HSAG recommended the following:

- Work with HFS to obtain the case-level survey data files to address provider data deficiencies identified during the survey.
- Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Additionally, 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.

Response

a. Describe why this weakness exists:
   - The COVID-19 public health emergency has led to significant provider burnout and staffing shortages nationwide. Providers and patients alike expressed heightened concerns about COVID-19 exposure, and patients were apprehensive to attend appointments in a potentially sick environment.

b. Describe initiatives implemented based on recommendations:
   - CountyCare tracks open availability by conducting ad hoc surveys and educates non-compliant practitioners of any previously identified deficiencies.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Results of the 2023 Access and Availability Telephone Survey illustrate that initial and follow-up oncology appointments improved significantly with initial at 96% and follow-up at 100% available within four (4) weeks.

d. Identify any barriers to implementing initiatives:
   - None identified.

e. Identify strategy for continued improvement or overcoming identified barriers:
   - In 2023 CountyCare engaged a new vendor to conduct the Access and Availability Telephone Survey. CountyCare also has implemented Incentive Agreements with specialist providers to incent timely appointments. Further, CountyCare is implementing a telehealth initiative to increase positive outcomes in accessibility and flexibility.

HSAG Assessment

Recommendation
In regard to the Access and Availability Telephone Survey, compliance with appointment availability standards was low, especially in the areas of allergy and immunology, pulmonology, and neurology. HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • The COVID-19 public health emergency has led to significant provider burnout and staffing shortages nationwide. Providers and patients alike expressed heightened concerns about COVID-19 exposure, and patients were apprehensive to attend appointments in a potentially sick environment.
b. Describe initiatives implemented based on recommendations: • CountyCare tracks open availability by conducting ad hoc surveys and educates non-compliant practitioners of any previously identified deficiencies.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • In 2023 CountyCare engaged a new vendor to conduct the Access and Availability Telephone Survey. CountyCare also has implemented Incentive Agreements with specialist providers to incent timely appointments. Further, CountyCare is implementing a telehealth initiative to increase positive outcomes in accessibility and flexibility.
HSAG Assessment

3. Prior Year Recommendations for CAHPS:
Recommendation
HSAG recommended the following for adult CAHPS: • Conduct a 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. Consider whether there are

disparities within populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the care members need.
Response
a. Describe why this weakness exists: • The 2023 Adult CAHPS survey results showed a small decline in Getting Needed Care (4.04%) but remain in the 10th percentile. Through the results of member surveys in FY2023, CountyCare determined that member expectations of timeframes for receiving needed care do not align with the appointment standards set. In many cases, members desired care or services in a timeframe that was not feasible based on regional availability and practitioner capacity. Additional barriers include members not understanding how to locate providers, lack of appointment availability during weekend or evening hours, and transportation barriers.
b. Describe initiatives implemented based on recommendations: • CountyCare implemented a CAHPS Workgroup that includes leaders from key departments. This multidisciplinary team continues to work on interventions that address the root causes of areas of low performance. 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 analyzes CAHPS supplemental questions to identify specialty areas of concern where member-reported access concerns exist. This workgroup is responsible for addressing these identified opportunities for improvement. 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 Network team completed a survey to assess access standards being upheld/met by provider groups. 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.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In 2023, Adult CAHPS survey results showed improvement in Getting Care Quickly with a 2.43% increase from the <10th percentile to the 10th percentile and the Rating of the Health Plan and Rating of Health care also significantly increased from the 10th to 75th percentile.
d. Identify any barriers to implementing initiatives: • CountyCare determined that member perception of timely access to care does not always align with set access and availability standards. Members may want appointments much more quickly than the standard specifies or health resources allow.
e. 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. Additionally, CountyCare is working to routinely educate members about access options, standards for access, and how to reach out for assistance if 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, 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 specialists in the area or if specialists are unwilling to contract with the health plan.
Response
a. Describe why this weakness exists: • The 2023 Child CAHPS survey results showed a small decline in Getting Needed Care (from 10th percentile to < 5th) and the Rating of Health Care (decreased by 4.2% but remain in 33rd percentile). Through the results of member surveys in FY2023, CountyCare determined that member expectations of timeframes for receiving needed care do not align with the appointment standards set. In many cases, members desired care or services in a timeframe that was not feasible based on regional availability and practitioner capacity. Additional barriers include members not understanding how to locate providers, lack of appointment availability during weekend or evening hours, and transportation barriers.
b. Describe initiatives implemented based on recommendations: • CountyCare implemented a CAHPS Workgroup that includes leaders from key departments. This multidisciplinary team continues to work on interventions that address the root causes of areas of low performance. 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 analyzes CAHPS supplemental questions to identify specialty areas of concern where member-reported access concerns exist. This workgroup is responsible for addressing these identified opportunities for improvement. 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 Network team completed a survey to assess access standards being upheld/met by provider groups. 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.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In 2023, Child CAHPS survey results showed improvement in Getting Care Quickly with a 5% increase from the <10th percentile to the 10th percentile.

d. Identify any barriers to implementing initiatives:
- CountyCare determined that member perception of timely access to care does not always align with set access and availability standards. Members may want appointments much more quickly than the standard specifies or health resources allow.

e. 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. Additionally, CountyCare is working to routinely educate members about access options, standards for access, and how to reach out for assistance if needed.

HSAG Assessment

4. Prior year recommendations for Care Management Staffing:

Recommendation

HSAG recommended the following for HealthChoice and MMAI:

- 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.

Response

a. Describe why this weakness exists:
- In 2022, CountyCare submitted an exemption request for 1 care coordinator, which was approved. The staff member had a Master's degree in Psychology and 8 years of managed care experience including several years as both a care coordinator and care coordinator manager in the LTSS field. CountyCare seeks out candidates with required qualifications and also candidates who demonstrate a strong work ethic, transferable skills, and the ability to perform at a high level based on examples and past successes in similar job roles.

b. Describe initiatives implemented based on recommendations:
- CountyCare participated in several Cook County Health job fairs in 2022-2023 that targeted specific waiver qualifications/education to ensure new hires had adequate experience to be assigned to waiver cases. CountyCare also partnered with temp agencies who screened potential candidates to ensure they had appropriate backgrounds.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- CountyCare was able to attract new talent via the job fairs and have them onboard at a quicker pace than the traditional hiring practice. Routine meetings with our temp agency partners allowed us to target specific roles and discuss specific waiver needs that include degree type and work history.

d. Identify any barriers to implementing initiatives:
- Navigating the typical challenges with hiring within a government system.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare plans to continue to target individuals that meet specific waiver qualifications/education via internal/external job postings, future job fairs, employee referrals and staffing agency partnerships.

HSAG Assessment

5. Prior Year Recommendations for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Prior challenges with accessing members residing in facilities during the PHE.

b. Describe initiatives implemented based on recommendations:
- The health plan resumed F2F contact with facility members in July 2022. The return to field work also improved and strengthened the relationship with facility staff. CountyCare resumed face-to-face contact with members in nursing homes and SLP facilities in July 2022 to help overcome the challenges of reaching this population by phone. Resumption of field work also served to strengthen working relationships with facilities.
- Member's health condition is used to determine follow-up participation.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- There have been improved timeframes for case resolution. As well as reassured confirmation of health safety & welfare.

d. Identify any barriers to implementing initiatives:
- Key LTC/SLP staff had limited availability to meet with health Plan Care coordinators for review and discussion of member's incident.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Maintain F2F contact with members and facility staff.
- Continue requirement of contact prior to closure of the CI and documenting any applicable cognitive or behavioral health conditions.
- Work to strengthen communication between the LTC/SLF staff and the health plan team by assigning consistent staff to the facility.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Each respective investigating authority (IA) required only the person who reported the critical incident to IA as the content, so process changes were required to comply with each case. Also each IA's responsiveness to reports varied, requiring different follow-up practices which we have finalized as to three calls for notification.

b. Describe initiatives implemented based on recommendations:
- Provide frequent Critical Incident training refresher courses to all case management teams with focus on communication expectations with investigating authorities. It include timelines and communication techniques for common challenges.
- Implement biweekly CI rounds with each team.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- There has been an upswing in reported CI from all teams within the health plan.

d. Identify any barriers to implementing initiatives:
- N/A

e. Identify strategy for continued improvement or overcoming identified barriers:
- The HSW team will continue to train and give feedback to CME on overall practice and individual case needs. This has been an effective approach with improvement in the quality of reports and timely follow-up.

HSAG Assessment

6. Prior Year Recommendations for HCBS Waiver Performance Measures (HealthChoice and MLTSS):
HSAG recommended the following: • Focus efforts on measures 35D, D6, D7, and G8 and benefit from implementing the performance measure specific recommendations provided by HSAG.
Recommendation
HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*: • 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).
Response
a. Describe why this weakness exists: • Internal auditing of performance measures tied to contractual compliance has historically been a manual process conducted by clinical managers overseeing the work of care coordination staff. The challenges with this process have been the need to individually go into case records to identify any areas of concern related to 35D to develop corrective action plans.
b. Describe initiatives implemented based on recommendations: • CountyCare has created a care coordination dashboard in CMIS that outlines compliance on key care coordination requirements. The dashboard allows a quick and easy overview of caseload compliance, helping management identify trends and areas for improvement. Manager and Care Coord review during monthly 1:1s allowing for open communication, feedback, and discussions about caseload compliance. Clinical management staff provided ongoing education to care coordinators regarding capturing verbal consent for service planning during PHE and physical signature post PHE. The health plan is also performing routine audits and tracking of service plan completion, providing real time feedback to staff and management regarding any findings. Refresher trainings occur quarterly.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CountyCare has plan has made significant improvement in 35D as performance for this measure in Q4 FY22 was at 65% and most recent performance for Q4 FY23 was at 84% for HealthChoice and MLTSS saw the same improvement. (source: SFY2023 HCBS Waivers CMS Performance Measures Record Review Summary of Findings and Recommendations)

d. Identify any barriers to implementing initiatives:

- Auditing for 35D is currently contingent on a manual review of dashboard and case file. There is no formal report pushed out to management/staff that outlines findings of care coordinator compliance.

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

- While we continue with the initiatives implemented, although manual, the health plan leadership will continue to work with CMIS on system enhancements as prioritized.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- 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.

Response

a. Describe why this weakness exists:

- Upon completion of root cause analysis, the following trends were identified for untimely contacts for PD and ELD waiver recipients: Care coordination staff did not have centralized dashboard outlining contacts due and dates since previous contacts. Care coordinators were not always aware of their untimely contacts, due to inefficient self-tracking mechanisms they used, which resulted in there not being any valid justification for untimeliness.

b. Describe initiatives implemented based on recommendations:

- CountyCare has created a care coordination dashboard in CMIS that outlines compliance on key care coordination requirements, including timely contact. The dashboard allows a quick and easy overview of caseload compliance, helping management identify trends and areas for improvement. Manager and Care Coord review during monthly 1:1s, allowing for open

communication, feedback, and discussions about caseload compliance. CountyCare has distinct HIV and BI teams that carry HIV or BI specific caseloads with 1:30 ratios. Staff refresher training on contacts and valid justification occur quarterly. CountyCare participated in several Cook County Health job fairs and successfully hired additional care coordinators for the waiver program.

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

d. Identify any barriers to implementing initiatives:
- NA

e. Identify strategy for continued improvement or overcoming identified barriers:
- NA

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D7, *the most recent service plan is in the record and completed in a timely manner*:

- 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.

Response

a. Describe why this weakness exists:
- Similar to 35D, internal auditing of performance measures tied to contractual compliance historically been completed manually by clinical managers overseeing the work of care coordination staff. The challenges with this process have been the need to individually go into case records to identify any areas of concern related to D7 to develop corrective action plans.

b. Describe initiatives implemented based on recommendations:
- CountyCare has created a care coordination dashboard in CMIS that outlines compliance on key care coordination requirements. The dashboard allows a quick and easy overview of caseload compliance, helping management identify trends and areas for improvement. Manager and Care Coord review during monthly 1:1s, allowing for open communication, feedback, and discussions about caseload compliance. Clinical management staff provided ongoing education to care coordinators regarding timeliness of required activities and documentation requirements from HFS during PHE and post PHE.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- CountyCare had slight improvement in this measure with performance at 80% for Q4 FY22 and most current report reflects 83% performance for Q4 FY23 for MLTSS and flat performance for HealthChoice at 82%.

d. Identify any barriers to implementing initiatives:
- Auditing for D7 is currently contingent on a manual review of dashboard and case file. There is no formal report pushed out to management/staff that outlines findings of care coordinator compliance.

e. Identify strategy for continued improvement or overcoming identified barriers:
- While we continue with the initiatives implemented, the health plan leadership will continue to work with CMIS on system enhancements as prioritized to reduce the amount of manual tracking and monitoring. CountyCare will continue with quarterly refresher trainings on service plan timelines. We will continue our care coordinator hiring efforts to adequately cover all cases and reduce caseload size.

7. Prior Year Recommendations for QA/UR/PR Annual Report:

Recommendation

HSAG recommended the following:
- Include a detailed analysis of access and utilization of dental services.
- Include a detailed analysis of cultural competency.

Response

a. Describe why this weakness exists:
- Although CountyCare had a structured process to develop and submit the Annual Report, there was a gap related to the inclusion of some required items in the FY21 report resulting in the lack of data and analysis for dental services and cultural competency.

b. Describe initiatives implemented based on recommendations:
- In order to close the previous year's gap, CountyCare created a core team for ongoing development and monitoring of content for report preparation and submission. CountyCare created a tracking log with all required items that includes a dedicated owner for each item, along with due dates and secondary review processes to assure all items are validated for accuracy and included in the report.
  - Cultural Competency: CountyCare implemented its cultural competency/humility plan in 2020 and updates this plan on an annual basis. In April 2023, CountyCare hired a director of health equity to oversee all cultural competency/humility activities. In addition, CountyCare incorporated training focused on health equity into the CountyCare New Hire Orientation. CountyCare will host a cultural humility/competency training in October 2023 and will continue to do so on an annual basis. We have implemented a process to improve tracking of provider compliance to cultural competency contractual requirements.
  - Dental Services: Dental Access and utilization is reviewed on an ongoing basis with delegated vendors and included in the quarterly UM Committee review.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- As a result of these initiatives, all required items including dental services and cultural competency were included in the following year's report (FY22).

d. Identify any barriers to implementing initiatives:
- None identified.

e. Identify strategy for continued improvement or overcoming identified barriers:
- CountyCare has established a proactive preparation process for all required reporting to include a structured approach to data and analytic needs and a secondary validation review to assure all items are accounted for prior to submission.

HSAG Assessment

8. Prior Year Recommendations for Mental Health Parity Review:

Recommendation

HSAG recommended the following:

- Review the systems and processes responsible for denial 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.

Response

a. Describe why this weakness exists:
- CountyCare identified that the HFS required template was not at 6th grade reading level. Note that HFS subsequently instructed health plans to limit the scope of their assessment to the denial rationale.
- During the 2022 HSAG Administrative Compliance Review, the threshold for compliance with reading level requirements for decision letters was 6.0. Prior to this review, CountyCare interpreted the 6th-grade reading level requirement to mean a threshold of 6.9. On behalf of Illinois MCOs, IAMHP sent a request for guidance to HFS on whether a threshold of 6.0 or 6.9 meets the intent of this requirement. As of September 2023, IAMHP has not received final clarification from HFS.

b. Describe initiatives implemented based on recommendations:
- CountyCare provided approved options for conversion of medical terms into layman's terms.
- Staff were educated on the requirement that letters meet a Flesch-Kincaid Grade level of 6.0.
- Audit [#23024] was performed of language used in letters. Guidance provided to the PA Team, and the letter language was updated to comply with the Flesch-Kincaid Grade level score of 6.0.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CountyCare oversight of delegate's operations related to denial letter creation at a 6.0 reading level. Audit and remediation testing revealed an improvement in scores. Overall scores decreased from an average of 8.5 to a range of 5-6.
d. Identify any barriers to implementing initiatives: • No barriers to implementing the initiative.
e. Identify strategy for continued improvement or overcoming identified barriers: • Strategy for continued improvement includes: - Routine and ongoing monitoring of the 6.0 level reading requirement during file reviews. - Clearly defining how reading levels are measured in audit instructions and in PA team educational training.
HSAG Assessment

Recommendation
HSAG recommended the following: • Ensure and demonstrate that adverse benefit determination decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).
Response
a. Describe why this weakness exists: • CountyCare's vendors are delegated for adverse benefits determination decisions and communications. Monthly delegate reporting and routine file reviews of our delegates indicate turn-around-times are maintained within a timely manner. Similarly, HSAG's ABD record review of the timeliness of communications demonstrated 93.33% compliance (14/15) for M/S and MH/SUD records.
b. Describe initiatives implemented based on recommendations: • CountyCare has processes in place to monitor monthly turn-around-time metrics.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • No performance improvement initiatives were needed.
d. Identify any barriers to implementing initiatives: • No barriers to implementation or review of metrics were identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • Monthly reporting and oversight provide identification of any opportunities for improvement.

HSAG Assessment

Recommendation
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. HSAG recommended the following: • Continue 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.
Response
a. Describe why this weakness exists: • Factors that contribute to weakness include: - Provider lack of understanding of PA requirements; - Provider utilization of avenues for submission of Prior authorization data that allows for incomplete submission; and - Differences in interpretation of the PA criteria requirements.
b. Describe initiatives implemented based on recommendations: • PBM: Promotion of utilization of the ePA system where all required PA criterion is made available during the submission process. • Evolent: Promotion of portal usage which serves as a shared location for requests and information. • Evolent: Auto-authorize services with historically high approval rates using utilization management system rules-based logic and a machine learning algorithm. • PBM & Evolent: Additional targeted education to behavioral health providers of the availability of the Peer-to Peer process.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • PBM & Evolent: Implementation of the Peer-to-Peer process resulted in an increase in Provider contact and education. The Peer-to-Peer process resulted in increased provider discussions prior to PA decision and submission of additional information when applicable. • Evolent: CountyCare denied MH/SUD services at a statistically significantly lower rate than M/S services in FY23 (Chi-square with Yates correction, p value=0.0001).
d. Identify any barriers to implementing initiatives: • Peer-to-Peer process requires provider outreach which can be difficult to schedule.
e. Identify strategy for continued improvement or overcoming identified barriers: • Monitoring of unable to contact providers allows for additional outreach and timely identification of cases that require provider or member engagement.

- Provide additional avenues for contact, including dates/times and availability, during first contact.
- Continue to develop and strengthen the auto-authorization process.

HSAG Assessment

Humana

1. Prior Year Recommendations for Care Management Staffing:
Recommendation
HSAG recommended the following: • 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.
Response
a. Describe why this weakness exists: • Long Term Services Support (LTSS) reevaluated the identified issue with the staff who was not qualified to have the Persons with Disability waiver case and it appeared that the member had a termed waiver but the waiver code had not dropped off and member was in a Long Term Care Facility. The identified staff member only manages members who are in Long Term Care Facilities.
b. Describe initiatives implemented based on recommendations: • We continue to monitor staff qualifications and ensure that the appropriate staff is assigned to the appropriate waivers. We also continue to ensure that our staffing and recruitment of new staff calls out specific educational requirements and qualifications needed for appropriate management of LTSS members.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • N/A
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment

2. Prior Year Recommendations for Critical Incident Monitoring:
Recommendation
HSAG recommended the following: • Revise 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.

Response

a. Describe why this weakness exists:
- Previous processes did not include a requirement to make documentation or outreach to the member's Power Of Attorney (POA) or documentation of cognitive or behavioral health conditions even when those existed.

b. Describe initiatives implemented based on recommendations:
- LTSS re-evaluated oversight and monitoring of members with an open critical incident. LTSS updated the process to include a monthly review cadence as well as adding a check for notification of the POA if the member is unable to speak for themselves. The LTSS team was retrained / reminded of the process (3/9/2023).

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- LTSS team initiated secondary oversight process were the Quality Improvement team reviews all Critical Incident's (CI) and ensures that the team is following process and contacting the appropriate parties for follow-up

d. Identify any barriers to implementing initiatives:
- No identified barriers at this time.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Continued monthly monitoring of CIs and follow-ups regarding needed steps when outreach to POA or documentation of cognitive or BH conditions may be needed.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Delay in Adult Protective Services (APS) notification to health plan, delay in APS return calls from follow-up, and occasionally APS has notified us that they cannot provide information. Occasionally we will receive a Notice Of Investigation (NOI) but no Report Of Substantiation (ROS). IDPH has advised that they will not provide updates for open cases. Report of Substantiation.

b. Describe initiatives implemented based on recommendations:
- Processes were reviewed and updated to in the event of the receipt of an APS NOI, care coordinators/care managers are required to notify the APS investigator of the receipt of the NOI and follow-up within 14 days if not reached. In the event that a substantiated APS ROS is received, care coordinators/care managers are required to notify the APS investigator of the receipt within 5 days and follow-up within 14 days if not reached. Contact occurs primarily by phone, but also by email. If voicemail is available, the care coordinators will leave voicemail. Care Coordinators documents attempts to communicate and successful communication in the member's case notes via the communication record. Re-training was conducted on 6/21/2023, 6/29/2023 and 7/19/2023.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

d. Identify any barriers to implementing initiatives:
- N/A

e. Identify strategy for continued improvement or overcoming identified barriers:
- Continued monthly monitoring of CIs, follow-up to staff as warranted, and biannual and as needed trainings.

HSAG Assessment

3. Prior Year Recommendations for HCBS Waiver Performance Measures (MMAI):

Recommendation

HSAG recommended the following:
- Focus efforts on measures 35D and D9 and benefit from implementing the performance measure-specific recommendations provided by HSAG.

Response

a. Describe why this weakness exists:
- For Measure D9 LTSS team identified issues and barriers that were related to Internal processes and created a structured process for Claims/service validations.

b. Describe initiatives implemented based on recommendations:
- Developed tools to simplify the claims review used for service validation; job aids were also developed. Developed an audit tool to focus on the service validation documentation by the Care Coordinators. Each audit tool was returned to the Care Coordinator with remediations identified, with expected remediation completion in 2 weeks.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Internal service validation audits began in August 2022 with an average score of 79.63%; audits in September 2023 so far are averaging 95.45%. We continue to complete ongoing internal audits on all cases to ensure that appropriate process is followed and all services are agreed upon by members and their supports.

d. Identify any barriers to implementing initiatives:
- Some noted barriers were compliance with staff using the appropriate tools and following process as outlined. These are often identified during internal audits and remediated accordingly.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Ongoing monthly internal audits to ensure the compliance.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures:*

- Ensure 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.

Response

a. Describe why this weakness exists:
- Due to the PHE LTSS care Coordinators needed to obtain a second verification for members agreement of service plan. This created a barrier as Care Coordinators often had to call members back to obtain the agreement with a second verifier on the call however those calls were not always successful. For the Supportive Living Program (SLP) members we identified issues getting the facility signature and this was also exacerbated by the PHE and inability to get the staff on the phone often times.

b. Describe initiatives implemented based on recommendations:
- Due to the PHE LTSS care Coordinators needed to obtain a second verification for members agreement of service plan. This created a barrier as Care Coordinators often had to call members back to obtain the agreement with a second verifier on the call however those calls were not always successful. For the Supportive Living Program (SLP) members we identified issues getting the facility signature and this was also exacerbated by the PHE and inability to get the staff on the phone often times. For Measure D9 LTSS team identified issues and barriers that were related to Internal processes and created a structured process for Claims/service validations.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Due to the Public Health Emergency (PHE) LTSS care Coordinators needed to obtain a second verification for members agreement of service plan. This created a barrier as Care Coordinators often had to call members back to obtain the agreement with a second verifier on the call however those calls were not always successful. For the Supportive Living Program (SLP)

members we identified issues getting the facility signature and this was also exacerbated by the PHE and inability to get the staff on the phone often times. For Measure D9 LTSS team identified issues and barriers that were related to Internal processes and created a structured process for Claims/service validations.

d. Identify any barriers to implementing initiatives:
- Some noted barriers were compliance with staff using the appropriate tools and following process as outlined. These are often identified during internal audits and remediated accordingly.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Ongoing monthly internal audits to ensure the compliance.

HSAG Assessment

4. Prior Year Recommendations for QA/UR/PR Annual Report:

Recommendation

HSAG recommended the following:
- Include a detailed analysis of access and utilization of dental services.
- Include a detailed analysis of cultural competency.

Response

a. Describe initiatives implemented based on recommendations:
- Humana's vendor for dental services is DentaQuest, which is contracted to provide statewide administrative services, they do not pro-actively have any analysis or programs related to disparities. Humana's previous Health Equity &Community Engagement team worked on several cultural competence initiatives along with the Adequacy and Access team. The newly formed Health Equity & Social Impact (HESI) team has several initiatives focused on cultural competency for associates and providers.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Humana implemented a regional review of dental grievances by county, gender, and category in an effort to identify trends starting in 2022. Humana's enterprise HESI team developed an evidence-based and provider focused cultural humility and implicit bias training program. This innovative training program was piloted with Humana primary care providers (PCP). Additionally, the team is developing a comprehensive and evidence-based health literacy toolkit designed with the core tenets of cultural humility to reflect Humana's diverse membership in partnership. The health literacy toolkit will be piloted with Humana associates engaging with members/patients with low health literacy needs. Humana collaborated with Chicago Meals on Wheels initiative to provide access to culturally relevant fresh and shelf-stable foods

c. Identify any barriers to implementing initiatives:
- During the reporting period, more members received services from a provider than previous years (FY2023: 5,368 and FY 2022: 4,624; FY 2021: 2,929; FY 2020: 2,578). There was a slight increase in overall member utilization percentage compared to the last two years (FY 2023

32.8% and FY 2022: 28%, FY 2021: 30%; FY 2020 36.4%). The network is robust with members having access to a provider requirements i.e., urban counties with one (1) provider in 30 miles = 99.2% access rate and rural counties with one (1) provider in 60 miles = 90.7% access rate. DentaQuest regularly conducts provider surveys, in 2022 survey results, 204 providers responded with 90% responding they were satisfied and 94% advising they were planning to continue remaining with the network. Additionally, 81% of providers said DentaQuest was easy to do business with, which is an increase from the previous year. Humana reported an overall decrease in dental grievances and has identified Cook County has the highest dental grievances for the second year without identified related trends at this time. The completion rate for 2022-2023 was greater than 90% for required Cultural Competency.
d. Identify strategy for continued improvement or overcoming identified barriers: • N/A
e. Identify strategy for continued improvement or overcoming identified barriers: • Humana will continue to trend all dental grievances including regions, gender, and categories. Access and provider satisfaction. Humana will continue annual cultural competency training for physicians, allied providers, and Humana associates. Humana's Adequacy and Access team will continue to track membership ethnicity and complaints regarding cultural or linguistic needs.
HSAG Assessment


Meridian

1. Prior Year Recommendations for Performance Measures:
Recommendation
HSAG recommended the following: • 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. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate. 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.
Response
a. Describe why this weakness exists: • Adults' Access to Preventive Services (AAP) performed in the 25th percentile as of MY 2022. Low performance can be partially attributed to: Members experiencing transportation challenges and concerns regarding the loss of pay from missing work, or further disciplinary action at work. Meridian identifying Black/African American men living in DIA ZIP code areas as having lower AAP compliance rates than the overall Medicaid population. Many network providers were unaware of this inequity and cited IT systems and personnel shortages as constraints that did not allow their analysis of patient data by health equity demographics.
b. Describe initiatives implemented based on recommendations: • Meridian has implemented a Member-Rewards Program incentive, offered in-home visits, digital campaigns, public and member-focused community events, and provider group outreach initiatives to address member access to care. Meridian conducted a focus group via both telephonic and in-person outreach to Black/African American men living in DIA ZIP codes. The Plan reached out to 4,277 members over a 3-month period and had a participation rate of 36%. Among the non-participants, 355 members declined to participate. (See 1d below.)
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During MY 2021 to MY 2022, the AAP measure's year-over-year performance demonstrated a modest decline of -1.72%. Meridian is working to develop methodologies to better assess the impact of interventions on HEDIS measure outcomes.
d. Identify any barriers to implementing initiatives: • Meridian identified the following barriers: Member feedback collected during Meridian's focus group indicated that members do not feel motivated to visit a doctor outside of times of illness. Member feedback collected during targeted telephonic and in-person outreaches to Black/African American men living in DIA zip codes indicated that the possibility of missed wages presented a barrier for this population. The State's required initiative approval-process timeline shortens Meridian's timeline to effectively implement initiatives within the measurement year regarding written member communication.

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

- Meridian will continue to have its Member and Consumer Advisory Committees gather and share member feedback to inform future AAP interventions. A workgroup focusing on health disparities in the Black/African American men living in DIA zip codes continues to discuss and develop strategies, implement meaningful tactics to improve outcomes, and monitor ongoing measure performance as we receive member feedback.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- The Well Child Visit (WCV) measure performed in the 50th percentile as of MY 2022. Low performance can partially be attributed to: Members taking children for "sick child" visits and often not considering well child visits in the absence of required child vaccinations. Members having difficulty taking time off work, concerns of lost pay, and children's anxiety toward healthcare. These factors may reduce motivation for parents to seek care outside of illness. Members having transportation challenges and members experiencing appointment scheduling conflicts with other responsibilities such as childcare or work.

b. Describe initiatives implemented based on recommendations:

- Meridian partnered with a third-party vendor, DigiDoc, to provide text message outreach for health reminders, screenings, and activities for members with open care gaps. Meridian's Vaccine Adherence in Kids (VAKs) Program, in partnership with Pfizer and Televox, promotes well-child visits, interacting with parents and caregivers through email, SMS text messages, telephone calls, and mail to encourage scheduling appointments and discussing vaccinations with their doctors. Meridian also partnered with a third-party vendor, PRIMIS, to provide telephonic outreach for health reminders, screenings, and upcoming community activities. Meridian uses social media campaigns via the Plan's Facebook, LinkedIn, and Twitter sites to raise awareness and educate the community. Meridian partners with a third-party vendor, Qartek, for member rewards programs including telephonic and email outreach to provide health reminders to members due for WCV services. Member newsletters are also used to educate Meridian's members.

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

- During MY 2021 to MY 2022, the WCV measure's year-over-year performance demonstrated a modest decline of -1.37%. Meridian is working to develop methodologies to better assess the impact of interventions on HEDIS measure outcomes.

d. Identify any barriers to implementing initiatives:

- Meridian has identified having accurate contact information for reaching members as a barrier to implementing initiatives.

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

- Meridian partners with a third-party vendor to provide transportation services to assist members with getting to appointments. Meridian established the Preventive Services Empower Performance Circle, a cross-functional workgroup, to design and implement targeted WCV interventions. Meridian will continue the Preventive Services Outreach Program that involves outreach to members with multiple care gaps through a variety of modalities, including telephonic and mailed information. The program also includes digital materials and campaigns, provider education and engagement campaigns, and public and member-targeted community health and wellness events which seek to inform members and the community of the importance of well visits and provide resources for how they can best access preventive care.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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 performance.

Response

a. Describe why this weakness exists:

- The Childhood Immunization Status-Combination 3 and 10 measures (CIS Combo 3 and 10) and the Adolescent Immunizations Combo 2 measure (IMA Combo 2) performed in the 25th, <25th, and <25th percentiles, respectively. Low performance can partially be attributed to: Members' health beliefs as influenced by the anti-vax movement. Member transportation challenges. Providers experiencing vaccine inventory costs and shortages.

b. Describe initiatives implemented based on recommendations:

- Meridian continues to conduct member advisory meetings as well as member telephonic, SMS texting, social media, and newsletter campaigns. Meridian enhanced and promoted a provider

toolkit program for the Early Preventive Screening, Diagnostic and Treatment (EPSDT) benefit that assists providers with informing members of preventive health services, e.g., vision, dental, hearing, etc., available for children under age 21.Meridian partnered with a third-party vendor PRIMIS, to provide telephonic outreach for health reminders, screenings, and activities to members due for services. Meridian uses social media campaigns via the Plan's Facebook, LinkedIn, and Twitter sites to raise awareness and educate the community. Meridian continued the VAKs Program which sends out monthly and quarterly mailings to members due Immunizations services. Meridian partners with a third-party vendor, Qartek, for member rewards programs including telephonic and email outreach to provide health reminders to members due for immunizations services. Meridian distributes member newsletters to educate Meridian members.

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

- During MY 2021 to MY 2022, the year-over-year performance for CIS Combo 3 and 10 and for IMA Combo 2 demonstrated an increase and declines of +5.60%, -1.70%, and -2.70%, respectively. Meridian is working to develop methodologies to better assess the impact of interventions on HEDIS measure outcomes.

d. Identify any barriers to implementing initiatives:

- Meridian identified the following barriers: Low member and provider attendance at Member and Community Advisory Committee meetings and Meridian educational webinars. Challenges with obtaining updated member contact information is also needed to ensure outreach methods are effective in reaching members and providers.

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

- Meridian established the Preventive Services Empower Performance Circle, a cross-functional workgroup, to design and implement targeted CIS and IMA interventions. The EPC also reviews data and analytics information, data visualization reports, and health disparities analyses to determine where interventions should be targeted to address inequities.

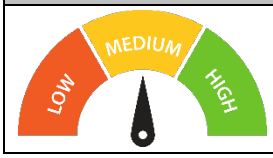
HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.

Response
a. Describe why this weakness exists: • Breast Cancer Screening (BCS) performed in the 25th percentile as of MY 2022. Low performance can partially be attributed to: Members' limited motivation to schedule and attend appointments that may result in loss of time and pay from work, especially if there is absence of signs, symptoms, or family history of Breast Cancer. The BCS test is uncomfortable for many members. Member transportation challenges, appointment scheduling, language barriers, and finding childcare support during the medical visit. Members need information regarding the appointment location and getting medication covered.
b. Describe initiatives implemented based on recommendations: • The Preventive Services Outreach Program is a corporate Centene program in which members with multiple care gaps are called and receive mailings. The program also includes digital campaigns, provider education campaigns, and public and member-targeted community events. Meridian also has implemented the Mammogram Days Community event in partnership with the local hospitals. Meridian partnered with a third-party vendor, PRIMIS, to contact members with care gaps. Meridian uses social media campaigns via the Plan's Facebook, LinkedIn, and Twitter sites to raise awareness and educate the community.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During MY2021 to MY 2022, the BCS measure's year-over-year performance shows a 25th percentile status that is ahead of the measure's prior year performance. Meridian is working to develop methodologies to better assess the impact of interventions on HEDIS measure outcomes.
d. Identify any barriers to implementing initiatives: • Meridian has identified a lack of mobile mammography screening services as a barrier to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • Meridian will continue a preventive health reminder program strategy including member and provider education via newsletter articles and face-to-face interactions as well as reminders of preventive health screenings and services via targeted telephonic, digital, and written outreach. Meridian has established a Preventive Services Empower Performance Circle, a cross-functional workgroup, to design and implement targeted BCS interventions. Meridian plans to implement a member survey via SMS Text to request feedback on what their barriers to completing breast cancer screening.
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 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.
Response
a. Describe why this weakness exists: • Cervical Cancer Screening (CCS) performed in the 25th percentile as of MY 2022. Low performance can partially be attributed to: The sensitivity of the measure and the uncomfortable nature of the screening. Member loss of wages and transportation concerns.
b. Describe initiatives implemented based on recommendations: • Meridian has implemented member telephonic outreach campaigns and SMS texting via a third-party vendor for appointment reminders. Meridian has a dedicated provider engagement team to educate providers on quality measure requirements, offers an Annual Quick Reference Guides available via Meridian website, and holds Monthly HEDIS webinars for providers and coding teams. Member-facing educational flyers encourage women's health screenings. Meridian uses social media campaigns via the Plan's Facebook, LinkedIn, and Twitter sites to raise awareness and educate the community.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From MY2021 to MY2022, the CCS measure moved from under the 25th to the 25th percentile. Meridian is working to develop methodologies to better assess the impact of each intervention on HEDIS measure outcomes.
d. Identify any barriers to implementing initiatives: • Meridian has identified challenges of getting cervical cancer screening reported in the medical records as a barrier to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • Meridian will continue a preventive health reminder program strategy including member and provider education via newsletter articles and face-to-face interactions as well as reminders of preventive health screenings and services via targeted telephonic, digital, and written outreach. Meridian established a Preventive Services Empower Performance Circle, a cross-functional work group that continues to meet and design and implement targeted interventions based on current data.
HSAG Assessment


Recommendation
HSAG recommended the following: • 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
Response
a. Describe why this weakness exists: • The Follow-Up After Hospitalization for Mental Illness (FUH) measure (all sub measures for both 7 and 30 day follow up) performed in the 25th and less than 25th percentiles as of MY2022. Low performance can partially be attributed to: Discharge planning which varies from facility-to-facility with varying levels of effectiveness. Appointment availability with mental health providers is limited, especially for members that do not already have a relationship established with a mental health practitioner. A patient has limited knowledge of the type of provider they could see to fulfill the requirements of FUH. Barriers that apply to most measures such as transportation and taking time off work also apply to FUH.
b. Describe initiatives implemented based on recommendations: • Meridian contracted with a behavioral health telehealth program that launches in September/October 2023 which will focus on those hospitalized for mental illness. Meridian's text-message campaign to send reminders to patients after a behavioral-health discharge is planned for Q3 2023. Meridian is working to embed a caseworker within the discharge department of a hospital system with poor readmission rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All FUH sub-measure scores increased from MY2021 to MY2022. Initiatives are in progress so improvement cannot be measured at this time.
d. Identify any barriers to implementing initiatives: • A patient has limited knowledge of the type of the provider they could see to fulfill the requirements of FUH, so even when text message reminders are initiated, additional educational initiatives will need to be deployed at the same time to close that education gap. The vendor that sends Meridian's text messages also requires a specific file format for patient information posing additional IT burden.
e. Identify strategy for continued improvement or overcoming identified barriers: • Meridian formed a cross-functional team that meets every other week with a focus on Behavioral Health HEDIS measure performance. The group's sole purpose is to identify improvement opportunities and actions for improved member outcomes and quality performance of these key behavioral health measures.

HSAG Assessment

Recommendation
For the HIV Viral Load Suppression measure, many health plans reported difficulty obtaining viral load data which may be leading to underreporting of performance. HSAG recommended the following: • Monitor 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.
Response
a. Describe why this weakness exists: • We receive HIV lab data from the state of Illinois; however, as instructed by HSAG and HFS, we do not utilize the Mer6 data in our rates due to potential privacy issues.
b. Describe initiatives implemented based on recommendations: • The plan has agreements in place with lab vendors Quest Diagnostics ® and Labcorp ® to obtain lab values, including viral load data. Care Management and Provider outreach program in collaboration with Meridian Pharmacy Department for members living with HIV with poor medication adherence to antiretroviral therapy (ART). Pharmacy completed outreach to providers letting them about members who had not filled their ART medication in 180 days. Care Management completed outreach to members to assist with ART adherence and address any barriers.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measure MY2021 HVL-AD Viral Load <200 copies/mL 16.4% MY2022 40.23% HVL-AD MY2021 Valid viral load lab result NA MY2022 43.52% HIV Viral Load Suppression (HCL-AD) - Viral Load <200 copies/mL - rate increased by 3% from Q2 to Q3 2022 after the collaborative outreach noted in 7b.
d. Identify any barriers to implementing initiatives: • HSAG and HFS guidance states to not to include MER6 data, due to potential privacy issues.
e. Identify strategy for continued improvement or overcoming identified barriers: • Meridian continues to monitor the HVL-AD rates.
HSAG Assessment


Recommendation
For the *LTSS Comprehensive Care Plan and Update* measure, 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. HSAG recommended the following: Monitor 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. • 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.
Response
a. Describe why this weakness exists: • Low performance was due to core and supplemental elements not being located within reportable fields, requiring manual validations, and increasing risk for error.
b. Describe initiatives implemented based on recommendations: • Meridian continues to pursue system enhancements which will increase the count of core and supplemental elements in reportable fields. This will minimize the use of manual chart reviews and risk for error.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For all quarters of 2022 Meridian successfully met 50 core and supplemental elements. After implemented changes, Meridian saw an increase. In Q1 of 2023 Meridian successfully met 77 of the 96 core and supplemental elements.
d. Identify any barriers to implementing initiatives: • Barriers include the timeline needed to implement process and system changes. System enhancements may take up to 3 months to implement, due to system changes required, testing and staff education.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued monitoring and review of additional system enhancements. Early identification will allow request of system enhancements, testing and education to occur and create positive impact on future submissions.
HSAG Assessment

Recommendation
For the *LTSS—Successful Transition After Long-Term Institutional Stay* measure, the health plans may not be including all enrolled MLTSS members in the eligible population for this measure due to states 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 Opt-Out members in the identification of the eligible population or calculation of observed discharges for the measure. HSAG recommended the following:

- Review the process for identifying the eligible population and their data sources for institutional facility claims.
- Evaluate clinical review processes 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.

Response

a. Describe why this weakness exists:
   - Low performance exists due to late identification of member admission and initiation of discharge planning process.

b. Describe initiatives implemented based on recommendations:
   - Meridian is leveraging ADT reporting to identify member's admission in a timely manner and building an automated dashboard to further identify and track members through the transition process. Meridian utilizes a clinical team of transition staff, allowing for a dedicated team to facilitate long term care transitions.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Initiatives are newly implemented. Performance improvements anticipated for future submissions.

d. Identify any barriers to implementing initiatives:
   - Timeline to hire additional staff for clinical transition team. Continued addition of long term care facilities to ADT platform for identification.

e. Identify strategy for continued improvement or overcoming identified barriers:
   - Meridian has built reporting to identify and monitor transitions. Meridian is currently in process of automating the report to allow for daily monitoring of transitions.

HSAG Assessment

2. Prior Year Recommendations for Network Adequacy:

Recommendation

In regard to the Access and Availability Telephone Survey, 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. HSAG recommended the following:

- Work with HFS to obtain the case-level survey data files to address provider data deficiencies identified during the survey.
- Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Additionally, 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.

Response

a. Describe why this weakness exists:

- Provider lack submissions related to change of coverage location is a driver of provider data deficiencies. Providers fail via roster to update Meridian on changes to practitioner participation (Retired, Deceased, Left Group). We also find the practitioner phone number changes are not frequently updated via provider roster. Numbers provided are disconnected or inaccurate, or the phone number is not the practice's appointment phone number (i.e., a billing or other administrative phone number). Specific to obtaining an appointment with surveyed locations, Meridian has found providers status in accepting new patients is often fluid and changes frequently due to various factors including staffing and seasonal demands. Provider practices do not often prioritize updating rosters or notifying the plan on a timely basis of changes or updates in practitioner panel status. It is more efficient for physician office staff to simply inform members, when they call to request an appointment, if a practitioner's panel is closed. Awareness of network participation by staff within an office may also be a factor.

b. Describe initiatives implemented based on recommendations:

- Meridian incorporates a variety of activities to continuously improve provider data accuracy. In Q2 2023, Meridian began project to evaluate the accuracy of data listed in the physician directory and to improve member experience by completing the following objectives: evaluate accuracy of office locations and phone numbers evaluate accuracy of accepting new patients evaluate accuracy of physician office staff awareness of participation in the organization's networks. This project is completed Customer Care Professional representatives who are trained to review practitioner demographic data, verify the accuracy, and gather updated information, as necessary. A phone survey script is used, which prompts the representative to specifically ask if the practitioner participates with the health plan, as well as confirm if the addresses, phone numbers, and panel status are accurate and complete based on the information stored in the source system. In addition to surveying via smaller sized offices via phone call, the health plan also initiated a mailing project with same data fields for larger offices. Meridian has also engaged 3rd Party Vendor VEDA to increase directory accuracy by leveraging vendors directory cleansing solution based in data science, machine learning, and web/social media sites to enhance and scrub provider data on a quarterly basis. Meridian completes an annual analysis of the accessibility of primary care providers, high-volume and high-impact specialty care practitioners, and behavioral health providers to ensure that providers are meeting access standards specific to regular/routine care and urgent care appointments to ensure members have access to services that align with their accessibility standards. Education is provided to offices that fail to meet standards. Enhancements to provider education included education on access and availability standards in the HEDIS® Quick Reference Guide, Quality Education Webinar, and annual CAHPS® training on Meridian's provider website. Meridian also increased provider awareness regarding the importance of maintaining accurate and updated provider demographic information via monthly newsletters, provider meetings and webinars. We are also increasing the awareness of network participation in person and virtual provider meetings to all provider

types. The health plan distributes promotional items to support provider staff and member easy identification of health plan network participation.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Not applicable at this time.

d. Identify any barriers to implementing initiatives:
- Meridian has received provider abrasion related to provider data accuracy initiatives. Offices prefer to limit all activities specific to provider demographics to roster submissions. While Meridian fully supports this approach, we encourage use of additional methods to confirm demographic information. Staffing shortages continue within physician offices driving inability to meet access availability standards.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Meridian will continue directory accuracy initiatives and provider education specific to the importance of updating all practitioner demographic detail via roster process. The health plan will also include provider education specific to appointment availability standards/guidelines in provider education activities. The health-plan will continue to promote/encourage the use of telemedicine and virtual visits where appropriate for members to receive care as soon as needed.

HSAG Assessment

Recommendation

In regard to the Access and Availability Telephone Survey, compliance with appointment availability standards was low, especially in the areas of allergy and immunology, pulmonology, and neurology. HSAG recommended the following:

- 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.

Response

a. Describe initiatives implemented based on recommendations:
- Providers lack knowledge specific to availability standards/guidelines or they were unable to satisfy the standards due to ongoing staffing shortages and limited operations in conjunction with high patent volume. Limited provider options are present in rural counties thus driving higher patient volume and appoint delays.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Increased contracting efforts implemented with focus on rural providers and larger health systems with full array of specialties. Provide education to practitioners on appointment availability standards and contractual requirements. Continue to promote/encourage the use of telemedicine and virtual visits where appropriate for members to increase appointment accessibility

c. Identify any barriers to implementing initiatives:
- Not applicable at this time.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Limited availability of allergy/immunology providers in certain rural areas of the state

e. Identify strategy for continued improvement or overcoming identified barriers:
- Meridian will continue to monitor appointment accessibility compliance of allergy and immunology, pulmonology, and neurology providers with the standards on an annual basis to ensure adequate appointment availability and accessibility is available to members when needed.

HSAG Assessment

Recommendation

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. HSAG recommended the following:

- 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. 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.

Response

a. Describe why this weakness exists:
- There are not enough pharmacies that can be solicited to meet adequacy requirements. There is a lack of oral surgery providers enrolled with IL Medicaid noted in one of the regions Meridian provides care to members. This is a rural region and there are not oral surgeons available in these counties.

b. Describe initiatives implemented based on recommendations:
- Every quarter, GeoAccess Reports (Pharmacy Network Adequacy) are reviewed to assess any pharmacies can be found to solicit. Example action plan: “12 pharmacies found that are not in network and on the state file. Meridian is unable to recruit any of them because of the types of pharmacies they are: 10 are Alternate dispensing site pharmacies; 1 is a Home infusion pharmacy; 1 is an Institutional pharmacy (CVSC will not solicit these types of pharmacies since not all members will be allowed to use them within the Meridian contract); 5 pharmacies in rural county but none are contracted with the state for Medicaid”. General dentists can perform certain oral surgery services and can provide care in network for members, however, are not credited as an oral surgeon. Meridian monitors IL Medicaid enrollment file for recruitment targets.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Not Applicable

d. Identify any barriers to implementing initiatives:
- There are not any pharmacies that can be solicited to help close the gap for Meridian, either because the pharmacy is not enrolled with the state or there are no pharmacies in the area that meet the requirements to join the network.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Continue to review reports each quarter and solicit pharmacies, as appropriate. There are contracted mobile dental anesthesia providers available in a nearby region. Access can be reviewed to determine the expansion of this unit as well as general dentists that can perform certain oral surgery services.

HSAG Assessment

3. Prior Year Recommendations for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct a 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. Consider whether there are disparities within populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the care members need.

Response

a. Describe why this weakness exists:
- Meridian conducted a root cause analysis to identify barriers and determine why members are not getting timely care or do not have access to care. Barriers identified include access and availability, member and provider education around access to care, and issues with transportation.

b. Describe initiatives implemented based on recommendations:
- Meridian completes an annual analysis of the accessibility of primary care providers, high volume and high-impact specialty care practitioners, and behavioral health providers to ensure that providers are meeting access standards. Enhancements to provider education included education on access and availability standards in the HEDIS® Quick Reference Guide, Quality Education Webinar, and annual CAHPS® training on Meridian's provider website. Member education around access and availability included the addition of 24/7 Nurse Advice Line information in member education and newsletter and information on social media and in the member newsletters on how to get urgent care or emergency care. Meridian also promotes telehealth services, when applicable, in member and provider education to improve access to

care. To address barriers with transportation impacting access to care, Meridian formed a workgroup with the transportation vendor to implement improvement strategies to address recurring transportation issues or barriers expressed by members. Meridian also utilizes alternative outreach platforms such as email and SMS text message to send member education and health reminders.

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

- Meridian's Provider Network team worked to expand the behavioral health network and have added two mobile dental anesthesia providers to expand access to dental services.

d. Identify any barriers to implementing initiatives:

- Transportation vendors are limited in the state. While Meridian works closely with the transportation vendor, MTM, to ensure that member transportation needs are met, issues with the vendor's internal system that can cause trip delays or cancellations are an additional barrier. Additionally, transportation providers are limited in the state and the availability of transportation drivers, especially in rural areas, is a barrier.

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

- Meridian conducts an internal workgroup to discuss initiatives from member and provider-facing departments, improvement strategies for member experience priority measures, and collaborative ways for the departments to work together. The workgroup will continue to analyze member feedback from the CAHPS® survey to identify barriers impacting access to care and the overall 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, 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 specialists in the area or if specialists are unwilling to contract with the health plan.

Response

a. Describe why this weakness exists:

- Meridian conducted a root cause analysis to identify barriers and determine why members are not getting timely care or do not have access to care. Barriers identified include access and availability, member and provider education around access to care, and issues with transportation.

b. Describe initiatives implemented based on recommendations:

- Meridian completes an annual analysis of the accessibility of primary care providers, high volume and high-impact specialty care practitioners, and behavioral health providers to ensure that providers are meeting access standards. Enhancements to provider education included education on access and availability standards in the HEDIS® Quick Reference Guide, Quality Education Webinar, and annual CAHPS® training on Meridian's provider website. Member education around access and availability included the addition of 24/7 Nurse Advice Line information in member education and newsletter and information on social media and in the member newsletters on how to get urgent care or emergency care. Meridian also promotes telehealth services, when applicable, in member and provider education to improve access to care. To address barriers with transportation impacting access to care, Meridian formed a workgroup with the transportation vendor to implement improvement strategies to address recurring transportation issues or barriers expressed by members. Meridian also utilizes alternative outreach platforms such as email and SMS text message to send member education and health reminders. Meridian also completes an annual analysis of the availability of PCPs, high-volume and high-impact specialty care practitioners, and high-volume behavioral health practitioner types to ensure there are adequate numbers and geographic distribution of providers to meet member needs. Meridian met the goal for the ratio standard for both high volume and high-impact specialty care practitioner types assessed.

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

- Meridian's Provider Network team worked to expand the behavioral health network and have added two mobile dental anesthesia providers to expand access to dental services.

d. Identify any barriers to implementing initiatives:

- Transportation vendors are limited in the state. While Meridian works closely with the transportation vendor (MTM) to ensure that member transportation needs are met, issues with the vendor's internal system that can cause trip delays or cancellations are an additional barrier. Additionally, transportation providers are limited in the state and the availability of transportation drivers, especially in rural areas, is a barrier. Members have also shared that time availability can be a barrier, especially for members with multiple children who do not have child care.

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

- Meridian conducts an internal workgroup to discuss initiatives from member and provider-facing departments, improvement strategies for member experience priority measures, and collaborative ways for the departments to work together. The workgroup will continue to analyze member feedback from the CAHPS® survey to identify barriers impacting access to care and the overall member experience. While the goals of the practitioner availability analysis were met, Meridian will continue to recruit, contract and credential all available practitioners and address any gaps in practitioner availability.

HSAG Assessment

4. Prior Year Recommendations for Care Management Staffing:
Recommendation
HSAG recommended the following for HealthChoice and MMAI: • 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.
Response
a. Describe why this weakness exists: • Low performance was due to certain educational requirements/degrees falling within the approved degrees listed within the admin code, but not matching the exact degree name listed.
b. Describe initiatives implemented based on recommendations: • Meridian reviewed its qualifications process and Meridian staff now complete the Staffing Qualifications survey upon hire and annually to ensure Meridian is capturing any changes to staff qualifications. Results from the survey are 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. Leaders utilize a licensure and certification report to ensure staff have the correct waiver assignments based on their qualifications. Meridian also updated internal audit processes to incorporate an internal review to identify if staff have accurate qualifications to manage specific waiver populations.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • With Meridian's last staffing workbook submission in April 2023, there was significant improvement with staff meeting education/qualification requirements managing waiver cases. Through updating our internal audit processes to include an additional review of requirements for waiver managing staff, Meridian ensures that all members are assigned to a case manager that is qualified to manage them based on education and experience, and that all case managers are managing the appropriate amount of members based on contractual guidelines.
d. Identify any barriers to implementing initiatives: • Degrees need to be specific to what is listed within the approved admin code.
e. Identify strategy for continued improvement or overcoming identified barriers: • Meridian will submit exemption requests to HFS for consideration for any degrees that are not listed specifically within the admin code but are similar to the listed degrees.

HSAG Assessment

Recommendation
HSAG recommended the following: • Review identify a plan to reassign caseloads to those case managers not meeting weighted, high-risk, or moderate-risk caseload limits.
Response
a. Describe why this weakness exists: • Historically, Meridian's staffing report included members who have not accepted and were not receiving care management. The reports included membership counts based on the members staff were attempting to contact to engage them in Care Coordination however, they were not all engaged and actively being managed. The previous report logic did not align with the contract requirements and included members we were attempting to contact, not members who requested or agreed to be in active care management.
b. Describe initiatives implemented based on recommendations: • Consistent with best practices of our sister health plans with Centene, during SFY 2023, Meridian implemented a new care management model to optimize outreach and engagement efforts. The model consists of two teams; an Onboarding Team dedicated to member outreach with the goal of assessment completion and engagement in care coordination, and a Care Management Team focused on care plan development and ongoing care coordination for members. Meridian updated reporting logic to pull members who accepted care coordination and are being actively managed by a care coordinator. When using this report logic, our results are in compliance with the contract. The previous report logic did not align with the contract requirements and included members we were attempting to contact, not members who requested or agreed to be in active care management. Meridian updated reporting logic to pull members who accepted care coordination and are being actively managed by a care coordinator.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All active cases have been assigned to the Care Management Team, while members not yet engaged in care management have been assigned to the aforementioned Onboarding Team for outreach. The 169 Meridian and four (4) Somatus HealthChoice caseloads that were previously exceeding the weighted caseload limit of 600 are now in compliance.
d. Identify any barriers to implementing initiatives: • Unengaged/unable to reach members.
e. Identify strategy for continued improvement or overcoming identified barriers: • Leadership is utilizing the Daily Dossier Report to review caseload information daily, as well as the Case Weight Report which is refreshed and reviewed weekly to ensure caseloads do not exceed limits.

HSAG Assessment

Recommendation
HSAG recommended the following for MMAI: • 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.
Response
a. Describe why this weakness exists: • Low performance was due to certain educational requirements/degrees falling within the approved degrees listed for the HIV waiver within the admin code, but not matching the exact degree name listed. In previous submissions, Meridian only submitted the primary qualifier and no supporting qualifications such as relative program experience.
b. Describe initiatives implemented based on recommendations: • Meridian undertook a comprehensive review of its waiver case assignment process. An updated waiver closure process has been implemented to prevent inappropriate waiver case assignments. Internal audit processes were updated to incorporate an extra review to identify whether or not staff has accurate qualifications to manage specific waiver populations.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • No cases require reassignment as all HIV/AIDS cases are assigned to staff meeting appropriate requirements. All licensure and qualification information is listed for all case managers that were assigned to HIV/AIDS cases in the 2023 IL Combined Staffing and Training report.
d. Identify any barriers to implementing initiatives: • Inaccurate responses within completed Qualifications surveys.
e. Identify strategy for continued improvement or overcoming identified barriers: • Prior to submission of the bi-annual staffing and training report, all case manager licensure and qualification information will be reviewed to ensure it is appropriately and accurately identified within submission. Leadership will utilize an additional licensure and certification report from Meridian's Human Resources Department to ensure staff have the correct waiver assignments based on their qualifications. Meridian will include all qualifiers within future staffing submissions. The Case Manager Senior Leadership team will perform an initial review with a final review to be completed by the Director of Case Management prior to submission. The review will reference the qualifications collected annually and upon hire via our internal qualification survey and compare them to ensure they are appropriately listed.

HSAG Assessment

5. Prior Year Recommendations for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:

- Weakness in this area is due to barriers in communication with skilled living facilities and long term care facilities.

b. Describe initiatives implemented based on recommendations:

- Meridian Health Plan reviewed its critical incident outreach process and is in the process of making revisions where applicable.

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

- Not applicable as Meridian Health Plan is in the process of revising the critical incident outreach workflow.

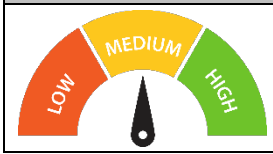
d. Identify any barriers to implementing initiatives:

- Meridian continues to experience barriers in communicating with members who reside in a skilled living facility and long term care facility due to poor and/or failed telephonic communication with facilities when attempting to reach the member directly.

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

- Quality Improvement and Care Management leadership will meet to review additional outreach strategies for these members following a critical incident. Revisions in the outreach workflow will be integrated by December 31, 2023.

HSAG Assessment



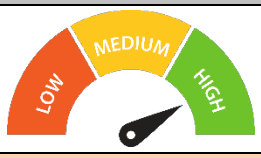
6. Prior Year Recommendations for HCBS Waiver Performance Measures (HealthChoice and MLTSS):
Recommendation
HSAG recommended the following: • Focus efforts on measures 35D and D6 and benefit from implementing the performance measure-specific recommendations provided by HSAG.
Recommendation
HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*: • 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).
Response
a. Describe why this weakness exists: • Staff were unable to obtain member signatures due to the PHE causing face-to-face visits to pause. Previously, SLP signature processing followed a faxing process to the Care Coordination Support Services (CCSS) team which caused a delay in processing and a lack of oversight with SLP related tasks. SLP provider: was difficult to obtain witness verbal consent of SLP staff over the phone.
b. Describe initiatives implemented based on recommendations: • Process improvements were made surrounding tasking to CCSS Team for Service Plan completions through Meridian's Case Management System, TruCare (TC). Re-education of documentation and signature requirements provided through the creation and rollout of the LTSS Plan of Care Signature Job Aid. Staff have received education regarding Service Plans as part of our HSAG remediation trainings which occurs quarterly. Internal audit expectations updated to include focus on signatures of enrollees and SLP provider. Witness Verbal Consent process has ceased due to staff fully returning back to the field and no longer utilizing telephonic outreach.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Contact requirements and standards updated for staff during PHE so member outreach could be completed virtually if members could not be seen face-to-face. SFY 2023 Measure 35D Performance – HealthChoice: Q1 SFY 2023: 85%; Q2 SFY 2023: 85%; Q3 SFY 2023: 88%; Q4 SFY 2023: 90%. SFY 2023 Measure 35D Performance – MLTSS: Q1 SFY 2023: 88%; Q2 SFY 2023: 86%; Q3 SFY 2023: 88%; Q4 SFY 2023: 88%. SFY 2023 Measure D6 Performance – HealthChoice: Q1 SFY 2023: 28%; Q2 SFY 2023: 40%; Q3 SFY 2023: 67%; Q4 SFY 2023:

69%. SFY 2023 Measure D6 Performance – MLTSS: Q1 SFY 2023: 25%; Q2 SFY 2023: 37%; Q3 SFY 2023: 70%; Q4 SFY 2023: 69%.

d. Identify any barriers to implementing initiatives:
- Staff were unable to obtain member signatures due to the PHE causing face-to-face visits to pause.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Continued reminders and education given to staff regarding SLP signature expectations and requirements. Leadership oversight of audit trends.

HSAG Assessment



Recommendation

HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- 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.

Response

a. Describe why this weakness exists:
- Member noncompliance due to PHE; Limited staffing

b. Describe initiatives implemented based on recommendations:
- Updates to mismanaged report, which highlights any cases that may not be in a correct case manager's caseload. LTSS production expectations updated. Automated dashboards and reporting - self-service automated reports for team members which also allow for daily overall metric tracking. Leaders utilize case weight report to help with oversight of caseload sizes and staffing ratios to ensure compliance.

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

- Percent contacts completed for HCBS Waiver Enrollees - Persons who are Elderly: Q1 SFY 2023: 83.17%; Q2 SFY 2023: 81.31%; Q3 SFY 2023: 84.52%; Q4 SFY 2023: 88.98%. Percent contacts completed HCBS Waiver Enrollees - Persons with a Brain Injury: Q1 SFY 2023: 96.58%; Q2 SFY 2023: 95.24%; Q3 SFY 2023: 96.36%; Q4 SFY 2023: 96.30%. Percent contacts completed HCBS Waiver Enrollees - Persons with HIV/AIDS: Q1 SFY 2023: 94.74%; Q2 SFY 2023: 95.20%; Q3 SFY 2023: 94.99%; Q4 SFY 2023: 94.82%. Percent contacts completed for HCBS Waiver Enrollees living in a Supportive Living Facility: Q1 SFY 2023: 99.27%; Q2 SFY 2023: 100.00%; Q3 SFY 2023: 99.15%; Q4 SFY 2023: 100.00%. Percent contacts completed for Enrollees living in a Nursing Facility: Q1 SFY 2023: 99.51%; Q2 SFY 2023: 99.21%; Q3 SFY 2023: 98.82%; Q4 SFY 2023: 99.62%. Percent contacts completed for HCBS Waiver Enrollees - Persons with Disabilities: Q1 SFY 2023: 88.99%; Q2 SFY 2023: 88.30%; Q3 SFY 2023: 90.57%; Q4 SFY 2023: 93.35%.

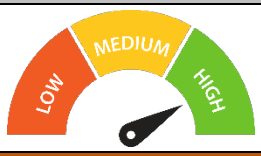
d. Identify any barriers to implementing initiatives:

- Limited staffing. Challenges with staffing appropriately within certain geographical areas of membership as staff begin returning to the field.

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

- Leaders to continue utilizing case weight report for caseload oversight. Leaders to continue utilizing mismanaged report to have oversight over any cases that are incorrectly managed by a staff member not qualified to manage the case. Overtime offered to staff to increase member engagement during alternative hours. Senior Leadership working with Human Resources to complete staffing analysis.

HSAG Assessment



7. Prior Year Recommendations for HCBS Waiver Performance Measures (MMAI):

Recommendation

HSAG recommended the following:

- Focus efforts on measures D6 and D7 and benefit from implementing the performance measure-specific recommendations provided by HSAG.

Recommendation

HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- 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.

Response

a. Describe why this weakness exists:

- Challenges staffing appropriately within certain geographical areas of membership as staff begin returning to the field. Increased enrollment in January 2023.

b. Describe initiatives implemented based on recommendations:

- Staff have received education regarding contacts as part of our HSAG remediation trainings which occurs quarterly. System enhancements to automated dashboards and reporting - self-service automated reports for team members which also allow for daily overall metric tracking. Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.

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

- SFY 2023 Measure D6 Performance - MMAI: Q1 SFY 2023: 57%; Q2 SFY 2023: 69%; Q3 SFY 2023: 62%; Q4 SFY 2023: 85%.

d. Identify any barriers to implementing initiatives:

- Limited staffing. Member non-compliance during PHE.

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

- Increased monitoring and remediation of internal failed audit measures for timely contact. Utilizing additional field staff for cross collaboration between teams for assistance in targeted outreach. Senior Leadership working with Human Resources to complete staffing analysis.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D7, *the most recent service plan is in the record and completed in a timely manner*:

- Ensure 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.

Response

a. Describe why this weakness exists:

- Limited staffing. Staff were unable to obtain member signatures due to the PHE causing face-to-face visits to pause. Inability to close waivers due to member non-compliance during PHE.

b. Describe initiatives implemented based on recommendations:

- Creating tasking process to Care Coordination Support Services (CCSS) Team for Service Plan completions through Meridian's Case Management System, TruCare (TC). Previously, these were faxed to the CCSS team. Updated SLP Calculator. Re-education of documentation and signature requirements provided through the creation and rollout of the LTSS Plan of Care Signature Job Aid. Internal reporting updates to identify newly waiver eligible members in a timely manner. Increased oversight through reporting and audit processes. Due date reporting trackers and compliance reporting trackers automated. Leaders meeting weekly to identify trends, barriers, and concerns.

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

- SLP completion rate for HCBS Waiver Enrollees - Persons with Disability: Q1 SFY 2023: 80.53%; Q2 SFY 2023: 82.97%; Q3 SFY 2023: 81.55%; Q4 SFY 2023: 86.52%. SLP completion rate for HCBS Waiver Enrollees - Persons with Brain Injury: Q1 SFY 2023: 73.58%; Q2 SFY 2023: 84.47%; Q3 SFY 2023: 78.78%; Q4 SFY 2023: 80.76%. SLP completion rate for HCBS Waiver Enrollees - Persons with HIV/AIDS: Q1 SFY 2023: 71.36%; Q2 SFY 2023: 86.36%; Q3 SFY 2023: 83.91%; Q4 SFY 2023: 82.95%. SLP completion rate for HCBS Waiver Enrollees - Persons who are Elderly: Q1 SFY 2023:
- 76.59%; Q2 SFY 2023: 81.30%; Q3 SFY 2023: 79.75%; Q4 SFY 2023: 85.52%. SLP completion rate for HCBS Waiver Enrollees living in a Supportive Living Facility: Q1 SFY 2023: 78.95%; Q2 SFY 2023: 79.41%; Q3 SFY 2023: 84.08%; Q4 SFY 2023: 94.82%.

d. Identify any barriers to implementing initiatives:

- Inability to close waivers due to member non-compliance during PHE.

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

- Meridian began the process of waiver closures for UTR members/non-compliant members as of September 2023, helping to close out member cases.

HSAG Assessment

8. Prior Year Recommendations for QA/UR/PR Annual Report:

Recommendation

HSAG recommended the following:

- Include a detailed analysis of access and utilization of dental services.
- Include a detailed analysis of cultural competency.

Response

a. Describe why this weakness exists:

- SFY2021 report owners were unaware of the requirements to include analyses of dental services and cultural competency.

b. Describe initiatives implemented based on recommendations: • From the SFY2022 Annual Report project on, Meridian has developed a detailed project plan identifying all deliverables required for the report and assigned designated department owners and accountable leaders to each item.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • SFY2022 Annual Report received a 100% score.
d. Identify any barriers to implementing initiatives: • Not applicable.
e. Identify strategy for continued improvement or overcoming identified barriers: • Meridian will continue to utilize the detailed project plan for all future years' reports.
HSAG Assessment

9. Prior Year Recommendations for Mental Health Parity Review:
Recommendation
HSAG recommended the following: • Review the systems and processes responsible for denial 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.
Response
a. Describe why this weakness exists: • Diversity of letters and content due to member specific decision rationale.
b. Describe initiatives implemented based on recommendations: • Meridian's (Centene) Population Health and Clinical Operations (PHCO) BH National Support Unit has a process around checking readability with all adverse determination letters. There are resources created and used to assist in pivoting medical jargon to easily understood language within the clinical description within notifications. Additionally, detailed workflows are put into place to assist the letter writers in completing the content accurately.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable at this time.
d. Identify any barriers to implementing initiatives: • Large team and ongoing training and monitoring efforts.
e. Identify strategy for continued improvement or overcoming identified barriers:

- This continues to be an area the team trains to. The leadership team conducts daily random audits in additional to monthly and quarterly reviews. These are all efforts to ensure accuracy and readability.

HSAG Assessment

Recommendation

HSAG recommended the following:

- Ensure and demonstrate that adverse benefit determination decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).

Response

a. Describe why this weakness exists:

- Short turnarounds for a high volume of complex cases.

b. Describe initiatives implemented based on recommendations:

- Meridian's PHCO National Support Unit and Utilization Management clinical teams partner to adhere to all turnaround time decisions including notification. Detailed reports have been created to monitor TAT adherence closely and identify root causes for areas of improvement.

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

- Population Health and Clinical Operations Medicaid has a 98% turnaround time adherence rate for notification 2023 YTD (Jan- July).

d. Identify any barriers to implementing initiatives:

- Not applicable

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

- The teams monitor all reports on a daily basis and mitigate challenges through action plans in order to adhere to turnaround time requirements and notifications.

HSAG Assessment

Molina

1. Prior Year Recommendation for Performance Measures:
Recommendation
HSAG recommended the following: • 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. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Molina continues to see the number of members who complete their annual wellness exam increase year over year. The number of AAP compliant members in the numerator was 64,106 in 2020; 96,571 in 2021; and 104,671 in 2022. The denominator for this measure has grown year over year since 2020 with a 52.45% increase from 2020-2021 (89,148– 135,907), and 10% from 2021-2022 (149,525). The demographic composition is majority members age 20-44 years, comprising 67.23% of the total eligible members in the measure; however, these members have the lowest rate of compliance compared to other age groups, which brings the overall rate of the measure down. Since 2020, rates for the 20-44 year old population has remained consistent with compliance rates of 68.12%, 68.12%, and 68.88% for MY2020, 2021, and 2022, respectively.
b. Describe initiatives implemented based on recommendations: • Molina implemented a text campaign in October 2022 targeting members with multiple gaps in care. Members who met this criteria and also consented to receive texts, were sent a text stating Molina covers annual checkups and instructing members to reach out to their provider schedule their needed visit. Additionally, Molina has a team of staff dedicated to outreaching and scheduling care-gap appointments for members. During these calls, outreach staff schedule needed appointments with providers and arrange any needed transportation. Thirdly, Molina also conducted an outreach campaign with a call vendor, Clark Resources, from October 2022-December 2022. Members targeted in this campaign were identified as "never compliant" for AAP.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through Molina's partnership with Clark Resources, 344 "never compliant" members were scheduled and completed closed their AAP gap. Additionally, Molina has seen some success with the AAP texting campaign in the Waiver and High Risk Populations; of the 654 waiver member who have opted-in and received a reminder text, 351 became compliant with the measure (53.70%). There were 19 high-risk members that received the text reminder and 16 of those members became compliant showing an 84.21% success rate.

d. Identify any barriers to implementing initiatives:

- Barriers to implementing initiatives include having accurate member demographic information and a lack of members currently opted-in for text messaging. Additionally, the large eligible population makes it more difficult to show larger increases in the rate.

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

- Molina has added more resources to address members whose only gap in care is the annual wellness visit. In addition, texting opt-in language has been added to member materials such as member incentive materials, the quarterly newsletter, and is included in talking points for member facing staff.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- In reviewing data for the W30 measure aged 0-15 months, White members performed higher (65.52%) than Black or African American members (48.91%). White members aged 15-30 months also performed at a higher rate (66.49%) than their Black or African American counterparts (51.39%).

b. Describe initiatives implemented based on recommendations:

- Molina Quality Outreach staff (Health Educators) outreach the parents/guardians of children in the measure to schedule the member into an appointment to complete their well visits. In addition, Molina's Healthcare Services Champions projects target childhood measures in area where populations are underperforming.

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

- Molina saw improvements in 2022 over 2021 in both age groups with 0-15 months going from a 58.51% compliance rate in 2021 to 61.64% in 2022. The 15-30 month age group saw similar improvement go from 59.84% in 2021 to 61.37% in 2022. This year over year improvement is continuing into 2023, with 0-15 month performance 1.05 percentage points ahead of same time last year, and the 15-30 month rate is 4.09 percentage points ahead of same time last year.

d. Identify any barriers to implementing initiatives:

- Having accurate contact information in order to outreach members. Members receiving services outside of the measure timeframes causing the members to reflect as "non-compliant". Another barrier is the large size of the denominator for this measure makes it more difficult to show larger increases in the rate.

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

- Continued direct outreach to schedule member into appointments with providers and also with the Molina Mobile Health Unit. The Mobile Health Unit is a fully equipped mobile health van with examination rooms where well child visits can be completed. The Mobile Health Unit will be utilized at various locations throughout Illinois.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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 performance.

Response

a. Describe why this weakness exists:

- Upon reviewing members who were W30 (0-30m) compliant, but were not compliant for all of the needed vaccines, Molina found that of the 1,946 members in this category, members were in fact getting the necessary vaccines, but outside of the measure time frame (2nd birthday). 319 members completed their needed vaccines outside of the measure window. Data for Combo 10 was also reviewed, and it showed a very low rate for the flu vaccine. Of the members in the data set, only 13.26% received the flu vaccine. This is likely due to state to vaccine hesitancy, which is being experienced across the nation. Of the members reviewed, 62 did not receive any vaccines. The majority of those members were in Central Illinois (29), followed by Cook/Collar Counties (22), Southern Illinois Counties (6) and Northern Illinois Counties (5).

b. Describe initiatives implemented based on recommendations:

- Molina Quality Outreach staff (Health Educators) outreach the parents/guardians of children in the measure to schedule the member into an appointment to complete their well visits. In addition, Molina's Healthcare Services Champions projects target childhood measures in area where populations are underperforming.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Molina is seeing an improvement in the CIS 3 rate in 2023. The current rate is 2.8 percentage points higher than the rate at the same time last year. Combo 10 is performing at the same rate as last year.

d. Identify any barriers to implementing initiatives:
- Parents in all areas of the state are vaccine hesitant and refusing to make appointments for their children's vaccination. In addition, many children are receiving their needed vaccinations but the provider is administering vaccines outside of recommend schedule. When the vaccination is received "late" it does not appear in the numerator for the measure. Additionally, there are known issues with the vaccine data the MCOs receive from HFS, and HFS is currently conducting a root cause analysis for all MCOs.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Molina is targeting calls for needed wellness visit(s) for babies 0-30 months who also need to complete vaccines during the wellness visit. The change in messaging to parents shifted from vaccine-centric language to focusing on the needed wellness visits where children will receive the needed vaccines. This strategy has shown to be impactful with year-over-year improvement in both wellness visits as well as childhood vaccine rates.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:
- The lookback period of two years prior to the measurement year for mammography had an effect on the rates. During the look-back period (October 1, 2022-December 31, 2022), the lingering effects of COVID and the public health emergency impacted rates in MY2022 due to office closures during part of the service window for compliance.

b. Describe initiatives implemented based on recommendations:
- Molina worked with providers to have Molina Clinic Day events where appointment times are set aside for Molina members to complete preventive services and screenings. Providers in low-performing zip codes and Safety Net facilities were targeted for this intervention. Molina Health Educators made direct outreach to members to fill those appointment slots, arrange needed transportation, and provide reminder calls prior to the clinic day events. Additionally, Molina

partnered with 5 provider groups in 2022 through Value Based Contracts targeting members in DIA zip codes. In 2022, 24% of BCS eligible members tied to the VBC provider groups lived in DIA zip codes.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Molina is seeing continued year over year improvement and is on track for improvement in 2023. As of August 2023, BCS rate is performing 1.02 percentage points ahead of same time last year, and 107 members became compliant from attending a Molina Day BCS event.

d. Identify any barriers to implementing initiatives:
- Member no-shows to scheduled appointments is a continued barrier to members completing the needed service. Additionally, some imaging centers require an order from a provider prior to completing the mammogram. This has caused a barrier to members receiving their screenings at Molina Day events.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Molina has made an effort to partner with more providers who will write orders on site for members rather than requiring an order prior to the event/appointment while still continuing to partner with providers who have the prior-order requirements. When making outreach for events in the latter category, an added step is taken to reach out to the members' PCP and getting the mammogram order faxed to the imaging center prior to the Molina Day event. Molina has increased the number of participating providers for Molina Day BCS events. In 2023 to date Molina has scheduled events with 13 different providers compared to 6 in 2022. Additionally, Molina has increased the number of members with VBC provider groups resulting in nearly 50% of members residing in DIA zip codes.

HSAG Assessment

Recommendation

HSAG recommended the following:

- 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

Response

a. Describe why this weakness exists:
- Molina reviewed a random sample of non-compliant members in the FUH measure, and found that the most common scenarios were that members were unable to contact (UTC) when the Case Manager or Transition of Care Coach outreached within 7 days of in-patient discharge. in an attempt to schedule them into appointments. Outreach was made not only to the member but

also to the inpatient facility, the PCP, and known pharmacy. Even with extensive outreach, oftentimes members remain UTC. A second common reason for lack of compliance in FUH measure is that when the member is contacted and engaged, members refuse services such as appointment scheduling assistance and telehealth options, or members are Even with FUH initiatives in place some members refuse follow up care referrals or are no shows to their scheduled telehealth appointments.
b. Describe initiatives implemented based on recommendations: • 1) The Molina Healthcare Services Team outreaches members with an in-patient or emergency room discharges within 7 day of discharge. During these outreach calls, the staff remind members to attend their follow up appointment with a behavioral health provider. If the member does not have an appointment scheduled, the Molina staff assists in scheduling, and also offers a telehealth provider. When members agree to agree to the telehealth option, the staff send daily referrals to a BEP provider who schedule follow-up appointments and complete the visit via telehealth. Visits are for members require follow up after hospitalization for mental illness, ER visit for mental illness, or ER visit for substance use disorder. The goal is to have the provider complete a telehealth visit within 7 days of discharge, but no later than 30 days post discharge. Due to the success of adult referrals throughout 2022, beginning February 2023, Molina added referrals for children to this program. 2) in April 2023, Molina partnered with a behavioral health hospital to provide a grant for a discharge planner to facilitate collaboration between the health plan and the facility. The Molina Transitions of Care team works with the discharge planner to coordinate follow-up telehealth visits for members with an inpatient mental health stay or and emergency room mental health visit.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina is seeing an improvement in 2023 in all Mental Health measures over the MY2022 final rates. Molina's telehealth provider partner completed 73 FUH 30 child telehealth visits from Jan-Jun 2023 and 120 adult telehealth visits.
d. Identify any barriers to implementing initiatives: • Many non-compliant member are also UTC. In addition, some members will refuse follow-up care or will be a no-show to scheduled appointments, including telehealth appointments.
e. Identify strategy for continued improvement or overcoming identified barriers: • Molina will continue with programs to outreach members and schedule telehealth visits and continue work with providers to enhance programs in currently in place.
HSAG Assessment

Recommendation
For the HIV Viral Load Suppression measure, many health plans reported difficulty obtaining viral load data which may be leading to underreporting of performance. HSAG recommended the following:

- Monitor 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.

Response

a. Describe why this weakness exists:
   - Providers did not include all necessary data points to report this measure

b. Describe initiatives implemented based on recommendations:
   - MCOs began to receive DPH viral load reporting on a monthly basis early 2022 which identifies missing information that was contributing to low 2021 rates

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Molina has seen significant improvements in the HVL-AD rates since 2021. The Q4 2022 rate was 62.76%, compared to the 16.84% rate seen in Q4 2022.

d. Identify any barriers to implementing initiatives:
   - None identified

e. Identify strategy for continued improvement or overcoming identified barriers:
   - With the receipt of DPH viral loading reporting, no additional strategies have been implemented at this time, and Molina will continue to monitor the rates.

HSAG Assessment

Recommendation

For the LTSS Comprehensive Care Plan and Update measure, 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. HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:
   - Member Care Plans are very specific to a members expressed needs, desires as identified through a comprehensive assessment therefore responses and care plans are built uniquely to each member. The assessment fields are open text fields and the Care Plans are individualized open text fields as well. Not all items are located in the Care Plan for the same reason – member's consent to which needs they approve to be documented in their care plan and which they prefer not be in their care plan. Additionally, our Level 1 members who have no documented needs

(most common amongst LTC and SLP waiver members) were historically not required to have a Care Plan developed.

b. Describe initiatives implemented based on recommendations:

- Molina is committed to member centered care and care planning and therefore has no plans to increase the number of reportable fields in its Care Plan. However, the plan has built out more extensive Care Plan process requirements to assure the elements required by this P4R report are located within each LTSS Care Plan. Since implementation of this P4R report, we have required Care Plans be developed for all Waiver and all LTC membership regardless of acuity level.

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

- Molina has shown dramatic improvement on the LTSS Care Plan Update report since implementation, improving compliance by over 72% overall.

d. Identify any barriers to implementing initiatives:

- Manual validation continues to be the barrier to outcomes. There have been no implementation barriers.

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

- Leaders and staff are held accountable to process implementation. Assessment, Care Plan and Service Plan elements are audited consistently with 3 audits per Case Manager per month. This assists in identifying opportunities for correction and improvement.

HSAG Assessment

Recommendation

For the LTSS—Successful Transition After Long-Term Institutional Stay measure, the health plans may not be including all enrolled MLTSS members in the eligible population for this measure due to states 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 Opt-Out members in the identification of the eligible population or calculation of observed discharges for the measure. HSAG recommended the following:

- Review the process for identifying the eligible population and their data sources for institutional facility claims.
- Evaluate clinical review processes 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.

Response

a. Describe why this weakness exists:

- The process for identifying members for this measure was inaccurate due to not having implemented the full HFS standard for IP claims when reviewing datasets. All available data sources had been used, but bill type and revenue code combinations were absent. Prior to the

Long Term Care Diversion Program implementation, there was not a keen focus on prioritizing community discharge planning over LTC/SMHRF discharges, either or both of which may have been appropriate to meet the member's care needs.
b. Describe initiatives implemented based on recommendations: • Molina initiated a Long Term Care (LTC) Diversion Program implemented at the start of Q2 2023. The intention of this program is to identify members while inpatient and work to build a community transition plan should it be safe and the member be agreeable. Molina holds twice weekly and as needed consultations to review these opportunities and respond timely. Molina has trained it's Utilization Management, Prior Authorization, Case Management and Medical Affairs team in identification and referral of appropriate members.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina has shown a 15% improvement in our Observed Transition Rates since implementation of the P4R report. As an initiative to impact this measure, our LTC Diversion Program has successfully transitioned 4 (13%) of the 30 members referred to the community. These members would have otherwise gone to a LTC setting.
d. Identify any barriers to implementing initiatives: • Notification of inpatient stays often lags leading to late identification of members for community discharge planning. In these cases, we work with the member and LTC facility with hopes to shorten the LTC stay, where appropriate, assuring the member is able to return to baseline and to the community – again where safe and agreeable by member/representative.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continual collaboration interdepartmentally with goal of raising awareness, early identification and referral for community discharge planning. Continually monitoring the denominator and rates for trends to ensure that all members are being included going forward.
HSAG Assessment

2. Prior Year Recommendations for Network Adequacy:
Recommendation
In regard to the Access and Availability Telephone Survey, 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. HSAG recommended the following: • Work with HFS to obtain the case-level survey data files to address provider data deficiencies identified during the survey. • Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Additionally, 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.

Response

a. Describe why this weakness exists:

- Due to staffing issues within some practices – new staff does send in the appropriate documentation to update provider information. Appointment times are difficult due to practices not having sufficient staffing and/or physicians at certain locations to perform services on the day/time in question

b. Describe initiatives implemented based on recommendations:

- Discussion with providers during monthly JOCs for larger provider groups and hospital systems. Also appointment times are listed in provider manuals to assist providers with the requirement.

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

- N/A

d. Identify any barriers to implementing initiatives:

- Provider offices stating that being short staffed and training new staff has poised unexpected turnovers which impact the ability to meet deadlines.

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

- Continued education on IAMHP Roster that providers need to complete with the most up to date information. Audits on the Provider Directory to ensure information is adequate and any provider discrepancy to be followed up on to obtain correct information. Memos to be released on requirements for POD information and Appt availability

HSAG Assessment

Recommendation

In regard to the Access and Availability Telephone Survey, compliance with appointment availability standards was low, especially in the areas of allergy and immunology, pulmonology, and neurology. HSAG recommended the following:

- 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.

Response

a. Describe why this weakness exists:

- Staff shortages is impacting both Urban and Rural providers. Administrative staff and availability of physicians to provide coverage at locations where a physician is needed.

b. Describe initiatives implemented based on recommendations:

- Discussions with provider organizations on the best practice to ensure that members are able to get appointments with specialist within the appropriate timeframes.

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

- N/A

d. Identify any barriers to implementing initiatives:

- Members miss appts and providers are more apt to move Medicaid to certain days to avoid revenue loss.

  Members not providing correct contact information to confirm appt

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

- To work with providers and CM to ensure that members are at appts. To work with providers to ensure that the appointment availability is open to all members regardless of day and time. Work these providers to ensure that they understand the necessity of making sure that members are able to make an appt timely.

HSAG Assessment

Recommendation

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. HSAG recommended the following:

- 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. 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.

Response

a. Describe why this weakness exists:

- For Oral Surgery – Adult and Pediatric, the amount of providers in the state – particularly the southern region – is low and has made it difficult to fill all of the needs in the southern part of the state. The Allergy and Immunology – Pediatric gap is due to the way that provider data was presented and interpreted, with some data being missing and needing to be supplemented. Molina believes that the Pharmacy gaps may have been identified in error, as the Geo Reports from CVS indicate 100% adequacy for all members in all counties.

b. Describe initiatives implemented based on recommendations:

- With regards to Oral Surgery – Adult and Pediatric, Molina has partnered with our dental delegate to push for additional providers to join the network, particularly in the portions of the

state where the availability of providers is low. For Allergy and Immunology – Pediatric, data is being reviewed and monitored for providers who may be missing a pediatric allergy and immunology taxonomy but do have an appropriate allergy and immunology taxonomy while accepting members within the pediatric age range. This review is ongoing.

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

- The process for assigning an oral surgeon for a member who has received a referral from a general dentist has improved over the second half of SFY2023. This allows for members to be placed with another dental specialty for extraction (or necessary service) if an oral surgeon is not truly necessary, allowing for members to be placed quicker. If a member needs to be placed with an oral surgeon, single case agreements are more readily being utilized in areas where providers are unavailable.

d. Identify any barriers to implementing initiatives:

- The shortage of Oral Surgeons in the state of Illinois who are willing to work with MCOs creates a significant barrier to closing these gaps.

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

- Molina and our PBM (CVS/Caremark) have conducted a GeoAccess evaluation for all regions. Our findings document that 100% of members in all regions 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. Molina and DentaQuest are continuing to monitor the status of the oral surgeon adequacy in the network throughout the state. The initiative will be ongoing for the foreseeable future to provide as much improvement as possible. Allergy and Immunology will continue to be monitored and data improved.

HSAG Assessment

3. Prior Year Recommendations for CAHPS:

Recommendation

HSAG recommended the following for adult CAHPS:

- Conduct a 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. Consider whether there are disparities within populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the care members need.

Response
a. Describe why this weakness exists: • The survey is sent to a random set of members whose demographic information is blinded to the plan making it difficult to complete a root cause analysis or targeted review of providers based on member response from the survey. The CAHPS scoring reports Molina receives do not identify results by region of the state which makes it difficult to identify regional or zip code specific gaps whose respondents score Molina negatively. In the 2022 Network Adequacy Report appointment availability results showed adequate access to providers. Although goals were met for numbers and provider ratio, not all goals were met for geographic distribution. In addition, CAHPS is a member driven report, based on member perceptions which may not always reflect the full picture. Low response rates to the survey also play a role in CAHPS rates. Lower responses lead to more volatility of the rates. The number of completed surveys in 2021 was 249 (14.3%), 2022 was 261 (11.6%) and 267 (11.8%) surveys were completed in 2023.
b. Describe initiatives implemented based on recommendations: • CAHPS Tip Sheets are available to network providers via the Provider Portal. These Tip Sheets educate providers on how the CAHPS survey affects the provider. A CAHPS closing script was provided to Member Services Agents during CAHPS season to encourage members who receive a survey to return it, as well as on-hold messaging with the messaging. Additional initiatives included articles in the quarterly member newsletter on expectations for their doctor appointments. Molina conducts an annual analysis of appointment wait times to determine if providers are out of compliance with contractual requirement. Provider networking staff follows up with providers that are out of compliance. The timeliness requirements for appointments is in the Provider Manual.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina saw an increase in the Getting Care Quickly rate in 2023. The 2023 rate is 82.4% compared to 77.9% in 2022. In addition the Rating of Healthcare rate increased from 71.4% in 2022 to 77.0% in 2023.
d. Identify any barriers to implementing initiatives: • CAHPS response rates continue to be low, causing lower denominators and results that are more volatile. A drop or increase in the denominator for a composite can cause large swings in final rates. Recipients of the CAHPS Survey are randomly selected so initiatives to improve scores may not have been felt by all recipients.
e. Identify strategy for continued improvement or overcoming identified barriers: • Potential for oversampling in order to increase responses.
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, 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 specialists in the area or if specialists are unwilling to contract with the health plan.
Response
a. Describe why this weakness exists: • The survey is sent to random members of the plan whose identity is blinded to the plan. Therefore it is difficult to determine the locations of the members whose expectations were not met and do a targeted review of providers in that area. The CAHPS scoring reports Molina receives do not identify results by region of the state to therefore it is difficult to identify specific gaps in a region or zip code for members who score the response negatively. In the 2022 Network Adequacy Report appointment availability results showed adequate access to providers. Although goals were met for numbers and provider ratio, not all goals were met for geographic distribution. In addition, CAHPS is a member driven report, based on member perceptions which may not always reflect the full picture. Low response rates to the survey also play a role in CAHPS rates. Lower responses lead to more volatility of the rates. The number of completed surveys in 2021 was 521 (11.4%) , 2022 was 496 (10.6%) and 548 (9.5%) surveys were completed in 2023. Molina oversampled by 180% in 2021, 186% in 2022 and 250% in 2023, however only increased the number of responses by 52 (9.49%) in 2023.
b. Describe initiatives implemented based on recommendations: • CAHPS Tip Sheets are available in the provider portal to educate providers on the CAHPS survey and how it affects the provider and the impacts on the member. A CAHPS closing script was provided to Member Services Agents during CAHPS season to encourage members who receive a survey to return it, as well as on-hold messaging with the messaging. Additional initiatives included articles in the quarterly member newsletter on expectations for their doctor appointments. Molina conducts an annual analysis of appointment wait times to determine if providers are out of compliance with contractual requirement. Provider networking staff follows up with providers that are out of compliance. The timeliness requirements for appointments is in the Provider Manual.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina saw an improvement in Rating of Healthcare score in 2023. It improved to 88.4% from 85.7%. Although the 2023 Getting Needed Care composite score dropped by 1.8 percentage points, the "getting care, tests or treatment when needed" question in that composite rose from 86.9% to 89.3%. Similarly, Getting Care Quickly composite score declined 2.1 percentage points in 2023. The "getting routine care or appointments for checkups" question improved from 79.8% to 81.7% in 2023.

d. Identify any barriers to implementing initiatives:
- CAHPS response rates continue to be low, causing lower denominators and results that are more volatile. A drop or increase in the denominator for a composite can cause large swings in final rates. Recipients of the CAHPS Survey are randomly selected so initiatives to improve scores may not have been felt by all recipients.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Molina oversampled by 180% in 2021, 186% in 2022 and 250% in 2023, and will continue promoting the importance of completing the survey through hold messaging, member newsletters, and provider communications with the goal to increase response rate.

HSAG Assessment

4. Prior Year Recommendations for Care Management Staffing:

Recommendation

HSAG recommended the following for HealthChoice and MMAI:

- 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.

Response

a. Describe why this weakness exists:
- Staff managing members with a waiver are hired and assigned based upon their level of education and qualifications as aligned with contractual requirements.

b. Describe initiatives implemented based on recommendations:
- Molina has sent an addendum listing staff degree and qualifications for those with atypical degrees, as evidence these staff meet contractual requirements for waiver, along with the last several Staff/Education Workbooks. We have implemented 2nd level reviews of the Workbooks prior to submission to assure enough detail is within the submission to assist HSAG in review. Future forward, Molina will proactively send exemption requests to HFS for consideration.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Molina HealthChoice and MLTSS have experienced improved outcomes as a result of implementations noted in 4b.

d. Identify any barriers to implementing initiatives:
- None

e. Identify strategy for continued improvement or overcoming identified barriers:
- As above 4e.

HSAG Assessment

5. Prior Year Recommendations for Critical Incident Monitoring:

Recommendation

HSAG recommended the following:

- Revise 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.

Response

a. Describe why this weakness exists:
- Members living in a SLF or LTC often times don't have a phone or are unable to participate in an outreach.

b. Describe initiatives implemented based on recommendations:
- Case managers have been encouraged to outreach the members when possible and if they have no phone they are to arrange a phone call with the member through the facility staff. This arrangement allows the member to be able to speak with the case manager. If a case manager is able to complete a face to face for that member it is encouraged.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- LTC Cms have begun completing more face to face visits and engaging through the staff phone calls; received a verbal 100% on ensuring HSW during the last HSAG audit.

d. Identify any barriers to implementing initiatives:
- Initiatives have been implemented, training and process updated to request contact with SLF/LTC member.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Long term case managers have returned to the field and are able to complete face to face visits to help members complete assessments when applicable and are able to assist the member with obtaining a cell phone. Ongoing education and internal oversight to ensure the members are contacted.

HSAG Assessment

Recommendation
HSAG recommended the following: • Revise 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.
Response
a. Describe why this weakness exists: • Our internal process has been changed to align with the external entity's communication requirements. We made these changes for our staff to follow when adult protective services implemented revised process expectations in 2020. We began accessing the notice of investigation when it because available through the adult protective services portal in 2023.
b. Describe initiatives implemented based on recommendations: • Updated the process to reflect an emphasis of using of the notice of investigation through APS portal. We provided a retraining on follow up expectations and process when we receive a report of substantiation or notice of investigation.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We check the portal daily and follow up with information is not received timely.
d. Identify any barriers to implementing initiatives: • APS portal process has been implemented successfully. Ongoing efforts to ensure investigating agency engagement.
e. Identify strategy for continued improvement or overcoming identified barriers: • We continue to review and retrain to our critical incident process a minimum of twice a year and orientation for a new employee in healthcare services. This past years trainings completed on 9/29/22, 12/22/22, 3/16/23.
HSAG Assessment

Recommendation
HSAG recommended the following: • Evaluate 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.
Response
a. Describe why this weakness exists: • Error in following the UTR process.

b. Describe initiatives implemented based on recommendations:

- Implementation and continued oversight through our internal critical incident software, Compliance HIPAA Management Program (CHAMP) system. We utilize a report that is generated and reviewed weekly by supervisors to review for members HSW, completion of process, and ensuring outreaches are being made.

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

- 100% reporting and ensuring members HSW for the last three audits.

d. Identify any barriers to implementing initiatives:

- Initiatives are implemented.

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

- We will continue to do the weekly reporting and oversight. We will also continue to train and retrain to our critical incident process a minimum of twice a year and orientation of new employees. This past years trainings completed on 9/29/22, 12/22/22, 3/16/23.

HSAG Assessment

6. Prior Year Recommendations for HCBS Waiver Performance Measures (HealthChoice and MTSS):

Recommendation

HSAG recommended the following:

- Focus efforts on measures 35D and D6 and benefit from implementing the performance measure-specific recommendations provided by HSAG.

Recommendation

HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*:

- 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).

Response
a. Describe why this weakness exists: • This weakness existed largely due to delays in reaching the member or provider as a result of unable to reach attempts and staffing fluctuations throughout the PHE related to the "great resignation".
b. Describe initiatives implemented based on recommendations: • Molina began messaging late contacts as "never events" indicating the importance of timely outreach and related compliance activities. We have developed new positions and processes with a goal of helping obtain and sustain compliance regardless of staff fluctuations referred to as Float Case Management and Safety Net Process accordingly. Reports have been enhanced to allow improved line of sight to due dates for activities such as contacts and Service Plan due dates. Our internal audit program does cover this measure. Staff with audit findings are expected to remediate those findings on their cases within 1 week of the audit result. Staff are trained and expected to work proactively on their caseloads assuring that delays in timeliness do not impact member care, compliance metrics. We have enhanced internal reporting for better line of sight to this measure and it's timeliness. Leaders have been trained on its use, expectations for use, oversight and performance activities. Staff have been trained on the use of the report and timeliness expectations. Routine staff training occurs in monthly Waiver Team meetings, after each HSAG audit and based upon internal audit results either individually or across the team dependent on findings and trends.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Timely service planning has improved by 9% from 2022 to 2023.
d. Identify any barriers to implementing initiatives: • Timely hiring was an issue that has resolved with end of "the great resignation" and end of the Public Health Emergency. Enhanced reporting is in production for better line of sight to timeliness.
e. Identify strategy for continued improvement or overcoming identified barriers: • Improved reporting has given leadership better line of sight to proactively identify impending and existing risks and have them addressed timely.
HSAG Assessment

Recommendation
HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*: • 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.

Response

a. Describe why this weakness exists:

- This weakness existed largely due to delays in reaching the member or provider as a result of unable to reach attempts and staffing fluctuations throughout the PHE related to the "great resignation".

b. Describe initiatives implemented based on recommendations:

- Molina began messaging late contacts as "never events" indicating the importance of timely outreach and related compliance activities. We have developed new positions and processes with a goal of helping obtain and sustain compliance regardless of staff fluctuations referred to as Float Case Management and Safety Net Process accordingly. Reports have been enhanced to allow improved line of sight to due dates for activities such as contacts and Service Plan due dates. Staff are trained and expected to work proactively on their caseloads assuring that delays in timeliness do not impact member care, compliance metrics. Our internal audit program covers timeliness of contacts including valid justification. TBI, HIV caseloads have consistently been maintained at 30 or below. Staffing has stabilized with >95% of waiver positions filled and in production. Routine staff training occurs in monthly Waiver Team meetings, after each HSAG audit and based upon internal audit results either individually or across the team dependent on findings and trends.

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

- Timely contacts have improved by 5% across waiver populations between 2022 and 2023.

d. Identify any barriers to implementing initiatives:

- Timely hiring was an issue that has resolved with end of "the great resignation" and end of the Public Health Emergency.

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

- Improved reporting has given leadership better line of sight to proactively identify impending and existing risks and have them addressed timely.

HSAG Assessment

7. Prior Year Recommendations for HCBS Waiver Performance Measures (MMAI):
Recommendation
HSAG recommended the following: • Focus efforts on measures 35D, D6, D7, and D9 and benefit from implementing the performance measure specific recommendations provided by HSAG.
Recommendation
HSAG recommended the following for Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*: • 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.
Response
a. Describe why this weakness exists: • This weakness exists due to system limitations. CCA does not automatically remind care managers of waiver service renewals. The care manager has to manually set a task for this reminder to prompt them.
b. Describe initiatives implemented based on recommendations: • The initiatives implemented based on recommendations was the revision and deployment of the waiver due report. This report is updated daily and provides oversight and monitoring for all waiver elements to ensure compliance. The report is able to capture service plans coming due as well as care plans that have been consented. Supervisors were trained on how to pull and manipulate the report to ensure compliance on their respective teams. The supervisors also complete monthly internal chart audits and hold regular 1:1 sessions with their care coordinators.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Annual service plan completion and documentation of witnessed verbal consent has significantly improved since deploying the revised waiver due report. Care coordinators returning to the field have also played a role because they are able to obtain member signature at these visits.
d. Identify any barriers to implementing initiatives: • Barriers identified were related to navigating the waiver due report for supervisors. During the initial roll out phase it took some time before supervisors felt comfortable filtering the

spreadsheet to extract the data they needed. Now that they have used this report on a daily basis they have become SMEs in utilizing it. Another barrier identified was SLP facility staffs availability/willingness to sign and return documents.

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

- Strategies for continued improvement and overcoming identified barriers include ongoing oversight/monitoring, internal chart audits by supervisors, ongoing education of staff, staff accountability with 1:1 counseling as needed. We also implemented aligning staff to specific SLP facilities to encourage collaboration and ongoing communication to increase SLP provider signatures. Leadership has encouraged staff to meet with SLP faculty staff on an ongoing basis to continue to develop those relationships in the best interest of our members.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*:

- 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.

Response

a. Describe why this weakness exists:

- This weakness exists due to individual employee performance. Leadership has identified employees that are not meeting the requirements of the role through reporting and data analytics. Poor performing employees are being held accountable through coaching sessions, disciplinary action, and annual merit reviews.

b. Describe initiatives implemented based on recommendations:

- The initiatives implemented were enhancements to the waiver due report. Supervisors also identified care coordinators with poor performance and held coaching sessions and issued performance improvement plans if necessary with some leading up to termination. Supervisors hold weekly meetings with their respective staff and review the waiver due report and provide instruction on any members that need to be remediated to ensure compliance. The director holds weekly meetings with the supervisors and has each supervisor report on their key performance indicators to maintain compliance.

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

- Member engagement has significantly increased over the last year since implementing initiatives. Care coordinators have also returned to field visits and we are seeing a decrease in

unable to contact rates as a result. Care coordinators have been made aware that they are going to be held accountable for their performance and as a result we are seeing higher compliance rates.

d. Identify any barriers to implementing initiatives:

- Barriers to implementing these initiatives falls on care coordinators who are not efficient and organized with their time. There is also the consideration to be made for the amount of time care coordinators are in the field and have to travel to see members. More time in the field is less time in their home office to complete documentation.

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

- Strategies for continued improvement include trying to implement more automation in our systems to reduce the amount of time spent on documentation. Strategies for overcoming identified barriers include better regionalization across teams to reduce travel time for field visits and enhanced technological capabilities to increase efficiency by completing documentation in real time.

HSAG Assessment

Recommendation

HSAG recommended the following for Measure D7, *the most recent service plan is in the record and completed in a timely manner*:

- Ensure 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.

Response

a. Describe why this weakness exists:

- This weakness exists due to system limitations. CCA does not automatically remind care managers of waiver service renewals. The care manager has to manually set a task for this reminder to prompt them.

b. Describe initiatives implemented based on recommendations:

- The waiver due report has the due dates for the service plans and we have also educated staff to align the due dates with the HRA due dates to ensure timely completion and compliance.

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

- Timely service plan completion has significantly improved as a result of re-educating the staff on the importance of aligning the annual HRA with the service plan. Prior to the revision of the waiver due report the care coordinators had to keep track of service plans manually through tasks in CCA or a personal spreadsheet. The waiver due report has given us the ability of partial

automation in that we can pull the data and see when service plans are coming due and make sure the care coordinator is completing timely.

d. Identify any barriers to implementing initiatives:

- Barriers identified include having to provide re-education to staff to remind them to align the HRA with the service plan as this was a change in process for them initially. The waiver due report still has to be manually pulled by leadership to review and identify any members at risk.

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

- Strategies that we have implemented for continued improvement is continued education in weekly and monthly staff meetings reminding care coordinators to align HRAs and service plans along with sending them members coming due in advance from the waiver due report. Strategies implemented to overcome identified barriers was training the supervisors on how to pull and filter the waiver due report to maintain compliance. The director also meets with them weekly to evaluate key performance indicators to ensure continued compliance.

HSAG Assessment

8. Prior Year Recommendations for QA/UR/PR Annual Report:

Recommendation

HSAG recommended the following:

- Include a detailed analysis of access and utilization of dental services.

Response

a. Describe why this weakness exists:

- The analysis of the access and utilization of dental services has been added to the Annual Report for SFY2023. Utilization saw an increase over SFY2022 and access to care continues to be monitored, particularly around Oral Surgeon access throughout the entire state.

b. Describe initiatives implemented based on recommendations:

- An initiative with DentaQuest has been pushed to improve the oral surgeon placement process as well as finding providers in areas where none currently are.

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

- N/A

d. Identify any barriers to implementing initiatives:

- There is a noted shortage of oral surgeons available in the southern portion of the state of Illinois. Without more providers willing to join Medicaid networks, it will be difficult to close identified areas of concern.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Molina will continue to monitor the status of the oral surgeon network and will make improvements as opportunities arise. Please see the "Dental Utilization" section of Molina's SFY 2023 QA/UR/PR for more information on progress to respond to this recommendation.

HSAG Assessment

9. Prior Year Recommendations for Mental Health Parity Review:

Recommendation

HSAG recommended the following:

- Review the systems and processes responsible for denial 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.

Response

a. Describe why this weakness exists:
- The readability protocol was not widely disseminated. Assessed knowledge throughout all UM systems of the readability protocol was not sufficient.

b. Describe initiatives implemented based on recommendations:
- Provided the clarifying document broadly throughout all Molina UM functions.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Provided education throughout Molina enterprise to successfully mitigate the sixth grade reading level.

d. Identify any barriers to implementing initiatives:
- Many UM functions throughout Molina- ensuring communication gets to all parties.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Clear identification of all UM parties within Molina and our delegates, ensuring UM communication is broadly disseminated at time of receipt.

HSAG Assessment

Recommendation
HSAG recommended the following: • Ensure and demonstrate that adverse benefit determination decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).
Response
a. Describe why this weakness exists: • UM systemic issues in tracking from receipt to letter sent
b. Describe initiatives implemented based on recommendations: • Creation of internal tracking protocols to support receipt to letter timeliness initiatives
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are able to clearly identify receipt and timeliness of letters. There are ongoing performance improvement strategies in place. We have improved from 84% to 91% for denial letter timeliness since being able to view the letter timeliness.
d. Identify any barriers to implementing initiatives: • System issues and data availability
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued monitoring of the letter notification timeliness.
HSAG Assessment


YouthCare

1. Prior Year Recommendations for Network Adequacy:
Recommendation
In regard to the Access and Availability Telephone Survey, 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. HSAG recommended the following: • Work with HFS to obtain the case-level survey data files to address provider data deficiencies identified during the survey. • Conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment. Additionally, 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.
Response
a. Describe why this weakness exists: • Provider lack submissions related to change of coverage location is a driver of provider data deficiencies. Providers fail via roster to update YouthCare on changes to practitioner participation (Retired, Deceased, Left Group). We also find the practitioner phone number changes are not frequently updated via provider roster. Numbers provided are disconnected or inaccurate, or the phone number is not the practice's appointment phone number (i.e., a billing or other administrative phone number). Specific to obtaining an appointment with surveyed locations, YouthCare has found providers status in accepting new patients is often fluid and changes frequently due to various factors including staffing and seasonal demands. Provider practices do not often prioritize updating rosters or notifying the plan on a timely basis of changes or updates in practitioner panel status. It is more efficient for physician office staff to simply inform members, when they call to request an appointment, if a practitioner's panel is closed. Awareness of network participation by staff within an office may also be a factor.
b. Describe initiatives implemented based on recommendations: • YouthCare incorporates a variety of activities to continuously improve provider data accuracy. In Q2 2023, YouthCare began project to evaluate the accuracy of data listed in the physician directory and to improve member experience by completing the following objectives: evaluate accuracy of office locations and phone numbers, evaluate accuracy of accepting new patients, evaluate accuracy of physician office staff awareness of participation in the organization's networks. This project is completed Customer Care Professional representatives who are trained to review practitioner demographic data, verify the accuracy, and gather updated information, as necessary. A phone survey script is used, which prompts the representative to specifically ask if the practitioner participates with the health plan, as well as confirm if the addresses, phone numbers, and panel status are accurate and complete based on the information stored in the source system. In addition to surveying via smaller sized offices via phone call, the health plan also initiated a mailing project with same data fields for larger offices. YouthCare has also engaged 3rd Party Vendor VEDA to increase directory accuracy by leveraging vendors directory

cleansing solution based in data science, machine learning, and web/social media sites to enhance and scrub provider data on a quarterly basis. YouthCare completes an annual analysis of the accessibility of primary care providers, high-volume and high-impact specialty care practitioners, and behavioral health providers to ensure that providers are meeting access standards specific to regular/routine care and urgent care appointments to ensure members have access to services that align with their accessibility standards. Education is provided to offices that fail to meet standards. Enhancements to provider education included education on access and availability standards in the HEDIS® Quick Reference Guide, Quality Education Webinar, and annual CAHPS® training on YouthCare's provider website. YouthCare also increased provider awareness regarding the importance of maintaining accurate and updated provider demographic information via monthly newsletters, provider meetings and webinars. We are also increasing the awareness of network participation in person and virtual provider meetings to all provider types. The health plan distributes promotional items

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

- Not applicable.

d. Identify any barriers to implementing initiatives:

- YouthCare has received provider abrasion related to provider data accuracy initiatives. Offices prefer to limit all activities specific to provider demographics to roster submissions. While YouthCare fully supports this approach, we encourage use of additional methods to confirm demographic information. Staffing shortages continue within physician offices driving inability to meet access availability standards.

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

- YouthCare will continue directory accuracy initiatives and provider education specific to the importance of updating all practitioner demographic detail via roster process. The health plan will also include provider education specific to appointment availability standards/guidelines in provider education activities. The health-plan will continue to promote/encourage the use of telemedicine and virtual visits where appropriate for members to receive care as soon as needed.

HSAG Assessment

Recommendation

In regard to the Access and Availability Telephone Survey, compliance with appointment availability standards was low, especially in the areas of allergy and immunology, pulmonology, and neurology. HSAG recommended the following:

- 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.

Response
a. Describe why this weakness exists: • Providers lack knowledge specific to availability standards/ guidelines or they were unable to satisfy the standards due to ongoing staffing shortages and limited operations in conjunction with high patent volume. Limited provider options are present in rural counties thus driving higher patient volume and appoint delays.
b. Describe initiatives implemented based on recommendations: • Increased contracting efforts implemented with focus on rural providers and larger health systems with full array of specialties. Provide education to practitioners on appointment availability standards and contractual requirements. Continue to promote/encourage the use of telemedicine and virtual visits where appropriate for members to increase appointment accessibility.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
d. Identify any barriers to implementing initiatives: • Limited availability of allergy/immunology providers in certain rural areas of the state.
e. Identify strategy for continued improvement or overcoming identified barriers: • YouthCare will continue to monitor appointment accessibility compliance of allergy and immunology, pulmonology, and neurology providers with the standards on an annual basis to ensure adequate appointment availability and accessibility is available to members when needed.
HSAG Assessment

Recommendation
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. HSAG recommended the following: • 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. 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.
Response
a. Describe why this weakness exists: • There are not enough pharmacies that can be solicited to meet adequacy requirements. There is a lack of oral surgery providers enrolled with IL Medicaid noted in one of the regions YouthCare

provides care to members. This is a rural region and there are not oral surgeons available in these counties.

b. Describe initiatives implemented based on recommendations:

- Every quarter, GeoAccess Reports (Pharmacy Network Adequacy) are reviewed to assess any pharmacies can be found to solicit. Sample action plan: YouthCare is unable to recruit any of them because of the types of pharmacies they are: 10 are Alternate dispensing site pharmacies; one is a Home infusion pharmacy; one is an Institutional pharmacy (CVSC will not solicit these types of pharmacies since not all members will be allowed to use them within the YouthCare contract); five pharmacies in rural county but none are contracted with the state for Medicaid. General dentists can perform certain oral surgery services and can provide care in network for members, however, are not credited as an oral surgeon. YouthCare monitors IL Medicaid enrollment file for recruitment targets.

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

- Not applicable.

d. Identify any barriers to implementing initiatives:

- There are not any pharmacies that can be solicited to help close the gap for YouthCare, either because the pharmacy is not enrolled with the state or there are no pharmacies in the area that meet the requirements to join the network.

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

- Continue to review reports each quarter and solicit pharmacies, as appropriate. There are contracted mobile dental anesthesia providers available in a nearby region. Access can be reviewed to determine the expansion of this unit as well as general dentists that can perform certain oral surgery services.

HSAG Assessment

2. Prior Year Recommendations for Care Management Staffing:

Recommendation

HSAG recommended the following for HealthChoice:

- Identify a plan to reassign caseloads to those case managers not meeting weighted, high-risk, or moderate-risk caseload limits.

Response

a. Describe why this weakness exists:

- In Q4 2022 YouthCare Program Coordinator Low Acuity caseloads were above recommended benchmarks, at an average of 865 cases, while Health Service Manager High/Complex acuity caseloads were below recommended benchmark at an average of 50 cases. In 2022 over 50% of Health Service Managers were new hires and held lower caseloads during onboarding. There was a need for additional Program Coordinator staffing to decrease caseload size. Caseloads

below recommended benchmark for Critical, High, and Moderate members is best practice due to the psychosocially complex needs of YouthCare members.

b. Describe initiatives implemented based on recommendations:

- YouthCare added 9 Program Coordinator positions in SFY 2023 to decrease low acuity caseloads. YouthCare developed an improved monthly auto-acuity process and daily case weight report to monitor caseload sizes. These improved processes enabled Care Coordinator caseloads to fall within/closer to recommended benchmarks and also addressed the clinical acuity needs of members.

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

- The average caseload size for Program Coordinator Low Acuity caseloads has decreased from 865 in 12/2022 to 690 in 08/2022. YouthCare is recruiting two additional Program Coordinator positions and has six new hires with lower caseloads during onboarding. Average caseloads will continue to decrease as these positions are filled and fully trained. On last staffing report YouthCare was meeting caseload requirements for complex, high and moderate member, and continues to meet these requirements.

d. Identify any barriers to implementing initiatives:

- Caseloads sizes for staff carrying members with urgent or critical needs. Allowing new staff to work up to a full caseload, to foster learning.

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

- Oversight and monitoring of caseloads. Movement of members when acuity decreases. Strategic review of staffing needs during each backfill vacancy, to ensure position best meets clinical acuity and caseload needs of membership.

HSAG Assessment

3. Prior Year Recommendations for Mental Health Parity Review:

Recommendation

HSAG recommended the following:

- Review the systems and processes responsible for denial 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.

Response

a. Describe why this weakness exists:

- Oversight and verification of reading level was not adequate.

b. Describe initiatives implemented based on recommendations: • Education to all UM staff and Medical Directors of the readability protocol was completed as well as training on how to verify readability.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All denial letter creations go through a readability level verification and the reading level is indicated on the denial log.
d. Identify any barriers to implementing initiatives: • No barriers were identified in the implementation.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued verification of all denial letters and tracking on the denial log for leadership oversight.
HSAG Assessment

Recommendation
HSAG recommended the following: • Ensure and demonstrate that adverse benefit determination decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).
Response
a. Describe why this weakness exists: • Understanding of Urgent Request and Turn-Around Time determination decisions was not understood fully by newly hired staff.
b. Describe initiatives implemented based on recommendations: • Re-education of all Utilization Management staff as well as quarterly reminders and monthly monitoring initiated to ensure turn-around time determinations are timely. Continue delegate monitoring.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Turn-Around Time determinations are being communicated timely over 95% of the time month-over-month.
d. Identify any barriers to implementing initiatives: • No barriers were identified in the implementation.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue with re-education on a quarterly basis as well as monthly monitoring and leadership discussions to ensure timely processing. Obtain monthly adverse benefit determination decision monitoring and detail report from delegates.

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.

HealthChoice Health Plan-Specific Conclusions

Aetna Better Health

Strengths Related to Quality, Access, and Timeliness	
+	For performance measures: • Aetna reported increases for the *Ambulatory Care—Outpatient Visits—Total* measure. • Aetna and the statewide average demonstrated an increase in performance for the *Annual Dental Visit* measure. • Aetna and the statewide average ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 1* measure. • Aetna demonstrated an increase in performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators. • Aetna and the statewide average ranked at or above the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure. • Aetna demonstrated significant improvement in the *Hemoglobin A1c Control for Patients with Diabetes* measure, reporting a 14.84 percentage point increase in the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)* measure indicator and a 16.3 percentage point decrease (lower is better) in the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* measure indicator. • Aetna and the statewide average demonstrated performance above the 50th percentile for the *Statin Therapy for Patients with Diabetes*.
+	In the Adult Behavioral Health performance measure domain, Aetna demonstrated an increase of more than 5 percentage points for the *Pharmacotherapy for Opioid Use Disorder* measure and met or exceeded the 50th percentile.
+	In the Child Behavioral Health performance measure domain: • Aetna plans and the statewide average ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure. • Aetna ranked above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator.
+	For Pay for Reporting performance measures: • Aetna was able to identify and correct source code errors for the state-specific child behavioral health measures for the MY 2022 reporting period. • Aetna reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update* measure.

Strengths Related to Quality, Access, and Timeliness	
+	In the Compliance Review: • Aetna achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For network adequacy: • For the majority of provider types, Aetna met or exceeded HFS' access standards. • Aetna was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. • Aetna met the pharmacy time/distance standard in rural counties and showed improvement from last year by meeting the pharmacy standard in one additional county. • Aetna met or exceeded HFS' time/distance standards for pulmonology, adult, and pediatric.
+	For CAHPS: • Adult Medicaid experience survey results for *Getting Care Quickly* and *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles.
+	For the CM staffing and training review: • Aetna and their delegates (when applicable) met all contract requirements related to caseloads. • Aetna met qualification/education requirements for case managers with Persons with HIV/AIDS Waiver caseloads.
+	For CI monitoring: • Aetna had consistent utilization of its internal process for communication with the investigating authority after initial CI report is made. • Aetna demonstrated compliance with APS ROS process policy. • Aetna's results of the file review demonstrated that the health plan was compliant with ensuring the HSW of the enrollee after the CI occurred. • Aetna's results of the file review demonstrated that the health plan effectively identified and reported CIs to the appropriate investigating authority. • Aetna remediated all findings from SFY 23.
+	For the QA/UR/PR review: • Aetna achieved a performance score greater than 90 percent on contract requirements. • Aetna demonstrated full compliance with general requirements. • Aetna received an assessment score of *Effective* on qualitative assessment.
+	In the MHP review: • Aetna used nationally recognized utilization review criteria.

Strengths Related to Quality, Access, and Timeliness	
	• Aetna's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that all health plans followed decision-making guidelines. • Aetna followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • Aetna demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
+	Aetna was fully compliant with all seven IS Standards.

Opportunities and Recommendations	
−	**Opportunity:** Aetna ranked below the 50th percentile for all of the Access to Care domain measures.
	Recommendations: HSAG recommends that Aetna consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** Aetna demonstrated a decreased performance for the *Child and Adolescent Well-Care Visits—Total* measure.
	Recommendations: HSAG recommends that Aetna consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA zip codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well care visits.
−	**Opportunity:** Aetna demonstrated a decreased performance for the *Childhood Immunization Status—Combination 10* measure.
	Recommendations: HSAG recommends that Aetna consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.
−	**Opportunity:** Aetna and the statewide average for the *Cervical Cancer Screening* measure ranked below the 50th percentile.
	Recommendations: HSAG recommends that Aetna consider further analysis of potential key drivers that may contribute to the observed low performance.
−	**Opportunity:** Aetna demonstrated a nearly five percentage point rate decrease in the *Blood Pressure Control for Patients with Diabetes* and *Eye Exam for Patients with Diabetes* measures.
	Recommendations: HSAG recommends that Aetna consider further analysis of potential key drivers that includes a drill down to consider if there are disparities and/or social determinants within its African American population that contribute to lower performance in a particular age stratification.

Opportunities and Recommendations	
−	**Opportunity:** In the Adult Behavioral Health domain, Aetna's overall performance for the *Follow-Up After Hospitalization for Mental Illness* measure remained low.
	Recommendations: HSAG recommends that Aetna consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification.
−	**Opportunity:** Aetna's rates on the *LTSS Successful Transition After Long-Term Institutional Stay* measure indicate room for improvement.
	Recommendations: HSAG recommended that Aetna review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation.
−	**Opportunity:** Aetna's rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure were too small to calculate a valid rate.
	Recommendations: HSAG recommended that Aetna review claims data extracts provided to its measure calculation vendor to ensure that all claims for long-term intuitional stays were provided in the extracts, including those with Illinois-specific billing codes as outlined in the MY 2022 P4R Reporting Guidance document.
−	**Opportunity:** For the Compliance Review, Aetna demonstrated opportunities for improvement related to CM documentation and processing of denials.
	Recommendations: Continue to evaluate care coordination staffing needs to ensure compliance with contractual requirements. Ensure oversight and monitoring of denials processing to ensure timeliness.
−	**Opportunity:** In the access and availability survey, Aetna's provider's contact information provided by the plan was incorrect.
	Recommendations: 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 and addresses that do not correspond to the sampled provider location).
−	**Opportunity:** The access and availability survey identified that Aetna's members are experiencing limited appointment availability and are experiencing wait times beyond the appointment compliance standards.
	Recommendations: HFS and the health plans should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plans should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.

Opportunities and Recommendations	
−	**Opportunity:** For the time/distance analysis, Aetna failed to provide the required access to oral surgeons for adult and pediatric enrollees in some areas, predominantly in rural counties located in Regions 1, 2, or 3.
	Recommendations: Aetna should continue to collaborate with HFS to contract with additional providers, if available.
−	**Opportunity:** Aetna did not meet the time/distance standard for Oral Surgery, Adult in 10 counties and did not meet the time/distance standard for Oral Surgery, Pediatric in 12 counties.
	Recommendations: Aetna should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
−	**Opportunity:** For CAHPS, Aetna's adult experience survey results were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service.*
	Recommendations: HSAG recommends that Aetna consider including information about the ratings from the CAHPS survey in provider communications during the year. Aetna should consider obtaining feedback from patients on their recent office visit.
−	**Opportunity:** For CAHPS, Aetna's child experience survey results were below the 50th percentile for every measure.
	Recommendations: HSAG recommends that Aetna prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. Aetna should continue promoting the results of its member experiences with its contracted providers and staff members.
−	**Opportunity:** In the CM staffing and training review, Aetna case managers with BI, ELD, or PD waiver caseloads did not meet qualification/education requirements.
	Recommendations: Aetna should review the qualification/education requirements for the BI, ELD, and/or PD waivers to ensure that only staff with those qualifications are assigned waiver caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment.
−	**Opportunity:** In the HCBS waiver measures review, Aetna performed at a statistically significantly lower rate than all other health plans.
	Recommendations: Aetna should consider reviewing its oversight processes to identify improvements to impact performance.
−	**Opportunity:** In the HCBS waiver measures review, Aetna had an opportunity to improve performance on Measure D6 (*the case manager made timely contact with the enrollee or there is valid justification in the record*).
	Recommendations: Aetna should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.

Opportunities and Recommendations	
−	**Opportunity:** In the HCBS waiver measures review, Aetna had an opportunity to improve performance on Measure D7 (*the most recent service plan is in the record and completed in a timely manner*).
	Recommendations: Aetna should 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.
−	**Opportunity:** In the HCBS waiver measures review, Aetna had an opportunity to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*).
	Recommendations: Aetna should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Aetna should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death
−	**Opportunity:** In the HCBS waiver measures review, Aetna had opportunity to focus efforts on Measure 35D (*the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: Aetna should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
−	**Opportunity:** For CI monitoring reviews, Aetna had an opportunity to improve utilization of its UTR process.
	Recommendations: Aetna should evaluate enrollee contact processes to ensure inclusion of attempts to contact enrollees, or authorized representative, who reside in SLP or LTC facility to ensure mitigation of identified risks prior to closure of the CI. Aetna should evaluate oversight processes to ensure timely completion of enrollee contact following identification of a CI and utilization of the UTR process prior to closure of the CI.
−	**Opportunity:** For CI monitoring reviews, Aetna had lack of thorough documentation within the CI report.
	Recommendations: Aetna should evaluate current CI reporting process and procedures to determine potential improvement in CI reporting template. Aetna should routinely provide training to staff on documentation requirements.

Blue Cross Blue Shield of Illinois

Strengths Related to Quality, Access, and Timeliness	
+	For performance measures: • BCBSIL and the statewide average demonstrated an increase in performance for the *Annual Dental Visit* measure. • BCBSIL and ranked at or above the 90th percentile for the *Immunizations for Adolescents—Combination 1* measure.

Strengths Related to Quality, Access, and Timeliness	
	• BCBSIL demonstrated an increase in performance and ranked at or above the 50th percentile for both *Well-Child Visits in the First 30 Months of Life* measure indicators. • BCBSIL and the statewide average demonstrated an increase in performance for the *Breast Cancer Screening* measure. • BCBSIL ranked at or above the 75th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. • BCBSIL and the statewide average ranked at or above the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure. • BCBSIL and the statewide average demonstrated performance above the 50th percentile for the *Statin Therapy for Patients with Diabetes*.
+	In the Child Behavioral Health performance measure domain, BCBSIL and the statewide average ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure.
+	For Pay for Reporting performance measures, BCBSIL reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update* measure.
+	In the Compliance Review: • The health plan achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For network adequacy: • For the majority of provider types, BCBSIL met or exceeded HFS' access standards. • BCBSIL was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. • BCBSIL met the pharmacy time/distance standard in rural counties and met the standard for allergy and immunology, adult, and pediatric, in two additional counties compared to last year's results. • BCBSIL corrected its failure to meet time/distance standards in a single county last year for endocrinology, adult providers, and met standards in all counties this year. • BCBSIL improved its performance in several counties compared to last year for adult and pediatric neurosurgery providers, adding four and five counties respectively to those that met time/distance standards. • BCBSIL met or exceeded HFS' time/distance standards for pulmonology, adult, and pediatric.
+	For CAHPS: • Adult Medicaid experience survey results for *Getting Care Quickly* and *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles. • Child Medicaid experience survey results for *Getting Care Quickly* and *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles.

Strengths Related to Quality, Access, and Timeliness	
+	For CI monitoring: • BCBSIL was compliant with ensuring the HSW of the enrollee after the CI occurred. • BCBSIL's results of the file review demonstrated that BCBSIL effectively identified and reported CIs to the appropriate investigating authority. • BCBSIL had a high percentage of enrollee contact to address and remediate the CI event and/or utilization of its UTR process prior to the CI closure. • BCBSIL demonstrated consistent utilization of its process for communication with the investigating authority after initial CI report is made. • BCBSIL remediated all findings from SFY 23.
+	For the CM staffing and training review: • BCBSIL and their delegates (when applicable) met all contract requirements related to caseloads. • BCBSIL met qualification/education requirements for case managers with all waiver caseload types.
+	For HCBS waiver review: • The measures averaging 90 percent or greater compliance indicate that BCBSIL demonstrated strengths in documenting enrollee risks, needs, goals, and backup plans in service plans; that updates to service plans are being completed when enrollees' needs change; that BCBSIL is ensuring enrollees' choice is honored and documented when selecting services; and that enrollees reported satisfaction with personal services. • BCBSIL achieved overall compliance rates higher than the statewide average. • BCBSIL averaged greater than 90 percent compliance.
+	For the QA/UR/PR review: • BCBSIL achieved a performance score of 100 percent on contract requirements. • BCBSIL demonstrated full compliance with the general requirements. • BCBSIL received a score of *Mature* based on the level of detail and process improvements identified from the prior year on the qualitative assessment.
+	In the MHP review: • BCBSIL used nationally recognized utilization review criteria. • BCBSIL's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that BCBSIL followed decision-making guidelines. • BCBSIL followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • BCBSIL demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
+	BCBSIL was fully compliant with all seven IS Standards.

Opportunities and Recommendations	
−	**Opportunity:** BCBSIL ranked below the 50th percentile for all of the Access to Care domain measures.
−	**Recommendations:** HSAG recommends that BCBSIL consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** BCBSIL reported rates for the *Ambulatory Care—ED Visits—Total* and *Ambulatory Care—Outpatient Visits—Total* measures that was materially biased.
−	**Recommendations:** HSAG recommends that BCBSIL determine the cause of the material bias in the *Ambulatory Care* measure.
−	**Opportunity:** BCBSIL demonstrated a decreased performance for the *Child and Adolescent Well-Care Visits—Total* measure.
−	**Recommendations:** HSAG recommends that BCBSIL consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA zip codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well care visits.
−	**Opportunity:** BCBSIL demonstrated a decreased performance for the *Childhood Immunization Status—Combination 10* measure.
−	**Recommendations:** HSAG recommends that BCBSIL consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.
−	**Opportunity:** In the Adult Behavioral Health domain, BCBSIL'S overall performance for the *Follow-Up After Hospitalization for Mental Illness* measure remained low.
−	**Recommendations:** HSAG recommends that BCBSIL consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification.
−	**Opportunity:** BCBSIL's rates on the *LTSS Successful Transition After Long-Term Institutional Stay* measure indicate room for improvement.
−	**Recommendations:** HSAG recommended that BCBSIL review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation.
−	**Opportunity:** In the access and availability survey, BCBSIL provider's contact information provided was incorrect.
−	**Recommendations:** Since BCBSIL 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 and addresses that do not correspond to the sampled provider location).

Opportunities and Recommendations	
−	**Opportunity:** The access and availability survey identified that BCBSIL's members are experiencing limited appointment availability and are experiencing wait times beyond the appointment compliance standards.
	Recommendations: HFS and BCBSIL should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. BCBSIL should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, BCBSIL should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
−	**Opportunity:** For the time/distance analysis, BCBSIL failed to provide the required access to oral surgeons for adult and pediatric enrollees in some areas, predominantly in rural counties located in Regions 1, 2, or 3.
	Recommendations: BCBSIL should continue to collaborate with HFS to contract with additional providers, if available.
−	**Opportunity:** BCBSIL did not met the time/distance standard for Oral Surgery, Adult in 10 counties and did not meet the time/distance standard for Oral Surgery, Pediatric in 12 counties.
	Recommendations: BCBSIL should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
−	**Opportunity:** BCBSIL network access results were worse than last year, meeting the time/distance standard for oral surgeons for adults in three fewer counties, and for children in two fewer counties.
	Recommendations: BCBSIL should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
−	**Opportunity:** BCBSIL failed to meet the time/distance standard for audiology standard for adult and pediatric in one county.
	Recommendations: BCBSIL should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
−	**Opportunity:** For CAHPS, BCBSIL's adult experience survey results were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service.*
	Recommendations: HSAG recommends that BCBSIL consider including information about the ratings from the CAHPS survey in provider communications during the year. BCBSIL should consider obtaining feedback from patients on their recent office visits.

Opportunities and Recommendations	
−	**Opportunity:** For CAHPS, BCBSIL's child experience survey results were below the 50th percentile for every measure.
	Recommendations: HSAG recommends that BCBSIL prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. BCBSIL should continue promoting the results of its member experience with its contracted providers and staff members.
−	**Opportunity:** In the HCBS waiver review, BCBSIL had an opportunity to improve performance on Measure D7 (*the most recent service plan is in the record and completed in a timely manner*).
	Recommendations: BCBSIL should 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.
−	**Opportunity:** In the HCBS waiver review, BCBSIL had an opportunity to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*).
	Recommendations: BCBSIL should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
−	**Opportunity:** In the HCBS waiver review, BCBSIL had opportunity to focus efforts on Measure 35D (*the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: BCBSIL should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
−	**Opportunity:** For CI monitoring reviews, BCBSIL had an opportunity to improve timely internal reporting of the CI event after CI identification.
	Recommendations: BCBSIL should continue ongoing oversight and monitoring of timely internal reporting and continued re-education when identified delay in reporting by CI team.
−	**Opportunity:** For CI monitoring reviews, BCBSIL had an opportunity to improve utilization of the APS ROS process policy.
	Recommendations: BCBSIL should continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.

CountyCare Health Plan

Strengths Related to Quality, Access, and Timeliness	
+	For performance measures: • CountyCare continued to demonstrate strong performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, ranking above the 75th percentile for all three measure indicators. • CountyCare demonstrated an increase in performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators. • CountyCare and the statewide average demonstrated an increase in performance for the *Breast Cancer Screening* measure. • CountyCare and the statewide average demonstrated performance above the 50th percentile for the *Statin Therapy for Patients with Diabetes*.
+	In the Child Behavioral Health performance measure domain, CountyCare and the statewide average ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure.
+	For Pay for Reporting performance measures, CountyCare reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan, and Update* measure.
+	For the Compliance Review: • The health plan achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For network adequacy: • For the majority of provider types, CountyCare met or exceeded HFS' access standards. • CountyCare was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. • CountyCare met pharmacy time/distance standard in rural counties. • CountyCare met or exceeded HFS' time/distance standards for pulmonology, adult, and pediatric.
+	For CI monitoring: • CountyCare's file review results demonstrated that the health plan effectively identified and reported CIs to the appropriate investigating authority. • CountyCare was compliant with ensuring the HSW of the enrollee after the CI occurred. • CountyCare demonstrated consistent application of its UTR process. • CountyCare demonstrated consistent utilization of its process for communication with the investigating authority after initial CI report is made. • CountyCare displayed a high utilization of crisis plans to mitigate risks identified as a result of the CI event. • CountyCare remediated all findings from SFY23.

Health Plan-Specific Conclusions

Strengths Related to Quality, Access, and Timeliness	
+	For the CM staffing and training review: • CountyCare and their delegates met all contract requirements related to caseloads. • CountyCare met qualification/education requirements for case managers with Persons with HIV/AIDS Waiver caseloads.
+	For HCBS waiver reviews, CountyCare achieved overall compliance rates higher than the statewide average.
+	For the QA/UR/PR review: • CountyCare achieved a performance score of 100 percent for contract requirements. • CountyCare received a score of *Mature* based on the level of detail and process improvements identified from the prior year on the qualitative assessment.
+	In the MHP review: • CountyCare used nationally recognized utilization review criteria. • CountyCare's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that CountyCare followed decision-making guidelines. • CountyCare followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • CountyCare demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
+	CountyCare was fully compliant with all seven IS Standards.

Opportunities and Recommendations	
−	**Opportunity:** CountyCare ranked below the 50th percentile for all of the Access to Care domain measures.
−	**Recommendations:** HSAG recommends that CountyCare consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** CountyCare demonstrated a decreased performance for the *Child and Adolescent Well-Care Visits—Total* measure.
−	**Recommendations:** HSAG recommends that CountyCare consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA zip codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well care visits.

Opportunities and Recommendations	
−	**Opportunity:** CountyCare demonstrated a decreased performance for the *Childhood Immunization Status—Combination 10* measure.
	Recommendations: HSAG recommends that CountyCare consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.
−	**Opportunity:** In the Adult Behavioral Health domain, CountyCare's overall performance for the *Follow-Up After Hospitalization for Mental Illness* measure remained low.
	Recommendations: HSAG recommends that CountyCare consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification.
−	**Opportunity:** CountyCare's rates on the *LTSS Successful Transition After Long-Term Institutional Stay* measure indicate room for improvement.
	Recommendations: HSAG recommended that CountyCare review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation.
−	**Opportunity:** In Compliance Review, CountyCare's results demonstrated opportunities for improvement related to CM documentation and adherence to the HFS Readability Protocol.
	Recommendations: Continue to evaluate care coordination staffing needs to ensure compliance with contractual requirements. Continue to evaluate opportunities for compliance to HFS' readability protocol.
−	**Opportunity:** In the access and availability survey, CountyCare provider's contact information was incorrect.
	Recommendations: Since CountyCare 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 and addresses that do not correspond to the sampled provider location).
−	**Opportunity:** The access and availability survey identified that CountyCare's members are experiencing limited appointment availability and are experiencing wait times beyond the appointment compliance standards.
	Recommendations: HFS and CountyCare should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. CountyCare should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, CountyCare should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.

Opportunities and Recommendations	
−	**Opportunity:** CountyCare did not meet the time and distance standard for Oral Surgery, Adult in 10 counties and did not meet the time/distance standard for Oral Surgery, Pediatric in 12 counties.
	Recommendations: CountyCare should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
−	**Opportunity:** For CAHPS CountyCare's adult experience survey results were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service.*
	Recommendations: HSAG recommends that CountyCare consider including information about the ratings from the CAHPS survey in provider communications during the year. CountyCare should consider obtaining feedback from patients on their recent office visit.
−	**Opportunity:** For CAHPS CountyCare's child experience survey results were below the 50th percentile for every measure.
	Recommendations: HSAG recommends that CountyCare prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. CountyCare should continue promoting the results of its member experiences with its contracted providers and staff members.
−	**Opportunity:** In the HCBS waiver review, CountyCare had an opportunity to improve performance on Measure D6 (*the case manager made timely contact with the enrollee or there is valid justification in the record*).
	Recommendations: CountyCare should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required. CountyCare should 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.
−	**Opportunity:** In the HCBS waiver review, CountyCare had an opportunity to improve performance on Measure D7 (*the most recent service plan is in the record and completed in a timely manner*).
	Recommendations: CountyCare should 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.
−	**Opportunity:** In the HCBS waiver review, CountyCare had an opportunity to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*).
	Recommendations: CountyCare should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.

Opportunities and Recommendations	
−	**Opportunity:** In the HCBS waiver review, CountyCare had opportunity to focus efforts on Measure 35D (*the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: CountyCare should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
−	**Opportunity:** For CI monitoring reviews, CountyCare had opportunity to improve timely follow-up with enrollee after identification of the CI.
	Recommendations: CountyCare should continue ongoing oversight and monitoring of timely enrollee follow up after CI identification. CountyCare should also provide education to those staff members who are identified as having delayed outreach to enrollee.
−	**Opportunity:** For CI monitoring reviews, CountyCare had opportunity to improve timely internal reporting of the CI from the date of CI identification.
	Recommendations: CountyCare should continue ongoing oversight and monitoring of timely internal CI reporting from date of CI identification. CountyCare should also provide education to staff members who are identified with delay in CI reporting.
−	**Opportunity:** For the QA/UR/PR review, CountyCare had a finding that would be resolved in future reports by inclusion of MPR statistic reports for all applicable areas.
	Recommendations: CountyCare should consider incorporating MPR measure performance into future reports.

MeridianHealth

Strengths Related to Quality, Access, and Timeliness
For performance measures: • Meridian reported increases for the *Ambulatory Care—Outpatient Visits—Total* measure. • Meridian and the statewide average demonstrated an increase in performance for the *Annual Dental Visit* measure. • Meridian and the statewide average ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 1* measure. • Meridian demonstrated an increase in performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators. • Meridian and the statewide average demonstrated an increase in performance for the *Breast Cancer Screening* measure. • Meridian ranked at or above the 75th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. • Meridian and the statewide average ranked at or above the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure.

Strengths Related to Quality, Access, and Timeliness	
	• Meridian demonstrated a 10 percentage point or more increase in MY 2022 for the *Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure,* and *Eye Exam for Patients with Diabetes* measures and the *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)* measure indicator. • Meridian and the statewide average demonstrated performance above the 50th percentile for the *Statin Therapy for Patients with Diabetes*.
+	In the Child Behavioral Health performance measure domain, • Meridian and the statewide average ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure. • Meridian ranked above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator.
+	For the Pay for Reporting performance measures: • Meridian was able to identify and correct source code errors for the state-specific child behavioral health measures for the MY 2022 reporting period. • Meridian reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan, and Update* measure.
+	In the Compliance Review: • The health plan achieved a final compliance score of 99 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For network adequacy: • For the majority of provider types, Meridian met or exceeded HFS' access standards. • Meridian was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. • Meridian met the pharmacy time/distance standard in rural counties. • Meridian met or exceeded HFS' time/distance standards for pulmonology, adult, and pediatric.
+	For CAHPS: • Adult Medicaid experience survey results for *Getting Care Quickly* and *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles.
+	For CI monitoring: • Meridian's results of the file review demonstrated that the health plan was compliant with assuring the HSW of the enrollee after the CI occurred. • Meridian's results of the file review demonstrated that the health plan effectively identified and reported CIs to the appropriate investigating authority and was compliant with requirements upon receiving notification from the investigating authority of a substantiated CI.

Strengths Related to Quality, Access, and Timeliness	
	• Meridian demonstrated integration of the CI reporting for HealthChoice and demonstrated improvement in consistency of internal CI reporting. • Meridian remediated all findings from SFY 23.
+	For the CM staffing and training review: • Meridian met all contract requirements related to caseloads. • Meridian met qualification/education requirements for case managers with all waiver caseload types.
+	For the HCBS Waiver Reviews: • The measures averaging 90 percent or greater compliance indicate that Meridian demonstrated strengths in documenting enrollee risks, needs, goals, and backup plans in service plans; that updates to service plans are being completed when enrollees' needs change; that Meridian is ensuring enrollees' choice is honored and documented when selecting services; and that enrollees reported satisfaction with personal services. • Meridian achieved overall compliance rates higher than the statewide average. • Meridian averaged greater than 90 percent compliance.
+	For the QA/UR/PR measures: • Meridian achieved a performance score of 100 percent for contract requirements. • Meridian received a score of *Mature* based on the level of detail and process improvements identified from the prior year on the qualitative assessment.
+	In the MHP review: • Meridian used nationally recognized utilization review criteria. • Meridian's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that Meridian followed decision-making guidelines. • Meridian followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • Meridian demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
+	Meridian was fully compliant with all seven IS Standards.

Opportunities and Recommendations	
−	**Opportunity:** Meridian ranked below the 50th percentile for all of the Access to Care domain measures.
−	**Recommendations:** HSAG recommends that Meridian consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.

Opportunities and Recommendations	
–	**Opportunity:** Meridian demonstrated a decreased performance for the *Child and Adolescent Well-Care Visits—Total* measure.
	Recommendations: HSAG recommends that Meridian consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA zip codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well care visits.
–	**Opportunity:** Meridian demonstrated a decreased performance for the *Childhood Immunization Status—Combination 10* measure.
	Recommendations: HSAG recommends that Meridian consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.
–	**Opportunity:** Meridian and the statewide average for the *Cervical Cancer Screening* measure ranked below the 50th percentile.
	Recommendations: HSAG recommends that Meridian consider further analysis of potential key drivers that may contribute to the observed low performance.
–	**Opportunity:** In the Adult Behavioral Health domain, Meridian's overall performance for the *Follow-Up After Hospitalization for Mental Illness* measure remained low.
	Recommendations: HSAG recommends that Meridian consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification.
–	**Opportunity:** Meridian's rates on the *LTSS Successful Transition After Long-Term Institutional Stay* measure indicate room for improvement.
	Recommendations: HSAG recommended that Meridian review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation.
–	**Opportunity:** For Compliance Review, results of file reviews demonstrated opportunities for improvement for Meridian related to CM.
	Recommendations: Continue recruitment efforts to hire open care coordination positions to ensure compliance with contractual requirements. Continue to evaluate ongoing care coordination staffing needs to ensure compliance with contractual requirements.
–	**Opportunity:** For Compliance Review, Meridian had opportunities for improvement related to timeliness of denial decisions and adherence to the HFS Readability Protocol.
	Recommendations: Continue to evaluate UM processes for areas of improvement to ensure compliance with coverage and authorization of service requirements.
–	**Opportunity:** In access and availability survey, Meridian provider's contact information provided was incorrect.
	Recommendations: Since Meridian 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

Opportunities and Recommendations	
	during the survey calls (e.g., disconnected telephone numbers or telephone numbers and addresses that do not correspond to the sampled provider location).
–	**Opportunity:** The access and availability survey identified that Meridian's members are experiencing limited appointment availability and are experiencing wait times beyond the appointment compliance standards.
	Recommendations: HFS and Meridian should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. Meridian should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, Meridian should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
–	**Opportunity:** Meridian did not meet the time/distance standard for Oral Surgery, Adult in 10 counties and did not meet the time/distance standard for Oral Surgery, Pediatric in 12 counties.
	Recommendations: Meridian should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
–	**Opportunity:** For CAHPS, Meridian's adult experience survey results for Meridian were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service.*
	Recommendations: HSAG recommends that Meridian consider including information about the ratings from the CAHPS survey in provider communications during the year. Meridian should consider obtaining feedback from the patients on their recent office visit.
–	**Opportunity:** For CAHPS, Meridian's child experience survey results for Meridian were below the 50th percentile for every measure.
	Recommendations: HSAG recommends that Meridian prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. Meridian should continue promoting the results of its member experiences with its contracted providers and staff members.
–	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to improve performance on Measure D6 (*the case manager made timely contact with the enrollee or there is valid justification in the record*).
	Recommendations: Meridian should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.

Opportunities and Recommendations	
−	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to improve performance on Measure D7 (*the most recent service plan is in the record and completed in a timely manner*).
	Recommendations: Meridian should 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.
−	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*).
	Recommendations: Meridian should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Meridian should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
−	**Opportunity:** For CI monitoring reviews, Meridian had opportunity to improve timely internal reporting of CIs after the date of CI identification.
	Recommendations: Meridian should continue ongoing reeducation to staff members on the expectations for timely internal reporting of CIs from the date of CI identification.
−	**Opportunity:** For CI monitoring reviews, Meridian had opportunity to improve timely reporting of CIs to the appropriate investigating authority.
	Recommendations: Meridian should continue ongoing reeducation to staff members on the expectations for timely external reporting of CIs from the date of CI identification.

Molina Healthcare of Illinois

Strengths Related to Quality, Access, and Timeliness
+ For performance measures: • Molina reported increases for the *Ambulatory Care—Outpatient Visits—Total* measure. • Molina and the statewide average ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 1* measure. • Molina demonstrated an increase in performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators. • Molina and the statewide average demonstrated an increase in performance for the *Breast Cancer Screening* measure. • Molina ranked at or above the 75th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure. • Molina and the statewide average ranked at or above the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure. • Molina and the statewide average demonstrated performance above the 50th percentile for the *Statin Therapy for Patients with Diabetes*.

Strengths Related to Quality, Access, and Timeliness	
+	In the Child Behavioral Health performance measure domain: • Molina and the statewide average ranked at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure. • Molina ranked above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator. • Molina ranked above the 90th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* measure indicator.
+	For Pay for Reporting performance measures, Molina reported rate increases for the *Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update* measure.
+	For the Compliance review: • The health plan achieved a final compliance score of 99 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For network adequacy: • For the majority of provider types, Molina met or exceeded HFS' access standards. • Molina was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. • Molina met the pharmacy time/distance standard in rural counties and showed improvement from last year by meeting the pharmacy standard in one additional county. • Molina met or exceeded HFS' access standards for pulmonology, adult and pediatric.
+	For CAHPS: • Adult Medicaid experience survey results for *Getting Care Quickly* and *Customer Service* improved from the prior year and were at or between the 50th and 74th percentiles.
+	For CI monitoring: • Molina's results of the file review demonstrated that the health plan was compliant with assuring the HSW of the enrollee after the CI occurred. • Molina's file review results demonstrated that the health plan effectively identified and reported CIs to the appropriate investigating authority. • Molina demonstrated consistent utilization of its process for communication with the investigating authority after initial CI report is made. • Molina remediated all findings from SFY 23.
+	In the CM staffing and training review: • Molina met all contract requirements related to caseloads. • Molina met qualification/education requirements for case managers with all waiver caseload types.

Strengths Related to Quality, Access, and Timeliness	
+	For the HCBS Waiver Reviews measures: • The measures averaging 90 percent or greater compliance indicate that Molina demonstrated strengths in documenting enrollee risks, needs, goals, and backup plans in service plans; that updates to service plans are being completed when enrollees' needs change; that Molina is ensuring enrollees' choice is honored and documented when selecting services; and that enrollees reported satisfaction with personal services. • Molina achieved overall compliance rates higher than the statewide average.
+	For the QA/UR/PR measures: • Molina achieved a performance score of 100 percent for contract requirements. • Molina had findings that would be resolved in future reports by ensuring inclusion of evaluation for efficacy of strategies and interventions to address the lowest performance on the HealthChoice report card. • Molina received an assessment score of *Effective* for the qualitative assessment.
+	In the MHP review: • Molina used nationally recognized utilization review criteria. • Molina's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated Molina followed decision-making guidelines. • Molina followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • Molina demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
+	Molina was fully compliant with all seven IS Standards.

Opportunities and Recommendations	
−	**Opportunity:** Molina ranked below the 50th percentile for all of the Access to Care domain measures.
−	**Recommendations:** HSAG recommends that Molina consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** Molina's performance for the *Annual Dental Visit* measure demonstrated a decline of almost six percentage points from the prior MY, and the percentile ranking decreased from above the 75th percentile to below the 50th percentile.
−	**Recommendations:** HSAG recommends that Molina consider additional analysis to consider if there are disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification.

Opportunities and Recommendations	
−	**Opportunity:** Molina demonstrated a decreased performance for the *Child and Adolescent Well-Care Visits—Total* measure.
	Recommendations: HSAG recommends that Molina consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA zip codes in a particular age or race/ethnicity stratification and to help determine why members are inconsistently receiving well care visits.
−	**Opportunity:** Molina demonstrated a decreased performance for the *Childhood Immunization Status—Combination 10* measure.
	Recommendations: HSAG recommends that Molina consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.
−	**Opportunity:** Molina and the statewide average for the *Cervical Cancer Screening* measure ranked below the 50th percentile.
	Recommendations: HSAG recommends that Molina consider further analysis of potential key drivers that may contribute to the observed low performance.
−	**Opportunity:** In the Adult Behavioral Health domain, Molina's overall performance for the *Follow-Up After Hospitalization for Mental Illness* measure remained low.
	Recommendations: HSAG recommends that Molina consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification.
−	**Opportunity:** Molina's rates on the *LTSS Successful Transition After Long-Term Institutional Stay* measure indicate room for improvement.
	Recommendations: HSAG recommended that Molina review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation.
−	**Opportunity:** In Compliance Review results of file reviews demonstrated opportunities for improvement for Molina related to CM.
	Recommendations: Continue case management system upgrades to ensure visible initial risk stratification. HSAG to conduct a follow-up file review to ensure compliance with this contractual requirement.
−	**Opportunity:** In Compliance Review, Molina had opportunities for improvement related to adherence to the HFS Readability Protocol.
	Recommendations: Distribute and conduct training on the HFS Readability Protocol for all staff members responsible for developing and auditing Illinois-specific enrollee written materials to ensure compliance with a sixth-grade reading level.
−	**Opportunity:** In the access and availability survey, Molina provider's contact information provided was incorrect.
	Recommendations: Since Molina 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

Opportunities and Recommendations	
	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 and addresses that do not correspond to the sampled provider location).
−	**Opportunity:** The access and availability survey identified that Molina's members are experiencing limited appointment availability and are experiencing wait times beyond the appointment compliance standards.
	Recommendations: HFS and Molina should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. Molina should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, Molina should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
−	**Opportunity:** For the time/distance analysis, Molina did not met the time and distance standard for Oral Surgery, Adult in 10 counites and did not meet the time/distance standard for Oral Surgery, Pediatric in 12 counties.
	Recommendations: Molina should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
−	**Opportunity:** For CAHPS, Molina's adult experience survey results for Molina were below the 50th percentile for every measure except *Getting Care Quickly* and *Customer Service.*
	Recommendations: HSAG recommends that Molina consider including information about the ratings from the CAHPS survey in provider communications during the year. Molina should consider obtaining feedback from patients on their recent office visit.
−	**Opportunity:** For CAHPS, Molina's child experience survey results for Molina were below the 50th percentile for every measure in Child CAHPS.
	Recommendations: HSAG recommends that Molina prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. Molina should continue promoting the results of its member experience with its contracted providers and staff.
−	**Opportunity:** In the HCBS waiver review, Molina had an opportunity to improve performance on Measure D6 (*the case manager made timely contact with the enrollee or there is valid justification in the record*).
	Recommendations: Molina should 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.

Opportunities and Recommendations	
−	**Opportunity:** In the HCBS waiver review, Molina had an opportunity to improve performance on Measure D7 (*the most recent service plan is in the record and completed in a timely manner*).
	Recommendations: Molina should 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.
−	**Opportunity:** In the HCBS waiver review, Molina had an opportunity to improve performance on Measure G1 (*the enrollee is informed how and to whom to report unexplained death, abuse, neglect, and exploitation at the time of assessment/reassessment*).
	Recommendations: Molina should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Molina should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
−	**Opportunity:** In the HCBS waiver review, Molina had opportunity to focus efforts on Measure 35D (*the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: Molina should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
−	**Opportunity:** For CI monitoring reviews, Molina's file review identified an opportunity for improvement in completing thorough documentation of the CI event in the case management system.
	Recommendations: Molina should reeducate staff members on ensuring that the CI reporting form includes who identified the CI event, who reported the CI event, when the CI was identified, where the CI occurred, a thorough narrative of the CI event, and specific information on reporting to the investigating authority.
−	**Opportunity:** For CI monitoring reviews, Molina's file review identified an opportunity for improvement in ensuring that the data entered in the CI reporting form are accurately transferred to the CI tracking platform (CHAMPS).
	Recommendations: Molina should reeducate staff members on accurate data transfer from the CI reporting form to CHAMPS.
−	**Opportunity:** For CI monitoring reviews, Molina had opportunity to improve consistent utilization of UTR process prior to closure of the CI event.
	Recommendations: Molina should continue ongoing oversight and monitoring of the application internal UTR process prior to closure of the CI event.
−	**Opportunity:** For CI monitoring reviews, Molina had opportunity to improve following APS ROS Process Policy requirements to complete consultation with APS and the enrollee after receiving the APS ROS form.
	Recommendations: Molina should continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.

YouthCare Specialty Plan

Strengths Related to Quality, Access, and Timeliness	
+	In the Compliance review: • The health plan achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For network adequacy: • For the majority of provider types, YouthCare met or exceeded HFS' access standards. • YouthCare was compliant with the requirement to contract with at least two providers for each of the required service categories across all regions. • YouthCare met the pharmacy time/distance standard in rural counties. • YouthCare showed improvement since last year by meeting the time/distance standard for oral surgeons for adults in two additional counties, and for children in one additional county. • YouthCare met or exceeded HFS' time/distance standards for pulmonology, adult, and pediatric.
+	For the CM staffing and training review: • YouthCare achieved 100 percent compliance for case management supervisor qualifications and credentials.
+	For the QA/UR/PR Measures: • YouthCare achieved a performance score of 100 percent on contract requirements. • YouthCare demonstrated full compliance with the general requirements. • YouthCare received a score of *Mature* based on the level of detail and process improvements identified from the prior year on the qualitative assessment.
+	In the MHP review: • YouthCare used nationally recognized utilization review criteria. • YouthCare's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that YouthCare followed decision-making guidelines. • YouthCare followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • YouthCare demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.

Opportunities and Recommendations	
–	**Opportunity:** In Compliance Review, YouthCare's results of file reviews demonstrated opportunities for improvement related to CM.
	Recommendations: Continue to evaluate care coordination staffing needs to ensure compliance with contractual requirements and continue recruitment efforts to fill the two vacant DCFS liaison positions.
–	**Opportunity:** In Compliance Review, YouthCare had opportunities for improvement related to timeliness of denial decisions and adherence to the HFS Readability Protocol.
	Recommendations: Work with DCFS and providers on challenges during transitions of care with the providers completing DCFS prior authorization paperwork for prescription drugs.
–	**Opportunity:** In the access and availability survey, YouthCare provider's contact information provided was incorrect.
	Recommendations: Since YouthCare 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 and addresses that do not correspond to the sampled provider location).
–	**Opportunity:** The access and availability survey identified that YouthCare's members are experiencing limited appointment availability and are experiencing wait times beyond the appointment compliance standards.
	Recommendations: HFS and YouthCare should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. YouthCare should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, YouthCare should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
–	**Opportunity:** YouthCare did not met the time/distance standard for Oral Surgery, Adult in 10 counties and did not meet the time/distance standard for Oral Surgery, Pediatric in 12 counties.
	Recommendations: YouthCare should continue to review provider categories (with HFS) for which the access standard were not met, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
–	**Opportunity:** In Staffing and Training, YouthCare was noncompliant with low risk caseload requirements.
	Recommendations: YouthCare should develop a plan to reassign caseloads to those case managers not meeting low risk caseload limits.
–	**Opportunity:** In Staffing and Training, YouthCare was noncompliant with case manager credentials requirements.
	Recommendations: The health plan should review the qualification/education requirements to ensure that only staff members with those qualifications are assigned caseloads and

Opportunities and Recommendations	
	develop a plan to ensure that qualifications are reviewed prior to caseload assignment. Staff members without the appropriate qualifications should have those cases reassigned to qualified staff members. The health plan may consider submitting exemption requests to HFS for consideration.
−	**Opportunity:** In Staffing and Training, YouthCare had an opportunity to ensure that case managers receive all required annual trainings.
	Recommendations: The health plan should review its oversight processes to ensure that it is tracking all required trainings and has a process to address outstanding trainings to be completed prior to the end of each calendar year.

MMAI Health Plan-Specific Conclusions

Aetna Better Health

Strengths Related to Quality, Access, and Timeliness	
+	For performance measures, HSAG validated the data collection and reporting processes used by Aetna to report the quality withhold performance measure data. Aetna received a validation finding of *Reportable* which is considered compliant with state specifications.
+	For the Compliance Review: • The health plan achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For CI monitoring: • Aetna had consistent utilization of its process for communication with the investigating authority after initial CI report is made. • Aetna demonstrated compliance with APS ROS process policy. • Aetna's results of the file review demonstrated that Aetna was compliant with assuring the HSW of the enrollee after the CI occurred. • Aetna's results of the file review demonstrated that Aetna effectively identified and reported CIs to the appropriate investigating authority. • Aetna remediated all findings from SFY 23.
+	For the CM staffing and training review: • Aetna met all contract requirements related to caseloads. • Aetna met contract requirements related to HIV/AIDS and BI waiver caseload limits.
+	In the HCBS waiver review, Aetna achieved significant increases in performance for measures impacted by COVID-19 PHE restrictions, including service plan updates, and enrollee signatures.

Strengths Related to Quality, Access, and Timeliness	
+	For the QA/UR/PR review: • Aetna achieved a performance score greater than 90 percent on contract requirements. • Aetna demonstrated full compliance with general requirements. • Aetna received an assessment score of *Effective* on qualitative assessment.
+	In the MHP review: • Aetna used nationally recognized utilization review criteria. • Aetna's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that Aetna followed decision-making guidelines. • Aetna followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • Aetna demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.

Opportunities and Recommendations	
−	**Opportunity:** For Compliance Review, Aetna's results of the appeals and grievances file reviews demonstrated opportunities for improvement related to timeliness of decisions and adherence to the HFS Readability Protocol.
	Recommendations: The Compliance Review findings suggest that Aetna develop the necessary policies and procedures and operationalized most of the required elements of the MMAI contract.
−	**Opportunity:** In the HCBS waiver review, Aetna had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment.*
	Recommendations: Aetna should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
−	**Opportunity:** In the HCBS waiver review, Aetna had an opportunity to focus efforts on Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*.
	Recommendations: Aetna should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.
−	**Opportunity:** In the HCBS waiver review, Aetna had opportunity to focus efforts on Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.*
	Recommendations: Aetna should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).

Opportunities and Recommendations	
−	**Opportunity:** For CI monitoring reviews, Aetna had an opportunity to improve utilization of its UTR process.
−	**Recommendations:** Aetna should evaluate enrollee contact processes to ensure inclusion of attempts to contact enrollees, or authorized representative, who reside in SLP or LTC facility to ensure mitigation of identified risks prior to closure of the CI. Aetna should evaluate oversight processes to ensure timely completion of enrollee contact following identification of a CI and utilization of the UTR process prior to closure of the CI.
−	**Opportunity:** For CI monitoring reviews, Aetna had lack of thorough documentation within the CI report.
−	**Recommendations:** Aetna should evaluate current CI reporting process and procedures to determine potential improvement in CI reporting template. Aetna should routinely provide training to staff on documentation requirements.

Blue Cross Blue Shield of Illinois

Strengths Related to Quality, Access, and Timeliness	
+	For the performance measures, HSAG validated the data collection and reporting processes used by BCBSIL to report the quality withhold performance measure data. BCBSIL received a validation finding of *Reportable* which is considered compliant with state specifications.
+	For the Compliance Review: • The health plan achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For the QA/UR/PR review: • BCBSIL achieved a performance score greater than 90 percent on contract requirements. • BSBCIL demonstrated full compliance with general requirements. • BCBSIL received a score of *Mature* based on the level of detail and process improvements identified from the prior year on the qualitative assessment.
+	For CI monitoring: • BCBSIL was compliant with ensuring the HSW of the enrollee after the CI occurred. • BCBSIL's results of the file review demonstrated that BCBSIL effectively identified and reported CIs to the appropriate investigating authority. • BCBSIL had a high percentage of enrollee contact to address and remediate the CI event and/or utilization of its UTR process prior to the CI closure. • BCBSIL demonstrated consistent utilization of its process for communication with the investigating authority after initial CI report is made. • BCBSIL remediated all findings from SFY 23.

Health Plan-Specific Conclusions

Strengths Related to Quality, Access, and Timeliness	
+	In the HCBS waiver Review: • BCBSIL achieved significant increases in performance for measures impacted by COVID-19 PHE restrictions, including service plan updates, and enrollee signatures. • BCBSIL achieved overall compliance rates higher than the statewide average.
+	In the MHP review: • BCBSIL used nationally recognized utilization review criteria. • BCBSIL's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that BCBSIL followed decision-making guidelines. • BCBSIL followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • BCBSIL demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
+	For the CM staffing and training review: • BCBSIL met all contract requirements related to caseloads. • BCBSIL met contract requirements related to HIV/AIDS and BI waiver caseload limits.

Opportunities and Recommendations	
−	**Opportunity:** BCBSIL ranked below the 50th percentile for all of the Access to Care domain measures.
−	**Recommendations:** HSAG recommends that BCBSIL consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** For the Compliance Review, BCBSIL demonstrated opportunities for improvement related to readability of enrollee materials including grievance and appeals letters.
−	**Recommendations:** Continue to evaluate opportunities for compliance to HFS' readability protocol.
−	**Opportunity:** In the CM staffing and training review, BCBSIL had ELD waiver case managers who did not meet qualification/education requirements.
−	**Recommendations:** BCBSIL should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads.

Opportunities and Recommendations	
–	**Opportunity:** In the HCBS waiver review, BCBSIL had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*.
	Recommendations: BCBSIL should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. BCBSIL should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
–	**Opportunity:** In the HCBS waiver review, BCBSIL had an opportunity to focus efforts on Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*.
	Recommendations: BCBSIL should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.
–	**Opportunity:** In the HCBS waiver review, BCBSIL had opportunity to focus efforts on Measure D7, *the most recent service plan is in the record and completed in a timely manner*.
	Recommendations: BCBSIL should reeducate care managers on expectations and time frames for completion of the annual service plan or valid justification for the delay.
–	**Opportunity:** In the HCBS waiver review, BCBSIL had opportunity to focus efforts on Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: BCBSIL 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. BCBSIL should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
–	**Opportunity:** For CI monitoring reviews, BCBSIL had an opportunity to improve timely internal reporting of the CI event after CI identification.
	Recommendations: BCBSIL should continue ongoing oversight and monitoring of timely internal reporting and continued re-education when identified delay in reporting by CI team.
–	**Opportunity:** For CI monitoring reviews, BCBSIL had an opportunity to improve utilization of APS ROS process policy.
	Recommendations: BCBSIL should continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.

Humana Gold Plan Integrated

Strengths Related to Quality, Access, and Timeliness	
+	For the performance measures, HSAG validated the data collection and reporting processes used by Humana to report the quality withhold performance measure data. Humana received a validation finding of *Reportable* which is considered compliant with state specifications.
+	For Compliance Review: • The health plan achieved a final compliance score of 100 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For CI monitoring: • Humana's results of the file review demonstrated that Humana was compliant with assuring the HSW of the enrollee after the CI occurred. • Humana's results of the file review demonstrated that Humana effectively identified and reported CIs to the appropriate investigating authority and was compliant with requirements upon receiving notification from the investigating authority of a substantiated CI. • Humana demonstrated consistent utilization of its process for communication with the investigating authority after initial CI report is made. • Humana remediated all findings from SFY23.
+	For the CM staffing and training review: • Humana met all contract requirements related to caseloads. • Humana met contract requirements related to HIV/AIDS and BI waiver caseload limits.
+	In the HCBS Waiver Review: • Humana achieved significant increases in performance for measures impacted by COVID-19 PHE restrictions, including service plan updates, and enrollee signatures. • Humana achieved overall compliance rates higher than the statewide average.
+	For the QA/UR/PR review: • Humana achieved a performance score greater than 90 percent in contract requirements. • Humana demonstrated full compliance with the general requirements. • Humana received an assessment score of *Effective* score for the qualitative assessment.

Opportunities and Recommendations	
–	**Opportunity:** In the HCBS waiver review, Humana had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*.
	Recommendations: Humana should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Humana should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
–	**Opportunity:** In the HCBS waiver review, Humana had opportunity to focus efforts on Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: Humana 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. Humana should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
–	**Opportunity:** Humana's results of the appeals and grievances file reviews demonstrated opportunities for improvement related to timeliness of decisions and adherence to the HFS Readability Protocol.
	Recommendations: The Compliance Review findings suggest that Humana develop the necessary policies and procedures and operationalized most of the required elements of the MMAI contract.
–	**Opportunity:** For CI monitoring reviews, Humana had opportunity for improving timely internal reporting of the CI from the date of CI identification.
	Recommendations: Humana should continue ongoing oversight and monitoring of timely internal CI reporting from date of CI identification. Humana should provide education to staff members who are identified with delay in CI reporting.
–	**Opportunity:** For CI monitoring reviews, Humana had an opportunity to improve utilization of APS ROS process policy.
	Recommendations: Humana should continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.
–	**Opportunity:** For CI monitoring reviews, Humana had an opportunity to improve utilization of UTR process policy.
	Recommendations: Humana should continue ongoing oversight and monitoring of the application internal UTR process prior to closure of the CI event.

MeridianHealth

Strengths Related to Quality, Access, and Timeliness	
+	For the performance measures HSAG validated the data collection and reporting processes used by Meridian to report the quality withhold performance measure data. Meridian received a validation finding of *Reportable* which is considered compliant with state specifications.
+	For Compliance Review: • The health plan achieved a final compliance score of 99 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.
+	For CI monitoring: • Meridian's results of the file review demonstrated that the health plan was compliant with assuring HSW of the enrollee after the CI occurred. The enrollee was contacted (or Meridian completed attempts to contact the enrollee), and Meridian mitigated the enrollee's needs, risks, and/or situation. • Meridian's results of the file review demonstrated that Meridian effectively identified and reported CIs to the appropriate investigating authority and was compliant with requirements upon receiving notification from the investigating authority of a substantiated CI. • Meridian demonstrated integration of the CI reporting for MMAI and demonstrated improvement in consistency of internal CI reporting. • Meridian remediated all findings from SFY 23.
+	For the CM staffing and training review: • Meridian met all contract requirements related to caseloads. • Meridian met contract requirements related to HIV/AIDs and BI waiver caseload limits.
+	In the HCBS Waiver Review: • Meridian achieved significant increases in performance for measures impacted by COVID-19 PHE restrictions, including service plan updates, and enrollee signatures. • Meridian achieved overall compliance rates higher than the statewide average. • Meridian performed at a statistically significantly higher rate than all other health plans. • Meridian averaged greater than 90 percent compliance.
+	For the QA/UR/PR measures: • Meridian achieved a performance score of 100 percent for contract requirements. • Meridian had a finding that would be resolved by submission of applicable appendices. • Meridian received a score of *Mature* based on the level of detail and process improvements identified from the prior year on the qualitative assessment.

Strengths Related to Quality, Access, and Timeliness	
+	In the MHP review: • Meridian used nationally recognized utilization review criteria. • Meridian's policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that all health plans followed decision-making guidelines. • Meridian followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions. • Meridian demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.

Opportunities and Recommendations	
−	**Opportunity:** Meridian ranked below the 50th percentile for all of the Access to Care domain measures.
	Recommendations: HSAG recommends that Meridian consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** For Compliance Review, results of file reviews demonstrated opportunities for improvement for Meridian related to CM.
	Recommendations: Continue recruitment efforts to hire open care coordination positions to ensure compliance with contractual requirements. Continue to evaluate ongoing care coordination staffing needs to ensure compliance with contractual requirements.
−	**Opportunity:** For Compliance Review, Meridian had opportunities for improvement related to timeliness of denial decisions.
	Recommendations: Continue to evaluate UM processes for areas of improvement to ensure compliance with coverage and authorization of service requirements.
−	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*.
	Recommendations: Meridian should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Meridian should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
−	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to focus efforts on Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record.*
	Recommendations: Meridian should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including

Opportunities and Recommendations	
	timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.
−	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*.
	Recommendations: Meridian should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Meridian should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.
−	**Opportunity:** In the HCBS waiver review, Meridian had an opportunity to focus efforts on Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*.
	Recommendations: Meridian should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.
−	**Opportunity:** For CI monitoring reviews, Meridian had opportunity to improve timely internal reporting of CIs after the date of CI identification
	Recommendations: Meridian should continue ongoing reeducation to staff members on the expectations for timely internal reporting of CIs from the date of CI identification.
−	**Opportunity:** For CI monitoring reviews, Meridian had opportunity to improve timely reporting of CIs to the appropriate investigating authority.
	Recommendations: Meridian should continue ongoing reeducation to staff members on the expectations for timely external reporting of CIs from the date of CI identification.

Molina Healthcare of Illinois

Strengths Related to Quality, Access, and Timeliness	
+	For the performance measures HSAG validated the data collection and reporting processes used by Molina to report the quality withhold performance measure data. Molina received a validation finding of *Reportable* which is considered compliant with state specifications.
+	In the HCBS waiver review: • Molina achieved significant increases in performance for measures impacted by COVID-19 PHE restrictions, including service plan updates, and enrollee signatures.
+	For Compliance Review: • The health plan achieved a final compliance score of 99 percent. • The health plan's policies and procedures were generally compliant with contract requirements and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.

Health Plan-Specific Conclusions

Strengths Related to Quality, Access, and Timeliness	
+	For CI monitoring: • Molina's results of the file review demonstrated that Molina was compliant with assuring the HSW of the enrollee after the CI occurred. • Molina's results of the file review demonstrated that Molina effectively identified and reported CIs to the appropriate investigating authority. • Molina demonstrated consistent utilization of its process for communication with the investigating authority after initial CI report is made. • Molina remediated all findings from SFY 23.
+	For the CM staffing and training review: • Molina met all contract requirements related to caseloads. • Molina met contract requirements related to HIV and BI waiver caseload limits.

Opportunities and Recommendations	
−	**Opportunity:** Molina ranked below the 50th percentile for all of the Access to Care domain measures.
	Recommendations: HSAG recommends that Molina consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommends increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.
−	**Opportunity:** In Compliance Review results of file reviews demonstrated opportunities for improvement for Molina related to CM.
	Recommendations: Continue case management system upgrades to ensure visible initial risk stratification. HSAG to conduct a follow-up file review to ensure compliance with this contractual requirement.
−	**Opportunity:** In Compliance Review, Molina had opportunities for improvement related to adherence to the HFS Readability Protocol.
	Recommendations: Distribute and conduct training on the HFS Readability Protocol for all staff members responsible for developing and auditing Illinois-specific enrollee written materials to ensure compliance with a sixth-grade reading level.
−	**Opportunity:** In the HCBS waiver review, Molina had an opportunity to improve performance on Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*.
	Recommendations: Molina should revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Molina should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.

Opportunities and Recommendations	
–	**Opportunity:** In the HCBS waiver review, Molina had an opportunity to focus efforts on Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*.
	Recommendations: Molina should conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.
–	**Opportunity:** In the HCBS waiver review, Molina had opportunity to focus efforts on Measure D7, *the most recent service plan is in the record and completed in a timely manner*.
	Recommendations: Molina should reeducate care managers on expectations and time frames for completion of the annual service plan or valid justification for the delay.
–	**Opportunity:** In the HCBS waiver measures, Molina performed at a statistically significantly lower rate than all other health plans.
	Recommendations: Molina should consider reviewing its oversight processes to identify improvements to impact performance.
–	**Opportunity:** In the HCBS waiver review, Molina had opportunity to focus efforts on Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures*.
	Recommendations: Molina 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. Molina should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).
–	**Opportunity:** For CI monitoring reviews, Molina's file review identified an opportunity for improvement in completing thorough documentation of the CI event in the case management system.
	Recommendations: Molina should reeducate staff members on ensuring that the CI reporting form includes who identified the CI event, who reported the CI event, when the CI was identified, where the CI occurred, a thorough narrative of the CI event, and specific information on reporting to the investigating authority.
–	**Opportunity:** For CI monitoring reviews, Molina's file review identified an opportunity for improvement in ensuring that the data entered in the CI reporting form are accurately transferred to the CI tracking platform (CHAMPS).
	Recommendations: Molina should reeducate staff members on accurate data transfer from the CI reporting form to CHAMPS.
–	**Opportunity:** For CI monitoring reviews, Molina had opportunity to improve consistent utilization of UTR process prior to closure of the CI event.
	Recommendations: Molina should continue ongoing oversight and monitoring of the application internal UTR process prior to closure of the CI event.

Opportunities and Recommendations	
–	**Opportunity:** For CI monitoring reviews, Molina had opportunity to improve following APS ROS Process Policy requirements to complete consultation with APS and the enrollee after receiving the APS ROS form.
	Recommendations: Molina should continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.

Appendix B. 2022–2023 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 2022 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 2022, 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 Meetings*, 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 (December 2022 through March 2023)

- Forwarded HEDIS MY 2022 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.

Audit Review Phase (January 2023 Through April 2023)

- 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 2023 Through July 2023)

- 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.
- 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 2021 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 2022 Measures Selected by HFS for HSAG's Validation

	Performance Measure Name	Acronym	Methodology
1	*Adults' Access to Preventive/Ambulatory Health Services*	*AAP*	Admin
2	*Blood Pressure Control for Patients With Diabetes*	*BPD*	Admin, Hybrid
3	*Follow-Up After Hospitalization for Mental Illness*	*FUH*	Admin
4	*Initiation and Engagement of Substance Use Disorder Treatment*	*IET*	Admin
5	*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 2022 Roadmap, published by NCQA as Appendix 2 to NCQA's *HEDIS Measurement Year 2022, 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 2022 (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 2022 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 2022 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 2022 using the QNXT system. Approximately 92 percent of claims were received electronically. There were no issues in 2022 with the electronic claims transmissions or paper claim scanning and conversion to electronic format.

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.

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 2022, 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 2022.

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. The crosswalk was reviewed and approved by the auditor.

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 inter-rater reliability (IRR) testing, and ongoing overread validation. The IRR testing was completed following training, with 90 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 evaluated chase measures for oversample and minimal sample requirements, conducted provider and location clean up, performed retrieval for electronic medical records (EMR), conducted non-responder calls, and performed additional overreads and targeted deep-dive research on non-compliant chases. One hundred percent of compliant cases were overread, with the goal of also overreading 100 percent of the non-compliant chases.

The auditor required a convenience sample due to the change in processes to a more centralized approach. The auditor selected PPC—*Postpartum Care and BPD. No critical errors were identified.* Aetna passed the final MRRV for the BPD and *PPC—Postpartum Care measures.*

Aetna was fully compliant with IS Standard 4.0 for MRR processes.

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

Aetna used 17 supplemental data sources for HEDIS MY 2022 reporting. 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, the auditor designated this as a standard database for HEDIS MY 2022.

Aetna developed a supplemental database from MXOtech data. MXOtech is a health information exchange (HIE) in Illinois that provides clinical data from several provider groups. The provider groups sending data are located throughout the State. The auditor conducted PSV of the database in MY 2021 and did not identify any issues. Since there were no changes to the processes, the auditor designated the data as standard for MY 2022.

Aetna continued to use supplemental data from Healthy Profits (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.

The Year-Round Medical Record Review Database was populated from internally conducted MRRs. However, Aetna did not have any additional hits from this data source on the samples after they were pulled; therefore, the data source was withdrawn from reporting.

Aetna developed a new supplemental database from Jersey Community Hospital electronic health record data. Since the data files are sent in CCD format, the auditor treated this source as non-standard, conducted PSV of the data, and approved the database.

All 17 data sources were approved to use for HEDIS MY 2022 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 2022 performance measure rates. The software is vendor hosted. The initial load was in January 2023, and additional loads took place in February, March, and April 2023.

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 and approved the mapping.

The source for all race and ethnicity data was the State 834 file. Aetna did not use any other sources to collect race and ethnicity data.

Aetna 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

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 2023 load. No significant issues for Illinois Medicaid were identified.

The auditor completed four queries during the virtual audit review.

For the first query, the auditor selected 15 compliant cases for the *WCV, BPD*, and *PPC—Postpartum Care* measures. For all cases except one WCV case, Aetna demonstrated the POS in QNXT. Aetna researched this case and determined it to be from a facility claim, which was provided to the auditor following the virtual audit and confirmed to be compliant.

For the second query, Aetna provided the pharmacy claim counts by month for 2022. The auditor reviewed the data with Aetna during the virtual audit review meeting. Following the virtual audit review, Aetna reported that the pharmacy claims counts increased significantly during May and

B-1 HEDIS Certified Measures[SM] is a service mark of the NCQA.
B-2 NCQA Measure Certification[SM] is a service mark of the NCQA.

December due to a large number of reversals. Aetna provided the monthly pharmacy data load to QSI-XL, showing a steady incline month-to-month.

For the third query, the auditor confirmed that the race and ethnicity values for 10 members in QSI-XL matched the values in QNXT.

For the fourth query, Aetna provided Illinois Medicaid membership per month for MY 2022. No issues were identified.

The auditor reviewed preliminary administrative rates during the virtual audit review meeting and identified no issues. The auditor did not identify any measures at risk at the time of the virtual audit review.

As part of the final rate review process, the auditor reviewed and approved the IDSS Tier 2 Warnings for Aetna's submission. The auditor confirmed by reviewing the IDSS warnings that the certified version of the HEDIS reporting software was used to produce each measure rate.

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. All final rates were determined to be reportable for MY 2022 reporting.

Aetna was fully compliant with IS Standard 7.0 for data integration and reporting.

NCQA HEDIS Compliance Audit Results for BCBSIL

HSAG conducted a MY 2022 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 2022 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 2022, Cognizant received approximately 84 to 85 percent of claims in standard 837 format with the remaining 15 to 16 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 2022, approximately 99.0 percent of all 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 2022. BCBSIL indicated

during the virtual audit review meeting that four federally qualified health centers (FQHCs) were reimbursed on a capitated basis but the HEDIS Roadmap Section 1 indicated all providers were reimbursed on a fee-for-service (FFS) basis; therefore, BCBSIL provided a subsequently revised HEDIS Roadmap Section 1 which indicated 0.62 percent of professional claims/encounters were reimbursed through capitation.

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 financial interest 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 2022. No other vendor data were included in the measures under the scope of the MY 2022 HEDIS Compliance Audit.

All BCBSIL vendor contracts included performance guarantees.

During the virtual audit, BCBSIL demonstrated sample reports it used to monitor and track both Prime Therapeutics' 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's overall membership increased from 2020 to 2021. Monthly membership counts also continuously increased throughout 2022 with the highest membership of the year in December. This was attributed to the ongoing State's redetermination freeze for Medicaid eligibility. BCBSIL further indicated it has a high auto-assignment rate which contributes to proportionately higher 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 2022, Cognizant did not experience any issues with meeting its internal timeliness standard to process the daily enrollment files within 24 hours of receipt. Most records loaded from the State files without any issues, and Facets included automated 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 2 to 5 percent of enrollment records required manual research throughout MY 2022.

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 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 practitioner 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, provider information was initially loaded into Salesforce. 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, along with provider effective dates. 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, and BCBSIL displayed date/time stamped system audit history.

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 project's progress. Provider chart chase logic was reviewed and determined to be sound. BCBSIL did not use any OCR technology for MRR for MY 2022, however, continued 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.

HSAG reviewed Inovalon's QSHR hybrid abstraction tools and participated in a live demonstration of the application to determine compliance with the HEDIS Technical Specifications. Following completion of the review, HSAG approved the QSHR abstraction tools.

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 overreads 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 overreads. BCBSIL completes 100 percent overread on all numerator compliant records and monitors interrater reliability (IRR) to ensure maintenance of a 95 percent or better score. The auditor did not require a convenience sample for MY 2022 since BCBSIL successfully passed medical record review validation (MRRV) in the prior year for all measures validated, there were no changes to its MRR process from the prior year, and the two hybrid measures under the scope of the audit (i.e., BPD and PPC) were not new to the plan and did not have any significant changes to the measure specifications.

BCBSIL passed the final MRRV process for the following measure and corresponding measure groups:

- Group A: Biometrics & Maternity—*BPD–BP Control for Patients with Diabetes*
- Group F: Exclusions—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 23 supplemental data sources for MY 2022 reporting. The auditor determined the following 20 data sources to be standard supplemental data: Advocate Lab, Advocate Physician Partners, Ardent/Lovelace, Boncura Dupage Medical Group, Cook County Health, Edward Elmhurst Health (Illinois Health Partners), EPIC Payer Platform, LabCorp, Lawndale Christian

Health Center, Loyola Physician Partners, MSOGL-Ravenswood Physician Associates, Northwest Community Health, Northwestern, Quest Diagnostics (Quest), Riverside Medical Group, Springfield Clinic, SSM Health, Tricore Laboratory, Unity Point, and University of Chicago. The three following data sources were determined by the auditor to be non-standard data: Village MD, Unified Physicians Network (UPN), and Diameter Health.

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 requires 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 (e.g., missing mandatory data, invalid values as defined by line number, data in the wrong format, etc.) were flagged. BCBSIL onboarded new vendors using its enterprise standard process whereas prior vendors were onboarded using the BCBSIL legacy process, as BCBSIL continued transitioning vendors to its updated process. 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.

The auditor determined the EPIC Payer Platform and MSOGL—Ravenswood Physician Associates to be standard for MY 2022. Both data sources were reviewed as non-standard in MY 2021 and primary source verification (PSV) of cases revealed no issues and 100 percent matching between the proof-of-service documents and the data source. Both follow the clearly defined BCBSIL supplemental data transformation steps and are subject to the BCBSIL standard process to oversee accuracy of all supplemental data sources through ongoing monitoring.

Unified Physicians Network (UPN) and Village MD both passed PSV for MY 2022 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.

All standard and non-standard supplemental data sources were approved by the auditor for MY 2022 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. These monthly calculations occurred in a data warehouse maintained separately from the HEDIS data warehouse, which was used for annual HEDIS reporting.

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 Quality Spectrum Insight-XL (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: *FUH* and *IET*. 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 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 2022 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 2022 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 2022, including claims processing. Evolent used Aldera as its claims transactional system. For MY 2022, 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 edits, 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 and their policy is to require an average audit score of 99 percent. 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 2022.

CountyCare primarily reimbursed providers through a FFS delivery system, with a small percentage of providers reimbursed through a capitation model. CountyCare indicated that it increased capitated arrangements in 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 of the Aldera claims system during the virtual audit. All HEDIS-relevant data elements were observed in the system.

CountyCare continued to contract with MedImpact as a pharmacy benefit manager (PBM) through the entire MY. MedImpact provided daily encounter files along with monthly reconciliation files. CountyCare also continued to contract with Avesis to process routine vision claims throughout MY 2022. 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 a 26,000 increase in membership from MY 2021 to MY 2022 which CountyCare attributed to the COVID-19 pandemic and residents losing commercial coverage.

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 was not performed by CountyCare. 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 2022, CountyCare contracted with Evolent as its medical record vendor. This was the first year for CountyCare to contract MRR to Evolent. HSAG reviewed the hybrid abstraction tools and participated in a live demonstration of the MRR application to determine compliance with HEDIS audit standards. The MRR system used for clinical documentation was Vital Data Technologies' (VDT's) Affinite system, which was also used to capture nonclinical chart details.

Evolent completed all chart chases and input the data into VDT's system. CountyCare conducted close oversight of Evolent's chart chase progress and abstraction to ensure complete and accurate data collection. During the project, Evolent performed overreads on 100 percent of compliant records and exclusions; non-compliant records were overread at a rate of 20 percent. For MY 2022, CountyCare conducted overreads of 100 percent of six measures and 5 percent of four additional measures. CountyCare documented its findings in the VDT system, Affinite. CountyCare met weekly with Evolent and VDT to discuss results of overreads as well as errors. This weekly meeting was also used to discuss and resolve any of the overreads where a disagreement was identified with the abstractions.

If a nurse was continuously identified as making errors, Evolent followed its policy for training or assignment to another measure. Evolent clinical abstractors were HEDIS-experienced and participated in extensive measure-specific training. Training content includes NCQA technical specifications, common errors, sample/mock charts, and testing for each measure. Evolent and CountyCare staff conducting overreads both take part in Evolent's training for consistency. CountyCare internal staff also undergo its own MRR training. CountyCare staff conducting overreads are full-time staff of CountyCare. CountyCare held the MRR accountability and was responsible for documenting final approval in Affinite.

Since the BPD and PPC measures were both selected for medical record review validation (MRRV) in the prior year and passed, the auditor determined that CountyCare was exempt from convenience sample validation for both measures. However, CountyCare indicated that it would prefer to participate in convenience sample validation and all three samples that were submitted passed validation.

CountyCare passed the final MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics & Maternity—*BPD—Blood Pressure Control for Patients with Diabetes*
- Group F: Exclusions

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. Lab data were procured from the labs based on CountyCare's contracts completed with the labs. EHR data were procured directly from the applicable providers. State immunizations (IMMS) data and Care Coordination historical claims data were sent monthly in 2022 from HFS. VDT conducted its own quality checks in batch form so that whenever data were submitted, the VDT data quality checks were performed. CountyCare provided process overviews describing data procurement, warehousing, and validations. The following 10 data sources were reviewed and determined to be standard supplemental data:

1. Care Coordination Claims Data (CCCD)
2. Medstar Labs
3. IMMS Registry
4. LabCorp Labs
5. Quest Labs
6. Stroger Labs
7. Athena EHR
8. Cerner EHR
9. Epic EHR
10. Sinai Labs

All ten supplemental data sources were approved to use for HEDIS MY 2022 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 has put stopgaps in place to ensure timeliness of data. Monthly meetings occur with all delegated entities to discuss during the joint operations committees (JOCs) which report up to

the quarterly delegation oversight committee that has a cross-functional team from all areas of delegation, as well as Chief Executive Officer (CEO) and compliance. Pre-delegation audits, annual audits, data/performance outliers and corrective action plan oversight occurs in this committee. The delegation oversight committee is overseen by the quality committee which reports to the Board. Claims delegates all must complete Sarbanes-Oxley Act (SOX) audits – MedImpact, Guardian Avesis, and Evolent all complete these annual SOX audits. Evolent has more frequent meetings because of the high volume of work they perform on behalf of CountyCare (e.g., biweekly or more often as needed, based on the specific work stream and scope with the subject matter experts at CountyCare).

Inbound and outbound data quality reports 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.

The auditor reviewed provider mapping files for primary care providers (PCPs), obstetricians/gynecologists (OB/GYNs), and mental health providers. The auditor requested validation that providers on the mapping file that were mapped as mental health providers and were listed as having licensure for treating substance use disorders and providers listed as having licensure for treating autism spectrum disorders (Behavior Analysts) were verified to have a mental health licensure type listed in the current HEDIS Volume 2: Technical Specifications for Health Plans. The auditor also requested validation that FQHCs and RHCs mapped as OB/GYNs on the mapping file were confirmed to have providers with one of the OB/GYN licensure types listed in HEDIS Volume 2. CountyCare provided information regarding licensure of providers who were included in the applicable measures and the auditor confirmed that the providers met the HEDIS requirements for the associated provider type.

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 2022 performance measure production. All HEDIS measures within the scope of the audit were included in VDT's measure certification. The VDT Affinite Quality tool was demonstrated live. VDT also demonstrated its Affinite 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: *FUH* and *IET*. 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 each measure were found to be compliant with the measure specification requirements. .

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 2022 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 2022 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

For MY 2022, Meridian continued to use the AMISYS Advance claim system to capture all claims. For MY 2022, approximately 99 percent of claims were received electronically in the standard 837 format. The remaining 1 percent of claims were received as paper claims, scanned, and converted to the standard 837 format for loading.

Approximately 97 percent of Meridian's claims auto-adjudicate with the remaining 3 percent pending to a workflow queue to resolve the issue (e.g., authorization, coordination of benefits, member eligibility issue, etc.). Meridian only accepts standard claims forms, diagnosis codes, and procedure codes. Electronic claims files were loaded into AMISYS and industry-standard edits were applied. Meridian had appropriate edits in place at the clearinghouse level for formatting as well as member validation, procedure code edits, and required field checks within AMISYS. The auditor verified that the AMISYS system appropriately captured the required fields used to produce all HEDIS measures under the scope of the review. AMISYS 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 Corporation's (Centene's) vendor for dental and pharmacy benefits. Starting April 1, 2022 Envolve Pharmacy Services began receiving encounters from CVS for the Illinois Medicaid product line as Centene's primary pharmacy benefit manager. Meridian reported that no significant issues were experienced with the receipt of encounter files during the transition, and the auditor verified through a

query that pharmacy transaction volume remained very stable throughout 2022. 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 dental and pharmacy 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 random sample of adjudicated claims as well as monthly audits of each claims analyst who are expected to maintain a score of 99.5 percent on payment accuracy and 98 percent on procedural accuracy. In addition, production standards were monitored daily and monthly by claims operations management to ensure compliance with standards.

Meridian was fully compliant with IS Standard 1.0 for medical services data.

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

For MY 2022, Meridian continued to rely on HFS for delivery and accuracy of the 834 enrollment files daily/monthly, and there were no manual steps in enrollment processing. 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. Meridian captured enrollment information in the Centene Unified Member View (UMV) system, which sits atop AMISYS. 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 for use in HEDIS processing.

Meridian was fully compliant with IS Standard 2.0 for enrollment data.

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

All of Meridian's provider data continued to be housed in Portico, Centene's provider system. Provider credentialing was centralized with HFS and therefore was not performed by Meridian. After receiving the HFS provider IMPACT files and conducting validation of provider data comparing the IMPACT files and provider roster files which Meridian received directly from providers, the files were loaded into Centene's Portico system. Once the provider was credentialed in the Portico system, the provider information was loaded through an automated downstream link into AMISYS. Centene had a process in place for validating provider information annually 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. Meridian chose a primary care provider (PCP) and a large Federally Qualified Health Center (FQHC) to review during the virtual audit review. Meridian was able to demonstrate that the provider specialty matched all systems for both professional and facility providers. AMISYS maintained all relevant information required for performance measure reporting. Both Portico and AMISYS contained unique identifiers and captured identical information as expected.

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 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The auditor found these policies and procedures to be consistent with the HEDIS MY 2022 IS 4.0 requirements. The auditor verified that Meridian 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 2022, but also used a vendor names CIOX as well as internal staff for chart retrieval.

Change Healthcare continued to conduct interrater reliability (IRR) for all staff and required all staff to maintain a 95 percent accuracy level to continue working on the project. HSAG requested IRR scores for both training and final results and the auditor confirmed the scores to be in the expected range.

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 Change Healthcare's hybrid abstraction tools to ensure all fields, edits, and drop-down boxes were accurate against NCQA's HEDIS MY 2022, Volume 2, Technical Specifications for Health Plans. HSAG reviewed and approved Change Healthcare's hybrid tools and instructions.

Since Meridian passed the final medical record review validation (MRRV) for the BPD and PPC measures in MY 2021 and there were no changes to the MRR process, the auditor determined that Meridian was exempt from convenience sample validation.

Meridian passed the final MRRV process for the following measure:

- Group A: Biometrics & Maternity—*BPD–BP Control for Patients with Diabetes*

Meridian was fully compliant with IS Standard 4.0 for MRR processes.

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

Meridian continued to utilize supplemental data to augment and improve its HEDIS rates. For HEDIS MY 2022 reporting, Meridian presented 49 supplemental data sources for consideration. The auditor determined 44 of the data sources to be standard data and five were considered non-standard data.

The standard databases contained data from various electronic medical records (EMR), laboratories, historical claims data, and Data Aggregator Validation (DAV)-certified entities such as various state health information exchanges. Meridian had sufficient processes in place to ensure the standard supplemental data sources were loaded correctly, and appropriately validated. Meridian provided the required documentation for these standard supplemental databases and all of the standard data sources were approved to use for HEDIS MY 2022 reporting.

Meridian identified the following non-standard supplemental databases for HEDIS MY 2022 reporting:

1. Athena
2. Azara non-DAV
3. Indiana Health Information Exchange
4. QCAT
5. WellCare Interoperability

Primary Source Verification (PSV) was conducted on the non-standard supplemental data sources according to NCQA's supplemental data guidelines. The Athena and WellCare Interoperability data sources did not pass the validation and were not approved for MY 2022 reporting; however, the three remaining non-standard supplemental data sources and all 44 standard data sources were approved to include in reporting.

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 2022 reporting.

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.

The auditor reviewed the provider mapping file for PCPs, Obstetricians and Gynecologists (OB/GYNs), and mental health providers. The auditor validated that providers in the mapping file who were mapped as mental health providers and listed as having a taxonomy as a Behavior Analyst or Addiction

Counselor had one of the licensure types listed in Appendix 3 of HEDIS MY 2022, Volume 2, Technical Specifications for Health Plans for mental health providers, since Addiction Treatment Services and Autism Treatment Services are often treated by providers with certification or licensure that does not meet NCQA's criteria as a mental health provider. Meridian provided additional licensure information for the individual providers mapped to these provider types that were included in the measures, and the auditor was able to validate that the providers met the requirements for inclusion.

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 2022. 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. HSAG confirmed that Inovalon passed certification for all measures under the scope of the audit for HEDIS MY 2022.

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.

PSV was conducted for five members in each of the following measures: *FUH* and *IET*. Enrollment, administrative, and practitioner data in the source systems were reviewed for each member to confirm compliance with measure specifications and system concordance. All cases reviewed met the requirements in the measure specifications.

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 2022 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 2022 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

There were no changes to the claims process for Molina since the prior MY. 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, up to the maximum billed on a Centers for Medicare & Medicaid Services (CMS) 1500/837P and UB-04/837I claim. Non-standard codes were not used for Illinois during the MY.

HSAG reviewed Molina's QNXT system and verified that it met industry standard claim edits and required providers to include identifiable information to process the claim. HSAG verified that missing procedure and diagnosis codes would result in the claim being denied for invalid/missing criteria. Additional edits were in place to reject claims if they were missing critical information, such as member demographics, dates of service, and missing or null fields.

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 electronic 837P or 837I format. Molina had sufficient processes in place to capture and validate encounter data submissions. Molina validated data submissions against State financial reports 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, which 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 did not identify any issues with claims receipt or processing during the MY that would have impacted HEDIS rates. Molina verified that they have control processes in place that identify missing information and that any missing or latent claims or encounters would be identified through their auditing process.

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. QNXT had appropriate fields to capture all vital information required for claims processing and HEDIS reporting. QNXT allowed for several identification (ID) 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.

HSAG reviewed Molina's process for capturing race and ethnicity. Molina indicated that it captures race and ethnicity values in QNXT using the HEDIS direct methodology only. The majority of this information is captured using the 834 files. However, the 834 files are not always complete and race and ethnicity is a combined field in the 834 file. HSAG reviewed the file and agreed that the field in the 834 is primarily for race. Molina is using the appropriate race and ethnicity mapping according to HEDIS specifications.

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 data processing systems for HEDIS MY 2022. 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 2022.

HSAG reviewed the process for identifying Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) and found that Molina was using appropriate methods utilizing CMS and NCQA guidelines. Molina appropriately mapped the FQHC and RHC entities to primary care providers (PCPs) for HEDIS reporting. Additionally, Molina credentials all providers at FQHCs and RHCs and requires that they bill a servicing provider on claims. This process ensures that specific provider specialties are captured for services rendered.

Molina 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 Molina's MRR process during the virtual audit. 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 was submitted to HSAG and no issues were identified. Molina requires all abstractors meet the 95 percent accuracy threshold before being allowed to proceed with the project. HSAG had no concerns with Molina's ability to abstract HEDIS measures from medical records.

Since Molina passed the final medical record review validation (MRRV) in MY 2021 and there were no changes to its MRR process, a convenience sample was not required.

MRRV was conducted for the *BPD* and *PPC—Postpartum Care* measures and all cases successfully passed the validation process.

Molina was fully compliant with IS standard 4.0 for MRR processes.

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

Molina submitted 33 supplemental databases for review for the Illinois measures under the scope of the audit. Two sources were determined to be non-standard data. The remaining 31 databases, which included lab results, prior year's audited medical records, electronic medical record (EMR) systems, historical claims from the State, and immunization registries were considered standard data.

PSV was conducted for the two non-standard supplemental data sources, Provider Registry and Centauri. HSAG selected a sample of cases for each non-standard supplemental data source and reviewed proof-of-service (POS) documentation provided by Molina. Molina successfully passed PSV for both of the non-standard data sources.

All standard and non-standard data sources were approved to use for HEDIS MY 2022 reporting.

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 (Cognizant) and used the vendor's ClaimSphere HEDIS Certified Measures software for generating its HEDIS MY 2022 performance measure rates.

The auditor performed PSV on a selection of cases for the ADV and WCV measures to ensure numerator compliance and no issues were identified. The auditor reviewed all data transfers and mappings and determined them to be managed appropriately by Molina. The health plan 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.

Molina included all paid, denied, and pended claims in its extract process for the MY data loads and loaded sufficient years of claims data to meet HEDIS reporting requirements.

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.

Molina monitored all data loads to ClaimSphere to ensure data were accepted. Any rejected data 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.

The auditor conducted primary source verification on two non-HEDIS measures since they were new to the health plan. The measures reviewed were *HVL-AD* and *MLTSS-8*. In addition to those two measures, the auditor reviewed a smaller sample of *Annual Dental Visit* and *Adolescent Well-Care Visits*. No issues were found in any of the samples reviewed.

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 Cognizant's HEDIS certified measures to generate its HEDIS performance measure rates. 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 2022 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 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 monitored 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 was designed with an audit table to gather all record counts for each file loaded. Queries were employed to perform reconciliation checks and balances for both post and pre-load processes. Queries verified 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.

Molina was fully compliant with IS Standard 7.0 data integration and reporting.

Illinois MCO Performance Reporting PMV Methodology

Background

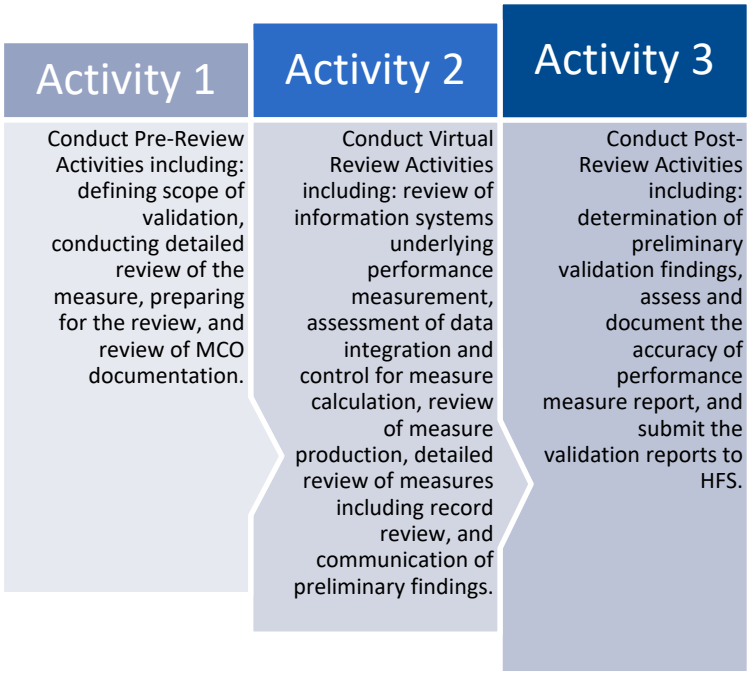
HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures. HFS selected four measures for validation from the HFS Managed Care Organization (MCO) Performance Reporting (MPR)/Quarterly Business Review (QBR) reporting requirements:

- New Enrollee Screening and Assessments
- Enrollee Engagement: Care Assessment and Individualized Plan of Care
- Enrollee Engagement: Reassessments Every 12 Months
- Enrollee Engagement: Contact Frequency

Methodology

HSAG validated the data collection and reporting processes used by the MCOs to report the performance measure data for July 1, 2021-December 31, 2021 in accordance with CMS' Protocol 2 cited earlier in this report. Figure B-2 presents the protocol activities conducted.

Figure B-1—Protocol 2 Activities



HFS provided the specifications and supplemental guidance that MCOs were required to use for reporting the performance measures, and which HSAG utilized to define the scope of the validation.

The following list describes the types of documentation and data collected and how HSAG conducted analysis of data:

- **Information systems review—**HSAG utilized each MCO's completed ISCAT and relevant supplemental documentation to assess the integrity of information systems and data processes used for collecting and processing data, and processes used for performance measure calculation. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification. Where applicable, HSAG used the information provided in each ISCAT to begin completing the review tools.
- **Source code (programming language) for performance indicators—**HSAG required each MCO that calculated the performance indicators using computer programming language to submit source code for each performance indicator being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). HSAG required each MCO that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCO took for indicator calculation.
- **Performance indicator reports—**HSAG reviewed the MCOs' prior rate reports along with the current reports to assess trending patterns and rate reasonability.
- **Primary source verification (PSV) —**HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirmed entry; and detected errors. HSAG selected cases across evaluated measures to verify that the MCOs had appropriately applied measure specifications for accurate rate reporting. The MCOs provided HSAG with a listing of the data each had reported to HFS, from which HSAG randomly selected a sample of cases. During the virtual site review, these data were reviewed live in the MCO's systems for verification. This approach enabled each MCO to explain its processes regarding any exception processing or unique, case-specific nuances that may or may not impact final measure reporting.
- **Supporting documentation—**HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

The PMV review of the MCO's reported data consisted of remote validation and post-validation activities focusing on enrollment and eligibility processes, care management activities, and performance measure production. HSAG conducted a virtual site review with each MCO between October 10, 2022, and October 21, 2022. The virtual site review included:

- A review of key information systems and the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff members familiar with the collection, processing, and monitoring of the MCO data used in producing performance measures.

- A review of the database management systems processes used to integrate key source data and the MCO's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- A demonstration of key information systems, database management systems, and analytic systems to support documented evidence and interview responses.

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-13 presents the PMV designations HSAG used for its review of the MPR measures audited during this activity.

Table B-8—Performance Measure Validation Designations

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 MCO 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 to Table B-12 display HSAG's validation finding for all MCOs.

Table B-9—Validation Findings for New Enrollee Screening and Assessments

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	Reportable	Reportable	Reportable	Reportable

Table B-10—Validation Findings for Care Assessment and Individualized Plan of Care

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	Reportable	Reportable	Reportable	Reportable

Table B-11—Validation Findings for Reassessments Every 12 Months

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	Reportable	Reportable	Reportable	Reportable

Table B-12—Validation Findings for Contact Frequency

Validation Finding				
Aetna	**BCBSIL**	**CountyCare**	**Meridian**	**Molina**
Reportable	Reportable	Reportable	Reportable	Reportable

MMAI IL 3.6 PMV Methodology

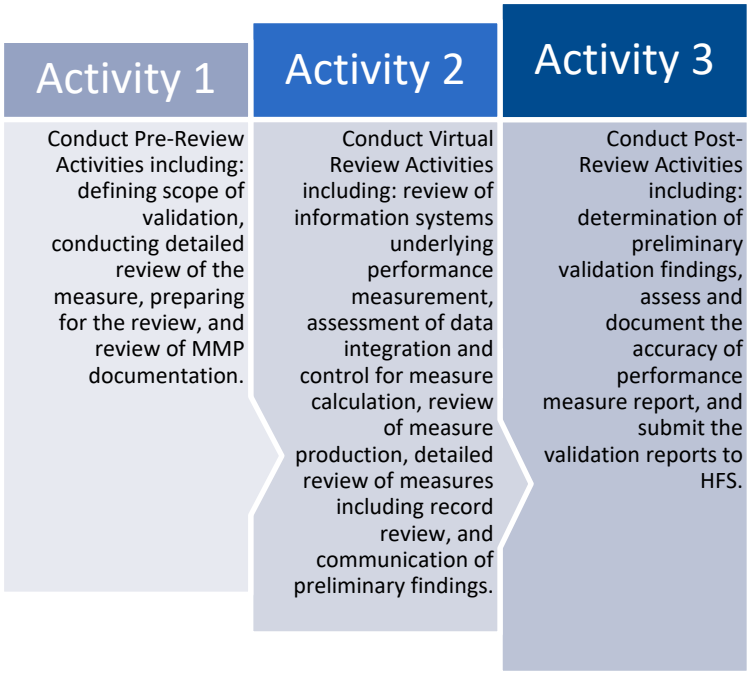
Background

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-2 presents the protocol activities conducted.

Figure B-2—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-13 presents the PMV findings HSAG used for its review of Measure IL 3.6.

Table B-13—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-14 displays HSAG's validation finding for all MMPs.

Table B-14—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.

Humana MMAI PMV Methodology

Background

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures. HFS selected two measures for validation for the MMAI program. Table B-15 presents the performance measures selected by HFS, the specifications the MMAI plans were required to use for each of the measures, and the method of data collection selected by HFS.

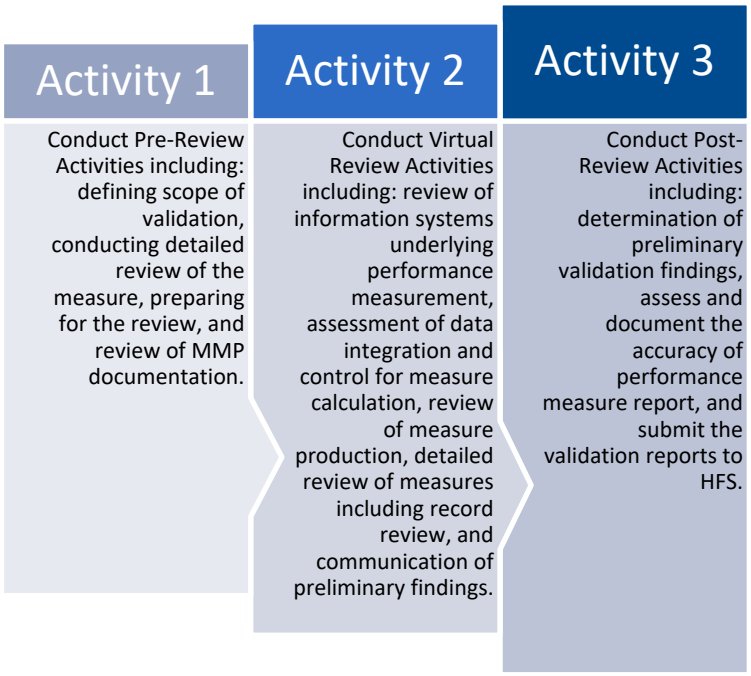
Table B-15—Performance Measures for Humana

Performance Measure	Specifications	Method
Adults' Access to Preventive/Ambulatory Health Services	HEDIS	Admin
Initiation and Engagement of Substance Use Disorder Treatment	HEDIS	Admin

Methodology

HSAG validated the data collection and reporting processes used by Humana to report the performance measure data for MY 2022 (January 1, 2022, through December 31, 2022) in accordance with CMS' Protocol 2 cited earlier in this report. Figure B-3 presents the protocol activities conducted.

Figure B-3—Protocol 2 Activities



The NCQA[B-6] provided the specifications and supplemental guidance that Humana was required to use for reporting the performance measures, and which HSAG utilized to define the scope of the validation.

The following list describes the types of documentation and data collected and how HSAG conducted analysis of data:

- **Information systems review**—HSAG utilized Humana's completed ISCAT and relevant supplemental documentation to assess the integrity of information systems and data processes used for collecting and processing data, and processes used for performance measure calculation. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification. Where applicable, HSAG used the information provided in each ISCAT to begin completing the review tools.
- **Source code (programming language) for performance indicators**—HSAG required MMPs that calculated the performance indicators using computer programming language to submit source code for each performance indicator being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the state-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any). HSAG required MMPs that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MMP took for indicator calculation.
- **Performance indicator reports**—HSAG reviewed Humana's prior rate reports along with the current reports to assess trending patterns and rate reasonability.
- **Primary source verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirmed entry; and detected errors. HSAG selected cases across evaluated measures to verify that Humana had appropriately applied measure specifications for accurate rate reporting. Humana provided HSAG with a listing of the data it had reported to HFS, from which HSAG randomly selected a sample of cases. Prior to and during the virtual site visit, screenshots of the data and Humana's live systems were reviewed for verification. This approach enabled Humana to explain its processes regarding any exception processing or unique, case-specific nuances that may or may not impact final measure reporting.
- **Supporting documentation**—HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

The PMV review of Humana's reported data consisted of remote validation and post-validation activities focusing on enrollment and eligibility processes, claims and encounter processes, and

[B-6] National Committee for Quality Assurance. HEDIS Measures and Technical Resources. Available at: https://www.ncqa.org/hedis/measures/ Accessed on: Mar 14, 2023.

performance measure production. HSAG conducted a virtual site review with Humana on April 14, 2023. The virtual site review included:

- A review of key information systems and the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff members familiar with the collection, processing, and monitoring of Humana's data used in producing performance measures.
- A review of the database management systems and processes used to integrate key source data and Humana's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- A demonstration of key information systems, database management systems, and analytic systems to support documented evidence and interview responses.

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-16 presents the PMV designations HSAG used for its review of the performance measures audited during this activity.

Table B-16—Performance Measure Validation Designations

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-17 displays HSAG's validation finding for Humana.

Table B-17—Validation Findings for Humana

Performance Measure	Measure Designation
Adults' Access to Preventive/Ambulatory Health Services	Reportable
Initiation and Engagement of Substance Use Disorder Treatment	Reportable

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.[C-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, 2024.

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

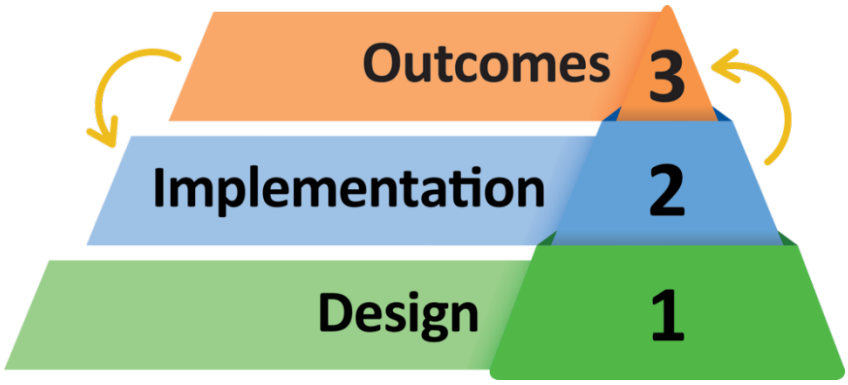
Each required step is evaluated on one or more elements. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP/QIP process as critical elements. For 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 2023, 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

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. Access and Availability Telephone Survey

HealthChoice Illinois

Illinois Department of Healthcare and Family Services

State of Illinois
Department of Healthcare and Family Services

State Fiscal Year 2023 Access and Availability Telephone Survey Report

August 2023

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

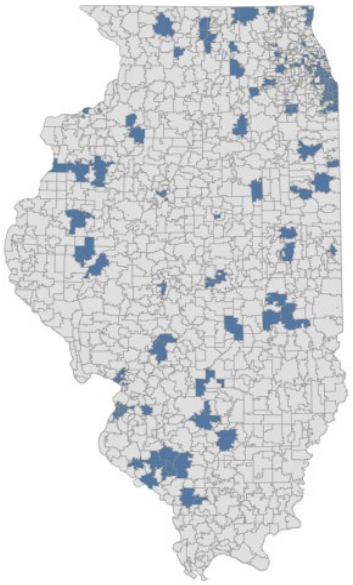
Introduction

The Illinois Department of Healthcare and Family Services (HFS) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct access and availability surveys to evaluate the accuracy of provider information and appointment availability for Illinois Medicaid enrollees with a dental provider or primary care provider (PCP). To support HFS' goal to identify and prioritize reducing health disparities, the focus of the study was on providers in disproportionately impacted areas (DIAs).[1] DIAs are defined as ZIP Codes that meet the following criteria:[2]

- Severely affected by coronavirus disease 2019 (COVID-19) based on positive case per capita rates
- One of the following poverty-related criteria was relatively higher than other ZIP Codes in that region:
  - Share of population consisting of children 6 to 17 years old in households with income less than 125 percent of the federal poverty level (FPL)
  - Share of population consisting of adults older than 64 years of age in households with income less than 200 percent of the FPL
  - Share of population in household with income less than 150 percent of the FPL
  - Share of population consisting of children ages 5 years and under in households with income less than 185 percent of the FPL

A map of the Illinois DIA ZIP Codes (shaded blue) is displayed in Figure 1-1.

Figure 1-1—DIA ZIP Codes



[1] The list of DIA ZIP Codes can be found at the following website: https://www.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: June 23, 2023.

[2] Illinois WorkNet Center. QCT – DIA Map. Available at: https://www.illinoisworknet.com/qctdiamap. Accessed on: June 15, 2023.

According to 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 appointments (i.e., routine and preventive care) are available within five weeks. Specific survey objectives included the following:

- Determine whether provider locations accept patients enrolled with a Medicaid health plan
- Determine whether provider locations accept new patients
- Determine appointment availability with the sampled specialty locations for routine dental and primary care services

To address the study objectives described above, HSAG used an HFS-approved methodology (Appendix B) and script (Appendix C) to conduct a non-secret (i.e., "revealed caller") telephone survey of PCP and dental providers' offices to collect information on enrollees' access to providers. The health plans assessed in this analysis included the following:

- Aetna Better Health of Illinois (Aetna)
- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare[3]
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare Specialty Plan (YouthCare)

[3] Available only in Cook County.

Summary of Access and Availability Survey Conclusions

Overall, the provider information maintained and provided by the plans is poor, which impacts access to care due to the ability of members to find a provider that delivers the requested services. The table below provides a summary of the findings from the study.

Table 1-1—Summary of Findings

Concerns	Findings
A substantial percentage of telephone numbers were inaccurate.	Approximately 15 percent of sampled providers' phone numbers were bad phone numbers, which included reaching a disconnected number, fax number, or a personal number or non-medical facility. 17 percent of phone numbers could not be used by an enrollee to make an appointment.
The providers' locations were wrong.	10 percent of the sampled providers were located at the wrong address.
Data issues seem to be higher for PCPs compared to dental providers.	Compared to the dental providers, fewer PCP locations confirmed the address, specialty, and insurance information noted in the health plan data.
The ability to make an appointment is limited by the accuracy of provider information.	An appointment was offered in only 40.9 percent of sampled dental cases and 16.8 percent of sampled PCP cases. This is due to inaccurate data which prevent the survey from continuing or reaching the provider office.
Members are having to wait for an appointment beyond the appointment compliance standards.	For those surveys wherein an appointment was offered, only 34 percent of dental appointments and 13 percent of PCP visits met the appointment standard.

If the surveyors were able to reach the correct provider location, overall accuracy of acceptance of the health plan, Medicaid, and new patients, and of offering the service was high. However, concerns with data accuracy need to be addressed as this is preventing most callers from reaching a provider office or appointment line.

When compared to the 2022 statewide Access and Availability Survey of specialty providers,[4] the DIA group performed worse than the specialty provider population for most study indicators. The poor quality of the provider information contributed to these findings and resulted in a decreased ability for enrollees in DIAs to access dental and primary care services. Additionally, when compared to similar studies in other states, the DIA response rates were lower across comparable surveys. Moreover, the DIA population experienced a higher number of bad phone numbers or offices that were unable to be

[4] The 2022 Access and Availability Survey evaluated appointment availability for routine appointments with the following provider specialties: cardiologists, pulmonologists, allergy and immunologists, neurologists, and licensed professional counselors.

reached than callers have experienced when conducting similar surveys. Overall, the poor quality of the provider data seen in the DIA population is generally worse than seen in other surveys.

Analytic Considerations

Due to the nature of the survey, the following limitations should be considered when generalizing survey results across all providers contracted with the health plans to serve Medicaid enrollees:

- Survey calls were conducted at least four weeks following HSAG's receipt of each health plan's provider data, resulting in the possibility that provider locations updated their contact information with the health plan prior to HSAG's survey calls.
- Time to the first available appointment is based on appointments requested with the sampled provider 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 Medicaid enrollees are willing to travel to an alternate location.
- 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).
- 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 an enrollee's experience when seeking an appointment. Of note, 2.8 percent of the sampled locations declined to participate in the survey (i.e., considered a refusal), an outcome that may differ for prospective patients.

High-Level Results

Figure 1-2 illustrates the flow of data collection during the survey calls, as well as the total number of cases with each potential survey outcome.

Figure 1-2—Survey Data Collection Process and Case Outcomes

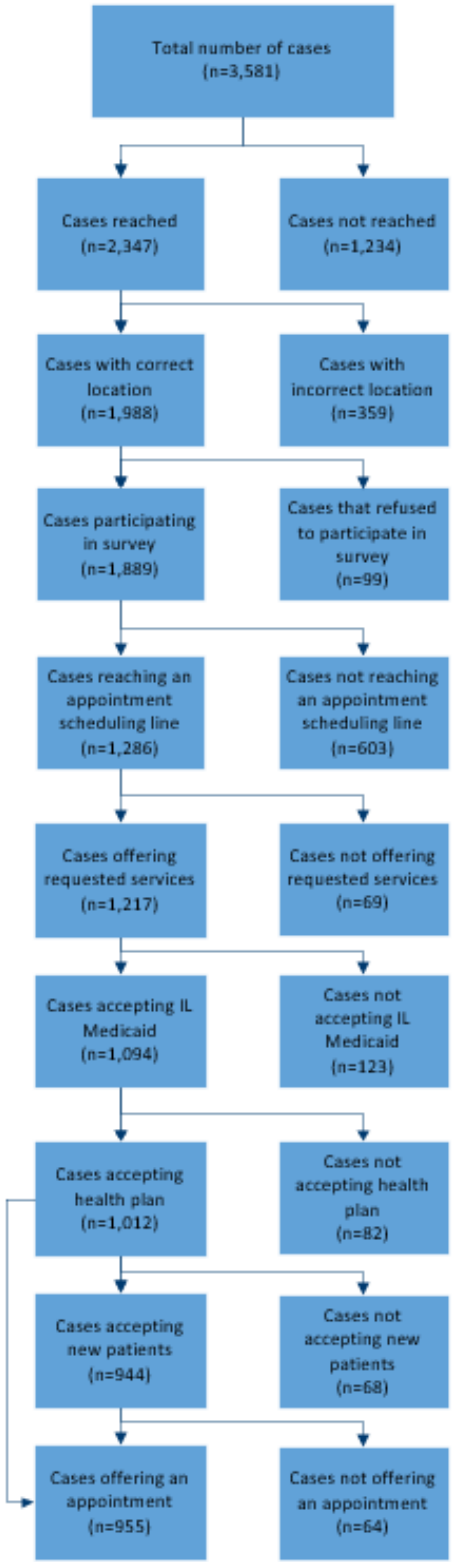


Table 1-2 displays the survey call outcomes, including the reasons that appointment availability could not be collected, including location could not be reached, incorrect address, refusal, non-appointment scheduling phone number, did not offer the requested services, did not accept the health plan or Medicaid, did not accept new patients, or had other limitations to scheduling. Overall, 25.4 percent of the calls placed to providers indicated having an available appointment, with appointment availability rates ranging from 21.1 percent (YouthCare) to 35.0 percent (BCBSIL).

Table 1-2—Survey Call Outcomes

Outcome	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	All Health Plans
Location Could Not Be Reached	260 (38.6%)	172 (29.2%)	226 (42.0%)	232 (35.8%)	143 (28.8%)	201 (31.6%)	1,234 (34.5%)
Location Address Incorrect	82 (12.2%)	44 (7.5%)	38 (7.1%)	67 (10.3%)	53 (10.7%)	75 (11.8%)	359 (10.0%)
Phone Number Not for Appointment Scheduling	101 (15.0%)	83 (14.1%)	61 (11.3%)	109 (16.8%)	115 (23.1%)	134 (21.1%)	603 (16.8%)
Refused to Participate	20 (3.0%)	23 (3.9%)	13 (2.4%)	16 (2.5%)	13 (2.6%)	14 (2.2%)	99 (2.8%)
Location Does Not Offer Requested Services	10 (1.5%)	5 (0.8%)	5 (0.9%)	25 (3.9%)	9 (1.8%)	15 (2.4%)	69 (1.9%)
Location Does Not Accept IL Medicaid	27 (4.0%)	23 (3.9%)	16 (3.0%)	21 (3.2%)	11 (2.2%)	25 (3.9%)	123 (3.4%)
Location Does Not Accept Plan	9 (1.3%)	8 (1.4%)	12 (2.2%)	4 (0.6%)	5 (1.0%)	44 (6.9%)	82 (2.3%)
Location Not Accepting New Patients	11 (1.6%)	12 (2.0%)	7 (1.3%)	12 (1.9%)	15 (3.0%)	11 (1.7%)	68 (1.9%)
Appointment Available	156 (22.3%)	221 (35.0%)	147 (25.5%)	170 (24.5%)	138 (24.7%)	123 (21.1%)	955 (25.4%)
Appointment Not Available Due to Limitation	7 (1.0%)	14 (2.4%)	23 (4.3%)	4 (0.6%)	10 (2.0%)	6 (0.9%)	64 (1.8%)

Survey callers did not specifically ask about scheduling considerations or reasons an appointment may not be offered; however, the information was captured if offered by survey respondents regarding scheduling considerations that might affect an enrollee's access to care. Among cases offering an appointment, the most common limitation listed was a unique age restriction. For cases in which an appointment was not offered, the most common limitations listed were that the schedule or calendar was not available at the time of the call or that the office required pre-registration or personal information to schedule.

Some of the scheduling considerations noted by the survey calls may be part of a provider office's standard medical practice; therefore, there may be valid reasons why a provider would not schedule an appointment. The limitations to scheduling appointments among survey calls are displayed in Table 1-3. Since callers identified all applicable scheduling considerations for a survey case, cases may be counted for one or more limitation categories.

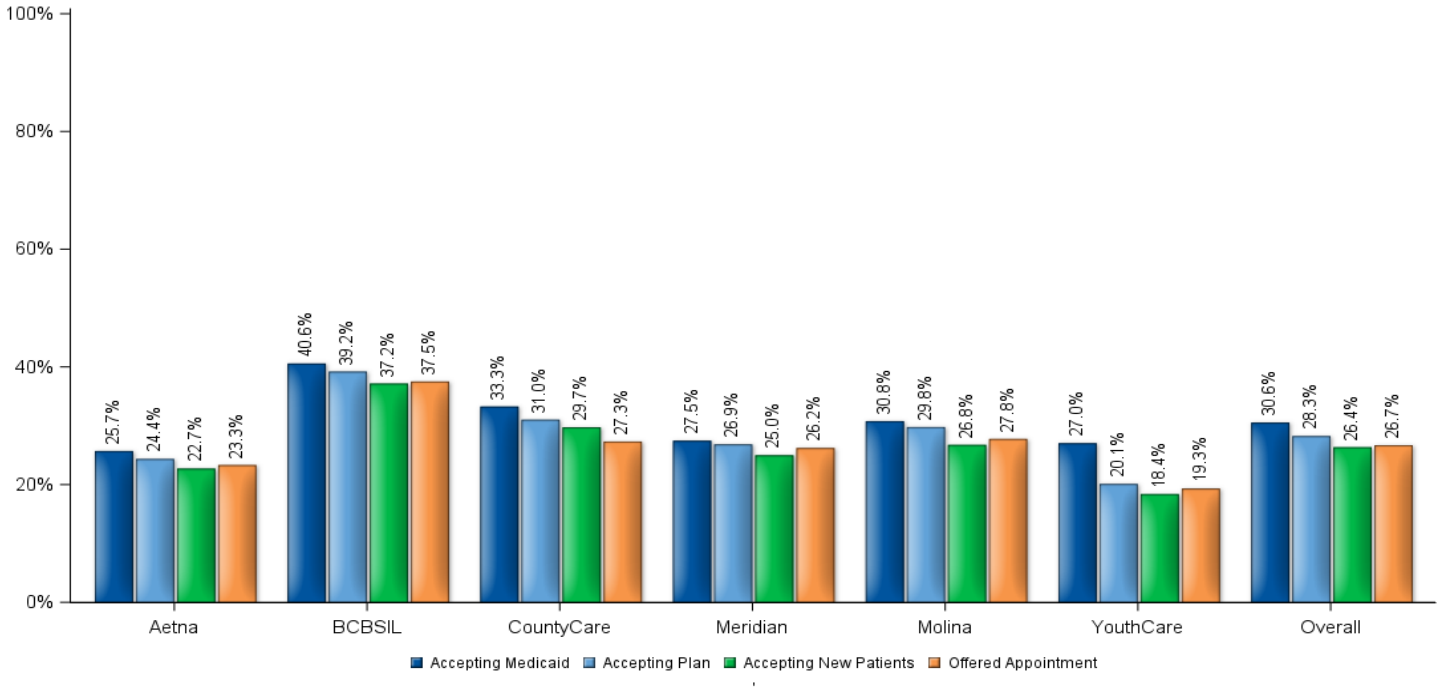
Table 1-3—Limitations to Scheduling Appointments

Limitation	Calls With Appointment[1]	Calls Without Appointment[2]
Requires pre-registration or personal information	8 (0.8%)	24 (42.1%)
Requires eligibility (Medicaid ID) verification	4 (0.4%)	3 (5.3%)
Requires medical record review	4 (0.4%)	2 (3.5%)
Initial evaluation required	9 (0.9%)	3 (5.3%)
Must designate provider as PCP first	5 (0.5%)	3 (5.3%)
Schedule/calendar not available	6 (0.6%)	26 (45.6%)
Unique age restriction	62 (6.5%)	3 (5.3%)
Other limitations	36 (3.8%)	10 (17.5%)

[1] The denominator includes cases responding to the survey that were offered an appointment date.
[2] The denominator includes cases responding to the survey that were not offered an appointment date.

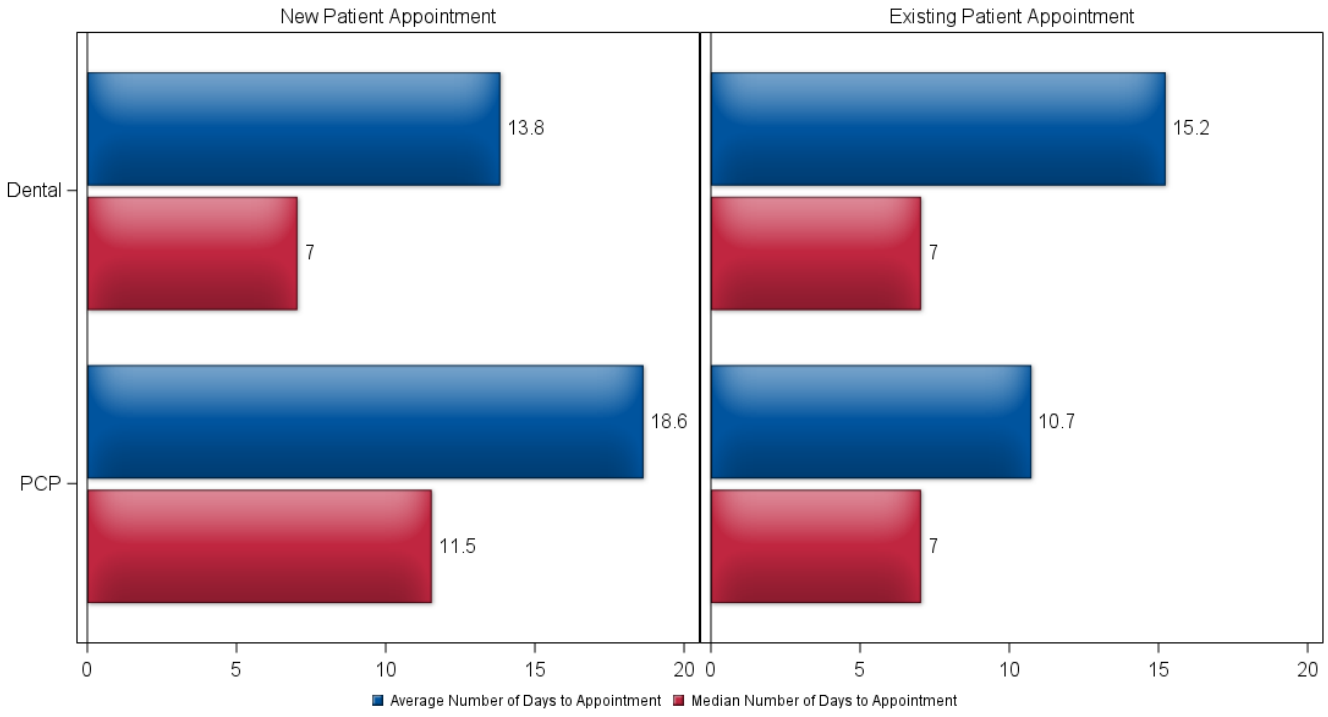
Overall, 65.5 percent of cases were able to be contacted. A case was considered contacted if the caller reached a live representative at a medical facility. Among the cases contacted, 30.6 percent accepted Illinois Medicaid, 28.3 percent confirmed the location accepted the plan, and 26.4 percent accepted new patients. Of the cases contacted and accepting Medicaid and the plan, 26.7 percent offered an appointment. Figure 1-3 displays the telephone survey call outcomes.

Figure 1-3—Outcomes of Survey Calls



The average time to an appointment was similar among the specialty categories. The average wait time for a new patient appointment with a dental provider was 13.8 days, while the average wait time to see a PCP was 18.6 days. The average wait time for an existing patient was 15.2 days for an appointment with a dental provider and 10.7 days to see a PCP. Figure 1-4 displays the wait time to schedule an appointment by visit type.

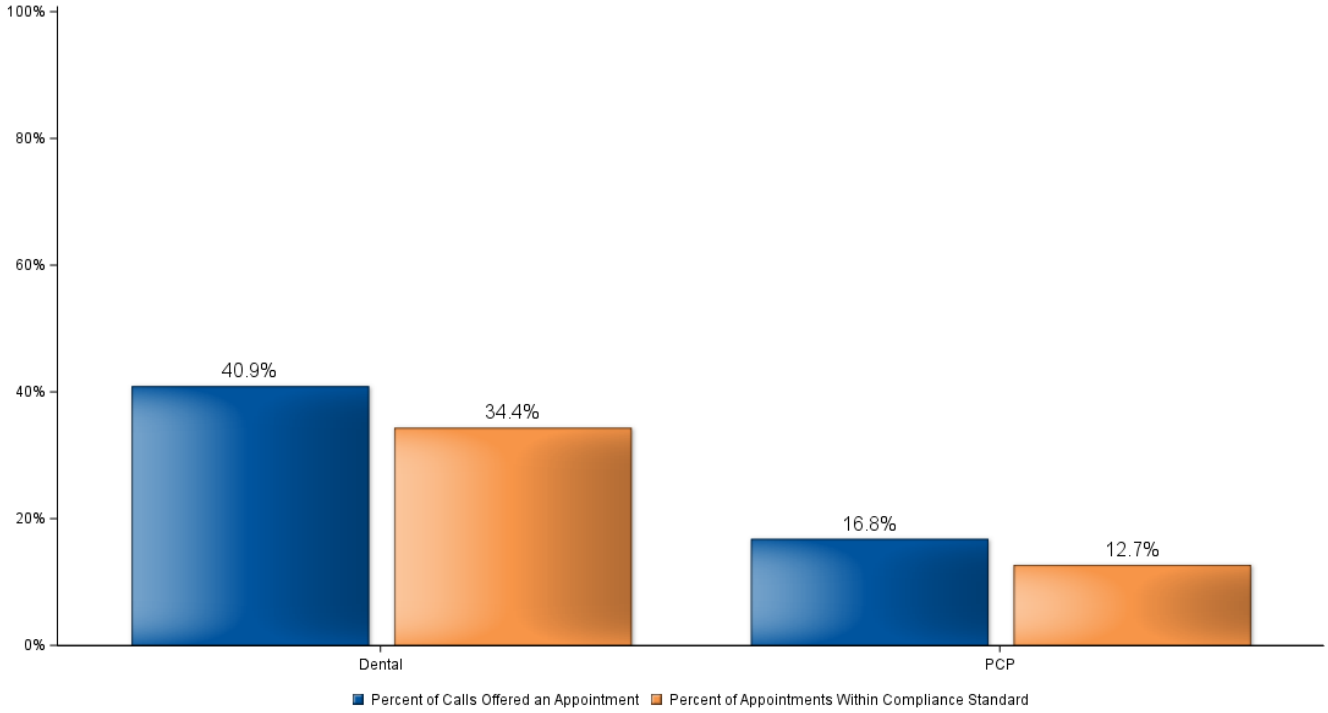
Figure 1-4—Appointment Wait Time by Visit Type



Appointment dates were only captured for 40.9 percent of dental respondents, with 34.4 percent of appointments meeting the compliance standard. PCP respondents offered an appointment in 16.8 percent of cases, with 12.7 percent of appointments meeting the compliance standard.

Figure 1-5 displays the percentage of calls offered an appointment and the percentage of appointments within compliance standards.

Figure 1-5—Appointments Meeting Compliance Standards by Visit Type



Recommendations

Based on the survey results presented in this report and the accompanying case-level analytic data files, HSAG offers the following recommendations to evaluate and address potential health plan provider data quality and/or access to care concerns:

- **The provider's contact information provided by the plans was incorrect—**HSAG was unable to reach 34.5 percent of sampled cases across all health plans. Of all surveyed cases, 16.8 percent indicated the telephone number did not connect to a patient scheduling line, and 10.0 percent indicated the address was incorrect.
  - 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 and addresses that do not correspond to the sampled provider location).

  - To further evaluate data inconsistencies, HFS could consider conducting a network validation survey (NVS) to evaluate the health plans' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the health plans' provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the plan-submitted data and the online provider directory, a call would be placed to the provider location to verbally confirm the directory information and request appointment availability.

- **Members are experiencing limited appointment availability—**HSAG was only able to obtain an appointment date with 25.4 percent of the sampled locations, with 50.5 percent of respondents offering a new patient appointment and 54.7 percent offering an existing patient appointment. For new and existing patient appointments, across all plans, dental appointments were more readily available than primary care appointments. The survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling and the schedule/calendar being unavailable. 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 enrollee's ability to schedule an appointment.
- **Members are experiencing wait times beyond the appointment compliance standards—** Appointment availability compliance rates were low, with 34.4 percent of dental appointments and 12.7 percent of PCP visits meeting the appointment standard.
  - The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
  - 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.
  - 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

Figure A-1 displays the survey response rates by specialty category and health plan, as well as the total response rate. A case was considered a respondent if callers were able to reach the intended location (i.e., the caller did not reach a disconnected line, fax number, voicemail, continuous ringing, extended hold time, or a busy signal after maximum attempts) and the number did not connect to a billing office or non-patient scheduling line that was unable to transfer the caller to the desired practice. Overall, a 48.7 percent response rate was achieved for this survey. For dental services, the response rate ranged from 53.4 percent for CountyCare to 67.3 percent for Molina. For PCP services, the response rate ranged from 35.4 percent for Aetna to 49.7 percent for BCBSIL.

Figure A-1—Response Rate

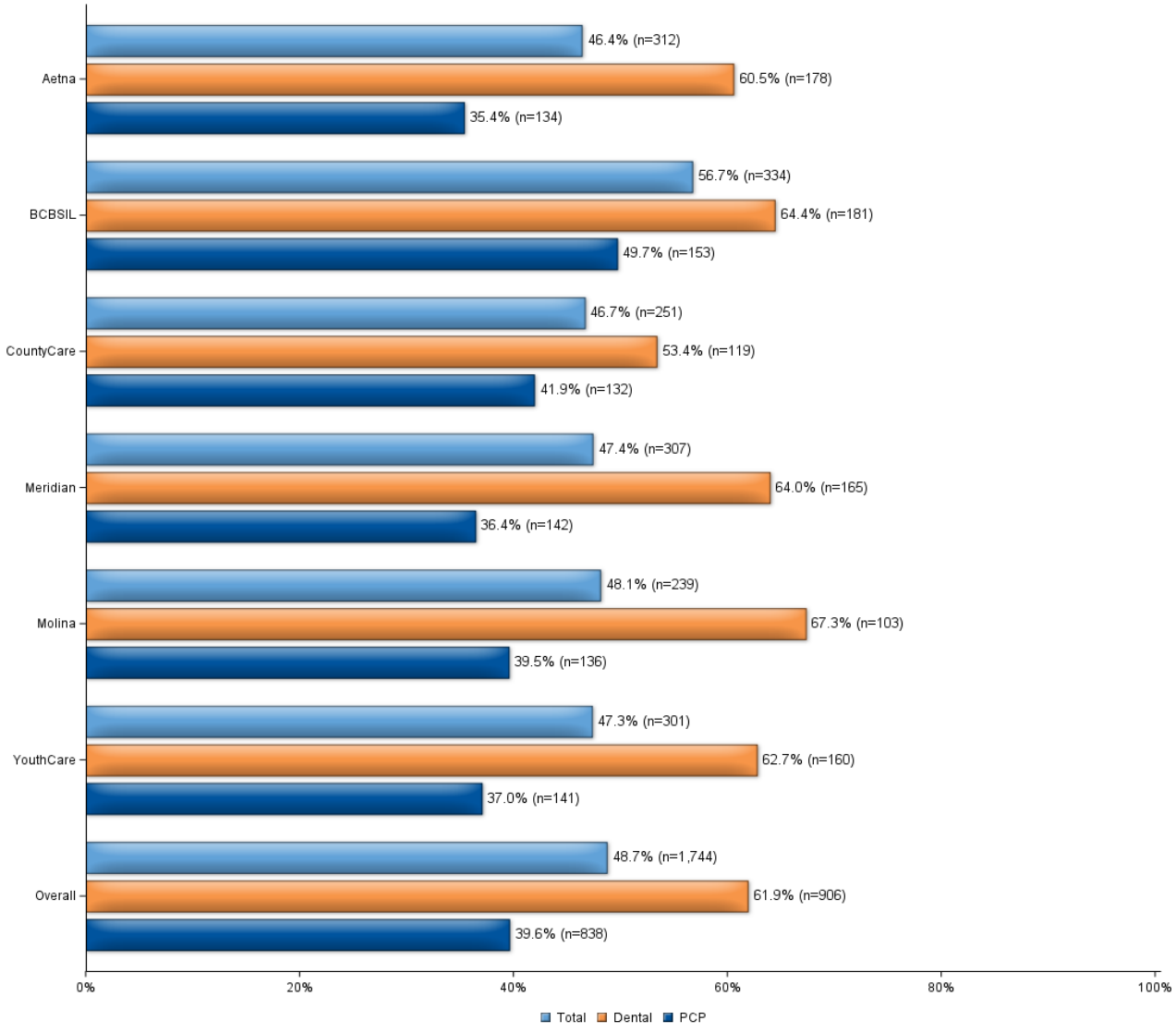


Table A-1 displays the survey dispositions and response rates by specialty category and health plan. Overall, 2.8 percent of cases refused to participate in the survey, 15.2 percent reached a bad phone number, and 19.3 percent were unable to be reached.

Table A-1—Survey Dispositions and Response Rates

Health Plan	Sampled Cases[1]	Respondents	Refusals	Bad Phone Number*	Unable to Reach**	Response Rate
Overall	**3,581**	**1,744**	**99**	**543**	**691**	**48.7%**
Dental Providers	**1,464**	**906**	**58**	**154**	**310**	**61.9%**
Aetna	294	178	14	24	72	60.5%
BCBSIL	281	181	16	25	58	64.4%
CountyCare	223	119	2	31	51	53.4%
Meridian	258	165	9	29	51	64.0%
Molina	153	103	7	12	27	67.3%
YouthCare	255	160	10	33	51	62.7%
PCPs	**2,117**	**838**	**41**	**389**	**381**	**39.6%**
Aetna	379	134	6	84	80	35.4%
BCBSIL	308	153	7	37	52	49.7%
CountyCare	315	132	11	70	74	41.9%
Meridian	390	142	7	77	75	36.4%
Molina	344	136	6	56	48	39.5%
YouthCare	381	141	4	65	52	37.0%

[1] Includes each plan asked about on a phone call as a single case.
* Includes reaching a disconnected number, fax number, or number that did not reach the sampled case (e.g., reached a personal number or non-medical facility).
** Includes reaching a voicemail, busy signal, continuous ringing, and/or extended hold time after two attempts.

Reasons the caller was unable to complete the survey included the following:

- For 341 cases (11.7 percent), the telephone number was disconnected.
- For 322 cases (11.1 percent), the survey respondent indicated that the address for the sampled location did not exist in the practice's computer system or directory.
- For 125 cases (4.3 percent), the telephone number connected to a non-medical facility.
- For 78 cases (2.7 percent), the survey respondent indicated that the telephone number connected to a medical facility that did not offer the requested services.
- For 42 cases (1.4 percent), the caller was placed on hold for longer than five minutes.

Figure A-2 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, 79.4 percent of the contacted locations indicated the caller reached the correct address. For dental services, the rate of respondents indicating the caller reached the correct location ranged from 82.5 percent for Molina to 92.3 percent for BCBSIL. For PCP services, the rate ranged from 56.7 percent for Aetna to 80.4 percent for BCBSIL.

Figure A-2—Respondents With the Correct Location

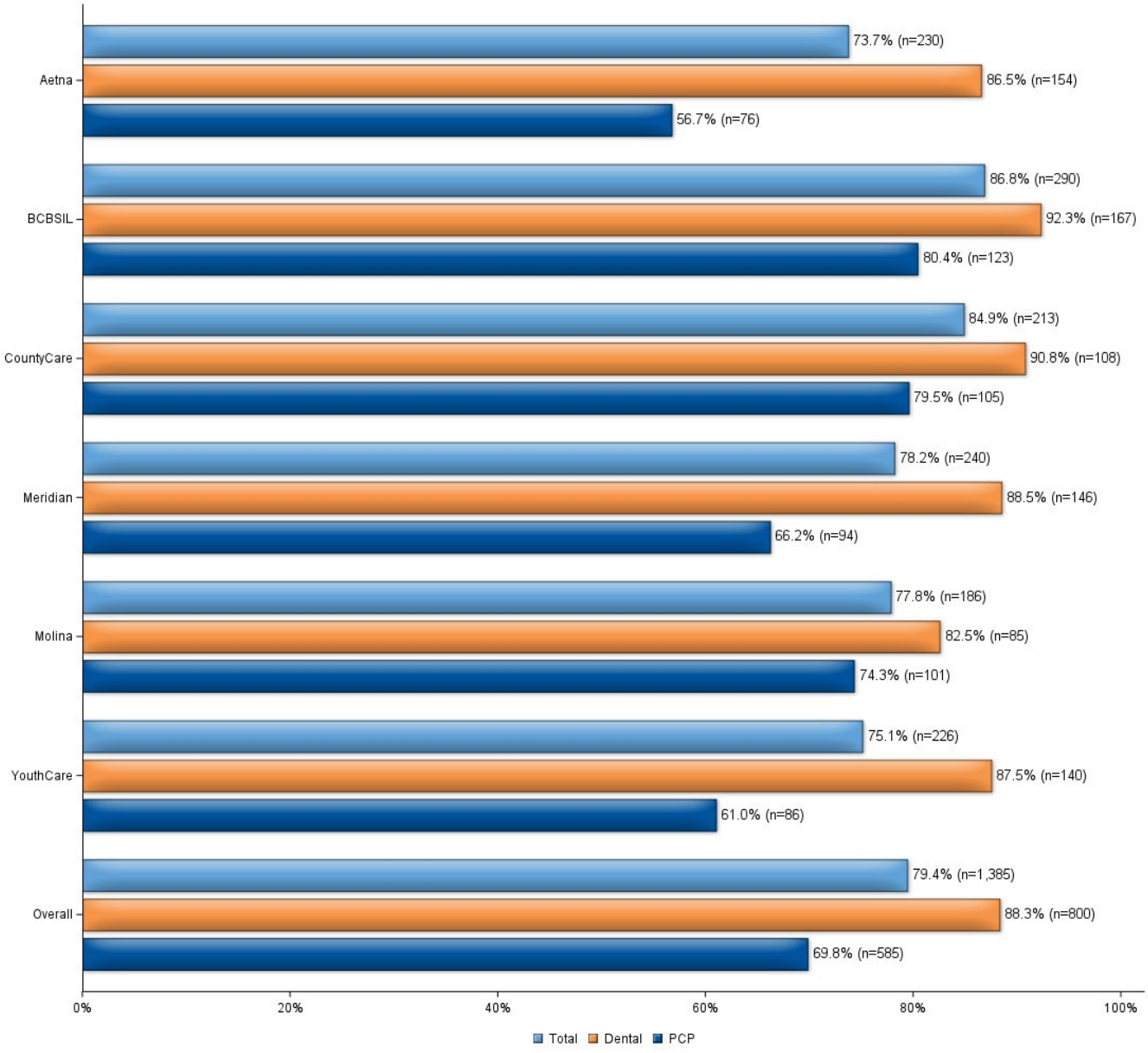


Figure A-3 displays, by specialty category and health plan, the number and percentage of cases in which the survey respondent indicated that the sampled location offered the requested services. Overall, 69.8 percent of the contacted locations offered the requested services. For dental services, the rate of providers offering the requested services ranged from 75.7 percent for Molina to 89.1 percent for CountyCare. For PCP services, the rate ranged from 43.7 percent for Meridian to 72.5 percent for BCBSIL.

Figure A-3—Locations That Offer Requested Services

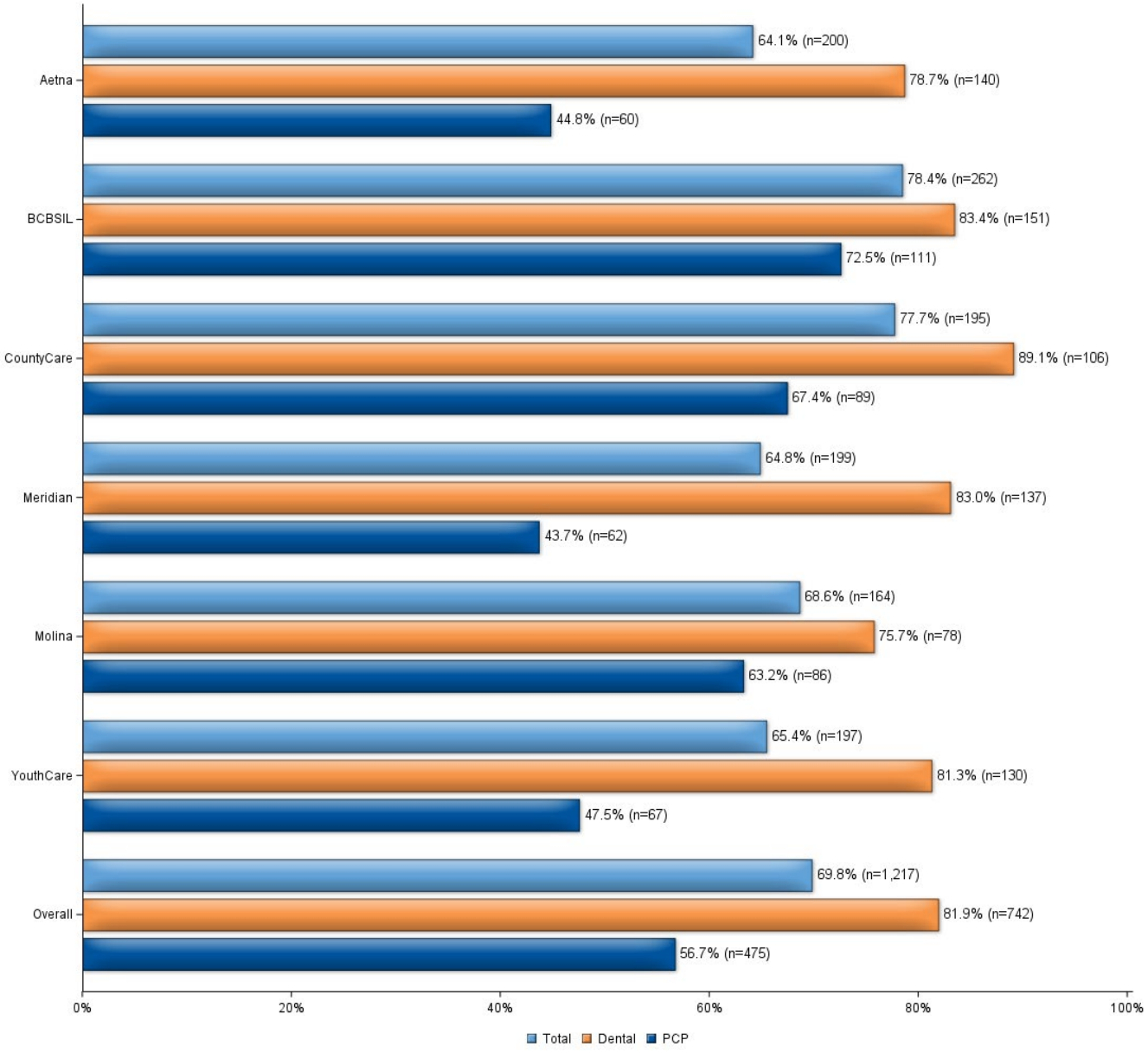


Figure A-4 displays, by specialty category and health plan, the number and percentage of cases accepting Illinois Medicaid. Overall, 62.7 percent of the sampled locations were still contracted with Illinois Medicaid. For dental services, the rate of provider locations accepting IL Medicaid ranged from 69.9 percent for Molina to 84.9 percent for CountyCare. For PCP services, the rate ranged from 36.6 percent for Meridian to 68.6 percent for BCBSIL.

Figure A-4—Accepting Illinois Medicaid

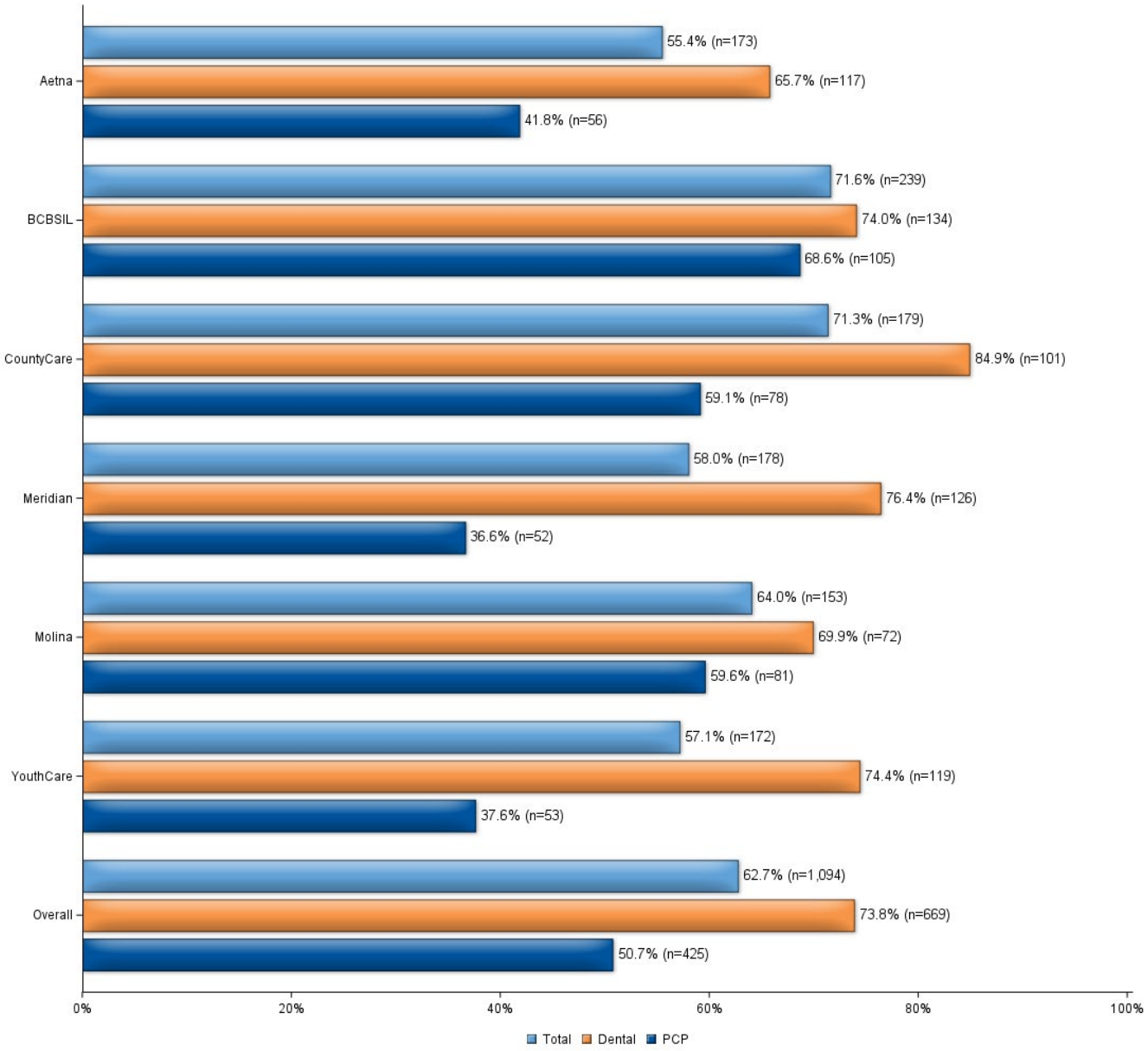


Figure A-5 displays, by specialty category and health plan, the number and percentage of cases accepting the requested health plan. Overall, 58.0 percent of the sampled locations were still contracted with the requested health plan. For dental services, the rate of provider locations accepting the requested health plan ranged from 55.0 percent for YouthCare to 82.4 percent for CountyCare. For PCP services, the rate ranged from 28.4 percent for YouthCare to 66.7 percent for BCBSIL.

Figure A-5—Accepting Health Plan

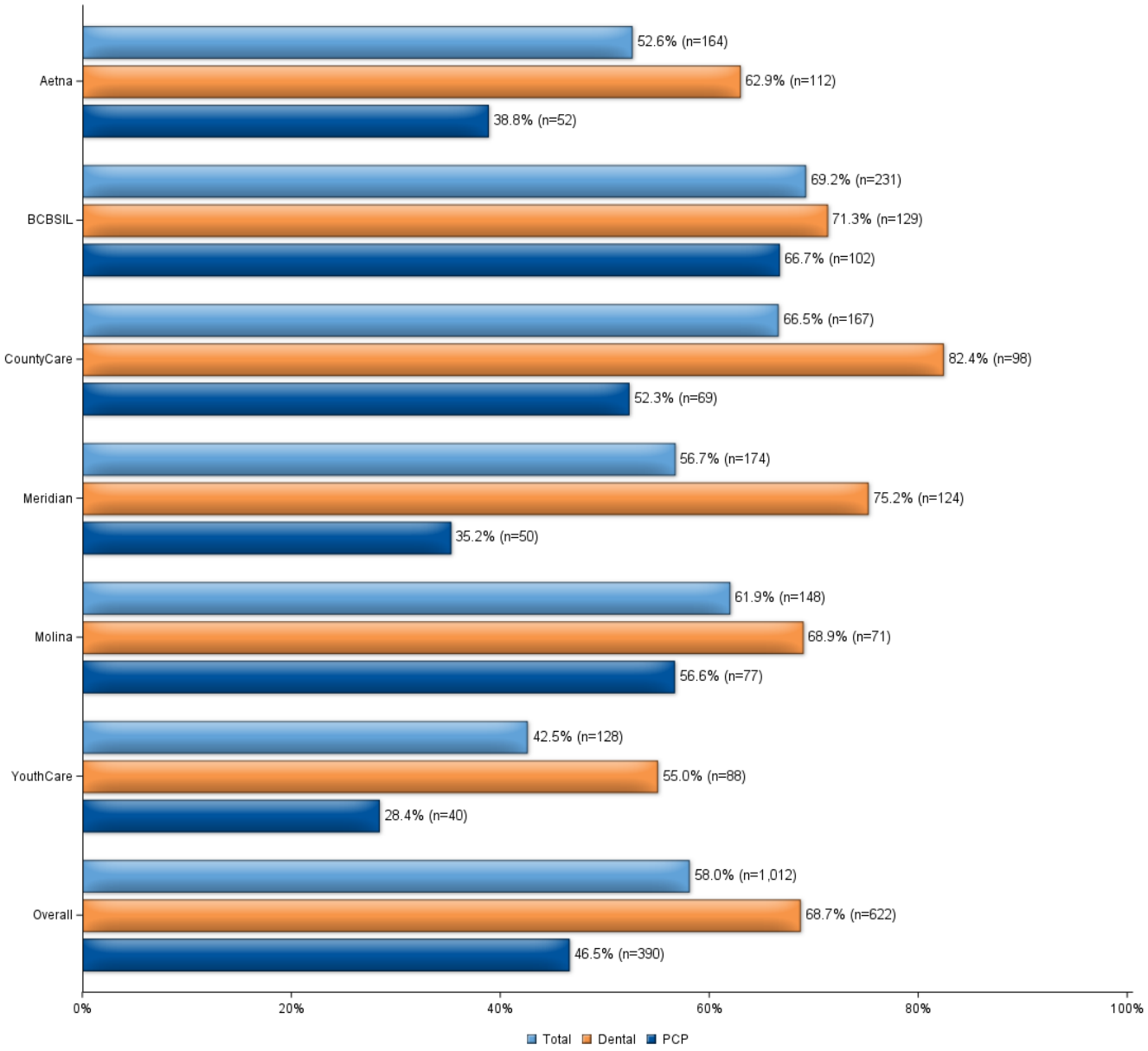


Figure A-6 displays, by specialty category and health plan, the number and percentage of cases where the location accepts new patients for the specified health plan. Overall, 54.1 percent of the contacted locations were accepting new patients. For dental services, the new patient acceptance rate ranged from 50.6 percent for YouthCare to 79.0 percent for CountyCare. For PCP services, the rate ranged from 25.5 percent for YouthCare to 63.4 percent for BCBSIL.

Figure A-6—Accepting New Patients

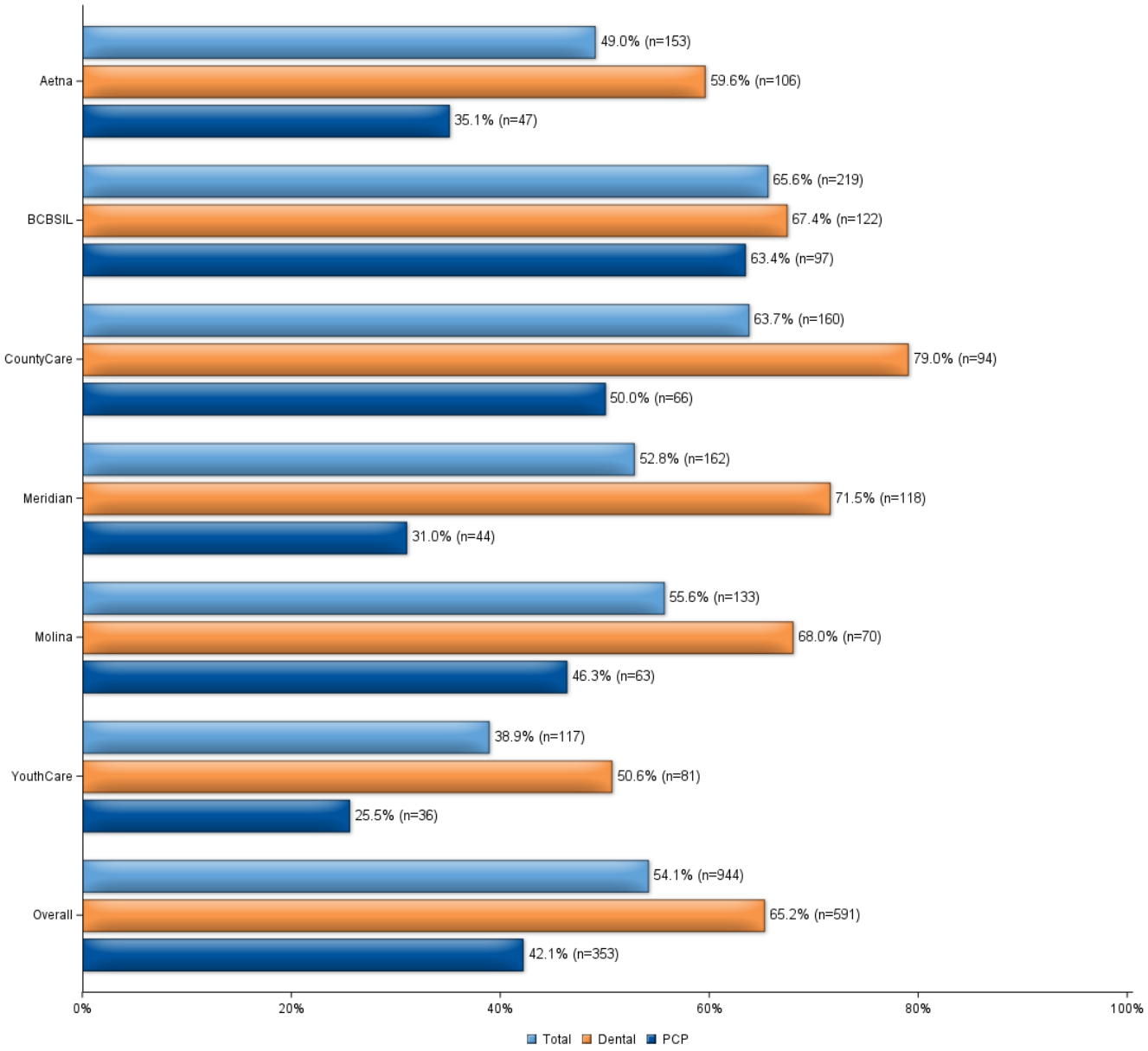


Figure A-7 displays, by specialty category and health plan, the number and percentage of cases for which the provider location offered a new patient appointment date. Overall, 61.8 percent of cases were offered a new patient appointment for a dental visit. Dental visit appointment availability ranged from 48.1 percent for YouthCare to 72.3 percent for CountyCare. A total of 38.2 percent of cases were offered a new patient appointment for a visit with a PCP. PCP appointment availability ranged from 24.1 percent for YouthCare to 60.1 percent for BCBSIL.

Figure A-7—New Patient Appointment Availability

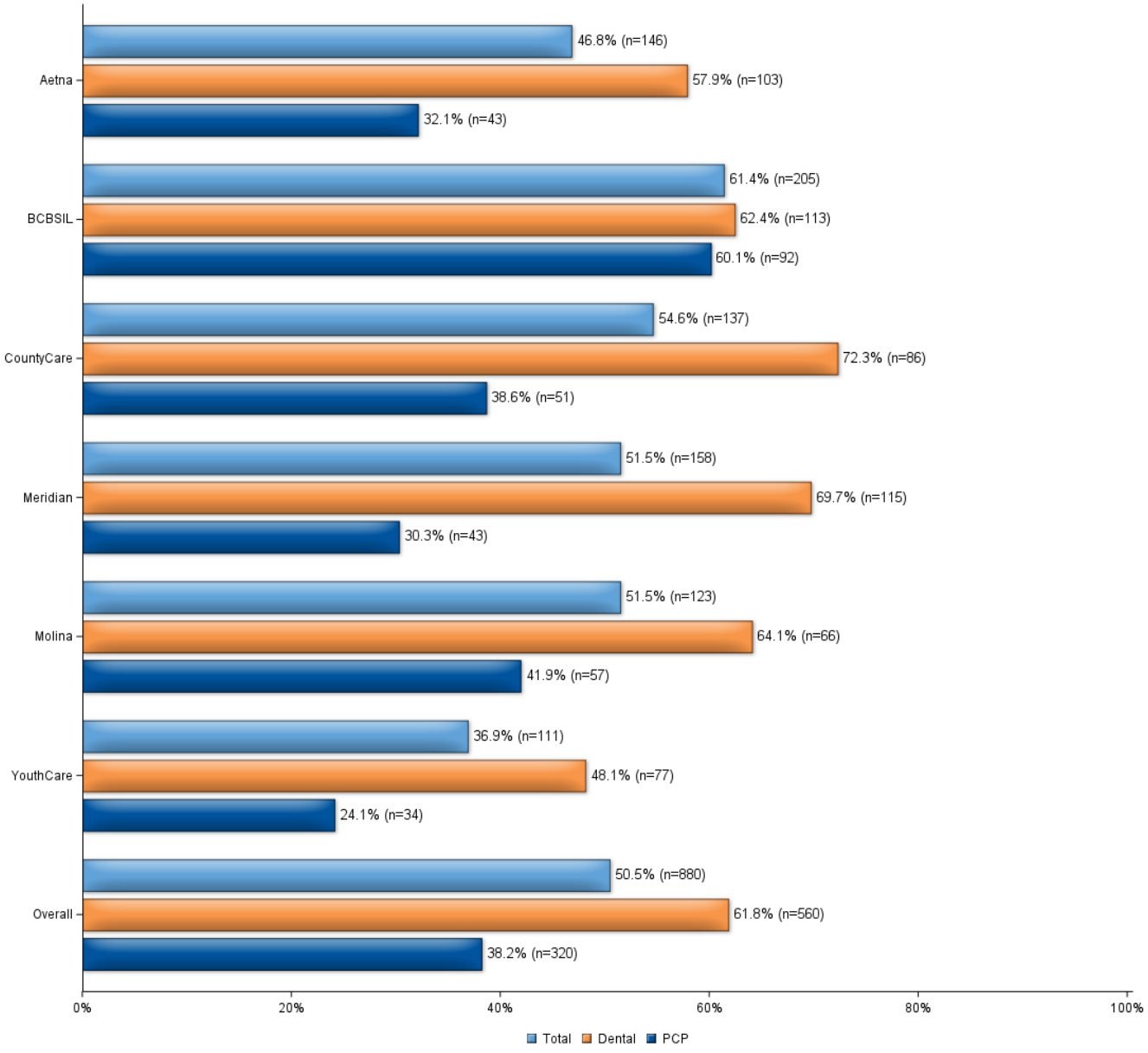


Figure A-8 displays, by specialty category and health plan, the number and percentage of cases in which the provider location offered an existing patient appointment date. Overall, 66.1 percent of cases were offered an existing patient appointment for a dental visit. Dental visit appointment availability ranged from 53.1 percent for YouthCare to 77.3 percent for CountyCare. A total of 42.4 percent of cases were offered an existing patient appointment with a PCP. PCP appointment availability ranged from 27.0 percent for YouthCare to 64.1 percent for BCBSIL.

Figure A-8—Existing Patient Appointment Availability

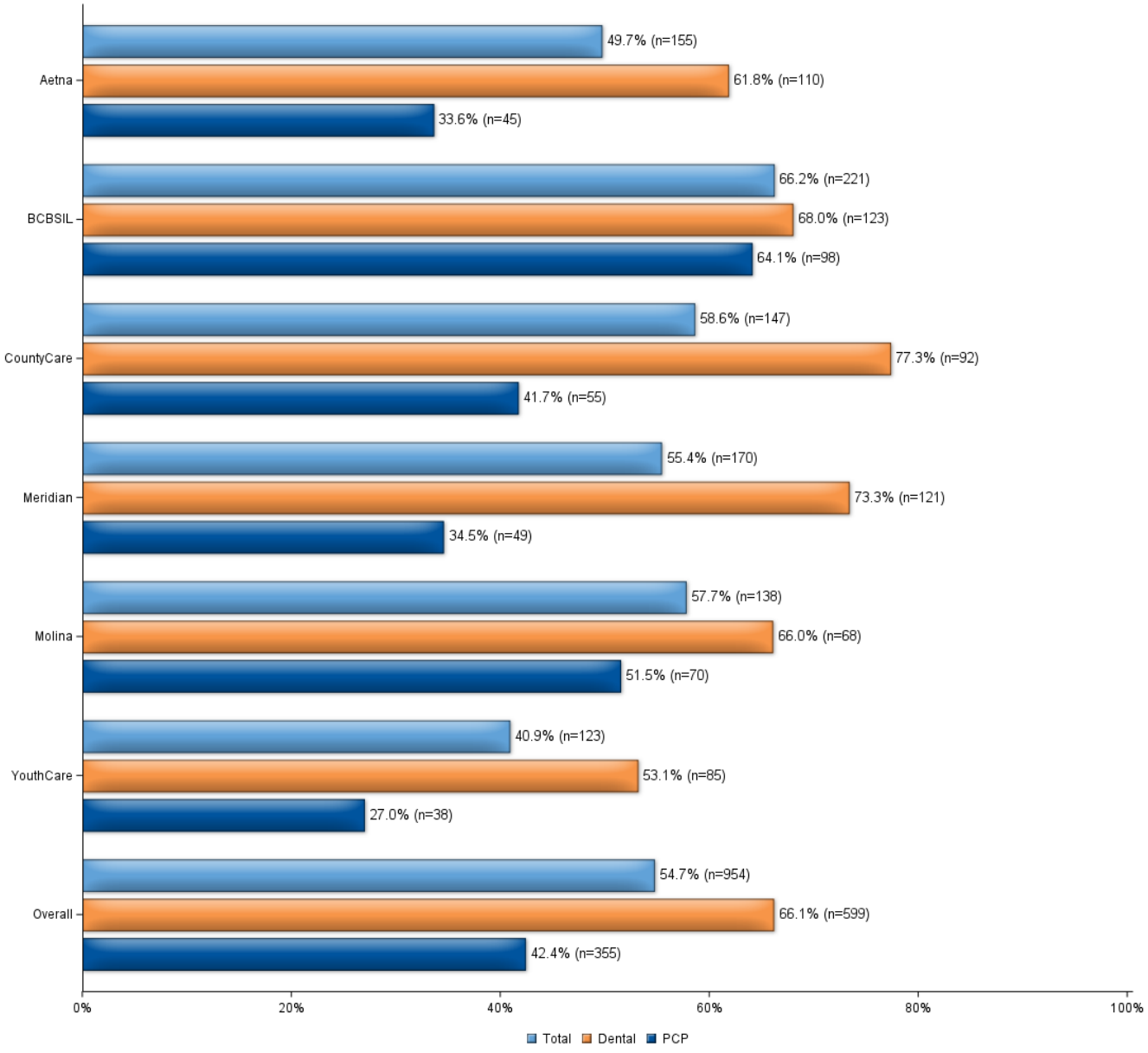
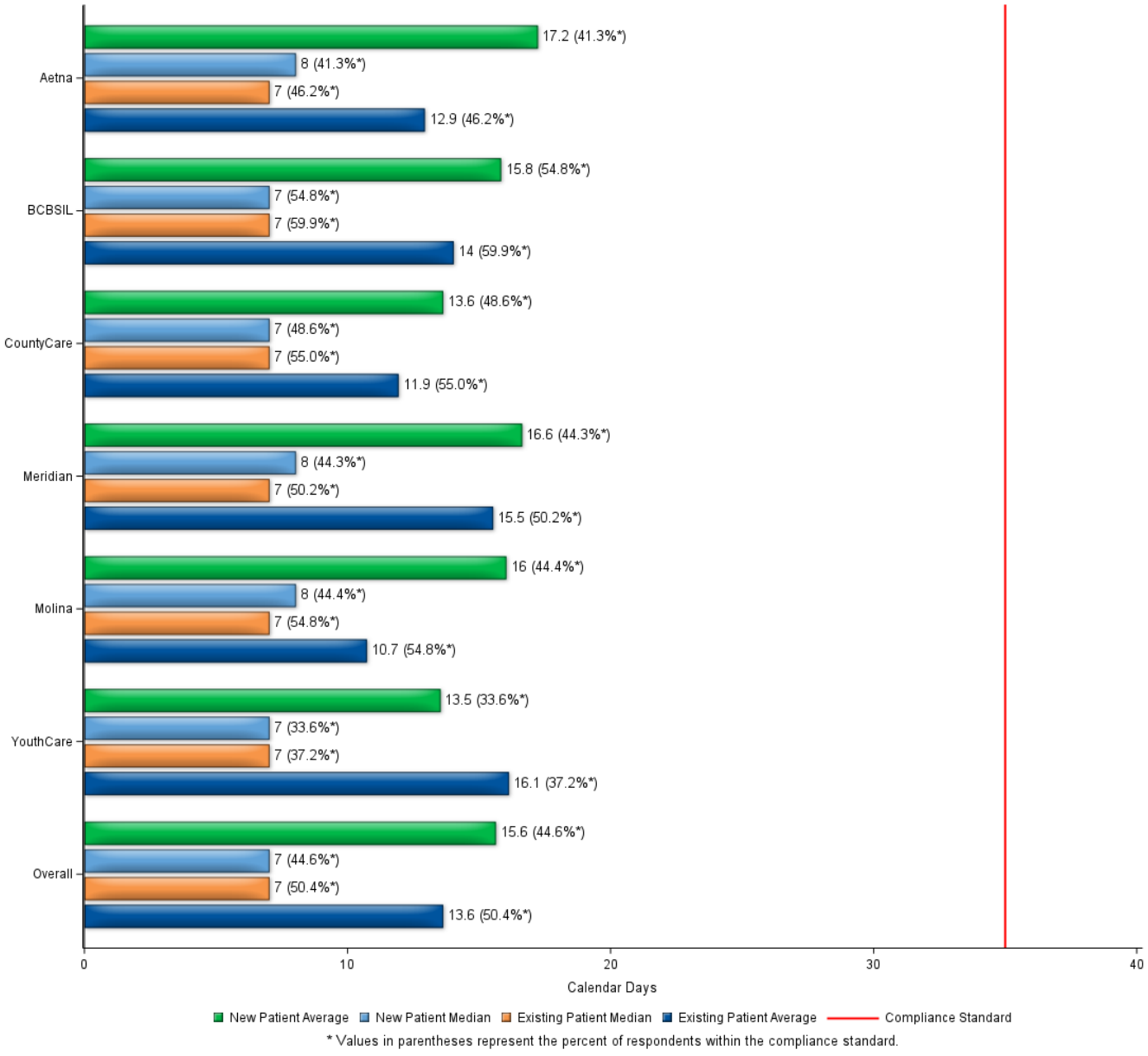


Figure A-9 displays the average and median wait times for new and existing patients for a non-urgent or routine visit. Overall, the average wait time for a new patient appointment was 15.6 days. Additionally, the average wait time for an existing patient appointment was 13.6 days.

Figure A-9—Appointment Wait Times



Appendix B. Access and Availability Survey Methodology

Eligible Population

The eligible population included dental and primary care locations in a DIA ZIP Code that were actively enrolled in the Illinois Medicaid program as of February 24, 2023, when the provider network files were submitted.

Data Collection

HSAG received provider data files from the health plans on approximately February 24, 2023. 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 type (e.g., general dentist, PCP); 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 identified locations based on unique phone numbers. If a phone number was associated with multiple addresses within a health plan, HSAG randomly assigned the number to a single plan and standardized address, prioritizing assignment to the least-represented plans. HSAG selected a statistically valid number of provider locations based on a 95 percent confidence interval and ±5 percent margin of error. A 25 percent oversample was included to increase the probability of capturing appointment availability information from a statistically valid number of service locations.

Telephone Survey Process

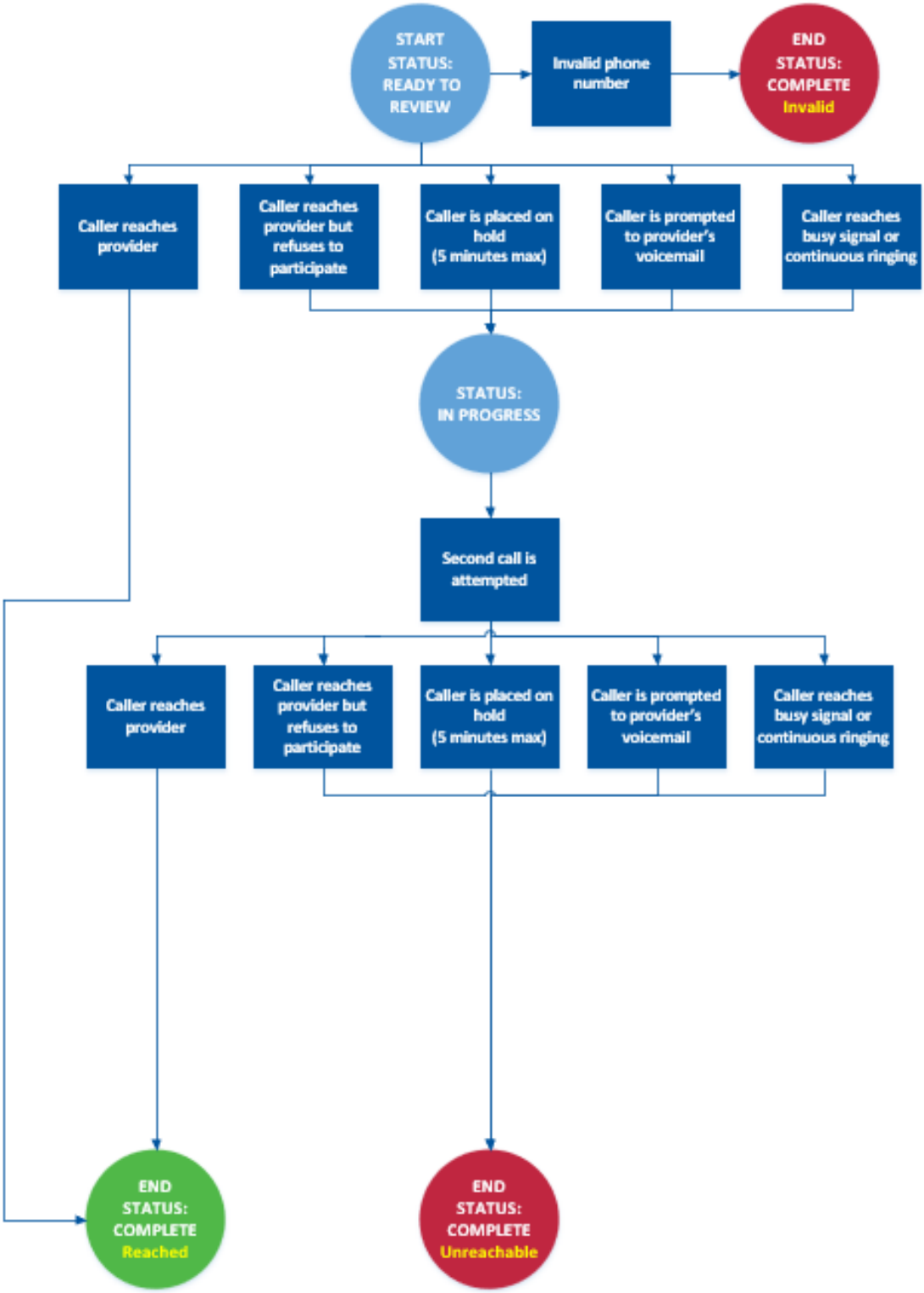
HSAG conducted the survey during March and April 2023. Survey calls requested appointment availability with the sampled health plans for the sampled location. Since HSAG revealed the interviewer's identity to the provider's office, interviewers used the same HFS-approved script (Appendix C) for all survey calls.

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).[5] Interviewers who were put on hold at any point during the call waited on hold for five 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 in the health plan's data file connects to a fax line or a message that the number is no longer in service)
- Telephone number connects to an individual or business unrelated to a medical provider, practice, or facility
- The caller is unable to speak with office personnel during either call attempt (e.g., the call is answered by an automated answering service or call center that prevents the caller from speaking with office staff)
- The caller was placed on an extended hold with additional unsuccessful attempts

[5] 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 that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. Callers attempted 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 the survey script presented in Appendix C, HSAG classified survey indicators into domains that consider provider data accuracy and appointment availability by health plan. Provider data accuracy was evaluated based on survey responses. In general, matched information 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.

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's identification as offering services for the designated provider specialty category
- Accuracy of accepting Medicaid
- Affiliation with the requested health plan

HSAG collected the following access-related information when calling sampled cases:

- Information concerning whether the provider location is accepting new patients
- Next available appointment date with any practitioner at the sampled location for a new and existing patient with a non-urgent or routine visit (i.e., dental cleaning or annual well-check)
- Any limitations to accepting new patients or scheduling an appointment. Limitations include, but are not limited to, the following:
  - Location requires a review of the member's medical records prior to offering an appointment
  - Location requires registration with the practice prior to offering an appointment
  - Location requires verification of the member's Medicaid eligibility prior to offering an appointment

Study Limitations

Due to the nature of the survey, the following limitations should be considered when generalizing survey results across all providers contracted with the health plans to serve Medicaid enrollees:

- Survey calls were conducted at least four weeks following HSAG's receipt of each health plan's provider data, resulting in the possibility that provider locations updated their contact information with the health plan prior to HSAG's survey calls.
- Time to the first available appointment is based on appointments requested with the sampled provider 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 Medicaid enrollees are willing to travel to an alternate location.

- 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).
- 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 an enrollee's experience when seeking an appointment. Of note, 2.8 percent of the sampled locations declined to participate in the survey (i.e., considered a refusal), an outcome that may differ for prospective patients.

Appendix C. Survey Script

Survey Script

This script guided callers 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 not to schedule appointments, only to ask about appointment availability at the sampled location.

1. Call the office.

   Note: If telephone number is disconnected, reaches a fax line, etc., the survey will end, and the case is considered a non-respondent (i.e., an invalid telephone number).

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 and office information. I'm trying to reach the number for the <<street name>> location. Are you at that location?"

   If yes, move to Element #3.

   If no and no alternate contact phone number is offered, move to Element #10 to end the survey.

3. "Is this a number patients can call directly to schedule medical appointments?"

   If yes, move to Element #4.

   If no, "Do you have an alternate number I can call to determine appointment availability?"

   If no alternate contact phone number is offered, move to Element #10 to end the survey.

4. "Do you offer << provider domain or specialty category>> services?"

   If yes, move to Element #5.

   If no, move to Element #10 to end the survey.

5. "Does your office accept Illinois Medicaid?"

   If yes, move to Element #6.

   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; move to Element #10 to end the survey.

6. "I'm now going to ask about the insurance plans accepted at the <<street name>> location. Can you please confirm that you are accepting <<health plan>>?"

   If the location is sampled for more than one health plan, the interviewer will ask elements #6-7 once for each health plan.

   If the respondent indicates that the location accepts patients with the requested health plan, move to element #7. If the location will not see any new or existing patients with any health plan, move to element #10 to end the survey.

7. Are you accepting new patients with <<health plan>> at this location?

   If yes, move to element #8.

   If no, move to element #9; return to element #6 for additional health plans; if all health plans are complete, move to element #10 to end the survey.

8. **If New Patient Dental Appointment**: "When is the next available appointment at the <<street name>> location for a dental cleaning for a new patient?"

   If New Patient Primary Care Appointment: "When is the next available appointment at the <<street name>> location for an annual well-check for a new patient?"

   Document the appointment dates and move to element #9. The interviewer will capture any information offered regarding barriers to scheduling.

9. **If Existing Patient Dental Appointment**: "When is the next available appointment at the <<street name>> location for a dental cleaning for an existing patient?"

   If Existing Patient Primary Care Appointment: "When is the next available appointment at the <<street name>> location for an annual well-check for an existing patient?"

   Document the appointment dates and move to element #10. The interviewer will capture any information offered regarding barriers to scheduling.

10. "Those are all of my questions. Thank you for your time and participation in this survey."

Appendix D3. Network Time/ Distance Analysis

HealthChoice Illinois

Illinois Department of Healthcare and Family Services

SFY 2023 Provider Network Time/Distance Analysis

June 2023

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

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HSAG HEALTH SERVICES ADVISORY GROUP

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

Executive Summary

Introduction

The Illinois Department of Healthcare and Family Services (HFS) helps Illinoisans access high quality healthcare by contracting with managed care health plans to provide healthcare services to people enrolled in HealthChoice Illinois, Illinois' Medicaid managed care program. HFS is responsible for overseeing these health plans and has set standards to make sure that enrollees have access to the care they need within a reasonable time and distance from their homes. To understand whether health plans are meeting those standards, HFS asked its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to conduct an analysis of the travel time or distance between enrollees and providers in the health plans' networks in State Fiscal Year (SFY) 2023.[1]

This kind of study is called a network adequacy validation (NAV) and is required by the Centers for Medicare & Medicaid Services (CMS) rule §438.358(b)(1)(iv).[2] The health plans assessed in this report are:

- Aetna Better Health of Illinois (Aetna)[3]
- Blue Cross Community Health Plan (BCBSIL)
- CountyCare[4]
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare HealthChoice Illinois (YouthCare)[5]

HFS has set access standards that define the minimum time and distance enrollees should have to travel to obtain care. These access standards are incorporated in the health plan contracts, and they require that at least 90 percent of a health plan's enrollees in each county have the necessary number of providers within the time and distance standards. Providers covered by the standards include primary care providers (PCPs), obstetricians and gynecologists (OB/GYNs), behavioral health providers, pediatric dentists, hospitals, and several necessary specialists. For this year's analysis, HFS requested an analysis of adult and pediatric specialists in six provider categories: allergy/immunology, audiology,

[1] Standards can be found 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.
[2] CMS issued its External Quality Review (EQR) Protocols in February 2023. The activities described in the protocol must be implemented beginning in February 2024 and validated in EQRO Technical Reports due in April 2025. This report does not apply the new protocols.
[3] Formerly IlliniCare Health.
[4] Available only in Cook County.
[5] YouthCare serves Illinois Department of Children & Family Services (DCFS), Youth In Care (YIC), and Former Youth In Care (FYIC) enrollees only.

endocrinology, neurosurgery, oral surgery, and pulmonology. In addition, 100 percent of enrollees must have access to a pharmacy within access standards.

This time/distance study examined the geographical distribution of each health plan's provider network in relation to its enrollees. The study calculated the percentage of each health plan's enrollees who have a provider located within the required access standards. These results provide one indication of access to care but do not take into account other important factors such as whether an enrollee depends on public transportation to visit a provider, or whether the nearest provider is accepting new HealthChoice patients. These factors must be considered in context with other available information.

Study Limitations

- Time/distance results only highlight the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations. These 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. They do not take into consideration whether providers are contracted with multiple health plans.
- 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.
- 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.

Key Findings

- **Statewide:** For the majority of provider types, all health plans met or exceeded HFS' access standards. Overall, 99 percent to 100 percent of HealthChoice enrollees had providers located within the required time and distance from their residence.
- **Health Equity**: There was little indication of disparities in access for enrollees related to race, ethnicity, age, sex, and Disproportionately Impacted Area (DIA) status. Deficits in access were similar across urbanicity, age, sex, race, and ethnicity. Enrollees residing in DIA ZIP Codes were more likely to have access to care within standards than those residing in non-DIA ZIP Codes, but this may be due to a correspondence between DIA status and urbanicity, and may or may not be a function of disparity.
- **Pharmacies**: Access to pharmacies is held to a higher standard than other provider categories, requiring that 100 percent of urban enrollees have access within 15 minutes or miles and rural residents have access within 60 minutes or miles from their residence. All statewide health plans met

this standard in rural counties, but some health plans did not meet the standard in all urban counties. While there was some variation in findings, no statewide health plan met the time and distance standard for pharmacies in DeKalb, McLean, or Vermilion counties. Two health plans, Aetna and Molina, showed improvement from last year by meeting the pharmacy standard in one additional county.

- **Oral Surgeons**: All statewide health plans failed to provide the required access to oral surgeons for adult and pediatric enrollees in some areas, predominantly in rural counties located in Regions 1, 2, or 3. Based on prior studies, the health plans have attributed the non-compliance for oral surgery to the lack of provider availability across the state and/or provider unwillingness to accept Medicaid rates.
  - No statewide health plan met the time and distance standard for Oral Surgery, Adult in any of the following counties: Franklin, Hamilton, Johnson, Massac, Pope, Pulaski, Saline, Union, White, and Williamson.
  - No statewide health plan met the time and distance standard for Oral Surgery, Pediatric in any of the following counties: Franklin, Gallatin, Hamilton, Hardin, Johnson, Massac, Pope, Pulaski, Saline, Union, White, and Williamson.
  - YouthCare showed improvement since last year by meeting the standard for oral surgeons for adults in two additional counties, and for children in one additional county.
  - BCBSIL access results were worse than last year, meeting the standard for oral surgeons for adults in three fewer counties, and for children in two fewer counties.
- **Allergy and Immunology**: Two health plans did not provide the required access to allergy and immunology providers in some areas, especially for pediatric populations.
  - One of those health plans, BCBSIL, met the standard for allergy and immunology, adult and pediatric, in two additional counties compared to last year's results.
  - The other health plan, Molina, met the standard for allergy and immunology, pediatric, in 12 fewer counties this year compared to last year.
- **Audiology**: One health plan, BCBSIL, failed to meet the standard for access for audiology, adult and pediatric in one county. All others met or exceeded HFS' access standards.
- **Endocrinology**: One health plan, BCBSIL corrected its failure to meet standards in a single county last year for endocrinology, adult providers, meeting standards in all counties this year.
- **Neurosurgery**: One health plan, BCBSIL, improved its performance in several counties compared to last year for adult and pediatric neurosurgery providers, adding four and five counties respectively to those that met standards.
- **Pulmonology**: All health plans met or exceeded HFS' access standards for pulmonology, adult and pediatric.

Successes

Overall, each of the six health plans have contracted with a broad network of providers with offices that are located reasonably close to the enrollees they serve. Figure 1 presents the standards that were met by

all health plans. For most provider categories, and across most parts of the State, health plan performance exceeded HFS' expectation that 90 percent of enrollees have access within these standards. In fact, with the exception of a limited number of provider categories discussed below, 99 percent to 100 percent of HealthChoice enrollees had providers located within the required time and distance from their residence.

Figure 1—Access Standards Met by All Health Plans

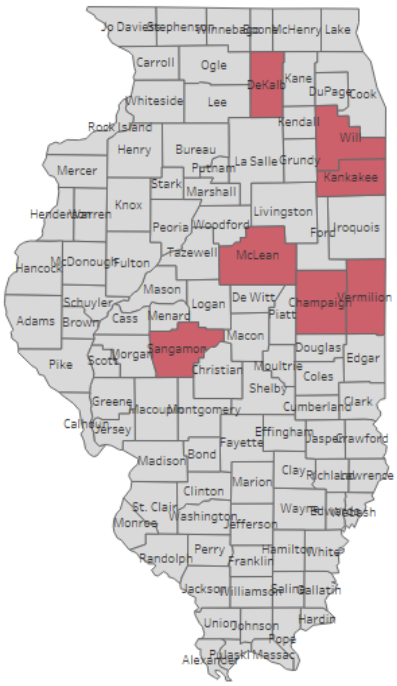
At least 90% of Urban Residents Could Reach	At least 90% of Rural Residents Could Reach
Within 30 minutes or miles: • 2 PCPs/Pediatricians • 2 Behavioral Health Providers • 2 OB/GYNs • 1 Pediatric Dentist • 1 Hospital	***Within 60 minutes or miles***: • 1 PCP/Pediatrician • 1 Behavioral Health Provider • 1 OB/GYN • 1 Pediatric Dentist • 1 Hospital
Within 60 minutes or miles: Specialist, Adult and Pediatric • Audiology • Endocrinology • Neurosurgery • Pulmonology	***Within 90 minutes or miles:*** Specialist, Adult and Pediatric • Audiology • Endocrinology • Neurosurgery • Pulmonology

Compared to last year's results, some health plans improved the number of passing standards, including addressing a lack of neurosurgery specialists. The SFY 2023 findings also demonstrated widespread access to specialists in two new categories analyzed this year, audiology and pulmonology. However, there are opportunities for improving access to pharmacies, oral surgery specialists, and to a lesser extent allergy and immunology specialists, as discussed in the next section of this report.

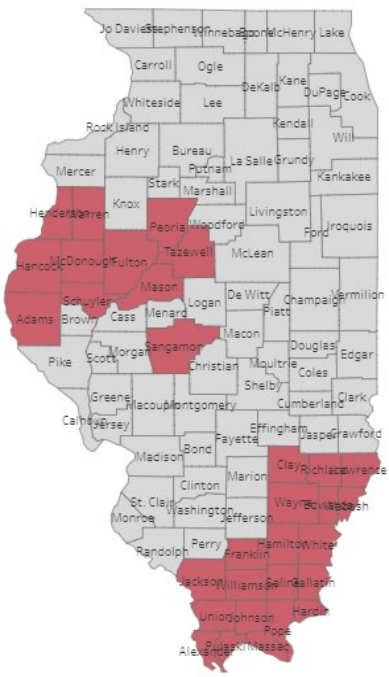
Opportunities for Improvement

The results that fell short of standards were found in three key areas, all of which were identified in prior years. The maps presented in Figure 2 illustrate the counties where required access to pharmacies and oral surgeons was not met by at least one of the health plans.

Figure 2—Counties Where Standards Were Not Met by One or More Health Plans



Pharmacies: All health plans met access standards for residents in rural counties. In urban counties some enrollees in some health plans did not have a pharmacy within the required 15 minutes or miles. These counties are highlighted in red in the above map.



Oral Surgeons: No health plans met access standards for adult and pediatric populations in several counties highlighted in red in the above map. These counties are predominantly, but not exclusively, rural.

The deficits in access to oral surgeons were most serious in Region 3, the southern portion of the State, where all statewide health plans provided access to between 70.4 percent and 84.2 percent of enrollees. This does not mean that health plans failed to meet standards in all counties. For example, BCBSIL met the access standard in 44.1 percent of counties in Region 3, and Molina did so in 41.2 percent of counties.

There were also issues with access to allergy and immunology specialists, but these were limited primarily to two health plans, and are addressed in the appendices, Detailed results for all provider categories, counties, and health plans in appendices Appendix A, B, and C.

On a regional level, service regions with the most rural counties (i.e. Regions 1, 2, and 3) had more noncompliant findings than areas with more urban counties (i.e. Regions 4 and 5).

Particular deficits that impacted a relatively large percentage of counties included the following:

- In Region 2, Molina provided the required access to pediatric allergy and immunology specialists for enrollees residing in 62.9 percent of counties in this region.
- In Region 3, Molina provided the required access to pediatric allergy/immunology specialists in less than half of the counties in this region (47.1 percent).
- Also in Region 3, none of the statewide health plans provided enrollees with the required access to oral surgery specialists for adults or children. Their results ranged from a low of 41.2 percentage of counties meetings access standards for adults and children (Molina), to a high of 62.5 percent of counties meeting access standards for adults and 55.9 percent of counties meeting access standards for children (YouthCare).

Findings From Stratified Time/Distance Analysis

When HSAG analyzed the data by race, ethnicity, age, sex, and DIA ZIP codes[6], there was no clear evidence of inequities in access within the constraints of this study. Few access issues were discovered for population subgroups outside of those discovered from analysis of the full population at the regional level; deficits in access were similar across urbanicity, age, sex, race, and ethnicity. Enrollees residing in DIA ZIP Codes were more likely to have access to care within standards than those residing in non-DIA ZIP Codes, but this is likely due to the correspondence between DIA status and urbanicity, and may or may not be a function of disparity.

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' access to healthcare services within reasonable limits of time and distance:

- While most health plans are meeting the contract standards for most provider categories and showed improvement over last year's results, HFS should continue to collaborate with the health plans to monitor the status of access standards for all provider categories.
- HFS should continue to collaborate with those health plans that do not meet the access standards in specific regions and help them contract with additional providers, if available. Provider categories of concern include pharmacy, allergy and immunology, and oral surgery. For provider categories wherein health plans are not meeting access standards, HSAG has provided lists of providers with

[6] Illinois Department of Commerce & Economic Opportunity. Zip Codes that Qualify as Disproportionately Impacted Areas for the Illinois Back to Business (B2B) Grant Program. Available at: diazipcodelist.pdf (illinois.gov). Accessed on: May 31, 2023.

which the health plans are not currently contracted. HFS and the health plans should review these lists as part of their contracting outreach efforts.

- HFS should continue to review provider categories for which no health plans met the access standards, with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.
- While a time/distance analysis can give an approximation of the level of difficulty enrollees face in traveling to a physician office, hospital, or pharmacy, it does not indicate whether enrollees can get an appointment to see a healthcare provider when they need one. HFS should continue using appointment availability surveys to evaluate providers' appointment 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 actively delivering services to enrollees still meets the defined access standards.
- HFS could consider conducting analyses of the extent to which the health plans are using telehealth services to address access issues.
- HFS may consider collaborating with HSAG to design and implement a focus study to investigate selected topics regarding access to care among enrollees by geographic region. Study topics could include how factors such as health disparities or access to public transportation are impacting access to care.

Appendix A. Compliance With Time/Distance Standards

Network Adequacy

As required by CMS regulations, HFS has set standards to ensure that enrollees have access to needed care within minimum travel time and distance standards.[A-1] These standards vary by the type of provider and whether the county is classified as urban or rural. This section of the report analyzes the percentage of enrollees in each region, and the percentage of counties in the region where enrollees have a health plan-contracted provider located within the minimum time and distance from their residence.

Region 1—Northwestern

Table A-1 displays the enrollment in each health plan contracted to provide care in Region 1 as of February 1, 2023.

Table A-1—Health plan Enrollments—Region 1

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	87,979	51,631	135,687	76,795	7,018

Table A-2 displays the percentage of enrollees who have a provider within the applicable standards as well as the percentage of the counties in Region 1 in which each health plan's provider network meets the standard. 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 that 100 percent of enrollees have coverage within the access standard.

Table A-2—Percentage of Enrollees With Access Required by Time/Distance Standards* and Percentage of Counties Meeting Standards by Health plan—Region 1

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)
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

[A-1] Presented in Table D-1.

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)
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
Dentists, Pediatric	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
Pharmacies	>99.9	95.8	99.9	95.8	99.9	95.8	>99.9	95.8	>99.9	95.8
Specialists										
Allergy and Immunology, Adult	100.0	100.0	89.5	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	91.7	83.3	100.0	100.0
Audiology, Adult	99.8	100.0	99.8	100.0	100.0	100.0	99.9	100.0	100.0	100.0
Audiology, Pediatric	99.8	100.0	99.8	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	>99.9	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	81.2	83.3	80.5	79.2	100.0	100.0	>99.9	100.0	100.0	100.0
Oral Surgery, Pediatric	82.7	83.3	84.5	79.2	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric	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	
	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 (%)

Note: This table presents the percentage of health plan enrollees in Region 1 with access to providers within provider category-specific time/distance standards. The percentage of counties meeting standards is calculated based on 24 counties located in Region 1, with five classified as urban and 19 classified as rural.
* Cells are shaded red for Enrollees Within Standard (%) when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or from Counties Meeting Standard (%) 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 health plan in Region 2 as of February 1, 2023.

Table A-3—Health Plan Enrollments—Region 2

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	68,449	51,482	111,318	74,283	7,438

Table A-4 displays the percentage of enrollees who have a provider within the applicable standards as well as the percentage of the counties in Region 2 in which each health plan's provider network meets the standard. 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 that 100 percent of enrollees have coverage within the access standard.

Table A-4—Percentage of Enrollees With Access Required by Time/Distance Standards * and Percentage of Counties Meeting Standards by Health Plan—Region 2

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)
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

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)
Dentists, Pediatric	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	96.8	97.1	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	99.6	88.6	99.7	88.6	99.6	88.6	99.2	91.4	99.4	91.4
Specialists										
Allergy and Immunology, Adult	100.0	100.0	94.8	94.3	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	96.2	94.3	100.0	100.0	37.6	62.9	100.0	100.0
Audiology, Adult	100.0	100.0	96.7	97.1	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	100.0	100.0	97.8	97.1	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
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	78.8	82.9	71.3	82.9	99.2	100.0	97.4	97.1	93.9	93.8
Oral Surgery, Pediatric	81.5	82.9	69.7	82.9	99.1	100.0	98.0	97.1	93.4	94.3
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in Region 2 with access to providers within provider category-specific time/distance standards. The
percentage of counties meeting standards is calculated based on 35 counties located in Region 2, with five classified as urban and 30 classified as rural.
* Cells are shaded red for Enrollees Within Standard (%) when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or from Counties Meeting Standard (%) 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 health plan in Region 3 as of February 1, 2023.

Table A-5—Health Plan Enrollments—Region 3

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	62,406	43,144	112,645	60,553	7,116

Table A-6 displays the percentage of enrollees who have a provider within the applicable standards as well as the percentage of the counties in Region 3 in which each health plan's provider network meets the standard. 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 that 100 percent of enrollees have coverage within the access standard.

Table A-6—Percentage of Enrollees With Access Required by Time/Distance Standards * and Percentage of Counties Meeting Standards by Health Plan—Region 3

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)
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
Dentists, Pediatric	100.0	100.0	100.0	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
Pharmacies	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	85.0	82.4	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	86.4	82.4	100.0	100.0	90.2	47.1	100.0	100.0
Audiology, 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	
	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 (%)
Audiology, Pediatric	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
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	71.5	58.8	72.0	44.1	79.2	52.9	83.7	41.2	80.5	62.5
Oral Surgery, Pediatric	71.4	58.8	70.4	44.1	81.7	52.9	84.2	41.2	77.1	55.9
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in Region 3 with access to providers within provider category-specific time/distance standards. The
percentage of counties meeting standards is calculated based on 34 counties located in Region 3, with two classified as urban and 32 classified as rural.
* Cells are shaded red for Enrollees Within Standard (%) when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards or from Counties Meeting Standard (%) 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 health plan in Region 4 as of February 1, 2023.

Table A-7—Health Plan Enrollments—Region 4

	Aetna	BCBSIL	Meridian	Molina	YouthCare	CountyCare
Enrollment	132,290	365,227	323,467	102,131	9,417	447,225

Table A-8 displays the percentage of enrollees who have a provider within the applicable standards as well as the percentage of the counties in Region 4 in which each health plan's provider network meets the standard. 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 that 100 percent of enrollees have coverage within the access standard.

Table A-8—Percentage of Enrollees With Access Required by Time/Distance Standards and Percentage of Counties Meeting Standards by Health Plan—Region 4

Provider Categories	Statewide Health Plans—Region 4					Cook County Only Health Plans—Region 4
	Aetna	BCBSIL	Meridian	Molina	YouthCare	CountyCare
	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)
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
Dentists, Pediatric	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
Pharmacies	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
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, 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

Provider Categories	Statewide Health Plans—Region 4					Cook County Only Health Plans—Region 4
	Aetna	BCBSIL	Meridian	Molina	YouthCare	CountyCare
	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)	Enrollees Within Standard (%)
Oral Surgery, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees in Region 4 with access to providers within provider category-specific time/distance standards.

Region 5—Collar Counties

Table A-9 displays the enrollment in each health plan in Region 5 as of February 1, 2023.

Table A-9—Health Plan Enrollments—Region 5

	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment	80,291	245,573	215,165	36,369	4,368

Table A-10 displays the percentage of enrollees who have a provider within the applicable standards as well as the percentage of the counties in Region 5 in which each health plan's provider network meets the standard. 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 that 100 percent of enrollees have coverage within the access standard.

Table A-10—Percentage of Enrollees With Access Required by Time/Distance Standards* and Percentage of Counties Meeting Standards by Health Plan—Region 5

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)
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	
	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 (%)
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
Dentists, Pediatric	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
Pharmacies	100.0	100.0	99.8	75.0	>99.9	87.5	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
Allergy and Immunology, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	>99.9	100.0	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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
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
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in Region 5 with access to providers within provider category-specific time/distance standards. The
percentage of counties meeting standards is calculated based on eight counties located in Region 5, with six classified as urban and two classified as rural.
* Cells are shaded red for Enrollees Within Standard (%) when less than 90 percent of a health plan's enrollees have access to providers (less than 100

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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 (%)

percent for Pharmacy) within the time/distance standards or from Counties Meeting Standard (%) 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. The percentage of enrollees with a provider within applicable standards is also shown.

Aetna

Oral Surgery, Adult

- Adams (0.7%), Alexander (0.0%), Franklin (54.4%), Fulton (64.0%), Gallatin (0.0%), Hamilton (12.8%), Hancock (0.0%), Hardin (0.0%), Henderson (66.2%), Jackson (85.1%), Johnson (0.0%), Mason (50.3%), Massac (0.0%), McDonough (1.9%), Peoria (0.2%), Pope (0.0%), Pulaski (0.0%), Saline (0.0%), Sangamon (3.2%), Schuyler (87.0%), Tazewell (0.6%), Union (0.1%), White (11.5%), Williamson (4.6%)

Oral Surgery, Pediatric

- Adams (0.5%), Alexander (0.0%), Franklin (53.7%), Fulton (61.8%), Gallatin (0.0%), Hamilton (12.1%), Hancock (0.0%), Hardin (0.0%), Henderson (57.9%), Jackson (85.1%), Johnson (0.0%), Mason (62.9%), Massac (0.0%), McDonough (0.7%), Peoria (0.2%), Pope (0.0%), Pulaski (0.0%), Saline (0.0%), Sangamon (3.8%), Schuyler (84.9%), Tazewell (0.3%), Union (0.0%), White (9.7%), Williamson (3.1%)

Pharmacies

- Champaign (99.9%), DeKalb (98.4%), McLean (95.9%), Sangamon (>99.9%), Vermilion (98.4%)

BCBSIL

Allergy and Immunology, Adult

- Champaign (87.5%), Crawford (12.8%), Edwards (72.7%), Lawrence (0.0%), Madison (34.1%), Richland (1.9%), Rock Island (<0.1%), Vermilion (0.3%), Wabash (2.4%)

Allergy and Immunology, Pediatric

- Champaign (80.4%), Crawford (24.3%), Edwards (64.5%), Lawrence (0.0%), Madison (33.9%), Richland (3.2%), Rock Island (0.0%), Vermilion (0.0%), Wabash (6.7%)

Audiology, Adult

- Vermilion (23.8%)

Audiology, Pediatric

- Vermilion (23.6%)

Hospitals

- Vermilion (19.6%)

Oral Surgery, Adult

- Adams (1.0%), Alexander (0.0%), Edwards (0.0%), Franklin (55.0%), Fulton (61.8%), Gallatin (0.0%), Hamilton (7.6%), Hancock (0.0%), Hardin (0.0%), Henderson (0.0%), Jackson (83.6%), Johnson (0.0%), Lawrence (0.0%), Mason (52.6%), Massac (0.0%), McDonough (0.0%), Peoria (0.2%), Pope (0.0%), Pulaski (0.0%), Richland (1.9%), Saline (0.0%), Sangamon (4.3%), Schuyler (83.8%), Tazewell (0.4%), Union (0.0%), Wabash (0.0%), Warren (81.1%), Wayne (35.8%), White (0.0%), Williamson (3.3%)

Oral Surgery, Pediatric

- Adams (1.6%), Alexander (0.0%), Edwards (0.0%), Franklin (53.2%), Fulton (59.6%), Gallatin (0.0%), Hamilton (12.7%), Hancock (0.0%), Hardin (0.0%), Henderson (0.0%), Jackson (83.7%), Johnson (0.0%), Lawrence (0.0%), Mason (58.9%), Massac (0.0%), McDonough (0.0%), Peoria (0.2%), Pope (0.0%), Pulaski (0.0%), Richland (3.7%), Saline (0.0%), Sangamon (5.0%), Schuyler (81.3%), Tazewell (0.5%), Union (0.0%), Wabash (0.0%), Warren (75.0%), Wayne (29.7%), White (0.0%), Williamson (3.3%)

Pharmacies

- Champaign (99.8%), DeKalb (98.8%), Kankakee (97.9%), McLean (96.8%), Sangamon (>99.9%), Vermilion (96.8%), Will (99.8%)

CountyCare

CountyCare met all network access standards.

Meridian

Oral Surgery, Adult

- Alexander (0.0%), Edwards (73.2%), Franklin (59.8%), Gallatin (0.0%), Hamilton (9.9%), Hardin (0.0%), Jackson (85.0%), Johnson (0.0%), Massac (0.0%), Pope (0.0%), Pulaski (0.0%), Saline (0.0%), Union (0.0%), Wayne (32.9%), White (0.0%), Williamson (4.6%)

Oral Surgery, Pediatric

- Alexander (0.0%), Edwards (76.9%), Franklin (62.0%), Gallatin (0.0%), Hamilton (10.6%), Hardin (0.0%), Jackson (86.7%), Johnson (0.0%), Massac (0.0%), Pope (0.0%), Pulaski (0.0%), Saline (0.0%), Union (0.0%), Wayne (33.7%), White (0.0%), Williamson (5.0%)

Pharmacies

- Champaign (99.9%), DeKalb (99.2%), Kankakee (99.6%), McLean (96.7%), Sangamon (99.9%), Vermilion (98.3%)

Molina

Allergy and Immunology, Pediatric

- Adams (25.0%), Alexander (0.0%), Carroll (75.9%), Champaign (0.0%), Clark (0.0%), Coles (0.0%), Crawford (0.0%), Cumberland (0.0%), Douglas (0.0%), Edgar (0.0%), Edwards (0.0%), Gallatin (0.0%), Hamilton (82.3%), Hancock (46.1%), Hardin (0.0%), Jasper (0.0%), Jo Daviess (2.3%), Johnson (2.2%), Lawrence (0.0%), Macon (0.0%), Massac (0.0%), Moultrie (5.2%), Pope (0.0%), Pulaski (0.0%), Richland (0.0%), Rock Island (0.0%), Saline (0.7%), Sangamon (4.7%), Shelby (34.7%), Union (64.2%), Vermilion (0.0%), Wabash (0.0%), White (0.0%), Williamson (87.3%), Winnebago (88.9%)

Oral Surgery, Adult

- Adams (14.8%), Alexander (0.0%), Clay (28.6%), Edwards (0.0%), Franklin (62.8%), Gallatin (0.0%), Hamilton (5.2%), Hardin (0.0%), Jackson (74.1%), Johnson (0.0%), Lawrence (0.0%), Massac (0.0%), Pope (0.0%), Pulaski (0.0%), Richland (3.1%), Saline (0.0%), Union (0.0%), Wabash (0.0%), Wayne (9.8%), White (0.0%), Williamson (1.5%)

Oral Surgery, Pediatric

- Adams (21.2%), Alexander (0.0%), Clay (36.0%), Edwards (0.0%), Franklin (61.9%), Gallatin (0.0%), Hamilton (8.9%), Hardin (0.0%), Jackson (77.6%), Johnson (0.0%), Lawrence (0.0%),

Massac (0.0%), Pope (0.0%), Pulaski (0.0%), Richland (4.4%), Saline (0.0%), Union (2.1%), Wabash (0.0%), Wayne (12.2%), White (0.0%), Williamson (3.2%)

Pharmacies

- Champaign (99.8%), DeKalb (99.0%), McLean (96.2%), Vermilion (98.8%)

YouthCare

Oral Surgery, Adult

- Adams (4.2%), Alexander (0.0%), Franklin (33.3%), Hamilton (25.0%), Hancock (60.0%), Johnson (0.0%), Massac (0.0%), Pope (0.0%), Pulaski (0.0%), Saline (0.0%), Union (0.0%), Wayne (33.3%), White (0.0%), Williamson (8.3%)

Oral Surgery, Pediatric

- Adams (9.1%), Alexander (0.0%), Edwards (70.8%), Franklin (61.8%), Gallatin (0.0%), Hamilton (4.6%), Hancock (85.9%), Hardin (0.0%), Johnson (0.0%), Massac (0.0%), Pope (0.0%), Pulaski (0.0%), Saline (0.0%), Union (1.5%), Wayne (21.1%), White (0.0%), Williamson (5.8%)

Pharmacies

- Champaign (99.9%), DeKalb (99.6%), McLean (94.4%), Vermilion (97.4%)

Appendix C. Stratified Time/Distance Findings

For each region, Appendix C presents percentages of enrollees with access within the time/distance standard by the assessed stratifications.

Urbanicity

Table C-1 through Table C-5 display the percentage of enrollees who have a provider within the applicable standards by urbanicity for each region. While the access standards vary by provider category and urbanicity, 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. For Cook County (i.e., Region 4), only results for enrollees living in urban areas are presented since Cook County is classified as an urban county.

Table C-1—Percentage of Enrollees With Access Required by Time/Distance Standards* by Urbanicity—Region 1

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
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
Dentists, Pediatric	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
Pharmacies	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	83.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	84.3	100.0	100.0	100.0	89.3	96.3	100.0	100.0

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Audiology, Adult	99.7	100.0	99.7	100.0	100.0	100.0	99.9	100.0	100.0	100.0
Audiology, Pediatric	99.7	100.0	99.7	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	>99.9	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	69.3	97.9	71.7	96.4	100.0	100.0	>99.9	100.0	100.0	100.0
Oral Surgery, Pediatric	71.5	98.2	77.7	96.8	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in urban and rural areas in Region 1 with access to providers within provider category-specific time/distance standards.
*Cells are shaded red when less than 90 percent of a health 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—Percentage of Enrollees With Access Required by Time/Distance Standards* by Urbanicity—Region 2

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
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
Dentists, Pediatric	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	93.5	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
Pharmacies	99.2	100.0	99.3	100.0	99.2	100.0	98.9	100.0	98.8	100.0
Specialists										
Allergy and Immunology, Adult	100.0	100.0	89.5	>99.9	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	91.9	>99.9	100.0	100.0	21.0	74.5	100.0	100.0
Audiology, Adult	100.0	100.0	93.3	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	100.0	100.0	95.3	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
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	72.8	85.1	58.5	83.9	98.4	100.0	99.5	93.2	99.2	87.8
Oral Surgery, Pediatric	76.7	86.4	51.5	86.0	98.3	100.0	99.4	95.0	98.2	88.3
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in urban and rural areas in Region 2 with access to providers within provider category-specific time/distance standards.
*Cells are shaded red when less than 90 percent of a health 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—Percentage of Enrollees With Access Required by Time/Distance Standards* by Urbanicity—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

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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
Dentists, Pediatric	100.0	100.0	100.0	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
Pharmacies	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	70.5	93.5	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	71.3	93.9	100.0	100.0	100.0	75.5	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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
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	60.3	100.0	55.5	100.0	60.7	100.0	60.0	100.0	64.6
Oral Surgery, Pediatric	100.0	63.0	100.0	55.6	100.0	64.0	100.0	60.4	100.0	63.8
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in urban and rural areas in Region 3 with access to providers within provider category-specific time/distance standards.

*Cells are shaded red when less than 90 percent of a health 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—Percentage of Enrollees With Access Required by Time/Distance Standards by Urbanicity—Region 4

Provider Categories	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
	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
Dentists, Pediatric	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
Pharmacies	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
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, 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
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees in urban and rural areas in Region 4 with access to providers within provider category-specific time/distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

Table C-5—Percentage of Enrollees With Access Required by Time/Distance Standards* by Urbanicity—Region 5

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

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
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
Dentists, Pediatric	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
Pharmacies	100.0	100.0	99.8	100.0	>99.9	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
Allergy and Immunology, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	>99.9	100.0	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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
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
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees in urban and rural areas in Region 5 with access to providers within provider category-specific time/distance standards.

*Cells are shaded red when less than 90 percent of a health 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.

Race

Table C-6 through Table C-10 display the percentage of enrollees who have a provider within the applicable standards by race for each region. 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 C-6—Percentage of Enrollees With Access Required by Time/Distance Standards* by Race—Region 1

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
Native Hawaiian/Other Pacific Islander (NHOPI)	100.0	100.0	100.0	100.0	NA
American Indian/Alaska Native (AI/AN)	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Other/Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Hospitals					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pharmacies					
White	99.9	99.8	99.9	>99.9	100.0
Black	>99.9	>99.9	>99.9	100.0	>99.9
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	>99.9	99.9	99.9	>99.9	100.0
Specialists					
Allergy and Immunology, Adult					
White	100.0	90.0	100.0	100.0	100.0
Black	100.0	87.0	100.0	100.0	100.0
Asian	100.0	85.5	100.0	100.0	100.0
NHOPI	100.0	91.7	100.0	100.0	NA
AI/AN	100.0	94.4	100.0	100.0	100.0
Other/Unknown	100.0	91.2	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Allergy and Immunology, Pediatric					
White	100.0	90.9	100.0	89.5	100.0
Black	100.0	80.8	100.0	89.9	100.0
Asian	100.0	82.1	100.0	77.8	100.0
NHOPI	100.0	88.9	100.0	100.0	NA
AI/AN	100.0	93.8	100.0	89.4	100.0
Other/Unknown	100.0	92.3	100.0	94.1	100.0
Audiology, Adult					
White	99.8	99.7	100.0	99.9	100.0
Black	>99.9	99.9	100.0	100.0	100.0
Asian	99.8	100.0	100.0	99.8	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	99.9	99.9	100.0	99.9	100.0
Audiology, Pediatric					
White	99.7	99.7	100.0	99.9	100.0
Black	99.9	99.9	100.0	>99.9	100.0
Asian	99.6	100.0	100.0	99.4	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	99.9	>99.9	100.0	>99.9	100.0
Endocrinology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					
White	100.0	>99.9	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
White	82.1	81.5	100.0	>99.9	100.0
Black	75.4	74.7	100.0	100.0	100.0
Asian	87.8	87.6	100.0	100.0	100.0
NHOPI	81.5	66.7	100.0	100.0	NA
AI/AN	81.9	85.2	100.0	100.0	100.0
Other/Unknown	84.1	84.0	100.0	100.0	100.0
Oral Surgery, Pediatric					
White	84.6	84.9	100.0	100.0	100.0
Black	78.7	82.4	100.0	100.0	100.0
Asian	86.9	81.4	100.0	100.0	100.0
NHOPI	100.0	88.9	100.0	100.0	NA
AI/AN	68.8	90.6	100.0	100.0	100.0
Other/Unknown	82.3	84.9	100.0	100.0	100.0
Pulmonology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by race in Region 1 with access to providers within provider category-specific time/distance standards. NA indicates that no enrollees of the specified race were identified for the health plan and provider category.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.
**NHOPI = Native Hawaiian/Other Pacific Islander. AI/AN = American Indian/Alaska Native. Other/Unknown combines the Multi-Race category (n = 0 across all MCOs) with the Did Not Answer/Unknown category (n = 101,709 across all MCOs).

Table C-7—Percentage of Enrollees With Access Required by Time/Distance Standards* by Race—Region 2

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Hospitals					
White	100.0	97.3	100.0	100.0	100.0
Black	100.0	93.5	100.0	100.0	100.0
Asian	100.0	97.2	100.0	100.0	100.0
NHOPI	100.0	96.3	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	98.3	100.0	100.0	100.0
Pharmacies					
White	99.5	99.6	99.6	99.1	99.3
Black	>99.9	99.9	99.9	99.9	99.6
Asian	99.8	99.6	100.0	99.7	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	99.0	98.9	97.9	100.0
Other/Unknown	99.5	99.7	99.5	99.1	99.3
Specialists					
Allergy and Immunology, Adult					
White	100.0	95.6	100.0	100.0	100.0
Black	100.0	91.6	100.0	100.0	100.0
Asian	100.0	93.7	100.0	100.0	100.0
NHOPI	100.0	94.4	100.0	100.0	NA
AI/AN	100.0	98.1	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Other/Unknown	100.0	95.6	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
White	100.0	96.4	100.0	43.2	100.0
Black	100.0	93.0	100.0	19.0	100.0
Asian	100.0	96.8	100.0	23.5	100.0
NHOPI	100.0	88.9	100.0	28.6	NA
AI/AN	100.0	95.5	100.0	39.0	100.0
Other/Unknown	100.0	97.0	100.0	40.1	100.0
Audiology, Adult					
White	100.0	97.5	100.0	100.0	100.0
Black	100.0	93.3	100.0	100.0	100.0
Asian	100.0	96.9	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	97.8	100.0	100.0	100.0
Audiology, Pediatric					
White	100.0	98.1	100.0	100.0	100.0
Black	100.0	94.4	100.0	100.0	100.0
Asian	100.0	98.4	100.0	100.0	100.0
NHOPI	100.0	88.9	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	98.7	100.0	100.0	100.0
Endocrinology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
White	80.8	73.9	99.1	96.8	93.1
Black	71.0	61.5	99.6	98.7	99.1
Asian	80.4	61.9	98.1	98.2	100.0
NHOPI	86.7	50.0	100.0	100.0	NA
AI/AN	77.1	61.1	100.0	100.0	100.0
Other/Unknown	81.0	74.4	99.2	98.4	90.2
Oral Surgery, Pediatric					
White	84.8	72.9	98.9	97.1	92.9
Black	71.7	58.1	99.4	98.7	94.5
Asian	86.3	68.4	96.3	98.8	83.3
NHOPI	80.0	100.0	100.0	100.0	NA
AI/AN	85.4	70.5	100.0	100.0	85.7
Other/Unknown	82.2	70.5	99.3	98.5	94.4
Pulmonology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by race in Region 2 with access to providers within provider category-specific time/distance standards.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.
**NHOPI = Native Hawaiian/Other Pacific Islander. AI/AN = American Indian/Alaska Native. Other/Unknown combines the Multi-Race category (n = 0 across all MCOs) with the Did Not Answer/Unknown category (n = 74,089 across all MCOs).

Table C-8—Percentage of Enrollees With Access Required by Time/Distance Standards* by Race—Region 3

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
White	100.0	100.0	99.8	100.0	99.7
Black	100.0	100.0	99.9	100.0	99.7
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	99.8	100.0	99.4
Hospitals					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pharmacies					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Specialists					
Allergy and Immunology, Adult					
White	100.0	84.1	100.0	100.0	100.0
Black	100.0	86.7	100.0	100.0	100.0
Asian	100.0	83.1	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	91.4	100.0	100.0	NA

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Other/Unknown	100.0	86.9	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
White	100.0	85.0	100.0	82.7	100.0
Black	100.0	85.2	100.0	97.7	100.0
Asian	100.0	81.8	100.0	95.6	100.0
NHOPI	100.0	100.0	100.0	77.8	NA
AI/AN	100.0	86.2	100.0	89.7	100.0
Other/Unknown	100.0	89.2	100.0	93.3	100.0
Audiology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
White	67.4	66.1	74.1	77.9	75.6
Black	86.5	88.4	92.6	95.1	93.2
Asian	78.6	76.8	85.7	84.5	NA
NHOPI	81.8	68.4	95.7	85.7	NA
AI/AN	71.9	68.6	67.0	85.7	NA
Other/Unknown	73.5	76.6	80.8	87.1	80.8
Oral Surgery, Pediatric					
White	67.9	62.0	76.3	74.7	73.9
Black	84.1	87.5	92.8	95.0	86.4
Asian	80.5	78.4	84.5	88.9	88.9
NHOPI	100.0	100.0	93.8	77.8	NA
AI/AN	89.7	69.0	76.5	86.2	100.0
Other/Unknown	71.0	73.7	81.5	87.3	80.5
Pulmonology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by race in Region 3 with access to providers within provider category-specific time/distance standards. NA indicates that no enrollees of the specified race were identified for the health plan and provider category.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.
**NHOPI = Native Hawaiian/Other Pacific Islander. AI/AN = American Indian/Alaska Native. Other/Unknown combines the Multi-Race category (n = 2 across all MCOs) with the Did Not Answer/Unknown category (n = 57,509 across all MCOs).

Table C-9—Percentage of Enrollees With Access Required by Time/Distance Standards by Race—Region 4

Provider Categories by Race*	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
PCPs, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race*	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Specialists						
Allergy and Immunology, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA

Provider Categories by Race*	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race*	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Neurosurgery, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult						
White	100.0	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric						
White	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race*	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Black	100.0	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by race in Region 4 with access to providers within provider category-specific time/distance standards. NA indicates that no enrollees of the specified race were identified for the health plan and provider category.
*NHOPI = Native Hawaiian/Other Pacific Islander. AI/AN = American Indian/Alaska Native. Other/Unknown combines the Multi-Race category (n = 0 across all MCOs) with the Did Not Answer/Unknown category (n = 462,890 across all MCOs).

Table C-10—Percentage of Enrollees With Access Required by Time/Distance Standards* by Race—Region 5

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Hospitals					
White	99.8	100.0	100.0	100.0	100.0
Black	>99.9	100.0	100.0	100.0	100.0
Asian	>99.9	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	99.9	100.0	100.0	100.0	100.0
Pharmacies					
White	100.0	99.8	>99.9	100.0	100.0
Black	100.0	99.8	>99.9	100.0	100.0
Asian	100.0	>99.9	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	99.7	100.0	100.0	100.0
Other/Unknown	100.0	99.9	>99.9	100.0	100.0
Specialists					
Allergy and Immunology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
White	100.0	100.0	100.0	99.9	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	>99.9	100.0
Audiology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Neurosurgery, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Pediatric					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult					
White	100.0	100.0	100.0	100.0	100.0
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	NA
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	NA
Other/Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
White	100.0	100.0	100.0	100.0	100.0

Provider Categories by Race**	Aetna	BCBSIL	Meridian	Molina	YouthCare
Black	100.0	100.0	100.0	100.0	100.0
Asian	100.0	100.0	100.0	100.0	100.0
NHOPI	100.0	100.0	100.0	100.0	NA
AI/AN	100.0	100.0	100.0	100.0	100.0
Other/Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by race in Region 5 with access to providers within provider category-specific time/distance standards. NA indicates that no enrollees of the specified race were identified for the health plan and provider category.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.
**NHOPI = Native Hawaiian/Other Pacific Islander. AI/AN = American Indian/Alaska Native. Other/Unknown combines the Multi-Race category (n = 5 across all MCOs) with the Did Not Answer/Unknown category (n = 202,870 across all MCOs).

Ethnicity

Table C-11 through Table C-15 display the percentage of enrollees who have a provider within the applicable standards by ethnicity for each region. 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 C-11—Percentage of Enrollees With Access Required by Time/Distance Standards* by Ethnicity—Region 1

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Hospitals					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pharmacies					
Hispanic/Latino	100.0	99.9	>99.9	100.0	100.0
Not Hispanic/Latino	>99.9	99.9	99.9	>99.9	>99.9
Unknown	>99.9	99.9	99.9	>99.9	100.0
Specialists					
Allergy and Immunology, Adult					
Hispanic/Latino	100.0	91.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	89.1	100.0	100.0	100.0
Unknown	100.0	90.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
Hispanic/Latino	100.0	92.6	100.0	90.1	100.0
Not Hispanic/Latino	100.0	87.9	100.0	90.2	100.0
Unknown	100.0	91.1	100.0	92.9	100.0
Audiology, Adult					
Hispanic/Latino	100.0	99.9	100.0	100.0	100.0
Not Hispanic/Latino	99.8	99.8	100.0	99.9	100.0
Unknown	99.8	99.8	100.0	99.9	100.0
Audiology, Pediatric					
Hispanic/Latino	99.9	100.0	100.0	100.0	100.0
Not Hispanic/Latino	99.8	99.8	100.0	99.9	100.0
Unknown	99.9	99.9	100.0	>99.9	100.0
Endocrinology, Adult					

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	>99.9	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
Hispanic/Latino	91.8	92.4	100.0	100.0	100.0
Not Hispanic/Latino	80.1	78.8	100.0	>99.9	100.0
Unknown	81.8	82.2	100.0	100.0	100.0
Oral Surgery, Pediatric					
Hispanic/Latino	92.6	92.3	100.0	100.0	100.0
Not Hispanic/Latino	81.8	81.8	100.0	100.0	100.0
Unknown	82.6	85.7	100.0	100.0	100.0
Pulmonology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by ethnicity in Region 1 with access to providers within provider category-specific time/distance standards.
*Cells are shaded when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.

Table C-12—Percentage of Enrollees With Access Required by Time/Distance Standards* by Ethnicity—Region 2

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Hospitals					
Hispanic/Latino	100.0	96.7	100.0	100.0	100.0
Not Hispanic/Latino	100.0	96.3	100.0	100.0	100.0
Unknown	100.0	98.0	100.0	100.0	100.0
Pharmacies					
Hispanic/Latino	99.6	99.6	99.8	99.8	100.0
Not Hispanic/Latino	99.6	99.7	99.7	99.3	99.4
Unknown	99.6	99.7	99.5	99.1	99.1

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Specialists					
Allergy and Immunology, Adult					
Hispanic/Latino	100.0	90.2	100.0	100.0	100.0
Not Hispanic/Latino	100.0	94.8	100.0	100.0	100.0
Unknown	100.0	95.4	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
Hispanic/Latino	100.0	93.3	100.0	23.4	100.0
Not Hispanic/Latino	100.0	95.6	100.0	35.6	100.0
Unknown	100.0	96.9	100.0	40.5	100.0
Audiology, Adult					
Hispanic/Latino	100.0	96.3	100.0	100.0	100.0
Not Hispanic/Latino	100.0	96.5	100.0	100.0	100.0
Unknown	100.0	97.5	100.0	100.0	100.0
Audiology, Pediatric					
Hispanic/Latino	100.0	97.9	100.0	100.0	100.0
Not Hispanic/Latino	100.0	97.1	100.0	100.0	100.0
Unknown	100.0	98.6	100.0	100.0	100.0
Endocrinology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
Hispanic/Latino	88.1	81.2	99.4	98.9	85.7
Not Hispanic/Latino	77.7	69.9	99.2	97.2	95.2

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Unknown	82.1	75.8	99.2	98.1	91.2
Oral Surgery, Pediatric					
Hispanic/Latino	92.0	84.0	99.7	99.3	94.5
Not Hispanic/Latino	79.9	67.5	99.0	97.4	93.2
Unknown	82.8	71.6	99.2	98.5	95.1
Pulmonology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by ethnicity in Region 2 with access to providers within provider category-specific time/distance standards.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.

Table C-13—Percentage of Enrollees With Access Required by Time/Distance Standards* by Ethnicity—Region 3

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
Hispanic/Latino	100.0	100.0	99.9	100.0	100.0
Not Hispanic/Latino	100.0	100.0	99.8	100.0	99.7
Unknown	100.0	100.0	99.8	100.0	99.6
Hospitals					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pharmacies					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Specialists					
Allergy and Immunology, Adult					
Hispanic/Latino	100.0	86.1	100.0	100.0	100.0
Not Hispanic/Latino	100.0	84.8	100.0	100.0	100.0
Unknown	100.0	85.6	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
Hispanic/Latino	100.0	84.7	100.0	93.3	100.0
Not Hispanic/Latino	100.0	85.0	100.0	87.7	100.0
Unknown	100.0	88.5	100.0	93.0	100.0
Audiology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
Hispanic/Latino	70.0	71.0	83.1	89.0	75.0
Not Hispanic/Latino	70.8	71.1	78.8	83.1	79.8
Unknown	75.2	76.1	81.1	86.3	82.2
Oral Surgery, Pediatric					
Hispanic/Latino	70.9	77.9	89.2	89.3	83.3
Not Hispanic/Latino	71.3	67.5	81.5	81.6	76.7
Unknown	71.6	74.1	81.6	87.0	80.7
Pulmonology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by ethnicity in Region 3 with access to providers within provider category-specific time/distance standards.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.

Table C-14—Percentage of Enrollees With Access Required by Time/Distance Standards by Ethnicity—Region 4

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
PCPs, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Specialists						
Allergy and Immunology, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric						
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by ethnicity in Region 4 with access to providers within provider category-specific time/distance standards.

Table C-15—Percentage of Enrollees With Access Required by Time/Distance Standards* by Ethnicity—Region 5

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
PCPs, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
PCPs, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Behavioral Health Providers, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers					

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Dentists, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Hospitals					
Hispanic/Latino	>99.9	100.0	100.0	100.0	100.0
Not Hispanic/Latino	99.8	100.0	100.0	100.0	100.0
Unknown	99.9	100.0	100.0	100.0	100.0
Pharmacies					
Hispanic/Latino	100.0	99.9	100.0	100.0	100.0
Not Hispanic/Latino	100.0	99.7	>99.9	100.0	100.0
Unknown	100.0	99.9	>99.9	100.0	100.0
Specialists					
Allergy and Immunology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	99.9	100.0
Unknown	100.0	100.0	100.0	>99.9	100.0
Audiology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Endocrinology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0

Provider Categories by Enrollee Ethnicity	Aetna	BCBSIL	Meridian	Molina	YouthCare
Endocrinology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Neurosurgery, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Oral Surgery, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric					
Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Not Hispanic/Latino	100.0	100.0	100.0	100.0	100.0
Unknown	100.0	100.0	100.0	100.0	100.0

Note: This table presents the percentage of health plan enrollees by ethnicity in Region 5 with access to providers within provider category-specific time/distance standards.
*Cells are shaded red when less than 90 percent of a health plan's enrollees have access to providers (less than 100 percent for Pharmacy) within the time/distance standards.

Age

Table C-16 through Table C-20 display the percentage of enrollees who have a provider within the applicable standards by age group for each region. 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 C-16—Percentage of Enrollees With Access Required by Time/Distance Standards* by Age (Years)—Region 1

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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
Dentists, Pediatric	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
Pharmacies	>99.9	>99.9	99.9	99.9	>99.9	98.4	99.9	99.9	99.5	>99.9	>99.9	99.9	>99.9	100.0	NA
Specialists															
Allergy and Immunology, Adult	NA	100.0	100.0	NA	89.5	88.7	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	91.7	NA	NA	100.0	NA	NA
Audiology, Adult	NA	99.8	99.9	NA	99.8	100.0	NA	100.0	100.0	NA	99.9	100.0	NA	100.0	NA
Audiology, Pediatric	99.8	NA	NA	99.8	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	>99.9	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	81.1	83.3	NA	80.2	84.9	NA	100.0	100.0	NA	>99.9	100.0	NA	100.0	NA
Oral Surgery, Pediatric	82.7	NA	NA	84.5	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
Pulmonology, 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
Pulmonology, 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 health plan enrollees by age group with access to providers within provider category-specific time/distance standards in Region 1.
*Cells are shaded red when less than 90 percent of a health 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 category and age group or that no one in the age group was enrolled.

Table C-17—Percentage of Enrollees With Access Required by Time/Distance Standards* by Age (Years)—Region 2

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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
Dentists, Pediatric	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	97.6	96.4	96.8	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA
Pharmacies	99.6	99.6	99.9	99.7	99.6	99.7	99.5	99.7	99.8	99.1	99.3	100.0	99.4	99.5	NA
Specialists															
Allergy and Immunology, Adult	NA	100.0	100.0	NA	94.7	95.9	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology, Pediatric	100.0	NA	NA	96.2	NA	NA	100.0	NA	NA	37.6	NA	NA	100.0	NA	NA
Audiology, Adult	NA	100.0	100.0	NA	96.7	96.9	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
Audiology, Pediatric	100.0	NA	NA	97.8	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	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	78.7	81.3	NA	71.2	72.8	NA	99.2	99.5	NA	97.5	94.7	NA	93.9	NA
Oral Surgery, Pediatric	81.5	NA	NA	69.7	NA	NA	99.1	NA	NA	98.0	NA	NA	93.4	NA	NA
Pulmonology, 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
Pulmonology, 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 health plan enrollees by age group with access to providers within provider category-specific time/distance standards in Region 2.
*Cells are shaded red when less than 90 percent of a health 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 category and age group or that no one in the age group was enrolled.

Table C-18—Percentage of Enrollees With Access Required by Time/Distance Standards* by Age (Years)—Region 3

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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

	Aetna			BCBSIL			Meridian			Molina			YouthCare		
Provider Categories	**<18**	**18–64**	**65+**	**<18**	**18–64**	**65+**	**<18**	**18–64**	**65+**	**<18**	**18–64**	**65+**	**<18**	**18–64**	**65+**
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
Dentists, Pediatric	100.0	NA	NA	100.0	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
Pharmacies	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	84.8	87.4	NA	100.0	100.0	NA	100.0	100.0	NA	100.0	NA
Allergy and Immunology, Pediatric	100.0	NA	NA	86.4	NA	NA	100.0	NA	NA	90.2	NA	NA	100.0	NA	NA
Audiology, 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
Audiology, Pediatric	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	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	71.3	75.3	NA	71.8	73.9	NA	79.1	82.7	NA	83.7	83.6	NA	80.5	NA
Oral Surgery, Pediatric	**71.4**	NA	NA	70.4	NA	NA	81.7	NA	NA	84.2	NA	NA	77.1	NA	NA
Pulmonology, 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

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
Pulmonology, 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 health plan enrollees by age group with access to providers within provider category-specific time/distance standards in Region 3.
*Cells are shaded red when less than 90 percent of a health 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 category and age group or that no one in the age group was enrolled.

Table C-19—Percentage of Enrollees With Access Required by Time/Distance Standards by Age (Years) — Region 4

Provider Categories	Aetna			BCBSIL			CountyCare			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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
Dentists, 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
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
Pharmacies	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
Audiology, 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
Audiology, 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

Provider Categories	Aetna			BCBSIL			CountyCare			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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
Pulmonology, 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
Pulmonology, 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 health plan enrollees by age group with access to providers within provider category-specific time/distance standards in Region 4. "NA" indicates that the standard is not applicable to the provider category and age group or that no one in the age group was enrolled.

Table C-20—Percentage of Enrollees With Access Required by Time/Distance Standards* by Age (Years)—Region 5

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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
Dentists, Pediatric	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA	100.0	NA	NA
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
Pharmacies	100.0	100.0	100.0	99.8	99.8	99.9	>99.9	>99.9	100.0	100.0	100.0	100.0	100.0	100.0	NA
Specialists															

Provider Categories	Aetna			BCBSIL			Meridian			Molina			YouthCare		
	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+	<18	18–64	65+
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
Audiology, 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
Audiology, Pediatric	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	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
Pulmonology, 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
Pulmonology, 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 health plan enrollees by age group with access to providers within provider category-specific time/distance standards in Region 5.
*Cells are shaded red when less than 90 percent of a health 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 category and age group or that no one in the age group was enrolled.

Sex

Table C-21 through Table C-25 display the percentage of enrollees who have a provider within the applicable standards by sex for each region. 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 C-21—Percentage of Enrollees With Access Required by Time/Distance Standards* by Sex—Region 1

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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
Dentists, Pediatric	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
Pharmacies	99.9	>99.9	99.9	99.9	99.9	99.9	>99.9	>99.9	>99.9	100.0
Specialists										
Allergy and Immunology, Adult	100.0	100.0	89.3	89.7	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	90.0	89.8	100.0	100.0	91.8	91.6	100.0	100.0
Audiology, Adult	99.8	99.8	99.8	99.8	100.0	100.0	99.9	99.9	100.0	100.0
Audiology, Pediatric	99.8	99.8	99.9	99.8	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	>99.9	>99.9	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	80.2	81.9	78.8	81.9	100.0	100.0	100.0	>99.9	100.0	100.0
Oral Surgery, Pediatric	82.7	82.8	84.6	84.4	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric	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	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female

Note: This table presents the percentage of health plan enrollees by sex with access to providers within provider category-specific time/distance standards in Region 1.
*Cells are shaded red when less than 90 percent of a health 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 category and enrollee sex or that no one of that sex was enrolled.

Table C-22—Percentage of Enrollees With Access Required by Time/Distance Standards* by Sex—Region 2

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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
Dentists, Pediatric	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	96.2	97.4	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	99.6	99.6	99.6	99.7	99.6	99.6	99.2	99.2	99.5	99.2
Specialists										
Allergy and Immunology, Adult	100.0	100.0	93.4	96.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	96.2	96.1	100.0	100.0	38.0	37.3	100.0	100.0
Audiology, Adult	100.0	100.0	95.7	97.5	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	100.0	100.0	97.7	97.9	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
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

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Oral Surgery, Adult	77.2	80.0	72.1	70.7	99.2	99.2	97.1	97.6	92.5	95.8
Oral Surgery, Pediatric	81.0	82.0	69.4	70.1	99.1	99.2	98.0	98.0	94.1	92.7
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees by sex with access to providers within provider category-specific time/distance standards in Region 2.
*Cells are shaded red when less than 90 percent of a health 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 category and enrollee sex or that no one of that sex was enrolled.

Table C-23—Percentage of Enrollees With Access Required by Time/Distance Standards* by Sex—Region 3

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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
Dentists, Pediatric	100.0	100.0	100.0	100.0	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
Pharmacies	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	85.8	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	86.7	86.0	100.0	100.0	90.3	90.1	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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	
	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	72.0	71.0	72.0	72.0	78.4	79.8	82.8	84.3	81.2	79.7
Oral Surgery, Pediatric	71.1	71.7	70.4	70.4	81.6	81.7	84.2	84.1	77.1	77.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees by sex with access to providers within provider category-specific time/distance standards in Region 3.
*Cells are shaded red when less than 90 percent of a health 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 category and enrollee sex or that no one of that sex was enrolled.

Table C-24—Percentage of Enrollees With Access Required by Time/Distance Standards* by Sex—Region 4

Provider Categories	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
	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
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
Dentists, 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
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
Pharmacies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Provider Categories	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
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
Audiology, 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
Audiology, 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
Pulmonology, 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
Pulmonology, 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 health plan enrollees by sex with access to providers within provider category-specific time/distance standards in Region 4.
*Cells are shaded red with a red font when less than 90 percent of a health 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 category and enrollee sex or that no one of that sex was enrolled.

Table C-25—Percentage of Enrollees With Access Required by Time/Distance Standards* by Sex—Region 5

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	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

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	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
OB/GYN Providers	NA	100.0	NA	100.0	NA	100.0	NA	100.0	NA	100.0
Dentists, Pediatric	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
Pharmacies	100.0	100.0	99.8	99.8	>99.9	>99.9	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
Allergy and Immunology, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	>99.9	>99.9	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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
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
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees by sex with access to providers within provider category-specific time/distance standards in Region 5.
*Cells are shaded red when less than 90 percent of a health 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 category and enrollee sex or that no one of that sex was enrolled.

Disproportionately Impacted Areas

Table C-26 through Table C-30 display the percentage of enrollees who have a provider within the applicable standards stratified by whether or not they reside in a ZIP Code identified by Illinois as a Disproportionately Impacted Area for each region. 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 C-26—Percentage of Enrollees With Access Required by Time/Distance Standards* by DIA Status—Region 1

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
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
Dentists, Pediatric	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
Pharmacies	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	88.6	90.0	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	88.1	90.9	100.0	100.0	95.7	88.7	100.0	100.0
Audiology, Adult	>99.9	99.7	>99.9	99.7	100.0	100.0	100.0	99.9	100.0	100.0
Audiology, Pediatric	>99.9	99.7	>99.9	99.8	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

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
Neurosurgery, Adult	100.0	100.0	100.0	>99.9	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	79.5	82.2	79.2	81.3	100.0	100.0	100.0	>99.9	100.0	100.0
Oral Surgery, Pediatric	81.5	83.5	83.5	85.1	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees by residence in DIAs with access to providers within provider category-specific time/distance standards in Region 1.
*Cells are shaded red when less than 90 percent of a health 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 available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: April 10, 2023.

Table C-27—Percentage of Enrollees With Access Required by Time/Distance Standards* by DIA Status—Region 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
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
Dentists, Pediatric	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	93.2	98.8	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	100.0	99.4	100.0	99.5	100.0	99.4	100.0	98.7	100.0	99.1

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	90.4	97.3	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	92.0	98.2	100.0	100.0	19.5	49.9	100.0	100.0
Audiology, Adult	100.0	100.0	92.5	99.1	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	100.0	100.0	94.5	99.4	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
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	74.2	81.9	64.5	75.2	100.0	98.8	100.0	95.5	100.0	90.1
Oral Surgery, Pediatric	77.7	84.0	63.1	73.0	100.0	98.6	100.0	96.7	100.0	90.3
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees by residence in DIAs with access to providers within provider category-specific time/distance standards in Region 2.
*Cells are shaded red when less than 90 percent of a health 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 available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: April 10, 2023.

Table C-28—Percentage of Enrollees With Access Required by Time/Distance Standards* by DIA Status—Region 3

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
PCPs, 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
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
Dentists, Pediatric	100.0	100.0	100.0	100.0	100.0	99.7	100.0	100.0	100.0	99.5
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	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	88.1	83.6	100.0	100.0	100.0	100.0	100.0	100.0
Allergy and Immunology, Pediatric	100.0	100.0	88.3	85.7	100.0	100.0	99.1	85.3	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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
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	89.8	64.3	92.5	62.8	94.5	71.9	95.7	77.1	96.1	71.9
Oral Surgery, Pediatric	90.8	64.4	92.3	62.3	95.6	75.0	96.6	77.4	92.8	71.0
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, Pediatric	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

Note: This table presents the percentage of health plan enrollees by residence in DIAs with access to providers within provider category-specific time/distance standards in Region 3.
*Cells are shaded red when less than 90 percent of a health 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 available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: April 10, 2023.

Table C-29—Percentage of Enrollees With Access Required by Time/Distance Standards by DIA Status—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
Dentists, 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
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
Pharmacies	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
Audiology, 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

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
Audiology, 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
Pulmonology, 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
Pulmonology, 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 health plan enrollees by residence in DIAs with access to providers within provider category-specific time/distance standards in Region 4. DIAs are ZIP Codes identified by the Illinois Department of Commerce & Economic Opportunity. A list of DIA ZIP Codes is available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: April 10, 2023.

Table C-30—Percentage of Enrollees With Access Required by Time/Distance Standards* by DIA Status—Region 5

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
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

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
Dentists, Pediatric	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
Pharmacies	100.0	100.0	99.9	99.8	>99.9	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
Allergy and Immunology, Pediatric	100.0	100.0	100.0	100.0	100.0	100.0	100.0	>99.9	100.0	100.0
Audiology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Audiology, Pediatric	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
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
Pulmonology, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology, 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 health plan enrollees by residence in DIAs with access to providers within provider category-specific time/distance standards in Region 5.
*Cells are shaded red when less than 90 percent of a health 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 available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: April 10, 2023.

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. HFS provided enrollee demographic and enrollment data as of February 1, 2023.

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 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 locations in the State of Illinois or in contiguous counties in neighboring states were included in the time/distance analyses. All 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, contract requirements state that the health plans must ensure that 90 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 were 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]
Primary Care Provider (PCP)—Adult[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
PCP—Pediatric[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
Behavioral Health Provider—Adult[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
Behavioral Health Provider—Pediatric[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
Dentist—Pediatric	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
Pharmacies		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
Audiology—Adult and Pediatric			
Endocrinology—Adult and Pediatric			
Neurosurgery—Adult and Pediatric			
Oral Surgery—Adult and Pediatric			
Pulmonology—Adult and Pediatric			

1 For these analyses, "urban" and "rural" were defined by the Medicaid Model Contract 2018-24-001.

2 Adult PCPs included 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 included 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 included 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 included providers with a specialty of obstetrics, gynecology, obstetrics/gynecology, or nurse midwife.

5 The SFY 2023 analyses evaluated network adequacy for six types of specialists, by adult and pediatric populations, as defined by HFS.

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 in a Tableau Dashboard.

Stratification of Results

HSAG stratified the time/distance analyses by race, ethnicity, age, sex, and highlights results for ZIP Codes that qualify as DIAs as identified by the Illinois DCEO.[D-3] The objective of presenting stratified

D-1 For pharmacy providers, the contract requirement states that 100 percent of enrollees must have access within the states 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 the average driving speed of 30 miles per hour for calculations in urban counties and 55 miles per hour for calculations in rural counties.

D-3 A list of DIA ZIP Codes is available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: April 10, 2023.

results was to ensure that issues in health plan networks that differentially affect population subgroups were not overlooked.

- Stratification by race, ethnicity, age, and sex: For each health plan, time/distance metrics were calculated by enrollee race, ethnicity, age, and sex to determine whether and to what extent differences in network quality were experienced by enrollees belonging to distinct demographic groups.
- Stratification by urbanicity: For each health plan, time/distance metrics were calculated by urbanicity to determine whether and to what extent differences in network quality were experienced by enrollees in urban versus rural areas.
- Targeting of disproportionately impacted areas: Time/distance results for enrollees living in ZIP Codes that qualify as disproportionately impacted areas were compared to results for enrollees outside these areas.

Targeted Provider Saturation Analysis

Based on the time/distance validation results, HSAG identified the provider categories for which each health plan failed to meet established time/distance standards at the county level. For each time/distance standard for which a health plan did not meet the time/distance requirements, HSAG identified available Medicaid providers contracted with other health plans within surrounding geographic regions that might be available to improve health plan compliance with time/distance requirements. HSAG provided each health plan with a list of these non-contracted Medicaid providers to help focus health plan contracting efforts.

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, which included both mail and telephone surveys for data collection, including the option to complete a web-based survey via the

E1-1 In 2022 and 2023, 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.

Internet. 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 for the adult population and in English and Spanish for the child population.

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 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 2023 top-box scores were compared to their corresponding 2022 scores to determine whether there were statistically significant differences. Statistically significant differences between the 2023 top-box scores and the 2022 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2023 than 2022 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2023 than 2022 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 2023 top-box scores were compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data and the resulting 2022 top-box scores were compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data.[E1-4, E1-5] 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.

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

E1-4 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA. September 2021.

E1-5 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022*. Washington, DC: NCQA. September 2022.

Appendix E2. Beneficiary Experience With Care Detailed Results

Adult CAHPS Medicaid Survey

Response Rates

The 2023 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—2023 Adult Response Rates

Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Aggregate
14.27%	23.48%	14.56%	11.87%	11.84%	15.10%

Adult Health Plan-Specific Findings and Comparisons

The 2022 and 2023 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—2022 and 2023 Adult Health Plan-Specific Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2022	79.5% ★	79.8% ★★	93.4% ★★★	90.1% ★★★
	2023	80.7% ★★	77.8% ★★	92.0% ★★	87.0% ★★
BCBSIL	2022	85.6% ★★★	82.1% ★★	92.3% ★★	91.3% ★★★★
	2023	82.6% ★★	80.2% ★★	93.0% ★★★	89.1% ★★
CountyCare	2022	80.2% ★	75.3% ★	90.5% ★	91.9%+ ★★★★+
	2023	76.2% ★	77.7% ★★	92.6% ★★	91.1% ★★★★
Meridian	2022	83.6% ★★	80.1% ★★	96.0% ★★★★★	86.8%+ ★+
	2023	84.1% ★★★	83.8% ★★★	90.7% ★	92.7%+ ★★★★★+

Experience With Care

Adult CAHPS Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2022	85.1% ★★★	77.9% ★	92.9% ★★★	83.7%+ ★+
	2023	81.4% ★★	82.4% ★★★	92.9% ★★	86.7%+ ★★+
Illinois Statewide Aggregate	2022	82.3% ★★	78.8% ★	93.8% ★★★	88.2% ★★
	2023	81.4% ★★	81.0% ★★★	91.7% ★★	90.2% ★★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

For CountyCare and Meridian, 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.

Opportunities for Improvement

Opportunity: Excluding Meridian, 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, BCBSIL, CountyCare, and Molina members may have difficulty obtaining the care, tests, or treatments they need.

Opportunity: Excluding Meridian and Molina, 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.

Opportunity: Excluding BCBSIL, experience survey results show that all health plans were below the 50th percentile for *How Well Doctors Communicate*, which indicates members did not perceive they were receiving thorough communication from their doctors.

Why the Opportunity Exists: When a member is receiving care, providers may not be communicating well or spending adequate time educating or explaining as much as the member expects or needs.

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—2022 and 2023 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	2022	51.5% ★	63.2% ★	61.9% ★	53.2% ★
	2023	47.9% ★	64.1% ★	61.9% ★	51.1% ★
BCBSIL	2022	58.2% ★★	73.6% ★★★★	75.2% ★★★★	70.3% ★★★★
	2023	54.7% ★★	71.1% ★★★	69.7% ★★★	66.2% ★★★★
CountyCare	2022	52.3% ★	62.7% ★	69.6%+ ★★★+	56.0% ★
	2023	61.3% ★★★★	73.9% ★★★★	63.8% ★	67.8% ★★★★
Meridian	2022	56.3% ★★	70.9% ★★★	67.6% ★★	63.8% ★★★
	2023	56.8% ★★★	64.4% ★★	62.5%+ ★+	56.0% ★
Molina	2022	54.9% ★★	71.4% ★★★	68.4%+ ★★+	58.9% ★★
	2023	57.6% ★★★	67.0% ★★	72.5% ★★★	58.7% ★★
Illinois Statewide Aggregate	2022	54.3% ★	67.7% ★★	67.0% ★★	59.3% ★★
	2023	55.9% ★★	66.8% ★★	64.3% ★	58.0% ★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths	For BCBSIL and CountyCare, experience survey results were at or between the 75th and 89th percentiles for *Rating of Health Plan,* which indicates that BCBSIL members had positive experiences with their health plan overall. Additionally, CountyCare's experience survey results were at or between the 75th and 89th percentiles for *Rating of Health Care* and *Rating of Personal Doctor,* which indicates that CountyCare members had positive experiences with their healthcare overall and their personal doctor.
Opportunities for Improvement	**Opportunity:** For *Rating of All Health Care*, experience survey results for BCBSIL were below the 50th percentile and for Aetna were below the 25th percentile, 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: For *Rating of Personal Doctor*, experience survey results for Meridian and Molina were below the 50th percentile and for Aetna were below the 25th percentile, which indicates that members may feel they are not getting quality care from their personal doctors. **Why the Opportunity Exists:** Aetna, Meridian, and Molina members may have received poor communication or service from their personal doctor.
	Opportunity: Experience survey results for Aetna, CountyCare, and Meridian were 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, CountyCare, and Meridian members may feel they are not getting quality care or treatment from the specialists they see most often.
	Opportunity: For *Rating of Health Plan,* experience survey results for Molina were below the 50th percentile and for Aetna and Meridian were below the 25th percentile, which indicates that members perceive an overall lack of quality of care and service with these health plans. **Why the Opportunity Exists:** Aetna, Molina, and Meridian 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 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, the health plans could consider focusing on improving provider-patient communications through provider bulletins or trainings. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers.

Child CAHPS Medicaid Survey

Response Rates

The 2023 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—2023 Child Response Rates

Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Aggregate
16.55%	11.48%	12.12%	9.97%	9.54%	11.67%

Child Health Plan-Specific Findings and Comparisons

The 2022 and 2023 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—2022 and 2023 Child Health Plan-Specific Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2022	89.5%+ ★★★★+	83.3%+ ★+	95.2% ★★★	89.1%+ ★★★+
	2023	83.4% ★★	81.5% ★	94.8% ★★★	81.2% ★
BCBSIL	2022	77.9% ★	78.6% ★	94.4% ★★★	90.2%+ ★★★+
	2023	73.1% ★	79.0% ★	92.6% ★★	87.7% ★★
CountyCare	2022	79.7%+ ★+	77.3%+ ★+	91.4% ★	96.1%+ ★★★★★+
	2023	74.4% ★	82.3% ★	94.5% ★★	86.2% ★★
Meridian	2022	74.9%+ ★+	85.0%+ ★★+	93.2% ★★	88.3%+ ★★★+
	2023	86.5% ★★★	86.0%+ ★★+	93.0% ★★	86.7%+ ★★+

Experience With Care

Child CAHPS Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2022	83.9% ★★	87.9% ★★★	93.2% ★★	89.1% ★★★
	2023	82.1% ★★	85.8% ★★	94.1% ★★	87.8% ★★★
Illinois Statewide Aggregate	2022	79.4% ★	82.4% ★	93.5% ★★	90.1% ★★★
	2023	80.4% ★	83.1% ★	93.5% ★★	86.3% ★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

No strengths were identified for the Child Medicaid experience survey results for any of the child health plans or the statewide aggregate; however, Aetna's *How Well Doctors Communicate,* Meridian's *Getting Needed Care,* and Molina's *Customer Service* experience results were at or between the 50th percentile and 74th percentile.

Opportunities for Improvement

Opportunity: For *Getting Needed Care,* experience results for Aetna and Molina were below the 50th percentile and for BCBSIL and CountyCare were below the 25th percentile, 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 treatments they need.

Opportunity: For *Getting Care Quickly,* experience survey results for Meridian and Molina were below the 50th percentile, and for Aetna, BCBSIL, and CountyCare were below the 25th percentile, 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: Excluding Aetna, experience survey results for all plans 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 parents/caretakers expect or need.

Opportunity: For *Customer Service,* experience survey results for BCBSIL, CountyCare, and Meridian were below the 50th percentile, and for Aetna were below the 25th percentile, which indicates that parents/caretakers of child members perceived a lack of quality of care from their health plan when they needed assistance

Why the Opportunity Exists: BCBSIL, CountyCare, Meridian, and Aetna customer service staff may not be providing the information parents/caretakers of child members need or treating them with courtesy and respect.

Recommendations: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why their members are not getting timely care or 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. Additionally, HSAG recommends that the plans conduct an evaluation of their current call center hours and practices to determine if the hours and resources meet members' needs. The plans could further promote the use of existing after-hours customer service to improve customer service results.

Global Ratings

Table E2-6—2022 and 2023 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	2022	65.9% ★	73.0% ★	73.0%+ ★★+	57.1% ★
	2023	63.3% ★	73.8% ★	72.3%+ ★★★+	58.1% ★
BCBSIL	2022	69.5% ★	77.3% ★★	71.8%+ ★★+	72.7% ★★★
	2023	66.0% ★	72.5% ★	60.6%+ ★+	72.1% ★★
CountyCare	2022	73.0% ★★	77.4% ★★	66.7%+ ★+	77.5% ★★★★
	2023	68.8% ★★	77.1% ★★	68.6%+ ★+	75.5% ★★★
Meridian	2022	65.3% ★	77.7% ★★	60.0%+ ★+	67.9% ★
	2023	71.2% ★★★	75.9% ★★	76.2%+ ★★★+	71.4% ★★
Molina	2022	65.6% ★	79.1% ★★★	73.3%+ ★★+	67.7% ★
	2023	70.0% ★★	78.1% ★★★	73.6% ★★★	63.8% ★
Illinois Statewide Aggregate	2022	67.6% ★	77.1% ★★	67.1% ★	69.0% ★★
	2023	68.4% ★★	75.2% ★★	70.4% ★★	69.5% ★★

\+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

No strengths were identified for the Child Medicaid experience survey results for any of the child health plans or the statewide aggregate; however, Aetna and CountyCare had one and Meridian and Molina had two experience survey results at or between the 50th percentile and 74th percentile.

Opportunities for Improvement	
	Opportunity: For *Rating of All Health Care,* experience survey results for CountyCare and Molina were below the 50th percentile, and for Aetna and BCBSIL were below the 25th percentile, which indicates 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 their child needs, leading to an overall lower level of experience in how they view the quality of the care their child received.
	Opportunity: For *Rating of Personal Doctor,* experience survey results for CountyCare and Meridian were below the 50th percentile, and for Aetna and BCBSIL were 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 BCBSIL and CountyCare were below the 25th percentile for *Rating of Specialist Seen Most Often*, 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: For *Rating of Health Plan,* experience survey results for BCBSIL and Meridian were below the 50th percentile, and for Aetna and Molina were below the 25th percentile, which indicates parents/caretakers of child members perceive an overall lack of quality of care and service from these health plans. **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 child's providers or health plan staff.
	Recommendations: 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 2023 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—2023 Statewide Survey Response Rates

Program Name	2023 Response Rate
All Kids	15.14%
Illinois Medicaid	17.76%
Illinois Statewide Aggregate	12.53%

General Child Population Findings and Comparisons

The 2022 and 2023 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—2022 and 2023 Statewide Survey General Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2022	78.5% ★	79.1% ★	77.1%+ ★+
	2023	81.5% ★★	81.8% ★★	81.1% ★
Getting Care Quickly	2022	79.5% ★	79.1% ★	80.1%+ ★+
	2023	82.4% ★	81.4% ★	83.6% ★

[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).

Experience With Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
How Well Doctors Communicate	2022	93.6% ★★	93.6% ★★	93.5% ★★
	2023	94.7% ★★★	94.9% ★★★	94.5% ★★
Customer Service	2022	79.2% ★	78.1%+ ★+	80.5%+ ★+
	2023	86.9% ★★	87.1% ★★	86.5% ★★
Global Ratings				
Rating of All Health Care	2022	66.3% ★	64.7% ★	69.0% ★
	2023	67.1% ★	70.0% ★★	63.6% ★
Rating of Personal Doctor	2022	74.6% ★	74.2% ★	75.3% ★
	2023	74.6% ★	74.8% ★★	74.4% ★
Rating of Specialist Seen Most Often	2022	64.4% ★	63.9%+ ★+	65.7%+ ★+
	2023	75.4% ★★★	77.9% ★★★★	72.1%+ ★★+
Rating of Health Plan	2022	59.0% ★	56.9% ★	62.3% ★
	2023	62.4% ★	62.6% ★	62.1% ★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

For *Rating of Specialist Seen Most Often,* experience survey results for All Kids were at or between the 75th percentile and 89th percentile, which indicates that parents/caretakers of child members had a positive experience with their child's specialist.

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 except *How Well Doctors Communicate* and *Rating of Specialist Seen Most Often* for the All Kids program, which indicates parents/caretakers may not be receiving the access to, timeliness of, and quality of healthcare

services they feel their child needs and may perceive a lack of quality care and service.

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.

Recommendations: 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 Illinois Medicaid program determine if 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 2022 and 2023 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—2022 and 2023 Statewide Survey CCC Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2022	78.3% ★	79.8% ★	75.4%$^{+}$ ★$^{+}$
	2023	82.3% ★	83.9%$^{+}$ ★$^{+}$	80.6%$^{+}$ ★$^{+}$
Getting Care Quickly	2022	84.4% ★	85.2% ★	83.1%$^{+}$ ★$^{+}$
	2023	88.0% ★★	85.7%$^{+}$ ★$^{+}$	90.2%$^{+}$ ★★$^{+}$
How Well Doctors Communicate	2022	91.5% ★	91.9% ★	90.7% ★
	2023	95.1% ★★★	96.0%$^{+}$ ★★★$^{+}$	94.2% ★★
Customer Service	2022	81.1%$^{+}$ ★$^{+}$	84.4%$^{+}$ ★$^{+}$	75.0%$^{+}$ ★$^{+}$
	2023	86.3%$^{+}$ NA	82.9%$^{+}$ NA	89.5%$^{+}$ NA
Global Ratings				
Rating of All Health Care	2022	61.8% ★	65.2% ★	55.5% ★
	2023	63.5% ★★	65.1% ★★	61.8% ★
Rating of Personal Doctor	2022	70.5% ★	68.2% ★	75.0% ★
	2023	74.0% ★★	73.2% ★★	74.8% ★★

[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	2022	64.4% ★	65.7% ★	61.4%+ ★+
	2023	75.7% ★★★	79.7%+ ★★★★★+	70.6%+ ★+
Rating of Health Plan	2022	52.5% ★	51.3% ★	54.7% ★
	2023	55.3% ★	54.6% ★	55.9% ★
CCC Composites and Items				
Access to Specialized Services	2022	58.2% ★	61.9%+ ★+	52.4%+ ★+
	2023	65.3%+ ★ +	71.2%+ ★★★+	59.9%+ ★+
FCC: Personal Doctor Who Knows Child	2022	89.5% ★	90.0% ★★	88.7% ★
	2023	90.8% ★	93.5%+ ★★★★★+	88.4%+ ★+
Coordination of Care for Children with Chronic Conditions	2022	73.8% ★	74.1%+ ★+	73.3%+ ★+
	2023	81.6%+ ★★★★★+	83.9%+ ★★★★★+	78.9%+ ★★★★+
Access to Prescription Medicines	2022	87.2% ★	88.7% ★	84.4% ★
	2023	91.8% ★★★	92.5% ★★★	91.2% ★★★
FCC: Getting Needed Information	2022	87.1% ★	87.0% ★	87.3% ★
	2023	95.0% ★★★★★	96.3% ★★★★★	93.6% ★★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA indicates NCQA's 2022 Quality Compass Benchmark and Compare Quality Data were not available; therefore, star results are not available.

Strengths

CCC experience survey results for All Kids were at or above the 90th percentile for *Rating of Specialist Seen Most Often*, *FCC*: *Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions*, and *FCC: Getting Needed Information*, which indicates parents/caretakers perceive quality of care from their child's personal doctor and with their child's coordination of care for the specific needs of their children with chronic conditions. Additionally, Illinois Medicaid CCC

experience survey results were between the 75th percentile and 89th percentile for *Coordination of Care for Children with Chronic Conditions,* which indicates parents/caretakers perceive quality of care with their child's coordination of care for the specific needs of their children with chronic conditions.

Opportunities for Improvement

Opportunity: CCC experience survey results for the All Kids program and Illinois Medicaid program were below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. In addition, CCC experience survey results were below the 25th percentile for *Access to Specialized Services* and *FCC: Personal Doctor Who Knows Child* for the Illinois Medicaid program. These results indicate parents/caretakers of child members are experiencing a lack of timeliness in receiving appointments, poor access to the medical equipment/prescription medicines or treatment needed for their child with chronic conditions and overall access to care and services, 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 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.

Recommendations: 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, the quality of care they need, or do not have access to care. The programs 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. Additionally, HSAG recommends that All Kids and Illinois Medicaid programs 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 and timeliness to care for CCC child members.

Appendix F. Administrative and Compliance Processes Methodologies

This section presents a description of the methodologies and additional information related to external quality review activities conducted to comply with 42 CFR Part 438 Subpart E.

Introduction

The Code of Federal Regulations (CFR) at 42 CFR §438.358 describes activities related to compliance with standards, one of three federally mandated activities for Medicaid managed care plans (health plans). States are required to conduct a compliance review of each health plan, within the previous three-year period, to determine health plan compliance with federal regulatory provisions, State standards, and contract requirements. The Illinois Department of Healthcare and Family Services (HFS) has an annual monitoring process in place to ensure that CFR and Balanced Budget Act of 1997, Public Law 105-33 (BBA) requirements are met over a three-year period.

Since June 2002, Health Services Advisory Group, Inc. (HSAG), has served as the EQRO for HFS. In state fiscal year (SFY) 2023, the first year of a new three-year review cycle, HSAG conducted an Administrative Processes and Compliance Review (Compliance Review) in accordance with §438.358 by evaluating a subset of standards selected by HFS for the health plans serving HealthChoice Illinois (HCI) and the Medicare-Medicaid Alignment Initiative (MMAI). In SFY 2024, the Compliance Review will cover the remaining HCI and MMAI standards that were not assessed, thereby completing the required compliance review once in a three-year period.

Throughout preparation for the Compliance Review and performance of the activities to complete the review, HSAG worked closely with HFS and the health plans to ensure a coordinated and supportive approach to completing the required activities.

This section describes the methodology HSAG utilized to complete the Compliance Review. HSAG followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[F-1]

Objectives for Conducting the Compliance Review

The primary objective of HSAG's Compliance 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.

[F-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: Nov 7, 2022.

In addition, HFS directed HSAG to utilize the Compliance Review to conduct post-implementation review and ongoing monitoring activities for the following:

1. Post-implementation review of MMAI plans following statewide expansion.
2. Review of any findings or status of remediation from the Special Needs Children (SNC) post-implementation review conducted in calendar year (CY) 2021 with the HCI health plans.

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 F-1 below.

Table F-1—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 HCI Medicaid Model Contract and MMAI 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.
	SFY 2023 Subset HCI
	Access Standards Standard III—Coordination and Continuity of Care including Transition of Care (TOC) Standard IV—Coverage and Authorization of Services Standard V—Credentialing and Re-Credentialing Structure and Operations Standards Standard XI—Grievance and Appeal Systems Standard XII—Organization and Governance Standard XV—Subcontractual Relationships and Delegation Measurement and Improvement Standards Standard XVIII—Quality Assessment and Performance Improvement Program (QAPI)
	SFY 2023 Subset MMAI
	Access Standards Standard III—Coordination and Continuity of Care including Transition of Care (TOC) Standard IV—Coverage and Authorization of Services Standard V—Credentialing and Re-Credentialing

For this step,	HSAG…
	Structure and Operations Standards Standard XI—Grievance and Appeal Systems Standard XII—Organization and Governance Standard XV—Subcontractual Relationships and Delegation Measurement and Improvement Standards Standard XVIII—Quality Assessment and Performance Improvement Program (QAPI)
Step 2a:	**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 compliance review tools, as well as specific file review tools.
Step 3:	**Defined levels of compliance.**
	HSAG assigned each element within the standards in the compliance review 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. *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 4:	**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 F-2 below.

Table F-2—Activity Two: Perform Preliminary Review

<table>
<tr><th>For this step,</th><th>HSAG…</th></tr>
<tr><td>Step 1:</td><td>Established early contact with the health plans.</td></tr>
<tr><td></td><td>HSAG coordinated with HFS and the health plans to set the schedule and establish expectations for the Compliance Review.</td></tr>
<tr><td>Step 1a:</td><td>Prepared and submitted the pre-assessment form to the health plans.</td></tr>
<tr><td></td><td>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 review. The form requires the health plans to describe their organization, key operational areas, and functions.</td></tr>
<tr><td>Step 1b:</td><td>Forwarded the standard review tool and file review tools to the health plans.</td></tr>
<tr><td></td><td>Health plan-specific standard review tools were provided to assist each health plan in preparing for the review. The standard tools include documents required for submission and review. In addition, the health plan was provided specifications for program description reviews and timelines and instructions for submitting the data required for sampling for the file reviews. Listed below are the standards and associated file reviews and program description reviews.
<table>
<tr><th>#</th><th>Standard Name</th><th>File Reviews</th></tr>
<tr><td colspan="3">Access Standards</td></tr>
<tr><td>III</td><td>Coordination and Continuity of Care (including TOC)</td><td>Case Management (CM) Program Description (PD)
CM Record Review</td></tr>
<tr><td>IV</td><td>Coverage and Authorization of Services</td><td>Utilization Management (UM) PD
Peer Review PD
Denial File Review</td></tr>
<tr><td>V</td><td>Credentialing and Re-Credentialing</td><td>None</td></tr>
<tr><td colspan="3">Structure and Operations Standards</td></tr>
<tr><td>XI</td><td>Grievance and Appeal Systems</td><td>Grievance File Review
Appeals File Review</td></tr>
<tr><td>XII</td><td>Organization and Governance</td><td>None</td></tr>
<tr><td>XV</td><td>Subcontractual Relationships and Delegation</td><td>Delegation Oversight and Monitoring Review</td></tr>
<tr><td colspan="3">Measurement and Improvement Standards</td></tr>
<tr><td>XVIII</td><td>QAPI</td><td>Quality Management PD</td></tr>
</table>
Appendices A–E contain CM, Denial, Grievance, Appeals, and Delegation Oversight and Monitoring file review methodologies.</td></tr>
</table>

For this step,	HSAG…
Step 1c:	**Responded to the health plan questions related to the review and provided additional information needed before the review.**
	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 email 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.
Step 1d:	**Received data files from the health plans, then selected and posted samples to HSAG's SAFE site for each health plan.**
	HSAG generated unique record review samples based on data files supplied by the health plans of each file review.
Step 2:	**Performed a preliminary document review (desk review).**
	Received the health plans' documents for HSAG's desk review and evaluated the information before conducting the virtual interviews with health plan staff. HSAG reviewers used the documentation to gain insight into each health plan's processes for providing access to care for its members, its structure and operations, and its quality assessment and performance improvement program. HSAG also used the documentation to begin compiling preliminary findings before the virtual 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 virtual review. • Identified information not found in the desk review documentation that HSAG would request during the virtual review.

Activity Three: Conduct Virtual Reviews

Due to coronavirus disease 2019 (COVID-19), HFS and HSAG worked with the health plans to schedule virtual webinar reviews. HSAG conducted webinars to conduct health plan staff interviews and collect the information necessary to assess the health plans' compliance with federal and State regulations. The steps of the virtual webinar review process are shown in Table F-3 below.

Table F-3—Activity Three: Conduct Virtual Reviews

For this step,	HSAG…
Step 1:	**Determined the length of webinar and the dates.**
	HFS determined that virtual reviews 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:	**Identified the number and types of reviewers needed.**
	The review team members that HSAG assigned were content area experts who had in-depth knowledge of 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 would be made in the same manner. Members of HSAG's review team were assigned specific standards, and communication and coordination were ongoing among the team members to ensure uniformity of the reviews. The team leader reviewed the findings and scores for all standards to ensure accuracy and consistency of approach among reviewers. 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 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.**
	The 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 sets the tone, expectations, the objectives, and time frames for the virtual 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 virtual review 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 webinar, 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.

For this step,	HSAG…
Step 5:	**Conducted 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 assistance from health plan staff members in answering specific questions or locating specific documents or other sources of information. • 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.
Step 6:	**Conducted exit interviews.**
	As a final step, HSAG reviewers met with staff members and HFS via webinar 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 noncompliance 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 F-4 below. The documented findings served as evidence of the comprehensiveness of the EQR process and validity of the findings.

Table F-4—Activity Four: Compile and Analyze Findings

For this step,	HSAG…
Step 1:	**Collected 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:	**Compiled data and information.**
	HSAG documented additional information it reviewed, including sources of the information and HSAG's findings about health plan compliance.
Step 3:	**Analyzed 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 review 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 and Assess Health Plan Remediation Actions

HSAG drafted reports with the results of the review of the health plans' compliance with federal and State requirements and monitored remediation using the steps shown in Table F-5 below.

Table F-5—Activity Five: Report Results

For this step,	HSAG…
Step 1:	**Submitted a report outline to HFS.**
	HSAG developed a report outline and submitted it to the State for approval. The outline was then used by the EQRO to draft a report to the State with the results of the health plan's compliance with federal and State requirements.
Step 2:	**Submitted an initial Compliance Review Report of Findings.**
	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 remediation. The reports were forwarded to HFS and the applicable health plan for their review and comment.
Step 3:	**Received and assessed health plan remediation.**
	HFS required health plans to remediate each element to which HSAG assigned a score of *Not Met*. The health plans had a 30-day remediation period in which to submit additional documentation or implement policies and procedures that met requirements. HSAG then assessed all remediation elements to determine if compliance with requirements had been met and assigned a final score, which is included in the final Compliance Review report.
Step 4:	**Submitted a final Compliance Review report to HFS.**
	Following closure of the remediation period and HFS' approval of each report, HSAG issued final reports to HFS and the applicable health plan.
Step 5:	**Monitored corrective action plans (CAPs).**
	For any elements that remained out of compliance following remediation, the health plan is required to submit a CAP to HFS. HFS and HSAG will monitor each health plan's progress toward correcting deficiencies. The following criteria will be used to evaluate the sufficiency of the CAP: • The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that the health plan will implement to bring the element into compliance. • The degree to which the planned activities/interventions meet the intent of the requirement. • The degree to which the planned interventions are anticipated to bring the health plan into compliance with the requirement. • The appropriateness of the timeline for correcting the deficiency. Any CAPs that do not meet the preceding criteria will require resubmission by the health plan until approved by HFS and HSAG. Implementation of the CAP will begin once approval is received.

Case Management Record Review Methodology

Purpose of Review

The purpose of the case management record review is to assess health plan compliance with general case management elements, as directed by the HCI and MMAI contracts. The review will include non-HCBS waiver and HCBS 1915(c) waiver enrollees. For waiver enrollees, only general case management requirements will be reviewed; the CMS performance measures will not be considered as they are assessed during quarterly HCBS reviews. Contract citations assessed in this review are noted at the end of this appendix.

Review Process

In collaboration with HFS, HSAG will identify an evaluation time frame for retrospective review of the health plans' case management files. Prior to the webinar review, the following process will be utilized to identify sample cases that will be assessed for element compliance during the webinar review.

Step 1: Request enrollee universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the enrollee file, identify number of enrollees in care coordination.

Step 3: Identify high-risk non-HCBS waiver enrollees, SNC waiver enrollees, and HCBS waiver enrollees.

Step 4: Select random sample cases of both non-HCBS waiver high-risk enrollees and waiver enrollees.

Step 5: Provide health plan with sample cases.

Webinar Review

During the webinar review, HSAG will conduct a file review, utilizing the sample files provided to the health plan. The file review will consist of the elements included within the Case Management File Review tool. The health plan's appropriate care management representative will navigate the health plan's care management system and respond to questions. The review team will determine evidence of compliance with each of the scored elements. A *Yes, No,* or *Not Applicable (N/A)* score will be assigned to each element under review.

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below. HSAG will also use a designation of *N/A* if the requirement is not applicable to the beneficiary's case; *N/A* findings will not be included in the two-point scoring methodology.

Yes indicates full compliance defined as all of the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.
- Cases reviewed had documentation that met "Due Diligence" criteria.

No indicates noncompliance defined as either of the following:

- Not all documentation was present.
- Cases reviewed did not have documentation that met "Due Diligence" criteria.

Not Applicable (N/A) indicates a requirement that will not be scored for compliance.

HSAG will calculate an overall percentage-of-compliance score for each of the care management requirements. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

HSAG will utilize the performance thresholds established by HFS as presented in the Quarterly Business Review (QBR)/Monthly Progress Reporting (MPR) Dashboard. For case management file review elements which do not have established MPR thresholds, HFS has established a threshold of 80 percent compliance.

HealthChoice Contract Language Assessed in File Review Tool:

5.13.1.4 Stratification. Based upon an analysis of the information gathered through the process in this section, Contractor shall stratify all Enrollees to determine the appropriate level of intervention by its Care Management program. Enrollees shall be assigned to one (1) of three (3) levels: Level 1 (Low), Level 2 (Moderate), Level 3 (High).

5.13.1.1 Health-risk screening (HRS). Contractor will develop and maintain a health risk screening tool, which includes Behavioral Health risk, and will provide that tool to the Department. Contractor shall administer the tool to all new Enrollees within sixty (60) days after enrollment to collect information about the Enrollee's physical, psychological, and social health. Contractor will use the results to guide the administration of more in-depth health assessments. Contractor may administer a health-risk assessment in place of the health-risk screening, provided it is administered within sixty (60) days after enrollment. Contractor shall notify the appropriate PCP[F-2] of the enrollment of any new Enrollee who has not completed a health-risk screening within the time period set forth above and whom Contractor has been unable to contact. Contractor shall conduct outreach to their Enrollees and to schedule visits.

5.13.2.1 Health Risk Assessment (HRA). All Level 3 (high-risk) Enrollees. The assessment will be conducted, in-person or over the phone, and an IPoC[F-3] will be developed within ninety (90) days after enrollment. Enrollees receiving HCBS Waiver Services[F-4] or residing in NFs[F-5] as of their Effective Enrollment Date with Contractor. The health-risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date.

5.13.2.2 Health Risk Assessment. Enrollees receiving HCBS Waiver services or residing in NFs as of the Effective Enrollment Date, who were enrolled in another MCO, but are transitioning to Contractor's Health Plan. The health-risk assessment relating to those Covered Services must be face-to-face and completed within the first ninety (90) days after the Effective Enrollment Date.

5.13.2.3 Health Risk Assessment. Enrollees transitioning to NFs. The health-risk assessment relating to those Covered Services must be face-to-face and completed within the first ninety (90) days after the Effective Enrollment Date.

5.13.2.4 Health Risk Assessment. Enrollees deemed newly eligible for HCBS Waiver Services. The health-risk assessment must be face-to-face and completed within fifteen (15) days after Contractor is notified that the Enrollee is determined eligible for HCBS waiver services.

5.16 Annual reassessment. At a minimum, Contractor shall conduct a health-risk reassessment annually for each Enrollee who has an IPoC.

5.16 Reassessment for significant change. In addition, Contractor shall conduct a face-to-face health-risk reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment.

F-2 Primary care provider (PCP) means a provider who is responsible for providing all preventive and primary care services to an enrollee.

F-3 Individual Plan of Care (IPoC) means a written plan that identifies services and supports that an enrollee's needs.

F-4 Home- and Community-Based Services (HCBS) Waiver Services are home and community services and programs that are designed to allow individuals who qualify for a waiver to remain in their homes and communities instead of needing institutional care.

F-5 Nursing facility (NF) is a facility or part of a hospital that provides long-term care (LTC) or skilled nursing services to enrollees.

5.15.1 Care Plan. Contractor shall develop a comprehensive, person-centered IPoC for Enrollees stratified as high-risk Level 3 (high risk) and Enrollees in a HCBS Waiver. The IPoC must be developed within ninety (90) days after enrollment. Contractor shall engage Enrollees in the development of the IPoC as much as possible. An IPoC may not be finalized until signature from the Enrollee or authorized representative has been received either by hand, e-signature, or voice recording. Enrollees must be provided with a copy of the IPoC upon completion and may request a copy at any time. The IPoC is considered an Enrollee-owned document.

5.15.5 Sharing of IPoC. Contractor shall ensure that the Enrollee's IPoC is communicated to all of the Enrollee's ICT members and Providers, as appropriate.

5.15.1.1-5.15.1.4.19 IPoC elements.

5.17.3-5.17.3.5 Contact standards.

5.14.2 ICT. Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity. Each ICT shall consist of clinical and nonclinical staff whose skills and professional experience will complement and support one another in the oversight of each Enrollee's needs.

5.23 Health, Safety, and Welfare Monitoring elements.

5.13.1.1 Contractor shall administer the tool to all new Enrollees within sixty (60) days after enrollment to collect information about the Enrollee's physical, psychological, and social health.

5.13.1.1 Contractor may administer a health-risk assessment in place of the health-risk screening, provided it is administered within sixty (60) days after enrollment. Contractor shall notify the appropriate PCP of the enrollment of any new Enrollee who has not completed a health-risk screening within the time period set forth above and whom Contractor has been unable to contact.

5.13.2.1 All Level 3 (high-risk) Enrollees. The assessment will be conducted, in-person or over the phone, and an IPoC will be developed within ninety (90) days after enrollment.

Section 5.16 Contractor shall conduct a health-risk reassessment annually for each Enrollee who has an IPoC.

5.16 Contractor shall conduct a face-to-face health-risk reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment.

5.15.1 Contractor shall develop a comprehensive, person-centered IPoC for Enrollees stratified as high-risk Level 3 (high risk) and Enrollees in a HCBS Waiver. The IPoC must be developed within ninety (90) days after enrollment.

5.15.1 An IPoC may not be finalized until signature from the Enrollee or authorized representative has been received either by hand, e-signature, or voice recording.

5.15.1 Enrollees must be provided with a copy of the IPoC upon and may request a copy at any time.

5.16 Contractor will provide updated IPoCs to Providers that are involved in providing Covered Services to Enrollee within no more than five (5) Business Days.

5.14.2 Each ICT will be person-centered, built on each Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and Cultural Competence, and dignity.

5.15.5 Contractor shall ensure that the Enrollee's IPoC is communicated to all the Enrollee's ICT members and Providers, as appropriate.

5.15.1.1-5.15.1.3 Incorporate all of the Enrollee's care needs, including: medical, Behavioral Health, Service Package II care, social, and functional needs; include identifiable short- and long-term treatment and service goals to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs; include, in the development, implementation, and ongoing assessment of the IPoC, an opportunity for Enrollee participation and an opportunity for input from the PCP, other Providers, a legal or personal representative, and the family or caregiver if appropriate;

5.15.1.4.1 the Enrollee's personal or cultural preferences, such as types or amounts of services;

5.15.1.4.2 the Enrollee's preference of Providers and any preferred characteristics, such as gender or language;

5.15.1.4.3 the Enrollee's living arrangements;

5.15.1.4.4 Covered Services and non-Covered Services to address each identified need, provided that Contractor shall not be required to pay for non-Covered Services;

5.15.1.4.5 actions and interventions necessary to achieve the Enrollee's objectives;

5.15.1.4.6 follow-up and evaluation;

5.15.1.4.7 collaborative approaches to be used;

5.15.1.4.8 desired outcome and goals, both clinical and nonclinical;

5.15.1.4.9 barriers or obstacles;

5.15.1.4.10 responsible parties;

5.15.1.4.11 standing Referrals;

5.15.1.4.12 community resources;

5.15.1.4.13 informal supports;

5.15.1.4.14 timeframes for completing actions;

5.15.1.4.15 status of the Enrollee's goals;

5.15.1.4.16 home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse, Neglect, or exploitation;

5.15.1.4.17 back-up plan arrangements for critical services;

5.15.1.4.18 Crisis Safety Plans for an Enrollee with Behavioral Health conditions; and

5.15.1.4.19 Wellness Program plans;

5.17.3 Care *Coordinators who provide Care Management shall maintain contact with Enrollees as frequently as appropriate.*

MMAI Contract Language Assessed in File Review Tool:

2.5.2 and 2.5.3.1.1 Requirements for an Interdisciplinary Care Team. Every Enrollee shall have access to and input in the development of an ICT led by a Care Coordinator. The ICT will be person-centered, built on the Enrollee's specific preferences and needs and with his or her input, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.3.6.3 Care Coordinator Contact Standards. Care Coordinators shall maintain contact with Enrollees as frequently as appropriate. Care Coordinators who provide Care Management to High Risk Enrollees, who are not receiving HCBS Waiver services, shall have contact with such Enrollees at least once every ninety (90) days unless less frequent contact is requested by the Enrollee Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows, but in no case less often than required by the HCBS Waiver, or other applicable Medicaid requirements, then in effect.

2.5.3.6.3.1 Persons who are Elderly Waiver: The Care Coordinator shall have a face-to-face contact with the Enrollee in the Enrollee's home not less often than once every ninety (90) days.

2.5.3.6.3.2 Persons with Brain Injury: The Care Coordinator shall have contact with the Enrollee in Enrollee's home not less often than one (1) time per month.

2.5.3.6.3.3 Persons with HIV/AIDS: The Care Coordinator shall contact the Enrollee at least one time each month by telephone, and not fewer than one (1) face-to-face contact every other month. The Care Coordinator shall contact the Enrollee more frequently upon the Enrollee's request.

2.5.3.6.3.4 Persons with Disabilities: The Care Coordinator shall have a face-to-face contact with the Enrollee no less often than once every ninety (90) days in the Enrollee's home.

2.5.3.6.3.5 Supportive Living Program: The Care Coordinator shall contact the Enrollee at least one (1) time per year.

2.6.1.1.3-2.6.1.1.4 The Contractor shall have a health risk screening and make its best efforts to administer the health risk screening and, if needed, a behavioral health risk assessment to all new Enrollees within sixty (60) days after enrollment, and will collect information about the Enrollee's medical, psychosocial, functional, and cognitive needs, and medical and behavioral health (including substance abuse) history. The Contractor may administer a health risk assessment in place of the health risk screening provided that it is administered within sixty (60) days after enrollment. The Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a health risk screening within the time period set forth above and whom the Contractor has been unable to contact. The Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

2.6.2 The Contractor shall have a risk assessment and make its best efforts to complete a health risk assessment, by following the procedures outlined in this section, within ninety (90) days after the Effective Enrollment Date for Enrollees stratified as high or moderate risk.

2.6.4.1 For those Enrollees receiving HCBS Waiver services or residing in a NF as of the Effective Enrollment Date, the health risk assessment must be face-to-face and completed within one hundred eighty (180) days of the Effective Enrollment Date.

2.6.4.2 For those Enrollees switching from another Medicaid MCO to the Contractor's Demonstration Plan who are receiving HCBS services or residing in NFs as of their Effective Enrollment Date, the health risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date.

2.6.4.3 For those Enrollees transitioning to NFs as of the Effective Enrollment Date, the health risk assessment must be face-to-face and completed within ninety (90) days after the Effective Enrollment Date.

2.6.4.4 For those Enrollees deemed newly eligible for HCBS services, the health risk assessment must be face-to-face and completed within fifteen (15) days after the Demonstration Plan is notified that the Enrollee is determined eligible for HCBS services.

2.6.3.1 Following stratification under Section 2.6.2, the Contractor shall assign an ICT, with a Care Coordinator, to the Enrollee; and, the ICT, in conjunction with the Enrollee, will develop a comprehensive person-centered Enrollee Care Plan for all Enrollees. The Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date.

2.6.4.1 For Enrollees new to the Demonstration Plan receiving HCBS Waiver services or residing in NFs as of the Effective Enrollment Date, the Enrollee Care Plan must be developed within one hundred eighty (180) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least one hundred eighty (180) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.

2.6.4.2 For Enrollees switching from another MCO to the Contractor's Demonstration Plan who are receiving HCBS Waiver services or residing in NFs as of their Effective Enrollment Date, the Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least ninety (90) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.

2.6.4.3 For Enrollees transitioning to NFs, the Enrollee Care Plan must be developed within ninety (90) days after the Effective Enrollment Date. For those Enrollees, any existing Enrollee Care Plan will remain in effect for a transition period spanning at least ninety (90) days, unless that period is changed with the input and consent of the Enrollee after completion of a health risk assessment.

2.6.4.4 For Enrollees deemed newly eligible for HCBS Waiver services, the Enrollee Care Plan must be developed within fifteen (15) days after the Demonstration Plan is notified that the Enrollee is determined eligible for HCBS Waiver services.

2.6..5.1 Incorporate an Enrollee's medical, behavioral health, LTSS, social, and functional needs (including those functional needs identified on the DON or other assessment tool that is adopted by the Department for HCBS Waiver Enrollees).

2.6..5.2 Include identifiable short-and long-term treatment and service goals to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs.

2.6..5.3 Include, in the development, implementation, and ongoing assessment of the Enrollee Care Plan, an opportunity for Enrollee participation and an opportunity for input from the PCP, other Providers, a legal representative, and the Enrollee's family and caregiver if appropriate.

2.6.5.4 Identify and evaluate risks associated with the Enrollee's care. Factors considered include, but are not limited to, the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee; and behavioral or other compliance risks. The Contractor shall incorporate the results of the risk assessment into the Enrollee Care Plan. Enrollee Care Plans that include Negotiated Risks shall be submitted to the Contractor's medical director for review. Negotiated Risks shall not allow or create a risk for other Residents in a group setting.

2.6.5.5.1 The Enrollee's personal or cultural preferences, such as types or amounts of services.

2.6.5.5.2 The Enrollee's preference of Providers and any preferred characteristics, such as gender or language.

2.6.5.5.3 The Enrollee's living arrangements.

2.6.5.5.4 Covered Services and non-Covered Services to address each identified need, provided that the Contractor shall not be required to pay for non-Covered Services.

2.6.5.5.5 Actions and interventions necessary to achieve the Enrollee's objectives.

2.6.5.5.6 Follow-up and evaluation.

2.6.5.5.7 Collaborative approaches to be used.

2.6.5.5.8 Desired outcome and goals, both clinical and nonclinical.

2.6.5.5.9 Barriers or obstacles.

2.6.5.5.10 Responsible parties.

2.6.5.5.11 Standing Referrals.

2.6.5.5.12 Community resources.

2.6.5.5.13 Informal supports.

2.6.5.5.14 Timeframes for completing actions.

2.6.5.5.15 Status of the Enrollee's goals.

2.6.5.5.16 Home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. § 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse, Neglect, or exploitation.

2.6.5.5.17 Back-up plan arrangements for critical services.

2.6.5.5.18 Crisis plans for an Enrollee with behavioral health condition(s).

2.6.5.5.19 Wellness Program plans.

2.6.6 The Contractor will analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, reassessments will be completed as necessary and Care Plans and interventions updated. The Contractor will review Enrollee Care Plans and intervention of Enrollees at high-risk at least every thirty (30) days, and Enrollees at moderate-risk at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum, the Contractor shall conduct a reassessment annually for each Enrollee. In

addition, the Contractor will conduct a face-to-face reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment.

2.6.8 The Contractor will support the Enrollee in actively participating in the development of the Enrollee Care Plan. The Contractor will also encourage Providers to support Enrollees in directing their own care and Enrollee Care Plan development. This will include giving PCPs a copy of the Enrollee Care Plan.

2.9.6 – 2.9.7 Health, Safety, and Welfare Monitoring elements.

Appeals File Review Methodology

Purpose of Review

The purpose of the appeals file review is to assess health plan compliance with timelines and reporting for appeals as required by State and federal statutes and regulations. Contract citations assessed in this review are noted at the end of this appendix.

HSAG will complete a file review and webinar review to evaluate the health plans' compliance with appeals requirements.

File Review Process

Methodology for File Review

In collaboration with HFS, HSAG will identify an evaluation time frame for retrospective review of the health plans' appeal processing. Prior to the webinar review, the following file review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Request appeals universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the appeals file, filter by date of receipt of appeal.

Step 3: Select random sample cases, accounting for responsible party and appeal type (standard, expedited, pharmacy) to ensure appropriate representation.

Step 4: Provide health plan with sample cases and request case documentation (including original denial) and appeal letters sent to enrollees.

Step 5: Upon receipt of submissions, complete file review tool.

File Review Assessment

HSAG will assess the health plans' appeals documentation for, at a minimum, the following elements.

- Use of department-approved template(s).
- Timely resolution of appeal.
- Compliance with reading level requirements for decision letter(s).

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below.

Yes indicates full compliance defined as all of the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as the following:

- Not all documentation was present.

HSAG will calculate an overall percentage-of-compliance score for each requirement. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

HFS has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will evaluate the files with a health plan staff member present so that the HSAG reviewer may ask the staff member questions and clarify processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the health plan staff member the opportunity to locate the missing information. File review findings may be revised if documentation reviewed during the webinar review supports revision.

HealthChoice Contract Language:

5.21.4.2 Reading level. All of Contractor's written communications with Potential Enrollees, Prospective Enrollees, and Enrollees must be produced at a sixth (6th)–grade reading level and easily understood by individuals with sixth (6th)–grade reading skills. Contractor will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written Materials will be presented in a layout and manner that enhance Enrollees' understanding in a culturally competent manner.

5.30.3.3 If an Enrollee requests an expedited Appeal pursuant to 42 CFR §438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of Appeal or supports an Enrollee's Appeal pursuant to 42 CFR §438.410(b).

5.30.3.4 If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. Contractor may extend this time frame for up to fourteen (14) days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate State agency's hearing office that there is a need for additional information and the delay is in the Enrollee's interest.

5.30.3.4.1 If Contractor extends time frame not at request of Enrollee, Contractor must: make reasonable efforts to give Enrollee prompt oral notice of delay, give Enrollee written notice within two (2) days, and resolve the Appeal expeditiously, but no later than expiration date of extension.

5.30.3.5 Final decisions of Appeals, including expedited Appeals, not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its fair hearing system within one hundred twenty (120) days after the date of the Contractor's decision notice. If Contractor fails to meet notice and timing requirements, the Enrollee is deemed to have exhausted the Appeals process and may initiate a State fair hearing.

5.30.3.6 Except for a denial of Waiver services, which may not be reviewed by an external independent entity, Contractor shall have procedures allowing an Enrollee to request an external independent review, at no cost to the Enrollee, on both standard and expedited time frames, of Appeals that are denied by Contractor within thirty (30) days after the date of Contractor's decision notice.

5.30.3.7 If an Appeal is filed with the State fair hearing system, Contractor will participate in the prehearing process, including scheduling coordination and submission of documentary evidence at least three (3) Business Days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of Contractor.

5.30.3.8 If Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services, and those services were not furnished while the Appeal was pending, Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date Contractor receives notice reversing the decision.

5.30.3.9 If Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, Contractor must pay for those services, in accordance with State policy and regulations.

5.30.3.10 If an Enrollee files for continuation of benefits on or before the latter of ten (10) days of Contractor sending the Adverse Benefit Determination, or the intended Effective Date of the proposed Adverse Benefit Determination, Contractor must continue the Enrollee's benefits during the Appeal process. A Provider, serving as Enrollee's authorized representative for the Appeal process, cannot file for continuation of benefits. Pursuant to 42 CFR §438.420, if the final resolution of the Appeal is adverse to the Enrollee, Contractor may recover the cost of the services that were furnished to the Enrollee.

MMAI Contract Language:

2.12.4 Level One Appeals

2.12.4.1 Process: All initial Appeal requests will be filed with the Contractor in accordance with applicable laws and regulations (Level One Appeal).

2.12.4.2. For Level One Appeals filed orally with the Contractor if the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R § 438.410 or § 422.584, the Contractor must send the Enrollee a written confirmation of the Enrollee's request to confirm the facts and basis of the Appeal.

2.12.4.2.1 Filing an Appeal: An Enrollee may file an oral or written Appeal with the Contractor within sixty (60) calendar days following the date of the notice of Adverse Benefit Determination that generates such Appeal.

2.12.4.2.2 If an Enrollee requests an expedited Appeal pursuant to 42 C.F.R. § 438.410, the Contractor shall notify the Enrollee, within twenty-four (24) hours after the submission of the Appeal.

2.12.4.2.3 For Level One Appeals filed orally with the Contractor, if the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. § 438.410 or § 422.584, the Contractor must send the Enrollee a written confirmation of the Enrollee's request to confirm the facts and basis of the Appeal.

2.12.4.3 Timeframes for Level 1 Appeal Resolution:

2.12.4.3.1 Unless an Enrollee requests an expedited Appeal, for Level One Appeals other than for Part B drugs the Contractor shall render its decision on the appeal within fifteen (15) business days after submission of the appeal and shall provide the enrollee with written notice of the resolution pursuant to the 42 C.F.R § 438.408.

2.12.4.3.2 For Level One Appeals other than for Part B drugs the Contractor may extend this timeframe for up to fourteen (14) calendar days if the Enrollee requests an extension or if the Contractor desires additional information and/or documents and is able to establish that the delay is in the interest of the Enrollee or if the Contractor demonstrates, upon request, to the satisfaction of the appropriate State agency's Hearing Office that there is a need for additional information and the delay is in the Enrollee's interest.

2.12.4.3.2.1 If the Contractor extends time frame not at request of Enrollee, the Contractor must: make reasonable efforts to give Enrollee prompt oral notice of delay, give Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with the delay within two (2) days, and resolve the Appeal expeditiously, but no later than expiration date extension.

2.12.4.3.3 Timeline for standard Appeals regarding Medicare Part B drugs: the Contractor shall render its decision on an Appeal regarding Medicare Part B drugs within seven (7) calendar days after submission of the Appeal. This timeline may not be extended.

2.12.4.3.4 If an Enrollee requests an expedited Appeal, the Contractor shall render a decision on an expedited Appeal no later than twenty-four (24) hours after receipt of the required information, within a maximum of seventy-two (72) hours after receiving the appeal, unless there is an extension, in accordance with 2.12.3.3.2. Extension requirements must comply with an Enrollee requests an expedited Appeal, the Contractor shall render a decision on an expedited Appeal within seventy-two (72) hours after the appeal, and no later than twenty-four (24) hours after receipt of the required information, unless there is an extension. Extension requirements must comply with Section 2.12.3.3.2.

2.12.4.3.4.1 For expedited resolutions, Contractor shall provide written notice and shall make reasonable efforts to provide oral notice.

2.12.4.3.4.2 The Contractor shall also inform the Enrollee of the limited time available for the Enrollee to present evidence, and allegations of fact or law, in person as well as in writing.

2.12.4.3.4.3 If the Contractor denies the Enrollee's request for an Expedited Appeal, it shall:

2.12.4.3.4.3.1 Transfer the Appeal to the appropriate timeframe for standard resolution of an Appeal;

2.12.4.3.4.3.2 Give the Enrollee prompt oral notice and deliver within two (2) calendar days written notice that:

2.12.4.3.4.3.2.1 Explains that the Appeal will be decided within the timeframe for a standard Appeal;

2.12.4.3.4.3.2.2 Informs the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision not to grant an expedited Appeal;

2.12.4.3.4.3.2.3 Informs the Enrollee of the right to resubmit a request for an expedited Appeal with any Physician's support; and

2.12.4.3.4.3.2.4 Provides instructions about the Grievance process and its timeframes.

2.12.4.4 The Contractor shall provide written notice to the Enrollee of the final decision of the Appeal, which shall comply with 42 CFR 438.408(e) and include:

2.12.4.4.1 Results of the Appeals;

2.12.4.4.2. Date of the Appeal resolution;

2.12.4.4.3. Right to request and how to request a State Fair Hearing;

2.12.4.4.4. Right to continued benefits pending a State Fair Hearing, and how to request continued benefits;

2.12.4.4.5. Notice that the Enrollee may be liable for the cost of any continued benefits if the Contractor's action is upheld at the State Fair hearing.

2.12.4.5 If the Contractor does not decide fully in the Enrollee's favor within the relevant timeframe or fails to meet the notice requirements the Contractor shall automatically forward the case file regarding Medicare services to the IRE for a new and impartial review.

2.12.5 Level 2 Appeals:

2.12.5.1 If the Level One Appeal regarding Medicare services or Medicare/Medicaid overlap services is not directed fully in favor of the Enrollee, the Contractor must auto-forward the Appeal to the IRE.

2.12.5.1.1 For standard Appeals except those regarding Medicare Part B drugs, the IRE will send the Enrollee and the Contractor a letter with its decision within thirty (30) calendar days after it receives

the case from the Contractor, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days.

2.12.5.1.2 For expedited Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within seventy-two (72) hours after it receives the case from the Contractor or at the end of up to a fourteen (14) calendar day extension.

2.12.5.1.3 For expedited Appeals regarding Medicare Part B drugs, if the IRE decides in the Enrollee's favor and reverses the Contractor's decisions, the Contractor must authorize or provide the Part B drug under dispute as expeditiously as the Enrollee's health condition requires but no later than twenty-four (24) hours from the date it receives notice reversing the decision.

2.12.5.2 If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or authorized representative may then request further levels of Appeal, including for Medicaid benefits a State Fair Hearing, or for Medicare benefits Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review.

2.12.5.2.1 The Contractor must send a notice to the Enrollee informing them of their rights to file an Appeal with either: (i) the State Fair Hearing system; (ii) or Administrative Law Judge: (iii) or both in the case of Medicare/Medicaid overlap benefits, at the choice of the Enrollee.

2.12.5.2.2 The Contractor must send the notice within three (3) Business Days after it received the IRE's decision in all cases. The Contractor must comply with any requests for information or participation from such further Appeal entities.

2.12.5.3 Appeals involving Medicaid benefits no resolved whole in favor of the Enrollee at Level 1 may be Appealed by the Enrollee to the State under its Fair Hearings system within one hundred twenty (120) calendar days after the date of Contractor's decision notice described in Section 2.12.3.4.

2.12.5.3.1 If an Appeal is filed with the State Fair Hearing system, the Contractor will participate in the pre-hearing process, including, but not limited to, scheduling coordination and submission of documentary evidence at least three (3) Business Days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of the Contractor.

2.12.5.3.2 If an Appeal is filed with the State Fair Hearing system, the Department will take final administrative action for Standard Appeals within ninety (90) calendar days after the Enrollee filed the Appeal with the Contractor, not including the number of days the Enrollee took to file for a State Fair Hearing, and final administrative action for Expedited Appeals must be taken within three (3) Business Days after the filing of an Appeal with the State Fair Hearing Agency. The Contractor will participate in the pre-hearing process, including scheduling coordination and submission of documentary evidence at least three (3) Business Days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of the Contractor.

2.12.5.4 Appeals involving Medicare-Medicaid overlap benefits not resolved wholly in favor of the Enrollee by the IRE may be Appealed by the Enrollee to the State under its Fair Hearing system within one hundred twenty (120) calendar days after the date of the Contractor's decision notice described in Section 2.12.3.4.

2.12.5.5 For all Appeals except expedited Appeals regarding Medicare Part B drugs, if the IRE or State Fair Hearing decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the

decision. Generally, the Contractor must provide the services under dispute as expeditiously as the Enrollee's health condition requires, but no later than fourteen (14) calendar days from the date it receives notice that the IRE reversed the determination.

2.12.6 Subsequent Appeal Levels:

2.12.6.1 If the Enrollee seeks review of the Administrative Law Judge's decision, the review of Medicare is to the Departmental Appeals Board and any further review is to federal court, and the review of Medicaid, pursuant to the State Administrative Review Law (735 ILCS 5/3-101 et seq.), is to State circuit court.

2.12.6.1.1 Any review of the final administrative action taken by the Department is to State circuit court pursuant to the State Administrative Review Law (735 ILCS 5/3-101 et seq.).

2.12.6.1.2 The Contractor must comply with any requests for information or participation from such further Appeal entities.

2.12.6.1.3 Any determination in favor of the Enrollee will require payment by the Contractor for the service or item in question.

2.12.7 General Requirements

2.12.7.1 The Contractor's Appeal procedures must: (i) be submitted to the Department in writing for Prior Approval by the Department; (ii) provide for resolution with the timeframes specified herein; and (iii) assure the participation of individuals with authority to require corrective action. Appeals procedures must be consistent with 42 C.F.R. § 422.560 et seq., 42 C.F.R. § 431.200 et seq., and 42 C.F.R. § 438.400 et seq. The Contractor must have a committee in place for reviewing Appeals made by Enrollees.

2.12.7.2 Provided for only on level of Appeal by Enrollee.

2.12.7.3 In compliance with 42 C.F.R. § 438.406(b), assure that the individuals who make decisions on Appeals were neither involved with a previous level of review nor were subordinates of any such individuals of review, and have appropriate clinical expertise to require corrective action for:

2.12.7.3.1 A denial of an Appeal based on lack of medical necessity.

2.12.7.3.2 Any Appeal involving clinical issues.

2.12.7.4 The Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution or Appeal or supports the Enrollee's Appeal pursuant to 42 C.F.R. § 438.410(b).

2.12.7.5 Except for a denial of HCBS Waiver services, which may not be reviewed by an external independent entity, the Contractor shall have procedures allowing an Enrollee to request an external independent review, at no cost to the Enrollee, on both standard and expedited time frames, of Appeals for Medicaid covered items and services that are denied by the Contractor, within thirty (30) calendar days after the date of the Contractor's decision notice.

2.12.8 Continuation of Benefits Pending an Appeal:

2.12.8.1 Continuation of Benefits Pending an Appeal: Consistent with the requirements of this section, the Contractor must provide continuing benefits for all previously approved non-Part D benefits that are being terminated or modified pending the Contractor's internal Appeal process. This means that such

benefits will continue to be provided by Providers to Enrollees and that the Contractors must continue to pay Providers for providing such services or benefits pending an internal Appeal.

2.12.8.2 Consistent with 42 C.F.R. § 438.420(b), if an Enrollee files for continuation of benefits on or before the latter of ten (10) calendar days after Contractor sending the Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination, the Contractor must continue the Enrollee's benefits during the Appeal process. A Provider, serving as Enrollee's authorized representative for the Appeal process, cannot file for continuation of benefits.

2.12.8.3 For Medicare-only benefits, continuation of benefits is available only for internal (level 1) Appeals and not at the IRE or subsequent levels of Appeal.

2.12.8.4 Pursuant to 42 C.F.R. § 438.420, if the final resolution of the Appeal is adverse to the Enrollee, the Contractor may recover the cost of the services that were furnished to the Enrollee.

2.12.8.5 Effectuation of decisions:

2.12.8.5.1 If the Contractor or the State Fair Hearing Officer reverses a decision to deny, limit or delay Covered Services, and those services were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date Contractor receives notice reversing the decision.

2.12.8.5.2 If the Contractor or the State Hearing Officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, the Contractor must pay for those services in accordance with State policy and regulations.

2.12.9 Hospital Discharge Appeals: The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.12.10 Other Medicare QIO Appeals: The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

Denials File Review Methodology

Purpose of Review

The purpose of the denials file review is to assess health plan compliance with timeliness and reporting for denials as required by State and federal statutes and regulations. Contract citations assessed in this review are noted at the end of this appendix.

HSAG will complete a file review and webinar review to evaluate the health plans' compliance with denials requirements.

File Review Process

Methodology for File Review

In collaboration with HFS, HSAG will identify an evaluation time frame for retrospective review of the health plans' authorizations and denials processing. Prior to the webinar review, the following file review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Request denials universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the denials file, filter by date of receipt of request.

Step 3: Select random sample cases, accounting for responsible party and case type to ensure appropriate representation.

Step 4: Provide health plan with sample cases and request case documentation and denial notices sent to enrollees.

Step 5: Upon receipt of submissions, complete file review tool.

File Review Assessment

HSAG will assess the health plans' denials documentation for, at a minimum, the following elements.

- Use of department-approved template(s).
- Timely resolution of denial.
- Compliance with reading level requirements for decision letter(s).

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below.

Yes indicates full compliance defined as all of the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as the following:

- Not all documentation was present.

HSAG will calculate an overall percentage-of-compliance score for each requirement. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

HFS has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will evaluate the files with a health plan staff member present so that the HSAG reviewer may ask the staff member questions and clarify processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the health plan staff member the opportunity to locate the missing information. HSAG will mark an element as deficient only if the staff member cannot locate the information needed to satisfy the element. File review findings may be revised if documentation reviewed during the webinar review supports revision.

HealthChoice Contract Language:

5.19.8 Services requiring prior authorization. Contractor shall authorize or deny Covered Services that require prior authorization, including pharmacy services, as expeditiously as the Enrollee's health condition requires. Ordinarily, requests for authorizations shall be reviewed and decided on within four (4) days after receiving the request for authorization from a Provider, with a possible extension of up to four (4) additional days, if the Enrollee requests the extension or Contractor informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. If the Provider indicates, or Contractor determines, that following the ordinary review and decision time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than forty-eight (48) hours after receipt of the request for authorization. Contractor shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization.

5.19.8.1 Contractor shall authorize services supporting individuals with ongoing or chronic conditions, or who require LTSS, in a manner that reflects the Enrollee's ongoing need for such services.

5.19.8.3 For authorizations for Enrollees residing in a NF, if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, the Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of the Contractor.

5.21.4.2 Reading level. All of Contractor's written communications with Potential Enrollees, Prospective Enrollees, and Enrollees must be produced at a sixth (6th)–grade reading level and easily understood by individuals with sixth (6th)–grade reading skills. Contractor will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written Materials will be presented in a layout and manner that enhance Enrollees' understanding in a culturally competent manner.

MMAI Contract Language:

1.9 Adverse Benefit Determination (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Demonstration Plan, the denial of an Enrollee's request to obtain services outside of the network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

2.9.4.3 Any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.9.4.5 The Contractor must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of Section 2.12.2, and must:

2.9.4.5.1 Be produced in a manner, format, and language that can be easily understood;

2.9.4.5.2 Be made available in Prevalent Languages, upon request; and

2.9.4.5.3 Include information, in the most commonly used languages about how to request language assistance services and Alternative Formats. Alternative Formats shall include materials which can be understood by persons with limited English proficiency.

2.9.4.6 The Contractor must make authorization decisions in the following timeframes and provide notice that meet the timing requirements set forth in 42 C.F.R. § 438.404 and 305 ILCS 5/5F-32:

2.9.4.6.1 Unless limited by Section 2.9.4.6.4, for standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.9.4.6.1.1 The Enrollee or the Provider requests an extension, or

2.9.4.6.1.2 The Contractor can justify (to the satisfaction of the Department and CMS upon request) that:

2.9.4.6.1.2.1 The extension is in the Enrollee's interest; and

2.9.4.6.1.2.2 There is a need for additional information where:

2.9.4.6.1.2.2.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received;

2.9.4.6.1.2.2.2 Such outstanding information is reasonably expected to be received within fourteen (14) calendar days; and

2.9.4.6.1.2.3. The Contractor provides the Enrollee with notice of the reason for the extension and informs the Enrollee of the right to file an Expedited Grievance if the Enrollee disagrees with the decision to extend the Service Authorization Notice timeframe.

2.9.4.6.2 Unless limited by Section 2.9.4.6.4, for expedited service authorization decisions, where the Provider indicates or the Contractor determines that following the standard timeframe in Section 2.9.4.6.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.9.4.6.2.1 The Enrollee or the Provider requests an extension; or

2.9.4.6.2.2 The Contractor can justify (to the Department and CMS upon request) that:

2.9.4.6.2.2.1 The extension is in the Enrollee's interest; and

2.9.4.6.2.2.2 There is a need for additional information where:

2.9.4.6.2.2.2.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.9.4.6.2.2.2.2 Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.9.4.7 Authorization decision regarding Medicare Part B drugs.

2.9.4.7.1 For standard authorization decisions regarding Medicare Part B drugs, consistent with 42 C.F.R. § 422.568(b)(2), the Contractor shall provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after the receipt of the request. No extension is permitted.

2.9.4.7.2 For expedited authorization decisions regarding Medicare Part B drugs, consistent with 42 C.F.R. § 422.572(a)(2), the Contractor shall provide notice as expeditiously as the Enrollee's health condition requires and no later than twenty-four (24) hours after the receipt of the request. No extension is permitted.

2.12.3.1 Integrated Denial Notice -Enrollees will be notified of all applicable Demonstration Medicare and Medicaid Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and the Department. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action. The Contractor must give notice of Adverse Benefit Determination on the day of the action when the action is a denial of payment.

2.12.3.1.1 The notice must explain:

2.12.3.1.1.1 The action the Contractor intends to take;

2.12.3.1.1.2 That the enrollee must first exhaust the plan level (Level 1) appeal process before accessing a state fair hearing or IRE review;

2.12.3.1.1.3 The right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

2.12.3.1.1.4 The reasons for the action and the citation to the regulations supporting such action;

2.12.3.1.1.5 The Enrollee's, the Network Provider's, or authorized representative's right to file an Appeal;

2.12.3.1.1.6 Procedures for exercising the Enrollee's rights to Appeal including how to request a state fair hearing;

2.12.3.1.1.7 Circumstances under which expedited resolution is available and how to request it; and

2.12.3.1.1.8 If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Enrollee may be required to pay the costs of these services.

2.12.3.1.2 The notice must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Potential Enrollees must be informed that information is available in alternative formats and how to access those formats.

2.12.3.1.3 The notice must be translated for the individuals who speak Prevalent Languages.

2.12.3.1.4 The notice must include language clarifying that oral interpretation is available for all languages and how to access it.

Grievances File Review Methodology

Purpose of Review

The purpose of the grievances file review is to assess health plan compliance with timelines, monitoring, and reporting for grievances as required by State and federal statutes and regulations. Contract citations assessed in this review are noted at the end of this appendix.

HSAG will complete a file review and webinar review to evaluate the health plans' compliance with grievance requirements.

File Review Process

Methodology for File Review

In collaboration with HFS, HSAG will identify an evaluation time frame for retrospective review of the health plans' grievances processing. Prior to the webinar review, the following file review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Request grievances universe from health plans, utilizing evaluation time frame for retrospective review.

Step 2: Upon receipt of the grievances file, filter by date of receipt of grievance.

Step 3: Identify the cases that were not resolved on call (to identify those cases which should have letters).

Step 4: Identify closed cases.

Step 5: Select random sample cases; include alternates in the event a letter was not sent.

Step 6: Provide health plan with sample cases and request grievance documentation including letters sent to enrollees.

Step 7: Upon receipt of submissions, complete file review tool.

File Review Assessment

HSAG will assess the health plans' grievances documentation for, at a minimum, the following elements.

- Use of department-approved template(s).
- Timely acknowledgment of grievance.
- Timely resolution of grievance.
- Compliance with reading level requirements for acknowledgment and resolution letter(s).

- Resolution addresses all enrollee complaints.
- Resolution is personalized.

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Yes* or *No* according to the criteria identified below.

Yes indicates full compliance defined as all of the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.

No indicates noncompliance defined as the following:

- Not all documentation was present.

HSAG will calculate an overall percentage-of-compliance score for each requirement. HSAG will calculate the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

Standard Performance

HFS has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will evaluate the files with a health plan staff member present so that the HSAG reviewer may ask the staff member questions and clarify processes or areas of concern. The HSAG reviewer may identify missing documentation and allow the health plan staff member the opportunity to locate the missing information. File review findings may be revised if documentation reviewed during the webinar review supports revision.

HealthChoice Contract Language:

5.21.4.2 Reading level. All of Contractor's written communications with Potential Enrollees, Prospective Enrollees, and Enrollees must be produced at a sixth (6th)–grade reading level and easily understood by individuals with sixth (6th)–grade reading skills. Contractor will use the Flesch Reading Ease and Flesch-Kincaid Grade level tests, or other reading level test as approved by the Department, to ensure appropriate reading level. Written Materials will be presented in a layout and manner that enhance Enrollees' understanding in a culturally competent manner.

5.30.1 Grievances. Contractor shall establish and maintain a procedure for reviewing Grievances by an Enrollee or an Enrollee's Authorized Representative. A Grievance may be submitted orally or in writing, using any medium, at any time, and all Grievances shall be registered with Contractor. Contractor's procedures must:

5.30.1.1 be submitted to the Department in writing and approved in writing by the Department;

5.30.1.2 provide for prompt resolution; and

5.30.1.3 assure the participation of individuals with authority, no previous involvement of review, and appropriate clinical expertise to require corrective action.

At a minimum, the following elements must be included in the Grievance process:

5.30.1.4 Contractor will acknowledge the receipt of a Grievance within forty-eight (48) hours.

5.30.1.5 Contractor shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) days from receipt of a Grievance. Contractor may inform an Enrollee of the resolution orally or in writing.

MMAI Contract Language:

1.61 Grievance — Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or Adverse Benefit Determination under 42 C.F.R. § 400, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Enrollee's rights, as provided for in Appendix B of this Contract).

2.11 Enrollee Grievance

2.11.1 Grievance Filing.

2.11.1.1 Internal Grievance Filing. An Enrollee, or an authorized representative, may file an Internal Enrollee Grievance at any time with the Contractor or its Providers by calling or writing to the Contractor or Provider. If the internal Enrollee Grievance is filed with a Provider, the Contractor must require the Provider to forward it to the Contractor. The Enrollee may file the Grievance at any time as allowed in 42 C.F.R. § 438.402(c)(2)(i).

2.11.1.2 External Grievance Filing. The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page. The Contractor must inform Enrollees of the email address, postal address, or toll-free telephone number where an Enrollee Grievance may be filed.

2.11.1.3 External Grievances filed with the Department shall be forwarded to the Contract Management Team (CMT) and entered into the CMS Complaints tracking module, which will be accessible to the Contractor.

2.11.2 Internal Grievance Administration Process: The Contractor must have a formally structured Grievance system, consistent with 215 ILCS 134/45, 42 C.F.R. § 422 Subpart M, 42 C.F.R. § 431 Subpart E and 42 C.F.R. § 438 Subpart F, in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The Contractor must maintain written records of all Grievance activities, which shall be accessible to the Department and available to CMS upon request and notify CMS and the Department of all internal Enrollee Grievances. The Contractor must also submit to the Department, in the format required by the Department, a quarterly report summarizing all Grievances heard by the Grievance Committee and the responses to and disposition of those Grievances. The Contractor must submit its Grievance procedures to the Department for Prior Approval. The system must meet the following standards:

2.11.2.1 Timely acknowledgement of receipt of each Enrollee Grievance;

2.11.2.2 Timely review of each Enrollee Grievance;

2.11.2.3 Informal attempt by Contractor to resolve all Grievances;

2.11.2.5 Providing the Enrollee with a form and instructions on how the Enrollee may appoint an authorized representative to represent the Enrollee throughout the Grievance process;

2.11.2.6 Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance; and

2.11.2.7 Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever the Contractor extends the Appeals timeframe (see Section 2.12 below) or the Contractor refuses to grant a request for an expedited Appeal;

2.11.2.8 Availability to Enrollees of information about Enrollee Grievances and Appeals, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.11.2.9 Ensure that decision makers on grievances were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

2.11.2.9.1 A grievance regarding denial of expedited resolutions of an appeal.

2.11.2.9.2 Any grievance involving clinical issues.

Delegation Oversight and Monitoring Methodology

Purpose of Review

The purpose of delegation oversight and monitoring is to assess health plan compliance with delegation oversight, monitoring, and reporting that is required by the HCI and MMAI contracts and State and federal regulations. Contract citations being evaluated are located at the end of this appendix.

File Review Process

Methodology for File Review

In collaboration with HFS, HSAG will identify an evaluation time frame for retrospective review of the health plans' records. Prior to the webinar review, the following desk review methodology will be utilized to identify compliance and findings requiring additional assessment during the webinar review.

Step 1: Review the health plans' Pre-Assessment form to identify a list of delegated entities.

Step 2: Compare the list of delegates to the health plans' annual QA/UR (utilization review)/PR (peer review) report to validate all delegates are listed.

Step 3: Select sample of delegated entities for review.

Step 4: Request the following documents from the health plan for review of specified delegates.

- Signed delegation agreement
- Pre-delegation audit
- Annual audit, if applicable
- Delegation oversight committee meeting minutes from CY 2021
- Joint Operation Committee meeting minutes from CY 2021
- Performance reporting of the delegates
- CAPs, if applicable
- Evidence of initial and annual training

Step 5: Complete the Delegation File Review tool.

File Review Assessment

HSAG will assess the health plans' documentation for, at a minimum, the following elements.

- List of delegated entities
- Signed delegation agreement
- Pre-delegation audit
- Annual audit, if applicable
- Delegation oversight meeting agendas and minutes

- Joint Operation Committee meeting agendas and minutes
- Quarterly performance reporting
- CAPs, if applicable
- Evidence of delegate training completion

Scoring Methodology for File Review

HSAG will use a two-point scoring methodology. Each requirement will be scored as *Met*, *Not Met*, or *Not applicable (N/A)* according to the criteria identified below.

Met indicates full compliance defined as the following:

- All delegation oversight contract requirements were present.

Not Met indicates noncompliance defined as the following:

- Delegation oversight contract requirements were not present.

N/A indicates compliance is not applicable as the following:

- Delegation oversight contract requirements not applicable

HSAG will calculate an overall percentage-of-compliance score for the delegation oversight contract requirements. HSAG will calculate the score for each requirement by adding the score, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points) or *N/A* (value: 0 points), and dividing the summed scores by the total number of applicable elements.

Standard Performance

HFS has established a performance benchmark of 80 percent compliance for each scored element.

Webinar Review

During the webinar review, HSAG will address any concerns or findings identified as a result of the desk review. HSAG will discuss concerns or findings with a health plan staff member present so that the HSAG reviewer may ask the staff member questions and clarify processes or areas of concern. File review findings may be revised if documentation reviewed during webinar review supports revision.

HealthChoice Contract Language:

5.35.7 Contractor shall establish written policies and procedures for all employees, Subcontractors, Network Providers, and agents that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the SSA, including administrative, civil, and criminal remedies for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, Abuse, mismanagement, and misconduct in federal health care programs. Contractor shall include in any employee handbook a description of these laws, the rights of employees to be protected as whistleblowers, and Contractor's policies and procedures for detecting and preventing Fraud, Waste, Abuse, mismanagement, and misconduct.

1.1.7.4 There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, appeals, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to the Department as part of the QA/UR/PR Annual Report.

1.1.7.5 Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit.

1.1.7.6 If Contractor or subcontractor identifies areas requiring improvement, Contractor and subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, the subcontractor must develop and implement a corrective action plan, with protections put in place by Contractor to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to the Department through quarterly or annual reporting, or through a timeframe established by the Department with Contractor.

2.2 Performance of services and duties. Contractor shall perform all services and other duties as set forth in this Contract in accordance with, and subject to, all applicable federal and State statutes, rules, and regulations.

5.40.4 Subcontractor oversight committee. Contractor shall have a Subcontractor oversight committee that meets, at minimum, on a quarterly basis. This committee shall, at a minimum, conduct the following with regard to each Subcontractor: a predelegation audit, a quarterly delegation oversight review of Subcontractor performance by the Subcontractor oversight committee, monthly joint operation meetings, an annual audit of Subcontractors, regular monitoring of Enrollee Complaints, documentation of issues, and development of a Corrective Action Plan (CAP), as warranted, to improve performance.

5.32.2 in writing, must specify the delegated activities, duties or obligations, including any related reporting responsibilities, and are subject to the following conditions:

5.32.2.1 The Network Providers and Subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the agreement or subcontract. Such requirements include the record keeping and audit provisions of this Contract, such that the

Department or Authorized Persons shall have the same rights to audit and inspect Network Providers and Subcontractors as they have to audit and inspect Contractor.

5.32.2.2 All Physicians who are Network Providers shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is a Network Provider; or, in lieu of these admitting and delivery privileges, the Physician shall have a written Referral agreement with a Physician who is a Network Provider and who has such privileges at a hospital that is a Network Provider. The Provider Contract shall include hospital affiliation. The agreement must provide for the transfer of medical records and coordination of care between Physicians.

5.32.3 Contractor shall remain responsible for the performance of any of its responsibilities delegated to Network Providers, subcontractors and other entities to which duties are delegated.

5.32.4 No Provider agreement or subcontract can terminate the legal responsibilities of Contractor to the Department to assure that all the activities under this Contract will be carried out.

4.15.2. If the Department determines that Contractor does not have the necessary Provider or administrative capacity to provide Covered Services to any additional Enrollees, the Department shall provide written notice of such determination to Contractor, containing an explanation of the methodology used by the Department to determine Contractor's Provider and administrative capacity and allowing Contractor sixty (60) days to restore Provider and administrative capacity. In the event the Department reasonably finds that Contractor has failed to restore Provider and administrative capacity within sixty (60) days after Contractor receives such notice, the Department may suspend enrollment (through automatic assignment, enrollment by Enrollee choice, or both), upon written notice to Contractor of such findings. Such suspension of enrollment may, at the sole discretion of the Department, be for an area that is not the entire Contracting Area. Thereafter, Contractor may, at any time, submit written evidence to the Department that Contractor has increased Provider and administrative capacity, which evidence the Department shall review in good faith. The Department shall, within thirty (30) days following the Department's receipt of such evidence, provide written notice to Contractor of its findings. If the Department finds that Contractor's Provider and administrative capacity has increased to the Department's satisfaction, the Department will resume Contractor's enrollment.

2.7.5 Subcontractors. Contractor shall require that its Subcontractors comply with Contractor's Cultural Competence plan and complete Contractor's initial and annual Cultural Competence training. Contractor's oversight committee, established pursuant to section 5.40.4, shall ensure compliance by Subcontractors with contractual and statutory requirements, including the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act.

2.8 All Provider locations where Enrollees receive services shall comply with the requirements of the Americans with Disabilities Act (ADA). Contractor's network shall have Provider locations that are able to accommodate the needs of individual Enrollees.

5.22.5 Contractor shall establish and maintain a Peer Review program approved by the Department to review the quality of care being offered by Contractor and its employees, Subcontractors, and Network Providers.

5.23.1 Contractor shall train all of Contractor's external-facing employees, Network Providers, Affiliates, and Subcontractors to recognize potential concerns related to Abuse, Neglect, and exploitation, and will train them on their responsibility to report suspected or alleged Abuse, Neglect, or

exploitation. Contractor's employees who, in good faith, report suspicious or alleged Abuse, Neglect, or exploitation to the appropriate authorities shall not be subjected to any Adverse Benefit Determination from Contractor, its Network Providers, Affiliates, or Subcontractors.

5.32.2.1 The Network Providers and Subcontractors shall be bound by the terms and conditions of this Contract that are appropriate to the service or activity delegated under the agreement or subcontract. Such requirements include the record keeping and audit provisions of this Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect Network Providers and Subcontractors as they have to audit and inspect Contractor.

5.20.1.1.9 Contractor shall not hold an Enrollee liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Enrollee.

5.27.1 Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this Contract. The system must provide information on areas including utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

5.28.1.4 Impact of noncompliance. Failure of Contractor to materially comply with reporting requirements may subject Contractor to any of the applicable monetary sanctions in article VII of this Contract. Any Contractor obligation(s) to provide reporting to the Department shall be contingent on the Department's ability to deliver to Contractor the information or necessary business specifications reasonably required by Contractor to complete its reporting requirements, as applicable. 5.32.10.5 that it will monitor the performance of all Network Providers and Subcontractors on an ongoing basis, subject each Network Provider and Subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Network Provider or Subcontractor take appropriate corrective action.

5.26.3 Patient records. Contractor shall require that a permanent medical record shall be maintained by each Enrollee's PCP. The medical record shall be available to the PCP, the WHCP, and other Providers. Copies of the medical record shall be sent to any new PCP to which the Enrollee transfers. Contractor shall require that the medical record contain documented efforts to obtain the Enrollee's consent when required by law. Contractor shall require that copies of records shall be released only to Authorized Persons upon request. Original medical records shall be released only in accordance with federal or State law, including court orders or subpoenas, or a valid records-release form executed by an Enrollee. Contractor shall assist Enrollees in accessing their records in a timely manner. Contractor shall protect the confidentiality and privacy of Enrollee and abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental-health records, and any other information about Enrollee. Contractor shall require that Network Providers maintain and share such records for the Department upon request and in accordance with professional standards. Medical records must include Provider identification. Medical-records reporting requirements shall be adequate to provide for acceptable Continuity of Care to Enrollees. All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable:

5.32.8 Contractor must retain the right to terminate any Provider agreement or subcontract or impose other sanctions if the performance of the Network Provider or Subcontractor is inadequate.

8.5 Termination for cause. In addition to any other termination rights under this Contract, if Contractor fails to perform to the Department's satisfaction any material requirement of this Contract or is in violation of a material provision of this Contract, the Department shall provide written notice to

Contractor requesting that the Breach or noncompliance be remedied within the period of time specified in the Department's written notice, which shall be no fewer than sixty (60) days. If the Breach or noncompliance is not remedied by that date, the Department may: (i) immediately terminate the Contract without additional written notice; or, (ii) enforce the terms and conditions of the Contract. In either event, the Department may also seek any available legal or equitable remedies and damages.

2.6 Provision of covered services through network providers. Where Contractor does not employ Physicians or other Providers to provide direct healthcare services, every provision in this Contract by which Contractor is obligated to provide Covered Services of any type to Enrollees—including provisions stating that Contractor shall "provide Covered Services," "provide quality care," or provide a specific type of healthcare service, such as the Covered Services in section 5.2—shall be interpreted to mean that Contractor shall arrange for the provision of those Covered Services through its Provider Network.

1.1.2.3.9 If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor.

5.35.1 as provided in section 9.1.29, suspected Fraud, Waste, Abuse, or financial misconduct in the HFS Medical Program by Enrollees, Providers, Contractor's employees, or Department employees. Contractor shall:

5.35.1.8 submit a quarterly report to the Department that includes all instances of suspected Fraud, Waste, Abuse, and financial misconduct, and certify that the report contains all such instances or that there was no suspected Fraud, Waste, Abuse, or misconduct during that quarter. The inclusion of an instance of suspected Fraud, Waste, or Abuse on a quarterly report shall be considered timely if the report of suspected Fraud, Waste, Abuse, or financial misconduct is made to Contractor's liaison as soon as Contractor knew or should have known, as determined by the Department, of the suspected Fraud, Waste, Abuse, or financial misconduct, and the newly included instance, with the required certification is received within thirty (30) days after the end of the quarter.

5.35.1.9 Contractor shall ensure that all its personnel, Network Providers, and Subcontractors receive notice of, and are educated on, these procedures, and shall require adherence to them.

Attachment Xi: Quality Assurance Section 1.1.7 Contractor shall remain accountable for all QAP functions, even if certain functions are delegated to other entities. If 1.1.7 Contractor delegates any QA activities to subcontractors:

8.4 In addition to any other termination rights under this Contract, the Department may terminate this Contract, in whole or in part, immediately upon notice to Contractor if it is determined that the actions, or failure to act, of Contractor or its agents, employees, or Subcontractors have caused, or reasonably could cause, jeopardy to health, safety, or property. This Contract may be terminated immediately if the Department determines that Contractor fails to meet any of the applicable requirements established by 89 Ill. Admin. Code Part 143

8.9 This Contract may be terminated immediately or upon notice by the 8.9.1 Department, at its sole discretion, in the event of the following:

5.21.4 Enrollees. The requirements outlined in this section 5.21.4 apply to all Key Oral Contacts and Written Materials. Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to promote the hiring of local staff to ensure Cultural Competence. All Contractor staff will receive training on all Contractor policies and procedures during new-hire

orientation and ongoing job-specific training to ensure effective communication with a diverse Enrollee population, including translation assistance, assistance to the hearing impaired, and assistance to those with limited English proficiency. Contractor shall meet quarterly with its Enrollee advisory and community stakeholder committee to assess the results of Enrollee calls. Enrollee feedback will be sought at the close of each contact to inquire if the Enrollee's needs or issues have been resolved. Contractor shall conduct targeted Enrollee focus groups to obtain additional input on Contractor materials and program information, and shall also seek input from local organizations that serve Enrollees.

5.21.5.2.5 request and receive a copy of the Enrollee's medical records, and to request that the records be amended or corrected.

5.20.1.1 Emergency services. Contractor shall cover Emergency Services for all Enrollees whether the Emergency Services are provided by a Network or a non-Network Provider.

5.8.1 Network adequacy standards. Contractor's Provider Network must include all necessary Provider types, including primary care Providers, Behavioral Health Providers, OB/GYNs, dental care Providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely Covered Services to Enrollees in accordance with the standards outlined herein. For each Provider type, Contractor must provide access to at least ninety percent (90%) of Enrollees within each county of the Contracting Area within the prescribed time and distance standard required by this section 5.8.1, with the exception of pharmacy services, which must provide one-hundred percent (100%) coverage to Enrollees as required in section 5.8.1.1.7. Exceptions to the time and distance standards may be considered and approved at the discretion of the Department. Exception requests must be submitted to the Department in writing.

4.1.1 become Enrollees in a Health Plan, except those Potential Enrollees who, pursuant to federal law or a waiver approved by Federal CMS, are subject only to voluntary enrollment or are part of an excluded population. The ICES shall be responsible for the enrollment of Potential Enrollees, including the provision of all education regarding Health Plan choices, enrollment by active choice, and enrollment by automatic assignment. Contractor shall continue to accept Potential Enrollees for enrollment until the Department determines that any further enrollments would exceed Contractor's capacity based on a review conducted pursuant to section 4.15. Contractor shall accept each Potential Enrollee whose name appears on the 834 Audit File and 834 Daily File. Enrollment shall be without restriction and shall be in the order in which Potential Enrollees apply or are assigned. Contractor will not discriminate against Potential Enrollees based on health status or need for healthcare services. Contractor shall not participate in facilitating enrollment, including during the Open Enrollment Period. Contractor may educate a Potential Enrollee regarding the specific elements of Contractor, provided that Contractor engages in no Marketing activities prohibited under section 4.17. Contractor shall refer all requests for enrollment to the ICES, which shall not be considered "facilitating enrollment." Nothing in this Contract shall be deemed to be a guarantee of any Potential Enrollee's enrollment with Contractor.

4.5.1 enrollment by automatic assignment at any time for any reason during the term of this Contract, and may provide that the algorithm considerations include Contractor's performance on quality measures, operational performance, and other measures relevant to program effectiveness. The Department shall provide written notice to Contractor at least sixty (60) days before implementation of

any significant modification, as determined by the Department, of the algorithm for enrollment by automatic assignment.

4.15.2 Contractor shall provide to the Department documentation that sets forth Contractor's physical, professional, and network capacity. The documentation must demonstrate that Contractor offers an appropriate range of preventive services, primary care, Behavioral Health, and specialty services that is adequate for the anticipated number of Enrollees, and that Contractor maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees.

5.34 Neither Contractor, its Network Providers, nor non-Network Providers shall seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to this Contract, except as permitted or required by the Department in 89 Ill. Adm. Code 125 and the Department's FFS copayment policy then in effect, and subject to section 7.8. Contractor acknowledges that imposing charges in excess of those permitted under this Contract is a violation of Section 1128B(d) of the Social Security Act and subjects Contractor to criminal penalties. Contractor shall have language in all its Provider agreements or subcontracts reflecting this requirement.

5.8.3 Appointments. Contractor shall require that time-specific appointments for 5.8.3 routine preventive care are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day after the request. Enrollees with problems or Complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester. Network Providers shall offer hours of operation that are no less than the hours of operation offered to Persons who are not Enrollees.

MMAI Contract Language:

2.1.7.6 Provide False Claims Education for all employees and First Tier, Downstream, and Related Entities as required in 42 U.S.C § 1396(a)(68).

2.13.9.4 There shall be evidence of continuous and ongoing evaluation and oversight of delegated activities, including approval of quality improvement plans and regular specified reports, as well as a formal review of such activities. Oversight of delegated activities must include no less than an annual audit, analyses of required reports and Encounter Data, a review of Enrollee complaints, grievances, Provider complaints and appeals, and quality of care concerns raised through Encounter Data, monitoring activities, or other venues. Outcomes of the annual audit shall be submitted to CMS and the Department as part of the QA/UR/PR Annual Report.

2.13.9.5 The Contractor shall be responsible for, directly or through monitoring of delegated activities, credentialing and re-credentialing, and shall review such credentialing files performed by the delegated entity no less than annually, as part of the annual audit.

2.13.9.6 If the Contractor or First Tier, Downstream, or Related Entity identifies areas requiring improvement, the Contractor and First Tier, Downstream, or Related Entity, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are

identified, the subcontractor must develop and implement a corrective action plan, with protections put in place by the Contractor to prevent such deficiencies from reoccurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to CMS and the Department through quarterly or annual reporting.

2.16.1.1 All information CMS and the Department require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation.

2.16.1.2 Any information CMS and the Department require to comply with all applicable federal or State laws and regulations.

2.7.2.2.1 The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. The Contractor shall require each First Tier, Downstream or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.7.2.2.2 The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. The Contractor is required to evaluate any potential First Tier, Downstream or Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.230. Additional information about subcontracting requirements is contained in Appendix C.

2.7.2.2.3 The Contractor must establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees.

2.7.4.5 The Contractor will provide the cultural competency requirements at orientation, training sessions, and updates as needed. This will also include Americans with Disabilities Act (ADA) compliance, accessibility, and accommodations as required in Section 2.9.1.6.

2.9.5.5 The Contractor shall establish and maintain a Peer Review Program approved by the Department to review the quality of care being offered by the Contractor and its employees, First Tier, Downstream, and Related Entities, and Affiliated Providers.

2.9.6.3 The Contractor shall train all of the Contractor's employees, Affiliated Providers, Affiliates, and First Tier, Downstream and Related Entities that have interaction with Enrollees or Enrollee's IPoC to recognize potential concerns related to Abuse, Neglect and exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect or exploitation. Contractor's employees who, in good faith, report suspicious or alleged Abuse, Neglect or exploitation to the appropriate authorities shall not be subjected to any Adverse Benefit Determination from the Contractor, its Affiliated Providers, Affiliates or First Tier, Downstream, or Related Entities.

Appendix C, Section B The Contractor shall specifically ensure HHS, the Comptroller General, the Department, the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and their designees, and other State and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and

documentation of the First Tier, Downstream and Related Entities and HHS's, the Comptroller General's, the Department's, the Department's Office of Inspector's General, the Medicaid Fraud Control Unit's of the Illinois State Police, the Illinois Auditor's General, and or their designees', and other State and federal agencies with monitoring authority related to Medicare and Medicaid, right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Appendix C, Section C The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following: Enrollee protections that include prohibiting Providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor; Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and the Department, including the requirements at 42 CFR 438.414 in relation to the grievance system; Language that specifies the delegated activities and reporting requirements; Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, the Department or the Contractor determine that such parties have not performed satisfactorily; Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary; Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.

Appendix C, Section E The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of Providers include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

Appendix C, Section F The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor has the right to terminate the contract with cause upon sixty (60) days' notice, and without cause upon 120 days' notice, and shall require the provider assist with transitioning Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee. In a for cause termination, Contractor must have an internal grievance procedure that allows the Provider to contest the grounds for the termination prior to the effective date of the termination.

Appendix C, Section G The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a Provider of the reason or reasons for termination with cause.

Appendix C, Section H The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers include additional provisions.

Appendix D, Section 2cix If Contractor delegates responsibility for utilization management, it shall have mechanisms to ensure that these standards are met by the subcontractor.

2.1.7 Program Integrity. The Contractor shall adopt and implement an effective compliance program to prevent, detect and correct Fraud, Waste, and Abuse consistent with 305 ILCS 5/8A-1 et. seq., 42 C.F.R. Part 420, et seq, 42 C.F.R. § 422.503, 42 C.F.R. §§ 438.600-610, 42 C.F.R. Part 455, and 1156 and 1902(a)(68) of the SSA.