





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

EXTERNAL QUALITY REVIEW ANNUAL REPORT

State Fiscal Years 2018-2019
(July 1, 2018-June 30, 2019)

Illinois Department of Healthcare
and Family Services
Division of Medical Programs

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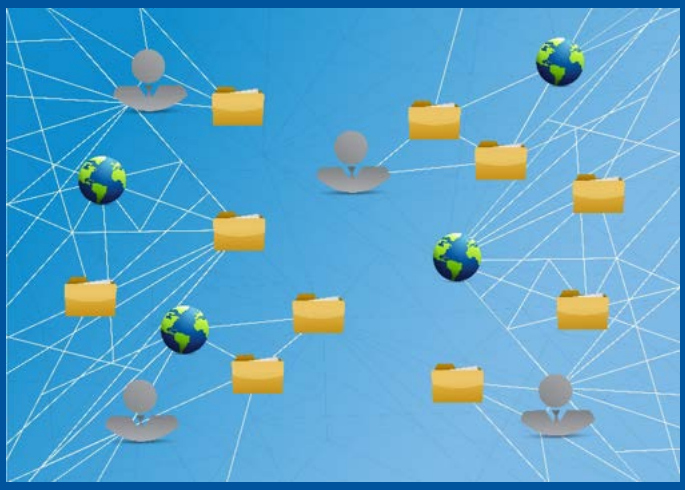
1. Executive Summary

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.



Purpose of This Report

The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO. This state fiscal year (SFY) 2019 External Quality Review (EQR) Technical Report focuses on federally mandated EQR activities that HSAG performed from July 1, 2018, to June 30, 2019. See the federal requirements for this report in Appendix A2.

Scope of Report

In accordance with 42 CFR §438.364, this report describes the EQR results for the mandatory and optional EQR activities set forth in §438.356. Additional details about the EQR activities conducted in SFY 2019 are described in Appendix A2. This report includes methodologically appropriate, comparative information to provide an assessment of each health plans' strengths and weaknesses with respect to the quality of, timeliness of, and access to healthcare services furnished to Medicaid beneficiaries and recommendations for improving quality of healthcare services. In Appendix A3, this report includes an assessment of the degree to which each health plan has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Illinois Medicaid Overview

Illinois Medicaid Expansion

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

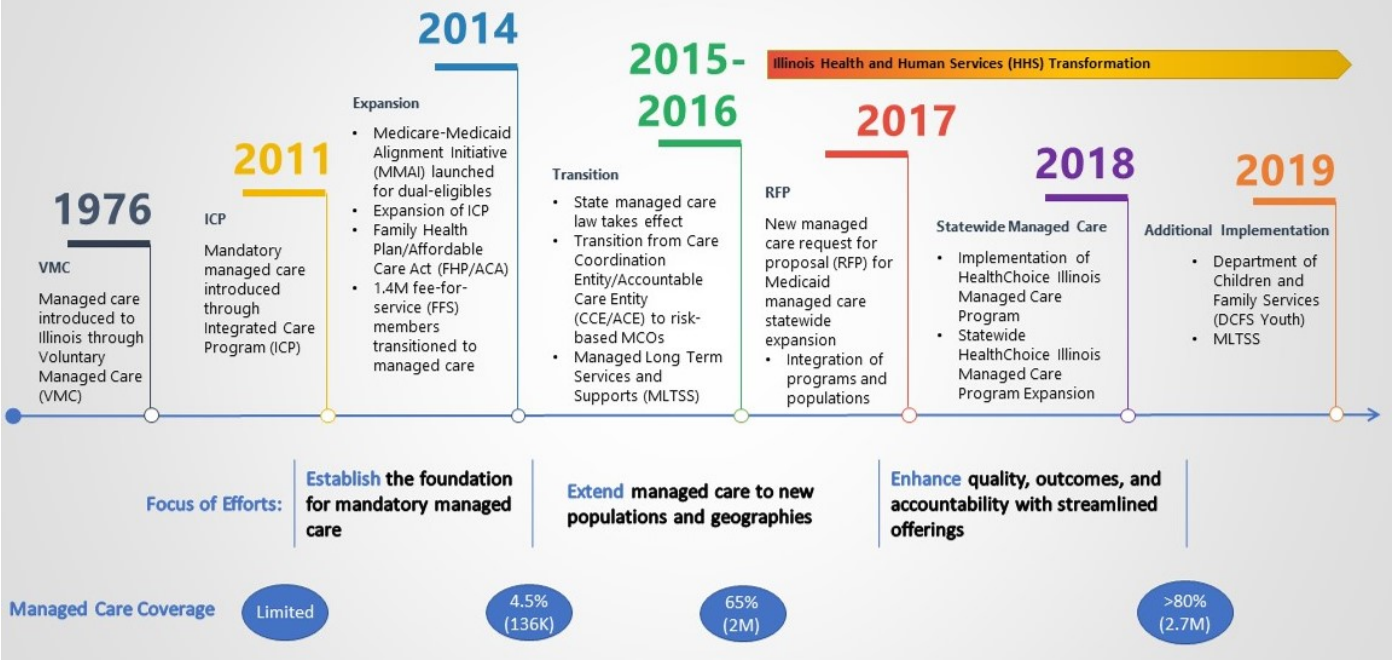
Previously, HFS operated four managed care programs: Family Health Plan/Affordable Care Act (FHP/ACA) program, Integrated Care Program (ICP), Medicare-Medicaid Alignment Initiative (MMAI), and Managed Long Term Services and Supports (MLTSS). In the fall of 2017, HFS announced that seven health plans would provide the full spectrum of Medicaid covered services through the HealthChoice Illinois Managed Care Program (HealthChoice Illinois). HealthChoice Illinois included the State's existing Medicaid managed care population and the statewide expansion of managed care. HealthChoice Illinois also consolidated previous programs (FHP/ACA, ICP, and MLTSS), and reduced the number of contracted health plans.

Awards were announced in SFY 2018 and on January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, launching HealthChoice Illinois to serve approximately 2.7 million residents. The managed care program prior to the reboot was designed to operate in 30 counties; as of April 1, 2018, expansion included all 102 counties statewide, covering close to 80 percent of Medicaid beneficiaries and reducing the number of managed care organizations (MCOs) operating in Illinois.

HFS contracted with seven health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Five of the HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. However, in 2019 Harmony Health Plan of Illinois, Inc. (Harmony), merged with MeridianHealth, Inc. (Meridian), so HealthChoice Illinois is served by six health plans.

HealthChoice Illinois' statewide expansion included other populations, such as children in the care of the Department of Children and Family Services (DCFS), including those formerly in care who have been adopted or who entered a guardianship (DCFS Youth) and MLTSS and waiver services. Additional details about Illinois' managed care programs are located in Appendix A2.

Figure 1-1—Illinois Medicaid Expansion



Medicaid Managed Care Health Plans (Health Plans)

HFS contracted with the six health plans shown in Table 1-1 to provide healthcare services to HealthChoice Illinois beneficiaries. Four of the six HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. Further details about the health plans and the program populations are included in Appendix A2.

Table 1-1—HealthChoice Illinois Health Plans for SFY 2019

Health Plan Name	Abbreviation
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (Serves Cook County only)	CountyCare
IlliniCare Health Plan	IlliniCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina
NextLevel Health Partners, LLC (Serves Cook County only)	NextLevel

Quality Strategy

HFS developed and maintains a Department of Healthcare and Family Services Comprehensive Medical Programs Quality Strategy (Quality Strategy) in accordance with 42 CFR §438.200 et seq. More details about the Quality Strategy are located in Appendix A2. This report provides a review of health plan performance in comparison to the Quality Strategy goals.

Performance Domains

Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] results are presented to demonstrate the overall strengths and weaknesses regarding the quality, timeliness, and access of the care provided by the health plans serving Illinois' Medicaid beneficiaries. Descriptions of the three performance domains can be found in Appendix A2.

Performance Snapshot

Table 1-2 below provides a high-level snapshot of statewide performance for HEDIS measures, compliance monitoring, Performance Improvement Projects (PIPs), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] results for SFY 2019. The HEDIS results represent the HFS priority measures (listed in Appendix A2), and percentiles refer to national Medicaid percentiles. Additional details about these results can be found in Appendix A2 and in subsequent sections of this report.

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

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

Table 1-2—Performance Snapshot SFY 2019

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	30 Quality Measure Rates[i]	6 Timeliness Measure Rates	8 Access Measure Rates[ii]
Notable	HEDIS	**Between the 75th and 89th Percentiles** • 1 of 30 measure rates (3.3%) o *Statin Therapy for Patients with Diabetes—Received Statin Therapy* **Between the 50th and 75th Percentiles** • 14 of 30 measure rates (46.7%)	**Between the 50th and 75th Percentiles** • 4 of 6 measure rates (66.7%) o *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care* o *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*	**Between the 50th and 75th Percentiles** • 5 of 8 measure rates (62.5%) o *Annual Dental Visits* o *PPC—Timeliness of Prenatal Care* and *Postpartum Care* o *IET—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*
	Compliance	All health plans demonstrated the ability to remediate deficient elements identified in the HealthChoice Illinois Pre-Implementation Readiness Reviews and follow-up on implementation of remediation. In the final overall scoring, most health plans scored above 90%, with the lowest performer scoring 87%.		
	PIPs	As approved by CMS, HFS implemented a new rapid-cycle approach for PIPs. The duration of rapid-cycle PIPs is 18 months; therefore, the two new mandatory PIPs, *Follow-Up After Hospitalization for Mental Illness* and *Transitions of Care—Patient Engagement After Inpatient Discharge*, will continue into the next fiscal year.		
	CAHPS	**At or Between the 50th and 74th Percentiles** Adult Aggregate Results: • *How Well Doctors Communicate* • *Customer Service* and *Rating of Personal Doctor*[iii] • *Rating of Specialist Seen Most Often*[iv] Child Aggregate Results: • *Shared Decision Making* • *Rating of All Health Care* • *Rating of Personal Doctor*	Not Applicable (NA)	NA

Table 1-3—Performance Snapshot SFY 2018

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	30 Quality Measures Rates[i]	6 Timeliness Measures Rates	8 Access Measures Rates[ii]
Needs Work	HEDIS	**≤ 25th Percentile** • 5 of 30 measure rates (16.7%) o *Adult Body Mass Index (BMI) Assessment* o *Childhood Immunization Status (CIS)—Combination 2* and *3* o *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **Between the 25th and 50th Percentiles** o 10 of 30 measure rates (33.3%)	**≤ 25th Percentile** • 2 of 6 measure rates (33.3%) o *FUH—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*	**≤ 25th Percentile** • 3 of 8 measure rates (37.5%) o *Adults' Access to Preventive/Ambulatory Health Services—Total* o *FUH—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
	Compliance	HealthChoice Illinois Pre-Implementation Readiness Reviews identified the following areas of noncompliance across all health plans: cultural competence plans did not address all requirements; plans lacked organizational structure for oversight and reporting fraud, waste, and abuse (FWA); plans provided inaccurate information for dental and vision providers in the online provider directory; provider complaint and resolution system did not meet requirements; and plans lacked delegation agreements and oversight of the Crisis and Referral Entry Services (CARES) line.		
	PIPS	NA		
	CAHPS	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Shared Decision Making* • *Rating of All Health Care* • *Rating of Health Plan* Child Aggregate Results: • *How Well Doctors Communicate* • *Rating of Specialist Seen Most Often*[v] • *Rating of Health Plan*[vi] **< 25th Percentile** Child Aggregate Results: • *Customer Service*[vii]	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Care Quickly* Child Aggregate Results: • *Getting Care Quickly*	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Needed Care* **< 25th Percentile** Child Aggregate Results: • *Getting Needed Care*

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 percentiles for HEDIS 2018. Refer to Appendix A2 for a list of the measures and rates that are included in the quality, timeliness, and access domains.
ii. Six timeliness measure rates were compared to national Medicaid percentiles for HEDIS 2018, but please note that all three measures (six measure rates) are also included in the quality and access domains.
iii. Statistically significantly higher than the score for 2018; star ratings improved from 2018–2019.
iv. Star ratings improved from 2018–2019.
v. Star ratings declined from 2018–2019.
vi. Star ratings declined from 2018–2019.
vii. Star ratings declined from 2018–2019.

Performance Measures Summary

Please see Appendix A1 for a snapshot of health plan performance on HFS priority performance measures.

Recommendations: Biggest Opportunities for Improvement

Recommendations for improvement are identified below. Recommendations for HFS are indicated with the HFS logo. Recommendations health plans are indicated with the following icon.

Implement effective care coordination/care management (CC/CM) processes

- **Enhance timely communication with primary care provider (PCP),** including the sharing of care plans and coordination of services to meet enrollees' needs.
- **Monitor case activity and provide regular feedback to care managers** to ensure timely completion of assessments/reassessments, care plans, and PCP communication.
- **Implement organization-wide strategies to identify** difficult-to-locate beneficiaries with complex needs and connect them with care managers during each contact.
- **Revamp children's behavioral health CC/CM program** to implement effective strategies for locating members, completing screenings, and crisis safety plans; enhance communication with PCPs; and ensure timely follow-up.
- **Establish a monitoring process to monitor caseloads** for high risk or moderate risk enrollees.
- **Implement and/or strengthen the use of internal audit tools** to address findings of the HCBS waiver record reviews and focus on remediation findings that result from the quarterly record reviews.
- **Consider care management system enhancements** to alert CC/CM of time frames to update waiver service plans and contact with beneficiaries.
- **Establish a process to complete ongoing claims validation** of the waiver service plan.
- **Establish compliance with HCBS mandatory training requirements for CC/CM assigned to HCBS waiver enrollees** by updating annual and waiver-specific training curriculum to comply with waiver-specific training requirements and establish methods to track completion of required training.
- **Conduct ongoing review of staffing ratios** to ensure case coordinators/care managers who manage human immunodeficiency virus (HIV) and brain injury (BI) waiver caseloads are not assigned caseloads greater than 30.

- **Establish monitoring of health plans to validate provision of required CC/CM services for children with behavioral health needs** through the review of case files.
- **Provide direction to the health plans related to caseload requirements for CC/CMs managing HIV and BI waiver members.** Discussion with health plans found that the health plans interpret the contract to mean that the 30-caseload limit pertains only to HIV and/or BI caseloads, as opposed to CC/CM total caseload (which may include other waiver and non-waiver cases).

Implement integrated health homes (IHH) to improve integration of physical and behavioral health

- **Promote understanding of the benefits of IHHs** among consumers and families.
- **Engage providers** in understanding the role and responsibility of an IHH and the role of the health plans in coordinating care for beneficiaries assigned to the IHH.

- **Establish IHH enrollment targets** for health plans.
- **Develop and implement quality standards, performance measures, reimbursement rates, and procedures for IHHs** and provide TA, consultation, and training resources.

Improve follow-up with members who are hospitalized for mental illness.

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care from emergency department (ED) settings, discharge planning, and handoffs to community settings for members with behavioral health needs.
- **Evaluate effectiveness of transition of care programs** to ensure timely follow-up with providers after hospital discharge and stabilization in the community.

- **Continue implementation and training for effective health plan participation** in the behavioral health rapid-cycle PIP.

Increase beneficiary participation in prevention and screenings.

- **Implement organization-wide strategies to contact members,** such as flagging enrollees who need screenings in the system, and to train member services, nurse advice line staff, and care managers to address the reasons for flagging during contact with the member.
- **Use the results of the annual access and availability survey** to evaluate provider compliance with appointment availability and after-hours telephone access and to follow up with providers who are noncompliant with appointment standards.
- **Use patient navigators for individualized assistance** in scheduling and completing screenings.
- **Evaluate care gap outreach programs** by evaluating methods used to identify care gaps, evaluating engagement programs and closure of care gaps through direct member, and provider engagement.
- **Evaluate structural barriers** by assessing availability of after-hours and weekend appointments, mobile screenings, and community-based screening events.

- **Consider a statewide focused study or survey** to identify barriers/facilitators to the provision/utilization of preventive screening services.

Improve health plan customer service to promote beneficiary and provider satisfaction with services.

- **Require service recovery programs** so health plan call center representatives have guidelines to follow for problem resolution.
- **Track trends and use data to improve service processes**, including service level reporting for customer service.
- **Train and empower front line employees to resolve enrollee complaints and grievances quickly and effectively,** including evaluation of data to identify failure points/root causes.
- **Evaluate the effectiveness of grievance and appeals resolution process** to address member dissatisfaction.
- **Use health consumer advisory committees** to determine opportunities to improve beneficiary satisfaction, including benefits or incentives.
- **Implement a provider complaint resolution process** to address provider dissatisfaction with timely resolution of provider complaints.

- **Continue to publish the HealthChoice Illinois Plan Report Card** to assist consumer choice when selecting a health plan.
- **Continue to work with the health plans to streamline the provider complaint resolution process** to address timely resolution and provider complaint dissatisfaction.

Improve Compliance with Provider Network Requirements

- **Improve accuracy of network provider data submission** by obtaining updated rosters from provider organizations that include all contracted providers within provider/physician groups, community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs).
- **Improve accuracy of the Specialty Pediatric Provider Network** through review of specialty provider contracts to validate the age groups served by network providers.
- **Improve accuracy of the HCBS Provider Network** through review of contracts and validation of the types of HCBS services provided.
- **Improve accuracy of the online and hard copy provider directory** by evaluating the frequency and effectiveness of completing directory audits and process for updating changes to the online and paper provider directory.
- **Improve accuracy of delegated vendor online directories** by conducting audits of the delegated dental and vision provider directories and holding delegated vendors accountable for remediation of audit findings.
- **Evaluate methods used to monitor open and closed PCP panels** and the process for updating the online directory for panel status changes.

- Continue to work with the HCBS waiver agencies to **develop an official list of approved HCBS waiver service providers** to allow for a more robust validation of network capacity for these providers.

Improve Oversight of Delegated Vendors

- **Improve oversight of delegated vendors** through compliance with conducting monthly joint operations meetings and quarterly review of vendor performance by the delegation oversight committee.
- **Develop delegation agreement, conduct a pre-delegation audit and implement oversight and monitoring** of the 24-hour CARES line.
- **Improve oversight of delegated dental and vision vendors** through regular audits of compliance with directory requirements and compliance with remediation of deficiencies identified as a result of directory audits.
- **Improve monitoring and oversight of delegated CC/CM vendors** for compliance with HCBS waiver caseloads requirements for CC/CM assigned to waiver enrollees.
- **Improve monitoring and oversight of delegated CC/CM vendors for compliance with waiver CC/CM training requirements**, including Elderly (ELD), BI, HIV, and Supportive Living Facility (SLF) waiver-specific required training.

Improve Critical Incident (CI) Reporting

- **Develop internal processes and reeducate staff** to improve compliance with reporting to the appropriate investigating authority.
- **Develop and implement a consistent process** and specific information required for closure of a CI event. The process should include evidence of outreach to the enrollee to ensure their health, safety, and welfare (HSW).

- Consider further refining CI definitions in order to ensure consistent reporting by the health plans.
- Consider providing education or guidance to the health plans on expected processes that must be documented to consider an incident closed/resolved.
- Consider providing guidance, or a formal approval of health plan process, on appropriate actions required to consider an incident closed/resolved if the enrollee is unable to reach post-event.
- Consider providing guidance to the health plans on whether fraud cases should be included in HSW/CI reporting or only included in compliance/ FWA reporting. If HFS intends for the health plans to include fraud cases in reporting, HFS should consider including the category in the *Critical Incident Guide* and providing additional direction related to appropriate reporting processes.

Improve Compliance with Key Leadership and CC/CM Staffing Requirements

- **Establish a process to confirm compliance with credentials/qualifications/experience** prior to hiring/assigning staff to manage waiver caseloads, especially for the physical disabilities (PD) and BI waivers.
- **Establish a process to monitor compliance** with key leadership staffing requirements.
- **Improve internal processes to notify the department** within two business days as required by contract for any staffing changes to key leadership positions.

- Consider requiring health plans to develop and audit process to ensure that required annual trainings, including general, waiver-specific, and waiver-specific hours, are completed with all CC/CM staff.
- Consider review of contractual licensure requirements to identify whether revisions are needed for specific key leadership positions (e.g., quality management coordinator).
- Examine implications for health plans not meeting requirements for required key leadership positions.
- Review the results of the key leadership staffing analysis against other available data to determine additional improvement opportunities for specific health plans.

2. Performance Measures

Overview

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 these areas:

- Access to Care
- Keeping Kids Healthy
- Women's Health
- Living With Illness
- Behavioral Health

HFS also contracts with HSAG, to conduct an annual validation of performance measures for the Primary Care Case Management (PCCM) Program and the Children's Health Insurance Program Reauthorization Act (CHIPRA). These results, along with additional measures and performance results, are presented in the appendices of this report.

HSAG is also contracted to validate quality withhold performance measures for the health plans participating in MLTSS. Results for the SFY 2018 MLTSS Quality Withhold Performance Measure Validation (PMV) validation are presented in this section.

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.[2-1] 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 the 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 and HFS-defined 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.

With statewide Medicaid expansion (HealthChoice Illinois) beginning in January 2018, HFS contracted with seven health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Due to Harmony acquiring Meridian, their data have been combined throughout this report and are displayed as Meridian, for a total of six health plans. Four of the HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only.

In this report, Illinois health plans' performance for required HEDIS 2019 measures is compared to NCQA's Quality Compass®[2-2] national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018, when available, which is an indicator of health plan performance on a national level (referred to as "percentiles" throughout this section of the report). Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2018 since this indicator is not published in Quality Compass.

To combine the HEDIS 2018 and HEDIS 2019 rates for Harmony and Meridian, a combined mean is calculated, weighted by the size of the eligible population within each health plan. This formula is used to compute the combined mean (X_c) for each applicable measure:

$$X_c = \frac{n_1 \overline{X}_1 + n_2 \overline{X}_2}{n_1 + n_2}$$

Where:

n_1 = number of Harmony beneficiaries in the eligible population

n_2 = number of Meridian beneficiaries in the eligible population

$\overline{X}_1$ = Harmony eligible population rate

$\overline{X}_2$ = Meridian eligible population rate

[2-1] NCQA. HEDIS & Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Nov 7, 2019.

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

Due to changes in the technical specifications for some measures in HEDIS 2019 (i.e., *Controlling High Blood Pressure*), NCQA does not recommend trending between 2019 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed.

Of note, NextLevel reported rates calculated using only administrative data for HEDIS 2018. Therefore, caution should be exercised when comparing NextLevel's measure results with a hybrid option to national benchmarks and to other health plans, which were established using administrative and/or medical record review (MRR) data.

The HEDIS 2018 statewide rates include additional health plans that had been providing services to HealthChoice Illinois beneficiaries; therefore, caution should be exercised when comparing to the HEDIS 2019 statewide rates.

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 benchmarks are illustrated within this report using proxy displays. Since the HEDIS process is retrospective, HEDIS 2018 results are calculated using calendar year (CY) 2017 data and HEDIS 2019 results are calculated using CY 2018 data.

Table 2-1 displays the health plans for SFY 2019.

Table 2-1—Health Plans for HEDIS 2019 Measure Performance

Health Plan Name	Abbreviation
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare (Serves Cook County only)	CountyCare
Harmony Health Plan of Illinois, Inc.*	Harmony
IlliniCare Health Plan	IlliniCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina
NextLevel Health Partners, LLC (Serves Cook County only)	NextLevel

* Harmony's data are combined with Meridian's data in this section of this report.

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

Table 2-2—HFS Required Measures by Domain of Care for HEDIS 2019

Measures
Access to Care
Adults' Access to Preventive/Ambulatory Health Services
Total

Measures
Adult BMI Assessment
Adult BMI Assessment
Ambulatory Care (per 1,000 Member Months)
ED Visits—Total
Outpatient Visits—Total
Annual Dental Visits
Annual Dental Visits
Keeping Kids Healthy
Childhood Immunization Status
Combination 2
Combination 3
Immunizations for Adolescents
Combination 1 (Meningococcal, Tdap)
Combination 2 (Meningococcal, Tdap, HPV)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Well-Child Visits in the First 15 Months of Life
Six or More Well-Child Visits
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Women's Health
Breast Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Total
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care

Measures
Living With Illness
Annual Monitoring for Patients on Persistent Medications
Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)
Diuretics
Total
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Testing
Eye Exam (Retinal) Performed
Medical Attention for Nephropathy
Controlling High Blood Pressure
Controlling High Blood Pressure
Medication Management for People With Asthma
Medication Compliance 50%—Total
Medication Compliance 75%—Total
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Statin Adherence 80%
Behavioral Health
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
Initiation of AOD Treatment—Total
Engagement of AOD Treatment—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Total

Summary of 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 2-3 presents the HEDIS 2018 and HEDIS 2019 rates for the measures in the Access to Care domain for the health plans and the statewide average compared percentiles, where applicable.

Table 2-3—Access to Care Domain Results for HEDIS 2018 and HEDIS 2019

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Access to Care								
Adults' Access to Preventive/Ambulatory Health Services								
Total	2018	★★ 76.48%	★★ 77.59%	★ 75.12%	★ 76.13%	★ 67.93%	★ 38.63%	★ 74.21%
	2019	★★★★★ 94.55%	★★ 77.14%	★ 74.68%	★★ 79.53%	★ 71.61%	★ 48.62%	★ 75.80%
Adult BMI Assessment								
Adult BMI Assessment	2018	★ 72.26%	★★★ 89.05%	★ 77.31%	★★★ 88.05%	★★ 81.92%	★ 25.04%†	★ 76.26%
	2019	★ 77.86%	★★ 87.79%	★★ 83.70%	★ 80.55%	★★★ 89.05%	★ 69.59%	★ 82.07%
Ambulatory Care (per 1,000 Member Months)								
*ED Visits—Total**	2018	★★★ 53.61	★★★ 53.05	★★ 64.69	★★★ 58.65	★★ 68.76	★★ 64.49	★★★ 58.33
	2019	★★★ 53.47	★★★ 56.64	★★ 63.83	★★★ 59.42	★★ 65.00	★★ 64.68	★★★ 59.07
Outpatient Visits—Total	2018	★★★★ 426.32	★★★★ 422.48	★ 280.20	★ 302.44	★ 270.25	★ 118.44	★★ 321.33
	2019	★★★ 370.24	★ 254.62	★ 275.87	★★ 308.34	★ 289.46	★ 136.85	★ 301.04

[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: Nov 7, 2019.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Annual Dental Visits								
Annual Dental Visits	2018	—	—	—	—	—	—	—
	2019	★★★★★ 69.31%	★★ 52.81%	★★★ 61.41%	★★★ 58.22%	★★ 55.27%	BR	★★★ 60.15%

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

† *NextLevel reported this measure using the administrative methodology in HEDIS 2018. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks calculated using the administrative and/or hybrid methodology.*

— *indicates the health plans were not required to report this measure in HEDIS 2018.*

BR indicates the rate was materially biased.

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average and measure rates for three of six (50.0 percent) health plans ranked at or above the 50th percentile for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure indicator for both HEDIS 2018 and HEDIS 2019.
- The statewide average and three of five (60.0 percent) health plans with reportable rates ranked at or above the 50th percentile for the *Annual Dental Visits* measure in HEDIS 2019.
- BCBSIL was the only health plan to exceed the 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Annual Dental Visits* measure indicators, demonstrating strength in these domains. Of note, BCBSIL's measure rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator improved by approximately 18 percentage points from HEDIS 2018 to HEDIS 2019.

Needs Work

- The statewide average and measure rates for three of six (50.0 percent) health plans fell below the 25th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Adult BMI Assessment* measure indicators for HEDIS 2019.
- NextLevel performed below the 50th percentile on every reportable measure indicator in this domain in HEDIS 2019, despite demonstrating improvement from HEDIS 2018 for the *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Adult BMI Assessment* measure indicators.

Access to Care Conclusions

In the Access to Care domain, the HEDIS 2019 statewide average for the *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Adult BMI Assessment* measure rates fell below the 25th percentile, indicating an area for improvement.

Of note, the measure rates for *Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total* should be used strictly for informational purposes only.

Keeping Kids Healthy

Illinois Medicaid provides healthcare to over 1.5 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 2-4 presents the HEDIS 2018 and HEDIS 2019 rates for the measures in the Keeping Kids Healthy domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-4—Keeping Kids Healthy Domain Results for HEDIS 2018 and HEDIS 2019

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Keeping Kids Healthy								
Childhood Immunization Status								
Combination 2	2018	★★★ 75.18%	★ 51.09%	★ 55.96%	★★ 73.99%	★★ 73.97%	★ 0.73%†	★ 66.05%
	2019	★★★ 76.64%	★★★ 75.18%	★ 51.34%	★ 69.35%	★★★★ 78.35%	★ 2.76%†	★ 67.17%
Combination 3	2018	★★ 68.13%	★ 49.64%	★ 51.09%	★★ 69.47%	★★ 68.61%	★ 0.00%†	★ 61.72%
	2019	★★★ 73.72%	★★★ 73.24%	★ 47.20%	★ 64.37%	★★ 69.59%	★ 2.34%†	★ 63.08%
Immunizations for Adolescents								
Combination 1 (Meningococcal, Tdap)	2018	★★★ 80.78%	★★★★ 86.62%	★★ 75.43%	★★★★★ 88.54%	★★★ 83.70%	★ 26.36%†	★★★ 81.64%
	2019	★★★ 85.40%	★★★ 80.29%	★★ 79.56%	★★★ 85.57%	★★★★ 85.89%	★ 28.04%†	★★★ 83.77%
Combination 2 (Meningococcal, Tdap, HPV)	2018	NC 33.82%	NC 39.42%	NC 28.22%	NC 34.80%	NC 30.90%	NC 4.55%†	NC 33.00%
	2019	★★★ 37.23%	★★★★ 39.42%	★★ 28.71%	★★★ 33.27%	★★★★ 38.93%	★ 6.27%†	★★★ 34.84%

[2-4] Illinois Department of Healthcare and Family Services. Annual Report, April 1, 2018. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/2018AnnualReport.pdf. Accessed on: Nov 8, 2019.

[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: Nov 8, 2019.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile Documentation—Total	2018	★★ 63.99%	★★★★ 86.62%	★★ 66.42%	★★★ 76.60%	★★★ 74.68%	★ 19.72%†	★★ 68.35%
	2019	★★ 73.72%	★★★★ 84.74%	★★★ 77.62%	★★ 70.98%	★★★ 77.62%	★★ 69.10%	★★ 75.28%
Counseling for Nutrition—Total	2018	★ 58.15%	★★★★ 80.54%	★★ 63.75%	★★★ 71.84%	★★ 65.06%	★ 12.76%†	★★ 63.79%
	2019	★★ 62.77%	★★★★ 81.31%	★★ 69.34%	★★ 64.25%	★★★ 69.59%	★★ 67.64%	★★ 67.79%
Counseling for Physical Activity—Total	2018	★★ 51.34%	★★★★ 75.18%	★★ 58.15%	★★★★ 68.72%	★★★ 60.51%	★ 8.19%†	★★ 58.28%
	2019	★★ 61.56%	★★★★ 78.19%	★★★ 66.91%	★★ 61.61%	★★ 63.26%	★★ 63.02%	★★★ 65.14%
Well-Child Visits in the First 15 Months of Life								
Six or More Well-Child Visits	2018	★★ 61.56%	★★★ 67.15%	★ 51.34%	★★★★★ 72.52%	★★★★★ 73.89%	★ 20.62%†	★★★ 63.33%
	2019	★★ 63.02%	★★ 65.45%	★★ 61.31%	★★ 64.95%	★★★ 67.88%	★ 32.74%	★★ 63.92%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life								
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	2018	★★★ 77.62%	★★★★ 79.56%	★★★ 72.75%	★★★★ 79.78%	★★★ 74.39%	★ 38.24%†	★★★ 77.17%
	2019	★★★ 76.40%	★★★★ 80.29%	★★ 70.80%	★★★ 76.31%	★★ 69.83%	★ 58.15%	★★★ 75.68%

† *NextLevel reported this measure using the administrative methodology in HEDIS 2018 and HEDIS 2019. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks calculated using the administrative and/or hybrid methodology.*

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 2018.

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average and measure rates for four of six (66.7 percent) health plans ranked at or above the 50th percentile for both *Immunizations for Adolescents* measure indicators for HEDIS 2019.
- The statewide average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator demonstrated an increase of approximately 7 percentage points from HEDIS 2018 to rank at or above the 50th percentile in HEDIS 2019. Of note, BCBSIL, IlliniCare, and NextLevel demonstrated improvement, with rate increases of greater than 8 percentage points.
- CountyCare performed at or above the 50th percentile for eight of nine (88.9 percent) measure indicators in the Keeping Kids Healthy domain for HEDIS 2019, demonstrating strength in this domain for the health plan.

Needs Work

- Despite demonstrating improvement from HEDIS 2018 to HEDIS 2019, the statewide average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total* continued to fall below the 50th percentile in HEDIS 2019.
- The statewide average and measure rates for five of six (83.3 percent) health plans for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* fell below the 50th percentile for HEDIS 2019. Additionally, Meridian and Molina each had rate declines of more than 6 percentage points from HEDIS 2018 to HEDIS 2019, demonstrating opportunities to ensure young children receive necessary well-child visits.
- Despite some large increases in measure rates from HEDIS 2018 to HEDIS 2019 (due to NextLevel reporting some measure indicators using the hybrid methodology in HEDIS 2019), NextLevel performed below the 25th percentile for six of nine (66.7 percent) measure indicators in the Keeping Kids Healthy domain for HEDIS 2019.

Keeping Kids Healthy Conclusions

In the Keeping Kids Healthy domain, the HEDIS 2019 statewide average ranked above the 50th percentile for only four of nine (44.4 percent) measure rates. Despite slight increases in the rates from HEDIS 2018, the *Childhood Immunization Status* measure rates continued to fall below the 25th percentile, indicating opportunities to increase immunizations for children. Additionally, the statewide average fell below the 50th percentile for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure indicator, demonstrating opportunities for health plans to ensure young children receive necessary well-child visits.

Women's 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, more effective treatment, and fewer deaths.[2-6]

Table 2-5 presents the HEDIS 2018 and HEDIS 2019 rates for the measures in the Women's Health domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-5—Women's Health Domain Results for HEDIS 2018 and HEDIS 2019

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Women's Health								
Breast Cancer Screening								
Breast Cancer Screening	2018	NC 55.54%	NC 63.08%	NC 54.80%	NC 57.11%	NC 51.72%	NA	NC 56.15%
	2019	★★ 56.28%	★★★★ 64.28%	★★ 53.41%	★★ 57.25%	★ 47.22%	★ 22.26%	★★ 55.91%
Cervical Cancer Screening								
Cervical Cancer Screening	2018	★★★ 62.53%	★★★ 61.31%	★★ 55.69%	★★★★ 65.97%	★★ 54.57%	★ 21.12%†	★★★ 58.92%
	2019	★ 53.53%	★★★ 61.22%	★ 51.58%	★★★ 60.72%	★★ 56.20%	★ 34.06%	★★ 56.83%
Chlamydia Screening in Women								
Total	2018	★★★ 58.51%	★★★ 62.81%	★★★ 60.13%	★★ 55.16%	★★★ 62.02%	★★★★ 66.77%	★★★ 58.03%
	2019	★★★ 58.42%	★★★★ 66.39%	★★★ 58.50%	★★ 55.36%	★★★ 60.60%	★★★ 63.92%	★★★ 59.38%
Prenatal and Postpartum Care								
Timeliness of Prenatal Care	2018	★★ 82.24%	★ 76.40%	★★ 83.10%	★★★ 86.93%	★★ 82.91%	★ 52.26%†	★★ 81.92%
	2019	★★★★ 90.02%	★★★ 86.84%	★★ 79.08%	★★★★ 87.68%	★★ 82.00%	★ 61.80%	★★★ 86.26%

[2-6] The Community Guide. *Cancer Screening: Evidenced-Based Interventions for Your Community*. Available at: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-CancerScreening.pdf. Accessed on: Nov 14, 2019.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Postpartum Care	2018	★★★ 67.88%	★★ 60.34%	★★ 60.87%	★★★★ 72.17%	★★ 60.55%	★ 37.33%†	★★★ 65.94%
	2019	★★★ 68.13%	★★ 63.29%	★★ 59.85%	★★★ 67.68%	★★ 61.31%	★ 46.47%	★★★ 65.35%

† *NextLevel reported this measure using the administrative methodology in HEDIS 2018. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks calculated using the administrative and/or hybrid methodology.*

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

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 2018.

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average and measure rates for five of six (83.3 percent) health plans ranked at or above the 50th percentile for the *Chlamydia Screening in Women—Total* measure indicator for HEDIS 2019.
- For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, performance improved for four of six (66.7 percent) health plans resulting in the statewide average improving from HEDIS 2018 to rank at or above the 50th percentile in HEDIS 2019. Of note, BCBSIL and Meridian demonstrated improvement from HEDIS 2018 to rank at or above the 75th percentile in HEDIS 2019.
- CountyCare was the only health plan to perform at or above the 75th percentile for the *Breast Cancer Screening* and *Chlamydia Screening in Women—Total* measure indicators for HEDIS 2019.

Needs Work

- The statewide average and measure rates for five of six (83.3 percent) health plans fell below the 50th percentile for the *Breast Cancer Screening* measure for HEDIS 2019. Of note, two of these health plans (Molina and NextLevel) fell below the 25th percentile.
- The statewide average for the *Cervical Cancer Screening* measure declined from HEDIS 2018 to rank below the 50th percentile in HEDIS 2019. Additionally, measure rates for four health plans declined from HEDIS 2018, with one health plans' rate (BCBSIL) declining by 9 percentage points and falling below the 25th percentile in HEDIS 2019.
- IlliniCare, Molina, and Next Level performed below the 50th percentile for both *Prenatal and Postpartum Care* measure indicators for HEDIS 2019, demonstrating opportunities for improvement for these health plans.

Women's Health Conclusions

In the Women's Health domain, the HEDIS 2019 statewide average ranked above the 50th percentile for three of the five (60.0 percent) measure rates. Conversely, the statewide average for the *Breast Cancer Screening* and *Cervical Cancer Screening* measure indicators fell below the 50th percentile, demonstrating opportunities for health plans to ensure women receive appropriate screenings.

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 2-6 presents the HEDIS 2018 and HEDIS 2019 rates for the measures in the Living With Illness domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-6—Living With Illness Domain Results for HEDIS 2018 and HEDIS 2019

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Living With Illness								
Annual Monitoring for Patients on Persistent Medications								
ACE Inhibitors or ARBs	2018	★★★ 88.64%	★ 85.84%	★★★ 90.02%	★ 83.33%	★★★ 88.29%	★ 81.75%	★★ 86.97%
	2019	NR	★★★ 88.37%	★★★★ 90.85%	★★ 86.23%	★★★ 89.03%	★ 84.28%	★★★ 88.27%
Diuretics	2018	★★ 87.41%	★ 84.76%	★★★ 89.58%	★ 82.91%	★★★ 88.07%	★ 81.64%	★★ 86.21%
	2019	NR	★★ 87.69%	★★★ 90.58%	★ 85.39%	★★★ 88.75%	★ 84.48%	★★ 87.72%
Total	2018	NC 88.15%	NC 85.36%	NC 89.84%	NC 83.16%	NC 88.20%	NC 81.70%	NC 86.65%
	2019	NR	★★ 88.07%	★★★★ 90.74%	★ 85.89%	★★★ 88.91%	★ 84.36%	★★ 88.04%
Comprehensive Diabetes Care								
HbA1c Testing	2018	★★★ 88.56%	★★★ 88.81%	★★★ 88.09%	★★★ 88.37%	★★★ 87.59%	★ 69.46%†	★★★ 88.00%
	2019	★★★ 90.27%	★★★ 90.27%	★★★ 88.56%	★★★ 88.08%	★★ 86.62%	★ 76.89%	★★★ 88.89%
Eye Exam (Retinal) Performed	2018	★ 46.23%	★★ 53.53%	★★★ 60.20%	★★★ 56.14%	★★★ 60.34%	★ 22.39%†	★★★ 55.83%
	2019	★★ 57.66%	★★ 53.28%	★★★ 58.39%	★★★ 60.88%	★★ 54.01%	★ 31.14%	★★ 56.69%

[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: Nov 19, 2019.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Medical Attention for Nephropathy	2018	★★ 89.29%	★★★★ 92.21%	★★★ 91.51%	★★ 89.82%	★★★ 90.75%	★ 84.04%†	★★★ 90.58%
	2019	★★★★★ 94.16%	★★ 90.27%	★★★ 91.31%	★★ 90.35%	★ 87.59%	★ 84.67%	★★★ 91.24%
Controlling High Blood Pressure								
Controlling High Blood Pressure[1]	2018	NC —	NC —	NC —	NC —	NC —	NC —	NC —
	2019	NC 48.66%	NC 50.12%	NC 48.91%	NC 50.90%	NC 57.66%	NC 37.71%	NC 50.04%
Medication Management for People With Asthma								
Medication Compliance 50%—Total[2]	2018	★★ 54.29%	★ 44.62%	★★ 56.54%	★★★ 64.81%	★★ 52.61%	★★★★★ 75.38%	★★ 56.85%
	2019	★★ 55.95%	★ 53.35%	★★ 58.42%	★★ 55.43%	★ 53.38%	★★ 54.74%	★★ 55.44%
Medication Compliance 75%—Total	2018	★★ 29.20%	★ 19.58%	★★ 31.95%	★★★★ 42.54%	★ 27.22%	★★★★★ 53.85%	★★ 32.73%
	2019	★★ 32.46%	★ 26.84%	★★ 35.05%	★★ 32.04%	★★ 30.54%	★ 22.11%	★★ 31.59%
Statin Therapy for Patients With Diabetes								
Received Statin Therapy	2018	★★★★ 66.94%	★★ 59.13%	★★★★★ 68.13%	★★★ 64.04%	★★★ 63.13%	★ 57.35%	★★★★ 65.07%
	2019	★★★★★ 70.74%	★★★★★ 69.60%	★★★★★ 69.84%	★★★★ 66.80%	★★★ 64.49%	★ 54.04%	★★★★ 68.49%
Statin Adherence 80%	2018	★ 50.35%	★★★ 60.00%	★★ 58.68%	★★★ 63.46%	★★ 54.45%	★★★★ 67.40%	★★ 59.19%
	2019	★★ 58.90%	★★★ 61.12%	★★★★ 66.11%	★★ 57.58%	★★★ 60.50%	★ 47.35%	★★★ 60.28%

[1] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.*

[2] *Quality Compass benchmarks were not available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes.*

† *NextLevel reported this measure using the administrative methodology in HEDIS 2018. Caution should be exercised when comparing administrative-only rates to other health plans and to national benchmarks calculated using the administrative and/or hybrid methodology.*

NR indicates the health plan did not report the rate.

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

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 2018 or HEDIS 2019.

— indicates that NCQA recommended a break in trending; therefore, the HEDIS 2018 rate is not displayed.

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average and measure rates for three of five (60.0 percent) health plans with reportable rates ranked at or above the 50th percentile for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure indicator.
- The statewide average ranked at or above the 50th percentile for two of the *Comprehensive Diabetes Care* measure indicators (*HbA1c Testing* and *Medical Attention for Nephropathy*). For the *HbA1c Testing* measure indicator, measure rates for three of six (50.0 percent) health plans demonstrated improvement from HEDIS 2018 and ranked at or above the 50th percentile in HEDIS 2019. Of note, BCBSIL's rate for the *Medical Attention for Nephropathy* measure indicator improved by 5 percentage points, exceeding the 90th percentile in HEDIS 2019.
- The statewide average and measure rates for four of six (66.7 percent) health plans ranked at or above the 75th percentile for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator.
- IlliniCare's rates for eight of 10 (80.0 percent) measures that could be compared to benchmarks in this domain ranked at or above the 50th percentile for HEDIS 2019. Of note, four of these measure rates ranked at or above the 75th percentile, demonstrating strength for IlliniCare in the Living With Illness domain.

Needs Work

- The statewide average and measure rates for three of five (60.0 percent) health plans with reportable rates fell below the 50th percentile for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* and *Total* measure indicators.
- The statewide average and measure rates for four of six (66.7 percent) health plans for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator fell below the 50th percentile in HEDIS 2019.
- The statewide average for both *Medication Management for People With Asthma* measure indicators demonstrated slight rate declines from HEDIS 2018 and continued to fall below the 50th percentile. Of note, measure rates for all six health plans for both measure indicators also fell below the 50th percentile in HEDIS 2019, with both Meridian and NextLevel demonstrating large rate declines from HEDIS 2018.
- NextLevel's rates for nine of 10 (90.0 percent) measures that could be compared to benchmarks in this domain fell below the 25th percentile for HEDIS 2019. Similarly, measure rates for CountyCare fell below the 50th percentile for six of 10 (60.0 percent) measures that could be compared to benchmarks in this domain.

Living With Illness Conclusions

In the Living With Illness domain, the HEDIS 2019 statewide average exceeded the 75th percentile for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator, indicating strength. Conversely, the statewide average fell below the 50th percentile for five of the 10 (50.0 percent) measure rates that could be compared to benchmarks. Of note, the statewide average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked at or above the 50th percentile in HEDIS 2018; however, despite a slight rate increase in HEDIS 2019, the measure rate fell below the 50th percentile. The health plans should ensure beneficiaries with diabetes receive appropriate eye exams to ensure the measure rate does not continue to fall.

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 2-7 presents the HEDIS 2018 and HEDIS 2019 rates for the measures in the Behavioral Health domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-7—Behavioral Health Domain Results for HEDIS 2018 and HEDIS 2019

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Behavioral Health								
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	2018	NC 18.54%	NC 24.70%	NC 31.37%	NC 36.04%	NC 29.40%	NC 9.94%	NC 28.65%
	2019	★ 17.87%	★ 25.38%	★ 28.75%	★★ 31.08%	★★ 29.69%	★ 5.27%	★ 26.08%
30-Day Follow-Up—Total	2018	NC 32.76%	NC 39.95%	NC 49.90%	NC 56.27%	NC 53.95%	NC 18.83%	NC 46.36%
	2019	★ 33.70%	★ 41.48%	★ 49.37%	★★ 51.36%	★★ 52.25%	★ 11.84%	★ 44.54%
Initiation and Engagement of AOD Abuse or Dependence Treatment								
Initiation of AOD Treatment—Total	2018	NC 46.40%	NC 41.98%	NC 48.20%	NC 42.41%	NC 40.19%	NC 47.68%	NC 44.08%
	2019	★★★ 45.18%	★★★ 44.03%	★★★★ 47.55%	★★★ 42.23%	★★ 40.16%	★★★★★ 50.25%	★★★ 44.14%
Engagement of AOD Treatment—Total	2018	NC 14.61%	NC 10.78%	NC 16.16%	NC 13.85%	NC 9.67%	NC 11.29%	NC 12.97%
	2019	★★★ 14.32%	★★ 12.67%	★★★ 16.93%	★★★ 15.42%	★★ 9.44%	★★ 12.74%	★★★ 14.15%

[2-8] U.S. Department of Health and Human Services. 2020 Topics & Objectives: Mental Health and Mental Disorders. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: Nov 14, 2019.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Total	2018	★★★ 38.58%	★★★ 32.53%	★★ 27.09%	★★★ 33.09%	★★ 29.20%	NA	★★★ 33.45%
	2019	★★★ 40.82%	★★★ 32.95%	★★★ 33.24%	★★★ 33.03%	★★★ 35.25%	★ 25.00%	★★★ 35.08%

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

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 2018.

Star ratings represent the following percentile comparisons:

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

Notable

- For both the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure indicators, the statewide average ranked at or above the 50th percentile, with five of six (83.3 percent) health plans ranking at or above the 50th percentile for the *Initiation of AOD Treatment—Total* measure indicator and three of six (50.0 percent) health plans ranking above the 50th percentile for the *Engagement of AOD Treatment—Total* measure indicator. Of note, IlliniCare's measure rate ranked at or above the 75th percentile and NextLevel's measure rate exceeded the 90th percentile for the *Initiation of AOD Treatment—Total* measure indicator.
- The statewide average and measure rates for five of six (83.3 percent) health plans ranked at or above the 50th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics*. Of note, measure rates for IlliniCare and Molina improved by approximately 6 percentage points from HEDIS 2018, ranking at or above the 50th percentile in HEDIS 2019.

Needs Work

- The statewide average and measure rates for four of six (66.7 percent) health plans fell below the 25th percentile for both *Follow-Up After Hospitalization for Mental Illness* measure indicators. Additionally, the two remaining health plans (Meridian and Molina) ranked at or above the 25th percentile, but below the 50th percentile, for both measure indicators.

Behavioral Health Conclusions

Within the Behavioral Health domain, the statewide average for HEDIS 2019 ranked at or above the 50th percentile for three of five (60.0 percent) measure rates. Conversely, the statewide average and measure rates for all six health plans ranked below the 50th percentile for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, demonstrating opportunities to ensure timely follow-up with beneficiaries after a discharge for mental illness from a hospital.

Recommendations for Improving Performance Measure Rates

HSAG recommends that HFS work with the health plans to analyze and identify components for the measure rates noted in this section that would lead to improved care for beneficiaries and improved measure rates. Health plans should conduct a root cause analysis of measure indicators that have been identified as areas of low performance to determine the nature and scope of problems, identify causes and their interrelationships, identify specific populations for targeted interventions, and establish potential performance improvement strategies and solutions.

Further, health plans are encouraged to use the Plan-Do-Study-Act (PDSA) worksheet for any interventions.[2-9] HSAG recommends that the health plan frequently measure and monitor targeted interventions to provide timely, ongoing feedback regarding the effectiveness of interventions in achieving desired results.

[2-9] Institute for Healthcare Improvement. *Plan-Do-Study-Act (PDSA) Worksheet*. Available at: http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed on: Nov 19, 2019.

Managed Long Term Services and Supports (MLTSS) Performance Measure Validation (PMV) Results

Introduction

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

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures for data collected by the health plans during CY 2017. HFS selected two measures for validation:

- MLTSS Measure 2.2: Moderate- and high-risk members with a comprehensive assessment completed within required timeframes.
- MLTSS Measure 3.2: Enrollees with documented discussions of person-centered care goals.

HFS selected one measure for validation of data collected by the health plans during CY 2018:

- MLTSS Measure IL 3.6: Movement of Members within Service Populations (non-HEDIS, state-defined measure).

To ensure full submission of data and complete all validation activities, HFS scheduled the MLTSS Quality Withhold PMV of Measure 2.2 and Measure 3.2 for completion during SFY 2019; validation of Measure 3.6 was completed as part of the separate HEDIS and non-HEDIS validation process during SFY 2019.

Methodology

Measure 2.2 and Measure 3.2

HSAG validated the data collection and reporting processes used by the health plans to report the quality withhold performance measure data for CY 2017 in accordance with the CMS publication *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[2-10] Details regarding the methodology are provided in Appendix B5 of this report.

[2-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 4, 2019.

Measure 3.6

HSAG completed a validation of Measure 3.6, for data collected by the health plans during CY 2018. The validation was conducted via an NCQA HEDIS Compliance Audit, in accordance with NCQA's *HEDIS 2019, Volume 5: HEDIS Compliance Audit Standards, Policies and Procedures* and *HEDIS 2019, Volume 2: Technical Specifications for Health Plans*. Details regarding the methodology are provided in Appendix B5 of this report.

Results

Measure 2.2 and Measure 3.2

HSAG completed PMV for the four health plans with MLTSS enrollees during CY 2017: Aetna Better Health, Inc. (Aetna), BCBSIL, IlliniCare, and Meridian. HSAG's PMV of Measure 2.2 found that three (Aetna, BCBSIL, and IlliniCare) of the four health plans did not have a process to differentiate enrollees per the technical specifications for the measure or had critical errors that led to incorrect categorization. As a result, only Meridian received a validation categorization of Report: measure data were compliant with CMS' specifications and the data, as reported, were valid. HSAG's PMV of Measure 3.2 found that three (Aetna, BCBSIL, and IlliniCare) of the four health plans did not have a process to differentiate enrollees per the technical specifications for the measure or had critical errors that led to incorrect categorization. One health plan, Meridian, could differentiate enrollees per the technical specifications for the measure; however, the PMV identified a lack of compliance to reporting requirements. As a result, all four health plans received a validation categorization of Not Reported (NR): measure data were materially biased.

Measure 3.6

HSAG's HEDIS Compliance Audit was completed for all seven health plans with MLTSS enrollees during CY 2018: BCBSIL, CountyCare, Harmony, IlliniCare, Meridian, Molina, and NextLevel. All health plans received a final result categorization of Reportable: a reportable rate was submitted for the measure.

Detailed Results

Detailed results are provided in Appendix B6 of this report.

Centers for Medicare & Medicaid Services (CMS) Home- and Community-Based Services (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/identify problems/issues 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 on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This summary of findings for the SFY 2019 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.

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 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

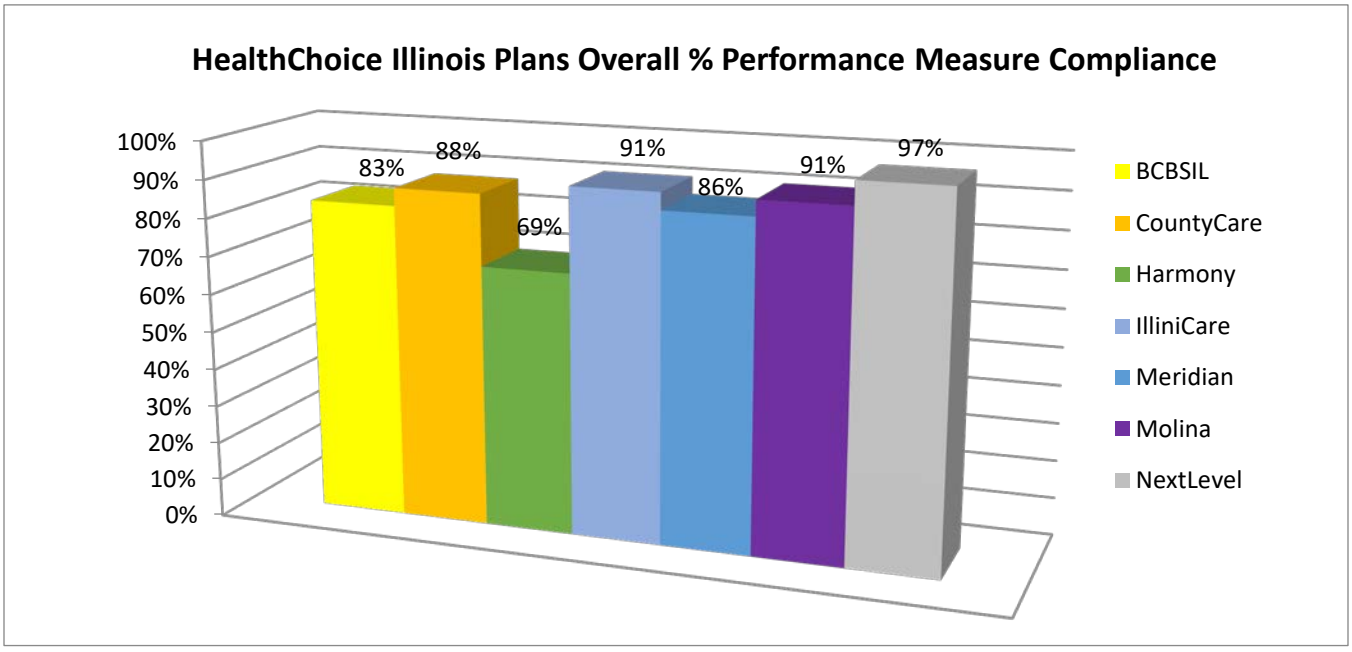
Table 2-8 displays the HealthChoice Illinois health plans reviewed by quarter for SFY 2019. A total of seven HealthChoice Illinois health plans were reviewed during SFY 2019. Due to an acquisition, Harmony Health Plan exited the HealthChoice Illinois market and was no longer reviewed effective the third quarter (Q3) of SFY 2019 (data for Harmony is provided through the second quarter (Q2) of SFY 2019). During SFY 2019, 1,576 records were reviewed utilizing HSAG's web-based data collection tool. As a result, 2,155 findings of noncompliance were identified.

Table 2-8—HealthChoice Illinois Plans Reviewed by Quarter SFY 2019

Health Plan	Q1	Q2	Q3	Q4
BCBSIL	X	X	X	X
CountyCare	X	X	—	X
Harmony	X	X	—	—
IlliniCare	X	X	X	X
Meridian	X	X	X	X
Molina	X	X	X	X
NextLevel	—	X	—	X

Figure 2-1 displays a computed average of the total performance achieved by each health plan on all 15 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 15 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.

Figure 2-1—Overall Compliance



Three of the seven health plans averaged 90 percent or greater overall compliance in SFY 2019. There was a 28-percentage point difference (69 percent to 97 percent) among health plans (Harmony was reviewed in the first quarter [Q1] and Q2 only).

The health plans had the greatest opportunities for improvement related to the following performance measures:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, which averaged 28 percent compliance during SFY 2019.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan,* which averaged 59 percent compliance during SFY 2019.

Health plans also had opportunity for improvement in the BI and HIV waivers related to measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record,* which averaged 51 percent and 42 percent compliance, respectively, during SFY 2019.

MMAI Record Reviews

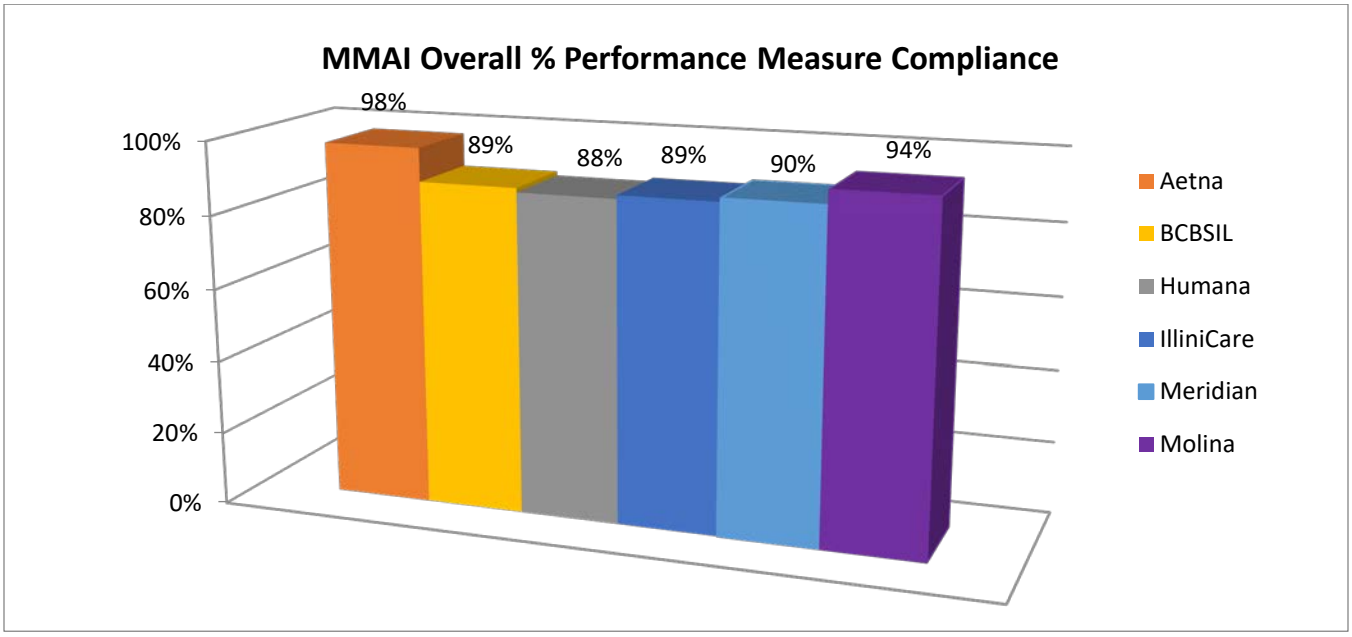
Table 2-9 displays the MMAI health plans reviewed by quarter. A total of six MMAI health plans were reviewed during SFY 2019. During SFY 2019, 1,248 records were reviewed using HSAG's web-based data collection tool. As a result, 1,257 findings of noncompliance were identified.

Table 2-9—MMAI Health Plans Reviewed by Quarter SFY 2019

MMAI Health Plan	Q1	Q2	Q3	Q4
Aetna	X	X	X	X
BCBSIL	X	X	X	X
Humana	X	X	—	X
IlliniCare	X	X	X	X
Meridian	X	X	X	X
Molina	X	X	X	X

Figure 2-2 displays a computed average of the total performance achieved by each health plan on all 15 CMS waiver performance measures reviewed by HSAG during SFY 2019. Each health plan's overall average on the 15 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.

Figure 2-2—Overall Compliance



Three of the six health plans averaged 90 percent or greater overall compliance in SFY 2019. There was a 10-percentage point difference (88 percent to 98 percent) among health plans.

The health plans had the greatest opportunities for improvement related to the following performance measures:

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, which averaged 30 percent compliance during SFY 2019.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan*, which averaged 65 percent compliance during SFY 2019.

Health plans also had opportunity for improvement in the BI and HIV waivers related to measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, which averaged 64 percent and 58 percent compliance, respectively, during SFY 2019.

Remediation, Health Plan Interventions, and Process Improvements

Remediation

As a result of the on-site reviews, HSAG identified noncompliant performance measures. The health plans received their individualized report of findings subsequent to each on-site record review and were required to remediate the noncompliant findings and implement performance improvement strategies to improve the quality of CC/CM activities for the waiver enrollees.

Remediation actions were defined in the HealthChoice Illinois and MMAI contracts and were specific to each CMS waiver performance measure. The time frame for remediation of findings was 60 days, except for two measures, 42G and 49G, which fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. Compliance with timely remediation of these findings was monitored by HSAG through review of completion of remediation actions within 30 and 60 days, as required by CMS and HFS. During SFY 2019, all health plans demonstrated full compliance with completion of remediation action documentation for all noncompliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans. Remediation validation for the health plans was conducted on-site during the Q2 and fourth quarter (Q4) SFY 2019 waiver performance measure reviews. Results of this validation are included in Appendix B6.

Health Plan Interventions

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG recommendations following the conclusion of SFY 2018 reviews, efforts to incorporate TA received during on-site reviews, and efforts to integrate HFS guidance into internal processes. Interventions and process improvements are summarized in Appendix B6.

HCBS Provider Network Monitoring

As described in Section 5, HSAG validates and monitors the network of HCBS providers for each health plan serving HCBS waiver enrollees.

EQRO TA

To assist with the health plans with improvement efforts, HSAG provided ongoing TA to the health plans throughout SFY 2019. TA was provided during the on-site record reviews, as requested by health plans and following HFS approval. TA included guidance on:

- Validation of waiver service provision.

- Effective preparation for HCBS on-site record reviews.
- HFS-valid justification for contact with enrollees.
- Person-centered planning with enrollees.
- Home modifications inclusions on waiver service plans.
- Timely assignment of case managers for newly eligible waiver enrollees.
- Timely case reassignment for enrollees who require a new case manager.
- Timely enrollee contact to ensure waiver service implementation and enrollee satisfaction.
- Effective use of online record review result reports.

3. Evaluation of Administrative and Compliance Processes

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

Administrative Compliance Reviews

One mandatory EQR requirement is a review, conducted within the previous three-year period, to determine the health plan's compliance with the standards set forth in subpart D of 42 CFR §438.358 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. In the prior fiscal year, HSAG completed the administrative compliance reviews by assessing the remaining standards for the five health plans that were exiting the Illinois Medicaid market and reviewing the remaining standards in the readiness review process for the seven health plans serving HealthChoice Illinois. In SFY 2019, HSAG engaged in preparatory activities for the next three-year review period. In collaboration with HFS, HSAG determined the scope of the review and scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the development of review tools. On-site reviews were scheduled for September 2019; therefore, compliance review results will be reported in the next EQR Technical Report.

HealthChoice Illinois Readiness Reviews

Federal regulations at 42 CFR §438.66(d)(2) require states to conduct comprehensive readiness reviews to verify whether contracted health plans are prepared to provide services prior to enrolling Medicaid beneficiaries in managed care. HFS implemented HealthChoice Illinois—the State's rebooted Medicaid managed care program—on January 1, 2018, to provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. As part of implementation of the HealthChoice Illinois program, HFS contracted with HSAG to conduct HealthChoice Illinois Pre-Implementation Readiness Reviews (Pre-Implementation Reviews) of each of the health plans selected to participate in HealthChoice Illinois to assess the health plans' processes, care coordination, provider network, staffing, contract oversight, and systems to ensure the capacity to serve new enrollment.

HSAG published the results of the Pre-Implementation Reviews in the prior fiscal year. As a follow-up to these reviews, HFS will require HSAG to conduct HealthChoice Illinois Post-Implementation Reviews (Post-Implementation Reviews), scheduled for SFY 2020, to assess whether the health plans have implemented corrective actions to remediate deficiencies identified in the Pre-Implementation Review. In SFY 2019, HSAG worked with HFS to determine the requirements to be included in the Post-Implementation Reviews to address standards in the operational areas of access, structure and operations, and measurement and improvement, as applicable to each health plan, based on areas of follow-up identified in the Pre-Implementation Reviews. HSAG also worked to develop a series of file reviews to assess compliance in various standards.

Post-Readiness Review Focused Remediation

The Pre-Implementation Reviews identified several areas of noncompliance across all health plans. HSAG and HFS designed an iterative process to assist the health plans throughout SFY 2019 to remediate the areas of noncompliance described below.

Cultural Competence Plan

A review of each health plan's cultural competence plan and associated policies and procedures was conducted during the Pre-Implementation Reviews to validate whether the plan addressed the challenges of meeting the healthcare needs of enrollees and the required contract standards and the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). Table 3-1 below identifies health plan compliance throughout the remediation process.

Table 3-1—Cultural Competence Plan Review Scores

Health Plan	Review Stage	Total Elements	Elements Met	Elements Not Met	Percent Compliance
BCBSIL	Initial Review	29	23	6	79%
	Post Remediation		29	0	100%
CountyCare	Initial Review	29	22	7	76%
	Post Remediation		23	6	79%
	Second Remediation		29	0	100%
Harmony	Initial Review	29	24	5	83%
	Post Remediation		26	3	90%
	Second Remediation		29	0	100%
IlliniCare	Initial Review	29	21	8	72%
	Post Remediation		27	2	93%
	Second Remediation		29	0	100%
Meridian	Initial Review	29	22	7	76%
	Post Remediation		29	0	100%
Molina	Initial Review	29	20	9	69%
	Post Remediation		23	6	79%
	Second Remediation		29	0	100%
NextLevel	Initial Review	29	26	3	90%
	Post Remediation		28	1	97%
	Second Remediation		29	0	100%

FWA Program

A review of each health plan's FWA program was conducted during each Pre-Implementation Review to verify that the plan had policies and procedures in place to comply with oversight, reporting, and investigation requirements. All health plan policies complied with the requirements; however, interviews with health plan staff did not verify compliance with the organizational structure for oversight and reporting of FWA. Therefore, HSAG requested that the health plans submit organizational charts to depict the structure and reporting requirements for the compliance committee and the FWA reporting requirements for the compliance officer.

All health plans submitted documentation that demonstrated compliance with requirements.

Provider Directory Review (Dental/Vision)

HSAG conducted a dental and vision provider directory file review to check the accuracy of information for dental and vision providers in the online electronic provider directory. The health plan is required to maintain and monitor the accuracy of its online and hardcopy provider directories. A random sample of five dental and five vision providers were selected from each health plans provider network data file. HSAG evaluated 12 data elements for each sampled provider:

- Name of provider
- Gender
- Address (location)
- Telephone number
- Specialty, skills, and training
- Office hours
- Languages spoken
- Board certification/licensing
- Accepting new patients
- Accessibility for people with physical disabilities
- Provider access by public transportation
- Provider directory available in print and on website

HSAG analyzed the provider directory information to determine the degree to which the health plan's provider directory complied with contract requirements. Table 3-2 below identifies health plan compliance throughout the remediation process.

Table 3-2—Provider Directory File Review Scores

Health Plan	Directory Type	Total Elements	Elements Met	Elements Not Met	Percent Compliance
BCBSIL	Dental	60	18	42	30%
	Vision		32	28	53%
CountyCare	Dental	60	34	26	57%
	Vision		31	29	52%
Harmony	Dental	60	48	12	80%
	Vision		36	24	60%
IlliniCare	Dental	60	60	0	100%
	Vision		60	0	100%
Meridian	Dental	60	19	41	32%
	Vision		60	0	100%
Molina	Dental	60	60	0	100%
	Vision		58	2	97%
NextLevel	Initial Review	60	52	8	87%
	Post Remediation		51	9	85%

Plans worked with vendors to address noncompliance. However, because they are national vendors, the revision process required an extended time period (changes were necessary at the national level). Therefore, the timeline for remediation was extended. HFS required continued work with vendors to achieve compliance, and HSAG will assess progress in the 2020 Post-Implementation Review (of all health plans).

Provider Disputes

HFS and its HealthChoice Illinois managed care health plans established a provider complaint and resolution system. As part of readiness, HFS, with assistance from HSAG, reviewed the health plans' provider complaint resolution policies and procedures and workflows to determine compliance with the HealthChoice Illinois model contract requirement to establish a provider complaint and resolution system for network and non-network providers. The review tool included the following review areas:

- Policy and procedure/workflow
- Intake process
- Tracking system(s)
- Documentation of resolution
- Timeliness of resolution
- Oversight and reporting
- Provider manual instructions on submitting a provider complaint

Table 3-3 below identifies health plan compliance throughout the remediation process.

Table 3-3—Provider Complaint and Resolution System Review

Health Plan	Review Stage	Total Elements	Elements Met	Elements Not Met	Percent Compliance
BCBSIL	Initial Review	27	5	22	19%
	Remediation		17	10	63%
	Second Remediation		27	0	100%
CountyCare	Initial Review	27	8	19	29%
	Remediation		19	8	68%
	Second Remediation		27	0	100%
Harmony	Initial Review	27	8	19	30%
	Remediation		26	1	96%
	Second Remediation		27	0	100%
IlliniCare	Initial Review	27	3	24	11%
	Remediation		14	13	52%
	Second Remediation		27	0	100%
Meridian	Initial Review	27	4	23	15%
	Remediation		19	8	70%
	Second Remediation		27	0	100%
Molina	Initial Review	27	1	26	4%
	Remediation		19	8	70%
	Second Remediation		27	0	100%
NextLevel	Initial Review	27	10	17	37%
	Remediation		25	2	93%
	Second Remediation		27	0	100%

Throughout the remediation process, HFS worked with health plans to develop a streamlined approach to resolve provider complaints. As a result, the Illinois Managed Care Provider complaint process is undergoing changes to improve complaint resolution and comply with requirements set forth in 305 Illinois Compiled Statutes (ILCS) 5/5-30.1. This statute requires HFS to maintain a provider complaint portal through which a provider can submit unresolved disputes with a health plan. Key changes include codified procedures, time frames, and self-service capabilities for providers and health plans. Unresolved disputes can be escalated to the HFS for final determination. An Administrative Rule has been drafted to support implementation of these procedures. The new system is also in development and expected to launch upon approval of the Administrative Rule.

Children's Behavioral Health

Illinois has a 24 hour CARES line. Delegation of the CARES line was reviewed during the Pre-Implementation Review and all plans were found to be noncompliant as they initially submitted scopes of work for operation of the CARES line but did not have delegation agreements in place that met the requirements.

HFS, HSAG, and the health plans worked together to establish requirements for delegation agreements with the goal that all health plans will execute agreements with 100 percent compliance. At the close of the remediation period, the health plans were in process of finalizing their CARES delegation agreements. Therefore, HFS designated CARES delegation as a follow-up item for the SFY 2020 compliance reviews.

CARES delegation agreements are required to include the following:

- Type of agreement/document submitted by plan
- Vendor monitoring and oversight plan in agreement
- Required reporting—type and frequency
- Crisis line—live answer (no telephonic menu)
- Availability 24/7/365 hours/days/year
- Crisis line staff qualifications—review of staff qualifications required by crisis line
- Crisis line staff training—staff educated on Disease Management Model for Children's Mental Health plan
- Policy and procedure

Corrective Action Monitoring

HSAG worked with HFS to monitor the health plans' efforts to remediate noncompliant findings. Plan-specific reports were produced that identified all areas of noncompliance and documented corrective actions the health plan was required to take to remediate the findings and demonstrate compliance with requirements. In addition, HSAG created plan-specific follow-up grids to track each health plan's progress on remediating noncompliant findings that would be reassessed in their Post-Implementation Review.

For areas the health plans were found to not be meeting expected performance levels or standards, a corrective action plan (CAP) was developed. The CAP detailed the identified deficiencies and provided a reporting structure for the health plan to demonstrate progress toward improvement, including the goals of the corrective action; the timelines associated with the actions; the identified changes in processes, structure, and internal and external education; the type of follow-up monitoring, evaluation, and improvement required; and the identified improvements and enhancements of existing outreach and

care-management activities, if applicable. HSAG monitored and evaluated corrective actions taken to assure that appropriate changes were made and were effective and conducted reevaluations to assess the sufficiency of the health plan's interventions, activities, and timelines to determine whether the actions would reasonably bring the health plan's performance into full compliance with the requirements.

During SFY 2019, the following CAPs were developed, reviewed, and remediated:

- Aetna: grievances and appeals
- BCBSIL: grievances and appeals and HCBS
- CountyCare: HCBS
- Humana: HCBS

Aetna's findings included:

- Noncompliance with timely processing of grievances and appeals and written acknowledgment to the enrollee of the receipt of a grievance and/or appeal.
- Staffing shortages within the grievances and appeals department, resulting in untimely processing and backlog of grievances and appeals.
- System issues in the grievances and appeals documentation system.
- Lack of oversight by the Quality Management Oversight Committee and the compliance officer to monitor and evaluate corrective actions to assure that appropriate changes were made to resolve noncompliance with the processing of grievances and appeals.
- Unclear handoff of quality of care grievances between the quality department and the grievances and appeals department, resulting in untimely processing and closure of quality of care grievances.

BCBSIL's HCBS findings included:

- Noncompliance with timely care management activities, including enrollee outreach, health risk assessment (HRA), care planning, and waiver service planning.
- Lack of process for accurate identification of newly eligible waiver beneficiaries.

BCBSIL was placed on a focused CAP for significant noncompliance with timely acknowledgement and resolution of both grievances and appeals and oversight of their delegated vendors contracted to process appeals. The focused CAP resulted in data and narrative submissions that required HSAG analysis and multiple on-site reviews with health plan leadership and department staff. BCBSIL made substantial process improvements, resulting in the closure of its CAP in SFY 2020.

CountyCare's findings included:

- Lack of oversight of its delegated entity related to HCBS care management.
- Noncompliance with care management activities, including risk stratification, waiver service planning, enrollee outreach, and interdisciplinary care team (ICT) activities.

- Lack of care coordination staff access to claims and utilization data to validate delivery of waiver services.
- Lack of follow-up to health, safety, and welfare (HSW) concerns identified during HSAG quarterly HCBS reviews.

Humana's findings included:

- Lack of waiver service validation process.
- Lack of oversight of delegated entity related to HCBS care management.
- Lack of care coordination staff access to claims and utilization data to validate delivery of waiver services.

As noted, each health plan fully remediated its CAP(s). Completion of the CAP(s) was validated by HSAG after review of health plan responses to required actions, including, but not limited to, review of revised or newly developed processes and/or policies, review of revised or newly developed staff member training content and validation of health plan staff member training, data validation, on-site file review, review of care management and/or claims software, and meetings with health plan leadership.

Additional Readiness Reviews

MLTSS

HFS' statewide expansion plans included MLTSS and waiver services. MLTSS was incorporated in the State's comprehensive mandatory Medicaid managed care program, HealthChoice Illinois. When HealthChoice Illinois was implemented, all health plans began receiving MLTSS enrollment in the Greater Chicago area. MLTSS services were expanded statewide to all counties when CMS approved Illinois' MLTSS waiver amendment, effective July 1, 2019. Prior to statewide MLTSS expansion, HFS contracted HSAG to conduct MLTSS Readiness Reviews. HSAG incorporated and built upon the results of the HealthChoice Illinois Pre-Implementation Readiness Reviews and the corrective actions performed by the plans as a result of those reviews (as many of the requirements assessed in that review were applicable to the MLTSS program).

The MLTSS Readiness Reviews included an assessment of the following 10 standards:

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity of Services
- Standard III—Coordination and Continuity of Care (Including Transition of Care)
- Standard IV—Coverage and Authorization of Services
- Standard VIII—Enrollee Information/Enrollee Rights

- Standard X—Enrollment and Disenrollment
- Standard XI—Grievance and Appeal System
- Standard XIII—Fraud, Waste and Abuse
- Standard XVI—Critical Incidents
- Standard XVIII—Quality Assessment and Performance Improvement Program

HSAG developed data collection tools to document the review. Network adequacy activities were also conducted to evaluate and report on the capacity of the health plan MLTSS provider network, as described in Section 5 of this report. To further assesses the plans' capacity to serve MLTSS beneficiaries for the statewide expansion, HSAG also conducted a review of state-selected requirements for CC/CM staff training, qualifications, and caseloads.

Additional details about the methodology, review tool, and CC/CM review are located in Appendix C.

Details regarding the MLTSS Readiness Review Findings and Recommendations can be found in the plan-specific reports that will be published in SFY 2020. The health plans were required to remediate all noncompliant findings. To validate the plans' remediation activities, HFS is requiring HSAG to conduct Post-Implementation Reviews in Q2 and Q3 of SFY 2020.

Children with Special Healthcare Needs

HFS' statewide expansion plans included Special Needs Children (SNC). HFS obtained a 1915(b) waiver to include populations of children with complex health and social service needs in the State's comprehensive mandatory Medicaid managed care program, HealthChoice Illinois. HFS defined the SNC population as children determined eligible for supplemental security income (SSI), determined disabled, receiving Title V care coordination services, in the care of DCFS, or formerly in the care of DCFS and receiving Title IV-E assistance. All of the HealthChoice Illinois health plans were contracted to provide services for the SNC Managed Care Program, scheduled for implementation February 1, 2020. Prior to implementation, HFS contracted with HSAG to conduct a SNC readiness review, which will be completed in SFY 2020.

DCFS

In addition, under HealthChoice Illinois, children in the care of DCFS will be served by IlliniCare. On December 3, 2019, HFS issued a letter to the State's Senators and Representatives informing them of a delay in the implementation of the DCFS program. This decision was made following discussions between HFS and DCFS in order to allow time to transition to upcoming administrative changes at the State level. HSAG will conduct a readiness review process in SFY 2019 specific to the DCFS population to assess IlliniCare's processes, care coordination, staffing, contract oversight, and systems to ensure the capacity to serve new DCFS enrollment. During this reporting year, HSAG worked with HFS and DCFS to understand the scope of the new program and develop readiness review tools.

4. Performance Improvement Projects (PIPs)

Overview

As part of its quality assessment and performance improvement program, HFS requires each health plan to conduct PIPs in accordance with 42 CFR §438.330.

The purpose of a PIP is to achieve, through ongoing measurement and intervention, significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving health plan processes can have a favorable effect on health outcomes and member satisfaction. Federal requirements for PIPs include:

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

Introduction to Rapid-Cycle PIPs

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the framework aligned with the current CMS PIP protocols. CMS agreed that, given the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed and gave approval for HSAG to implement this new approach for PIPs.

Statewide Mandatory Topics

After the final validation of the *Community Based Care Coordination* and *Follow-Up After Hospitalization for Mental Illness* PIPs in SFY 2018, HFS retired these PIPs and initiated the rapid-cycle PIP approach in SFY 2019. Due to the lack of improvement achieved, HFS elected to continue with the topic of *Follow-Up After Hospitalization for Mental Illness,* with emphasis on 30-day follow-up. The second state-mandated topic selected is *Transitions of Care – Patient Engagement After Inpatient Discharge*. Both topics are based on HEDIS measures; however, with the rapid-cycle approach, the MCOs use data analyses to determine a narrowed focus for each PIP. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services.

The duration of rapid-cycle PIPs is 18 months; therefore, these PIPs will continue into the next fiscal year.

Implementation and Training

Due to the rebid and award of HSAG's EQRO contract for the HealthChoice Illinois program, implementation of the rapid-cycle PIP process was delayed until March 2019. The MCOs initiated the new PIPs in March 2019 with the submission of Module 1 and Module 2 for each topic for validation.

Prior to the submission of Module 1 and Module 2, HSAG provided training to the MCOs and HFS on the rapid-cycle PIP approach, components, submission process, and validation criteria. In addition to this training, HSAG conducts module-specific trainings throughout the PIP process. The module-specific trainings solely focus on the requirements of the targeted module. The MCOs may also seek one-on-one individualized TA throughout the PIP process and between the initial submission and resubmission(s) of modules.

Objectives

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

Federal regulations, specifically 42 CFR §438.350, requires states that contract with MCOs to conduct an EQR of each contracting MCO. An EQR includes analysis and evaluation by an EQRO of aggregated information on healthcare quality, timeliness, and access. HSAG serves as the EQRO for HFS, which is responsible for the overall administration and monitoring of the HealthChoice Illinois program.

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012*.[4-1]

Validation of PIPs

For the rapid-cycle PIP approach, HSAG developed five modules, an accompanying reference guide, and corresponding validation tools. HSAG's validation requirements were approved by HFS and stipulate that the MCOs must achieve the goal set for each component of the Specific, Measurable, Attainable, Relevant, and Time-bound (SMART) Aim for the PIP to receive a rating of *High Confidence* or *Confidence*. See *Appendix D–PIPs Methodology* for more information on validation scoring.

Plan-Specific Validation Results

Table 4-1 and Table 4-2 summarize the MCOs' performance for each PIP topic validated during SFY 2019. During SFY 2019, the primary PIP activities included training and TA for the MCOs on the rapid-cycle PIP process and the development of the foundation of the projects in the first two modules of the process. At this stage, PIPs are not being evaluated on outcomes or receiving a final validation status.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sept 26, 2018.

Follow-Up After Hospitalization for Mental Illness

Table 4-1—Plan-Specific Validation Results

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
BCBSIL	➡ Goal: 33.4% to 43.4% By 12/31/2020, increase the percentage of 30-day follow-up rate for Hartgrove Hospital from 33.4% to 43.4% for members ages 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who maintained their 30-day *FUH* appointment following a visit from each acute inpatient discharge from Hartgrove Hospital.	Module 1	3	Completed and Passed
		Module 2	3	Completed and Passed
CountyCare	➡ Goal: 34.84% to 50% By 12/31/2020, increase the percentage of acute inpatient discharges for members assigned to Care Management Entity (CME)-Complex Care Coordination with a principle diagnosis of mental health or intentional self-harm for which members 6 years of age and older received a follow-up visit with a mental health practitioner within 30 days from 34.84% to 50%.	Module 1	3	Completed and Passed
		Module 2	3	Completed and Passed
IlliniCare	➡ Goal: 43.97% to 59.66% By 12/31/2020, increase the percentage of discharges from Universal Health Service of Hartgrove, Presence Hospitals, Chicago Behavioral Hospital, and Riveredge Hospital for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses that are followed by an office visit within 30 days with a mental health practitioner from 43.97% to 59.66%.	Module 1	2	Completed and Passed
		Module 2	2	Completed and Passed

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
Meridian	➡ Goal: 49.91% to 55.24% By 12/31/2020, increase the percentage of follow-up visits with a mental health practitioner for acute inpatient discharges for *FUH—30 Day* among members who were discharged from Riveredge, Hartgrove, or Loretto Hospitals from 49.91% to 55.24%.	Module 1	1	Completed and Passed
		Module 2	1	Completed and Passed
Molina	➡ Goal: 43.3% to 59.7% By 12/31/2020, increase the percentage of acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm from Methodist Medical Center for which HealthChoice Illinois members 6 years of age and older had a follow-up visit with a mental health practitioner within 30 days of discharge from 43.3% to 59.7%	Module 1	2	Completed and Passed
		Module 2	2	Completed and Passed
NextLevel	➡ Goal: 13.5% to 50% By 12/31/2020, increase the percentage of follow-up after hospitalization with a mental health practitioner within 30 days from 13.5% to 50% or greater for acute inpatient discharges ages 6 or greater with a principal diagnosis of mental health or intentional self-harm receiving care or care coordination through ACCESS Community Health Network .	Module 1	2	Completed and Passed
		Module 2	2	Completed and Passed

Transitions of Care–Patient Engagement After Inpatient Discharge

Table 4-2—Plan-Specific Validation Results

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
BCBSIL	➡ Goal: 58% to 60% By 12/31/2020, increase the percentage of acute or nonacute discharges from Advocate Christ Hospital for which BCBSIL members 18 years of age and older had patient engagement (outpatient visit with or without a telehealth modifier, a telephone visit, or transitional care management services) follow-up within 30 days of discharge from 58% to 60%.	Module 1	3	Completed and Passed
		Module 2	3	Completed and Passed
CountyCare	➡ Goal: 64.74% to 70% By 12/31/2020, increase the percentage of discharges 18 years and older, as of the last day of the baseline measurement period, with engagement through an outpatient visit, telephone visit, or other transitional care management service provided within 30 days of discharge from J H Stroger Hospital and assigned to CME-Complex Care Coordination from 64.74% to 70%.	Module 1	1	Completed and Passed
		Module 2	1	Completed and Passed
IlliniCare	➡ Goal: 47.9% to 62.3% By 12/31/2020, increase the percentage of acute and nonacute discharges for which the discharged member from Presence Rural Health Clinic (RHC), Ingalls, and Metro South has a patient engagement (e.g., office visits, visits to the home, telehealth) follow-up event within 30 day after discharge for members 18 years of age and older, during the measurement year (MY) from 47.9% to 62.3%.	Module 1	3	Completed and Passed
		Module 2	3	Completed and Passed

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
Meridian	⇨ Goal: 41.75% to 45.44% By 12/31/2020, increase the percentage of acute or nonacute discharges for which members 18 years of age and older had patient engagement follow-up with a PCP from Advocate's Physician Partners within 30 days of discharge from 41.75% to 45.44%.	Module 1	2	Completed and Passed
		Module 2	2	Completed and Passed
Molina	⇨ Goal: 50.40% to 54.42% By 12/31/2020, increase the percentage of acute or nonacute discharges within Southern Illinois Healthcare Foundation's HealthChoice Illinois membership for which members 18 years of age and older had patient engagement (outpatient visit with or without telehealth, a telephone visit, or transitional care management services) follow-up within 30 days of discharge from 50.40% to 54.42%.	Module 1	2	Completed and Passed
		Module 2	2	Completed and Passed
NextLevel	⇨ Goal: 70% to 90% By 12/31/2020, increase the percentage of follow-up visits within 30 days after acute or nonacute inpatient discharge for all aged, blind, or disabled (ABD) ACCESS males ages 18 years and older who are continuously enrolled from the date of discharge through 30 days after discharge from 70.0% to 90.0%. Engagement for follow-up includes outpatient visits with or without telehealth, a telephone visit, or transitional care management.	Module 1	2	Completed and Passed
		Module 2	2	Completed and Passed

The validation results show that the MCOs successfully completed Module 1 and Module 2 and developed methodologically sound projects. The MCOs were also successful in building internal and external quality improvement teams and developing collaborative partnerships with their targeted providers and/or facilities.

Next Steps

The MCOs will progress to the next stage of the rapid-cycle PIP process, where they will complete a process map and failure modes effects analysis (FMEA) at the level of their selected narrowed focus to identify gaps or opportunities for improvement. These quality improvement tools assist the MCOs in determining interventions that will be tested using iterative PDSA cycles. The results from these quality improvement tools and module validation results will be reported in the next annual EQR Technical Report.

5. Network Adequacy Validation

This section presents a description of the activities HSAG conducted to validate and monitor the health plans' provider network adequacy during the preceding state fiscal year to comply with requirements set forth in §438.358(b)(1)(iv) and by request of HFS.

Section Contents

Monitoring of HealthChoice Illinois Network Adequacy

Introduction

During SFY 2019, health plans were required to submit quarterly provider network data files for required provider types outlined in the *Provider Network Data Submission Instruction Manual* provided by HSAG. The data files were used to conduct analysis and monitoring of the provider network to ensure compliance with the Medicaid Model contract and federal requirements.

Health plans must notify HFS of provider terminations for network providers serving 100 or more active enrollees. HSAG was required to conduct analysis of the impact of the provider termination(s) to the health plan network. Based on the results of the termination analysis, health plans were required to develop contingency plans to transition enrollees to other network providers, and if necessary, contract with available providers within the affected service area to remediate network gaps. Results of the impact analyses conducted during SFY 2019 are available upon request.

In addition, HSAG conducted a time and distance analysis of selected provider types to evaluate compliance with access standards. Results for the time and distance analysis are included in the next section.

For additional details for the network adequacy methodology see Appendix E1.

Results

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

Analysis and monitoring of the HealthChoice Illinois provider network throughout SFY 2019 verified that the health plans contracted with a sufficient number of required providers types within each service region. SFY 2019 quarterly provider network reports are available upon request.

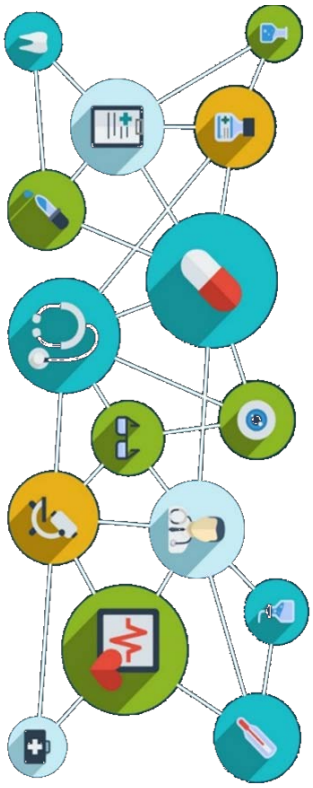
Recommendations

The following recommendations are based on the HealthChoice Illinois network capacity review.

- Continue monitoring health plans' contracting efforts and network development through a review of the provider data.
- Continue to enhance the accuracy of reporting for all pediatric providers.
- Evaluate health plan resources and systems to more efficiently complete the loading process for newly contracted providers.

- Continue to improve the accuracy of reporting individual providers within provider/physician groups, hospitals, CMHCs, FQHCs, and RHCs.
- Evaluate the frequency of online and paper provider directories audits for compliance with directory requirements.
  - Examine the process and timeliness of completing updates to the provider directory.
  - Include audits of the delegated online directories for compliance with directory requirements; for example, dental and vision provider directories.
- Pursue contracts with any available provider(s) within rural areas.
- Continue to pursue single-case agreements with out-of-network providers until a qualified in-network provider is contracted/available.

Time/Distance Analysis



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

This time/distance analysis included two phases. The first phase, presented in the SFY 2018 EQR Technical report, was conducted in mid-2018 and included seven HealthChoice Illinois health plans. The second phase of the analysis, summarized in this report, included the five health plans contracted statewide. Future network adequacy analyses will include all HealthChoice Illinois health plans.

Methodology

Time/distance standards limit how long and/or how far an enrollee must travel to access a specified type of provider. Time/distance requirements are a common metric for measuring the adequacy of a health plan's provider network.

Geographic network distribution analyses assess whether enrollees in each county are required to travel a reasonable amount of time or distance to reach the nearest provider. HFS established time/distance standards by provider category for the maximum allowable distance or time an enrollee should be required to travel to receive care, as detailed in Appendix E4 of this report. While the time/distance standards vary by provider category, the contract standard for each provider category requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

HFS and the health plans provided Medicaid enrollee demographic information and provider network files to HSAG for use in the time/distance analysis. The health plans submitted the provider data as part of their regular, ongoing submissions to HSAG. HSAG cleaned, processed, and used the provided data to define unique lists of providers, provider locations, and enrollees for inclusion in the analysis. Then, HSAG standardized and geocoded all Medicaid enrollee and provider addresses and conducted analyses by region to illustrate differences by Illinois region. Additional details about the methodology for the time/distance analysis are in Appendix E4.

Findings

This report presents the percentage of enrollees with each health plan who have access to providers within the time/distance standards statewide and for each region and the percentage of counties per region meeting the contract requirements defined in the HealthChoice Illinois Medicaid model contract.

Table 5-1 and Table 5-2 display overall health plan compliance with the time/distance standards for all provider categories included in the study for all regions. The overall percentages of health plan compliance with the time/distance standards in urban and rural counties for the five statewide health plans that serve enrollees in regions 1, 2, 3, and 5 are displayed in Table 5-1. Table 5-2 displays health plan compliance with the time/distance standards for Region 4 (Cook County). Overall time/distance results for all five regions are summarized below:

- All five health plans were compliant with the time/distance standards for all provider categories in Region 4 (Cook County).
- Across regions 1, 2, 3, and 5, BCBSIL was compliant with the time/distance standards for 88.8 percent of provider categories in urban counties and 93.8 percent in rural counties.
- Across regions 1, 2, 3, and 5, Harmony was compliant with the time/distance standards for 80.0 percent of provider categories in urban counties and 91.3 percent in rural counties.
- Across regions 1, 2, 3, and 5, IlliniCare was compliant with the time/distance standards for 93.8 percent of provider categories in urban counties and 96.3 percent in rural counties.
- Across regions 1, 2, 3, and 5, Meridian was compliant with the time/distance standards for 96.3 percent of provider categories in both urban and rural counties.
- Across regions 1, 2, 3, and 5, Molina was compliant with the time/distance standards for 98.8 percent of provider categories in urban counties and 95.0 percent in rural counties.

Table 5-1–Health Plan Compliance With Time/Distance Standards for Urban and Rural Counties—Regions 1, 2, 3, and 5 (Northwestern, Central, Southern, and Collar)*

Statewide Health Plans										
Health Plans	**BCBSIL**		**Harmony**		**IlliniCare**		**Meridian**		**Molina**	
Urbanicity	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**
Enrollment Count as of September 1, 2018	139,713	20,555	89,959	67,563	145,429	89,935	319,222	129,114	100,281	49,077
Total Provider Categories	80	80	80	80	80	80	80	80	80	80
Within Time/Distance Standard*	71	75	64	73	75	77	77	77	79	76
Not Within Time/Distance Standard	9	5	16	7	5	3	3	3	1	4
Within Time/Distance Standard (%)	88.8%	93.8%	80.0%	91.3%	93.8%	96.3%	96.3%	96.3%	98.8%	95.0%
Not Within Time/Distance Standard (%)	11.3%	6.3%	20.0%	8.8%	6.3%	3.8%	3.8%	3.8%	1.3%	5.0%

* Provider categories are considered "within the time/distance standard" if 90.0 percent of enrollees have access to providers within the time/distance standard. Please note this is different from meeting the contract requirements, which requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Table 5-2—Health Plan Compliance with Time/Distance Standards for Region 4 (Cook)*

	Statewide Health Plans				
Health Plans	**BCBSIL**	**Harmony**	**IlliniCare**	**Meridian**	**Molina**
Urbanicity	**Urban**	**Urban**	**Urban**	**Urban**	**Urban**
Enrollment as of September 1, 2018	255,432	88,858	106,853	160,097	69,589
Total Provider Categories	20	20	20	20	20
Within Time/Distance Standard*	20	20	20	20	20
Not Within Time/Distance Standard	0	0	0	0	0
Within Time/Distance Standard (%)	100.0%	100.0%	100.0%	100.0%	100.0%
Not Within Time/Distance Standard (%)	0.0%	0.0%	0.0%	0.0%	0.0%

* Provider categories are considered "within the time/distance standard" if 90.0 percent of enrollees have access to providers within the time/distance standard. Please note this is different from meeting the contract requirement, which requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Overall, the Illinois SFY 2018 Provider Network Time/Distance Phase II Analysis results suggest that the Illinois health plans have comprehensive provider networks in regions 4 and 5, with targeted opportunities for improvement in regions 1, 2, and 3. Enrollees residing in regions 4 and 5 have access to a broad range of providers within the time/distance standards for all health plans.

The comparison of results between Phase I and Phase II revealed that several health plans did not meet the standards in either analytic phase for oral surgery or endocrinology provider networks. For regions 1, 2, and 3, BCBSIL, Harmony, and Meridian consistently did not meet the standards in both analytic phases for oral surgery provider networks. At least one health plan met the standard for endocrinology providers for each region, indicating that endocrinology providers are available for contracting in all regions. No health plans met the time/distance standards for oral surgery in the Southern region (Region 3), which may indicate that not enough oral surgery providers are available for contracting for enrollees in the Southern region. IlliniCare made significant improvement for several provider categories between both analytic phases in regions 2 and 3, and BCBSIL enrollees living in regions 2 and 3 had improved access to endocrinology providers. Harmony consistently had provider networks that provided less than 90.0 percent of enrollees with access to several provider categories in regions 1 and 2 for both analytic phases of the study. Across both phases of the study, enrollees in regions 4 and 5 had access to all provider categories within the time/distance standards.

Recommendations

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

- HFS and the health plans should continue to work with their EQRO to ensure that provider data submitted by the health plans accurately reflects the services provided and the populations served by the providers, especially regarding pediatric providers. It is important to ensure that these providers are accurately represented in the health plans' networks so that the analysis of time/distance standards provide the most robust results for the unique needs of the pediatric population.
- HFS should continue to collaborate with the health plans to contract with additional providers, if available, in the areas identified as having excessive travel times or travel distances. Provider categories of concern include allergy and immunology, endocrinology, infectious disease, and oral surgery.
- HFS should conduct an in-depth review of provider categories in which each plan did not meet the time/distance standards, with the goal of determining whether the health plan's failure to meet the time/distance network access standard(s) was the result of a lack of providers or an inability to contract with providers in the geographic area. Specifically, HFS should work with health plans to investigate changes in provider networks between Phase I and Phase II in which enrollee access to providers decreased substantially. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories in which providers may not be available or willing to contract with the health plans.
- As the time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should consider

using appointment availability and utilization analyses to evaluate providers' availability and enrollees' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess enrollees' utilization of services and potential gaps in access to care resulting from inadequate provider availability.

- HFS should continue to develop requirements for Long-Term Services and Supports (LTSS) providers that require the enrollee to travel to the provider. LTSS network requirements are included in the new requirements governing network adequacy in the 2016 Medicaid Managed Care Rule.

Provider Network Readiness Reviews

MLTSS Readiness Reviews

During SFY 2019 HSAG conducted a readiness review for the HealthChoice Illinois plans prior to statewide expansion to evaluate the progress in contracting providers to ensure sufficient network capacity to serve MLTSS enrollees. Health plans were required to submit provider network data files for required provider types specific to the MLTSS benefit package.

HSAG conducted a statewide analysis to evaluate the contracting of nursing facilities and, therefore, determine the number of nursing facilities not contracted by any health plan. Based on the results of this analysis, HFS estimated the number of assigned enrollees within the noncontracted nursing facilities and required all health plans to begin contracting efforts with these facilities to ensure a seamless transition for enrollees residing in these nursing facilities. Health plans were required to update the nursing facility contracting workbook to document the status of contracting efforts. In addition, health plans were also required to have single case agreements with each of the noncontracted facilities where they have assigned enrollment until execution of a provider agreement.

For additional details for the network adequacy methodology used in the MLTSS readiness review, see Appendix E1.

Results

HSAG conducted a thorough analysis of the health plan provider data files and completed reports summarizing findings by provider type/region/county. The provider data files submitted by the health plans demonstrated compliance with the MLTSS provider network readiness review requirements. HSAG and HFS maintained ongoing communication with the plans to address and correct any gaps in the MLTSS network prior to implementation. Additional review by HSAG verified that the plans had contracted with the required providers in each service region. If necessary, health plans were required to establish single case agreements with out-of-network providers until a qualified in-network provider was contracted/available.

Initially, health plans were also required to submit geographic maps plotting enrollee and affiliated provider locations by zip code for their existing MLTSS enrollment. HFS has suspended GeoAccess reporting until access standards are established for the HCBS waiver providers.

Detailed reports of the MLTSS provider network adequacy are located in Appendix E2.

Recommendations

The following recommendations are based on the findings for the MLTSS statewide expansion network capacity readiness review:

- Continue monitoring health plans' contracting efforts and network development through a review of the provider data and contracting workbook submission for nursing facilities.
- Enhance the accuracy of reporting for HCBS and MLTSS providers.
- Evaluate health plan resources and systems to more efficiently complete the loading process for newly contracted providers.
- Improve the accuracy of reporting providers within large provider groups.
- Evaluate the effectiveness of online and paper provider directories audits for compliance with directory requirements.
  - Examine the process and timeliness of completing updates to the provider directory.
  - Include audits of the delegated online directories for compliance with directory requirements; for example, dental and vision provider directories.
- Establish timely single-case agreements with out-of-network providers until a qualified in-network provider is contracted/available.
- Pursue contracts with any available provider within rural areas.
- Continue contracting efforts with HCBS and MLTSS providers in the expansion regions.
- Continue to monitor health plan contracting efforts to execute contracts with the "noncontracted" nursing facilities.
- Continue to work with the HCBS waiver agencies to develop an official list of approved HCBS waiver service providers to allow for a more robust validation of network capacity for these providers.

YouthCare Network Readiness Review

Children in the care of the DCFS, including those formerly in care who have been adopted or who entered a guardianship (DCFS Youth), were incorporated into HealthChoice Illinois. IlliniCare was contracted as the DCFS Youth Managed Care Specialty Plan (YouthCare) to provide managed care services for DCFS Youth. In preparation for program implementation, HFS approved YouthCare to begin outreach and contracting efforts with HealthWorks agencies.

HealthWorks agencies will provide interim medical case management services to all DCFS Youth in care through the first 45 days of DCFS' custody of the youth. HFS requested that HSAG monitor YouthCare's contracting progress with the HealthWorks agencies. IlliniCare was required to submit provider network data files via a secure HSAG file transfer protocol (FTP) site that included HealthWorks agencies.

Program Implementation

The DCFS Youth managed care program (YouthCare) implementation was scheduled for November 1, 2019, at which time YouthCare began limited care coordination support activities for the following six priority populations identified by DCFS:

- Priority 1—Beyond medical necessity (BMN)/Currently in psychiatric hospitalization
- Priority 2—In-state and out-of-state residential placement
- Priority 3—Medically complex
- Priority 4—Those seen by a nurse (caseworker identified a medical issue needing attention and referred it to DCFS nurses)
- Priority 5—Specialized foster care
- Priority 6—Department of Juvenile Justice (DJJ)

HSAG is scheduled to continue network readiness review activities prior to program implementation to evaluate the progress in contracting providers to ensure sufficient network capacity to serve YouthCare enrollees.

Results

Review of the plan network data verified that the plan had contracted with all 19 HealthWorks agencies as of May 2019.

More details are available in the DCFS Healthworks Agencies Network Review Report located in Appendix E3.

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, specific zip code analysis and county-specific analysis for individual provider types. HSAG also prepares network reports to CMS in order to provide information prior to implementation of programs that are jointly administered by CMS.

The reports listed below were produced in SFY 2019 in response to HFS provider network requests:

- HCBS Utilization Data Review—prior to MLTSS program implementation
- Provider-Specific Comparative Analysis—compared capacity of specific provider types across health plans
- FOIA Data Request—health plan provider network data files
- Statewide review of Medicaid enrollees assigned to nursing facilities transitioning to managed care
- Provider network impact analysis—plan-specific provider termination(s)
- Environmental scan to gather information on Medicaid network standards in other states

6. Beneficiary Satisfation 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 nine 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 and results are presented in Appendix F1 and Appendix F2 of this report.

CAHPS Measures

The CAHPS surveys were administered to the adult and child Medicaid populations. The survey questions were categorized into nine measures of experience. These measures included four global ratings and five 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.

With statewide Medicaid expansion beginning in January 2018, the majority of the State's existing Medicaid managed care program contracts were rebid to consolidate multiple previous programs (including FHP/ACA and ICP) into a single streamlined program, HealthChoice Illinois. HFS contracted with seven health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Five of the HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. However, in 2019, Harmony merged with Meridian, so HealthChoice Illinois is served by six health plans.[6-1,6-2] In this report, HSAG has combined the 2018 CAHPS results for the FHP/ACA and ICP health plans for the adult Medicaid population.[6-3] Table 6-1 displays the health plans that reported CAHPS data for SFY 2019.

Table 6-1—HealthChoice Illinois Health Plans for 2019 CAHPS

Health Plan Name	Abbreviation
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare (Serves Cook County only)	CountyCare
IlliniCare Health Plan	IlliniCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina
NextLevel Health Partners, LLC (serves Cook County only)	NextLevel

6-1 Please exercise caution when evaluating Meridian's 2019 results, since Harmony merged with Meridian in 2019.

6-2 HSAG included Harmony, along with the six health plans that reported CAHPS data for SFY 2019 in the 2018 aggregate; therefore, caution should be exercised when comparing the 2019 and 2018 aggregate results.

6-3 Due to combining the FHP/ACA and ICP health plans, HSAG calculated a weighted aggregate for the 2018 results for the adult population.

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 2019 top-box scores to the corresponding 2018 top-box scores. Top-box score results that were statistically significantly higher in 2019 than in 2018 are noted with upward (▲) triangles. Top-box scores that were statistically significantly lower in 2019 than in 2018 are noted with downward (▼) triangles. Top-box scores in 2019 that were not statistically significantly higher or lower than scores in 2018 are not noted with triangles.

In addition to the trend analysis, HSAG compared the top-box scores for each measure to national Medicaid percentiles.[6-4] 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

[6-4] In 2019, HSAG changed the benchmarking source for the percentile distributions from previous reports; therefore, the star ratings may not be comparable to reports in prior years.

Summary of Performance

Adult CAHPS Medicaid Surveys

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.

Table 6-3—Adult Aggregate Results

	2018	2019	Trending Results (2018–2019)
Composite Measures			
Getting Needed Care	75.8% ★	82.1% ★★	▲
Getting Care Quickly	77.5% ★	82.0% ★★	▲
How Well Doctors Communicate	91.8% ★★★	92.9% ★★★	—
Customer Service	87.0% ★★	89.8% ★★★	▲
Shared Decision Making	76.7% ★	78.9% ★★	—
Global Ratings			
Rating of All Health Care	51.9% ★★	54.6% ★★	—
Rating of Personal Doctor	64.1% ★★	69.0% ★★★	▲
Rating of Specialist Seen Most Often	65.1% ★★	68.1% ★★★	—
Rating of Health Plan	56.9% ★★	59.3% ★★	—

▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
— Indicates the 2019 score is not statistically significantly higher or lower than the 2018 score.

Notable

- Star ratings improved from 2018 to 2019 for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.
- The 2019 scores were statistically significantly higher than the 2018 scores for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Personal Doctor*.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that adult members reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*.

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.

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

	2018	2019	Trending Results (2018 - 2019)
Composite Measures			
Getting Needed Care	77.7% ★	79.7% ★	—
Getting Care Quickly	83.9% ★	85.6% ★	—
How Well Doctors Communicate	93.2% ★★	93.6% ★★	—
Customer Service	86.4% ★★	87.1% ★	—
Shared Decision Making	78.6% ★★	80.1% ★★★	—
Global Ratings			
Rating of All Health Care	69.9% ★★	70.6% ★★★	—
Rating of Personal Doctor	78.2% ★★★	77.1% ★★★	—
Rating of Specialist Seen Most Often	75.3% ★★★	72.9% ★★	—
Rating of Health Plan	71.0% ★★★	69.7% ★★	—

— Indicates the 2019 score is not statistically significantly higher or lower than the 2018 score.

Notable

- Star ratings improved from 2018 to 2019 for *Shared Decision Making* and *Rating of All Health Care*.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.
- Star ratings declined from 2018 to 2019 for *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.
- Overall, no statistically significant trends were observed.

Statewide Survey 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 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set; however, HSAG uses this survey for Illinois Medicaid and All Kids.

General Population

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

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

	2018	2019	Trending Results (2018–2019)
Composite Measures			
Getting Needed Care	82.7% ★★	85.0% ★★★	—
Getting Care Quickly	85.9% ★	88.1% ★★	—
How Well Doctors Communicate	92.1% ★	93.6% ★★	—
Customer Service	85.1% ★	87.1% ★	—
Shared Decision Making	78.2% ★★	73.2% ★	—
Global Ratings			
Rating of All Health Care	63.2% ★	70.0% ★★	▲
Rating of Personal Doctor	74.6% ★★	77.0% ★★★	—
Rating of Specialist Seen Most Often	76.6% ★★★	80.2% ★★★★★	—

[6-5] NCQA does not publish separate benchmarks for the Children's Health Insurance Program (CHIP) population; therefore, caution should be exercised when interpreting the results of the national comparisons analysis (i.e., star ratings).

	2018	2019	Trending Results (2018–2019)
Rating of Health Plan	61.3% ★	63.1% ★	—

▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
— Indicates the 2019 score is not statistically significantly higher or lower than the 2018 scores.

Notable

- Compared to national Medicaid percentiles, 2019 experience survey results indicated that parents/caretakers of child members from the general child population for the Illinois statewide program aggregate were generally satisfied with *Rating of Specialist Seen Most Often*.
- The 2019 score was statistically significantly higher than the 2018 score for *Rating of All Health Care*.
- Star ratings improved from 2018 to 2019 for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members from the general child population for the Illinois statewide program aggregate reported top-box scores below the 50th percentile for *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*.
- The star rating declined from 2018 to 2019 for *Shared Decision Making*.

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

	2018	2019	Trending Results (2018–2019)
Composite Measures			
Getting Needed Care	84.8% ★★	83.1% ★	—
Getting Care Quickly	88.8% ★	88.7% ★	—
How Well Doctors Communicate	94.3% ★★	93.7% ★★	—
Customer Service	81.7% ★	83.8% ★	—
Shared Decision Making	83.2% ★	82.4% ★	—
Global Ratings			
Rating of All Health Care	61.7% ★	62.2% ★	—
Rating of Personal Doctor	71.4% ★	75.0% ★★	—
Rating of Specialist Seen Most Often	72.8% ★★★	74.8% ★★★	—
Rating of Health Plan	53.4% ★	56.0% ★	—
CCC Composites and Items			
Access to Specialized Services	72.8% ★	68.9% ★	—
Family-Centered Care: Personal Doctor Who Knows Child	90.1% ★★	91.1% ★★	—
Coordination of Care for Children with Chronic Conditions	79.4% ★★★	77.7% ★★★	—
Access to Prescription Medicines	87.8% ★	88.2% ★	—

	2018	2019	Trending Results (2018–2019)
Family-Centered Care: Getting Needed Information	90.5% ★★	90.1% ★	—
— Indicates the 2019 score is not statistically significantly higher or lower than the 2018 scores.			

Notable

- The star rating improved from 2018 to 2019 for *Rating of Personal Doctor*.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members from the CCC population for the Illinois statewide program aggregate reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Specialized Services*, *Family-Centered Care: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *Family-Centered Care: Getting Needed Information*.
- Star ratings declined from 2018 to 2019 for *Getting Needed Care* and *Family-Centered Care: Getting Needed Information*.

Overall Findings and Conclusions

For the adult aggregate results of all HealthChoice Illinois health plans combined, the 2019 scores were statistically significantly higher than the 2018 scores for three composite measures (*Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*) and one global rating (*Rating of Personal Doctor*), indicating that adult members' experience with the timeliness of their care, their health plan's customer service, and their personal doctor is improving. However, the 2019 scores for the *Getting Needed Care* and *Getting Care Quickly* measure fell below the 50th percentile compared to national Medicaid benchmarks, along with three other measures (*Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*).

Although the child aggregate results of all health plans combined showed that there were no statistically significant differences between the 2019 and 2018 scores, the star ratings of two measures (*Shared Decision Making* and *Rating of All Health Care*) increased from below the 50th percentile to at or between the 50th and 74th percentiles compared to national Medicaid benchmarks between 2018 and 2019. However, the star ratings of three measures (*Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*) decreased between 2018 and 2019.

When the 2019 scores for the general child population for the Illinois statewide program aggregate were compared to national benchmarks, one measure (*Rating of Specialist Seen Most Often*) scored at or above the 90th percentile; however, three measures (*Customer Service*, *Shared Decision Making*, and *Rating of Health Plan*) performed poorly, falling below the 25th percentile compared to national Medicaid benchmarks. When comparing the Illinois statewide program aggregate 2019 top-box scores to 2018 for the general child population, one measure (*Rating of All Health Care*) increased substantially.

Although there were no statistically significant differences between the 2019 and 2018 scores for the CCC population for the Illinois statewide program aggregate, the star rating of one global rating (*Rating of Personal Doctor*) increased from below the 25th percentile to at or between the 25th and 49th percentiles compared to national Medicaid benchmarks between 2018 and 2019. However, the star ratings of two measures (*Getting Needed Care* and *Family-Centered Care: Getting Needed Information*) decreased between 2018 and 2019.

Based on these results for both the adult and child populations, HealthChoice Illinois health plans and the Illinois statewide program aggregate have opportunities for improvement regarding customer service skills and doctors working with members on making medical decisions. Improvements in these areas may increase members' overall rating of their health plan.

7. Additional EQR Activities

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

Section Contents

Quality Rating System

Overview

Federal regulation 42 CFR §438.334 requires the development of a Medicaid managed care quality rating system. In SFY 2019, HFS updated its consumer quality comparison tool, called the HealthChoice Illinois Plan Report Card (report card), to reflect the performance of each of the seven HealthChoice Illinois health plans.

HSAG was tasked with developing a report card to evaluate the performance of health plans serving HealthChoice Illinois beneficiaries. The report card was targeted toward a consumer audience; therefore, it was user-friendly, easy to read, and addressed areas of interest for consumers. As part of the EQRO contract, HSAG analyzed 2019 HEDIS results, including 2019 CAHPS data from seven Illinois health plans.

Due to the merger of Harmony and Meridian, HSAG combined results for Harmony and Meridian health plans for 2018 (CY 2017) and 2019 (CY 2018). HSAG created two report cards. The Cook County report card included an analysis of the six plans that are available to Medicaid beneficiaries in Cook County. The statewide report card included an analysis of the four plans that are available statewide to Medicaid beneficiaries (i.e., the two plans that are only available in Cook County were excluded from the analysis). The report card analyses helped support HFS' public reporting of MCO performance information.

The report card is published online at https://www.illinois.gov/hfs/healthchoice/reportcard/Pages/statewide_sc.aspx.

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 and Patient Engagement:** Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate, shared decision

[7-1] NCQA. *Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports For Consumers*. Oct 1998.

making, 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, children's and adolescents' access to dentists, and whether adults had their BMI documented.
- **Women's Health:** Includes HEDIS measures that assess how often women-specific services are provided (e.g., breast cancer, cervical cancer, and chlamydia screenings and prenatal and postpartum care).
- **Living With Illness:** Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions, such as asthma, diabetes, and hypertension. In addition, this category includes HEDIS measures that assess if members on persistent medications receive appropriate monitoring.
- **Behavioral Health:** Includes HEDIS measures that assess if members with behavioral health conditions received appropriate follow-up after hospitalization and the initiation and engagement of alcohol and other drug dependence treatment. In addition, this category includes a HEDIS measure that assesses if children and adolescents using antipsychotic prescriptions receive appropriate metabolic testing.
- **Keeping Kids Healthy:** Includes HEDIS measures that assess how often preventive services are provided (e.g., child and adolescent immunizations, well-child visits, and weight assessment and counseling for children/adolescents).

Measures Used in Analysis

HFS, in collaboration with HSAG, chose measures for the report card based on a number of factors, such as measures that best approximate the reporting categories that are useful to consumers; the available data; and nationally recognized, standardized measures of Medicaid and/or managed care.

Forty-two measures were chosen, 13 CAHPS and 29 HEDIS, along with their associated weights. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contributed equally to the derivation of the final results.

Comparing Plan/Plan Category Performance to National Benchmarks

HSAG presented measure-level ratings on the selected HEDIS and CAHPS measures based on comparisons to national Medicaid benchmarks. A five-level rating scale was used to report how HEDIS and CAHPS measures compared to the 2018 Quality Compass national Medicaid benchmarks. In order to ensure the CAHPS results are consumer-friendly, HSAG compared the top-box responses ("Usually/Always") for the CAHPS measures to the 2018 Quality Compass national Medicaid benchmarks.

In addition, HSAG provides consumers with category-level trending information for the selected categories to indicate whether the MCO's average rating in each category improved, declined, or stayed the same from 2018 to 2019, 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 report card to meet the requirements of the legislation. In response, HSAG is assisting HFS in designing an online, interactive version of the report card.

Evaluation of Quality Strategy

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

On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, launching HealthChoice Illinois; therefore, HFS published a fully revised and restructured Quality Strategy in 2018. However, due to additional program changes, such as incorporating SNC populations in HealthChoice Illinois and the statewide expansion of MLTSS, HFS plans to revise its Quality Strategy and republish in 2020.

During SFY 2019, in preparation of the revision and in accordance with 42 CFR §438.340(c)(2)(i), HFS conducted an evaluation of its Quality Strategy with the assistance of HSAG. HSAG stays abreast of CMS requirements for states' Quality Strategy and advised HFS on the development of its Quality Strategy in accordance with CMS' *Quality Strategy Toolkit for States*.[7-2]

[7-2] Centers for Medicare & Medicaid Services. *Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Mar 19, 2018.

Staffing Reviews

CC/CM Staffing Review

HSAG was contracted by HFS to conduct a CC/CM staffing review of state-selected requirements for the Medicaid managed care plans and their delegates, as applicable. The CC/CM staffing review assessed qualifications, related experience, caseloads and training against contract requirements for the HealthChoice Illinois and MMAI waiver and nonwaiver programs. These requirements are included in Appendix G2 of this report.

HSAG reviewed the educational qualifications, related experience, full time equivalency (FTE) allocation, caseloads, and annual training of CC/CM staff serving the Medicaid managed care population against the HealthChoice Illinois, MMAI, and CMS HCBS contract requirements. Caseloads, training, and qualifications categories were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

Staffing Findings and Recommendations

During SFY 2019, the staffing review identified that, for most health plans, staff providing care coordination services to waiver enrollees did not meet the education, experience, and qualifications requirement. Due to the timing of the staffing review, Harmony's enrollees had already transitioned to Meridian; therefore, Harmony was not evaluated.

- Five of the six HealthChoice Illinois health plans, or their delegates, employed staff who did not have the credentials/qualifications required to manage waiver caseloads.
- All six MMAI health plans, or their delegates, employed staff who did not have the credentials/qualifications required to manage waiver caseloads.

- All six HealthChoice Illinois and all six MMAI health plans, or their delegates, employed staff who had all of the related experience required to manage HIV waiver caseloads.
- One of the six HealthChoice Illinois health plans, or their delegates, had staff managing HIV and/or BI waiver caseloads with a total caseload of over 30.
- Two of the MMAI health plans had staff managing HIV and/or BI waiver caseloads with a total caseload of over 30.

During SFY 2019, the staffing review also identified that most health plans were in compliance with caseload requirements. The review identified the following:

- Three of the six HealthChoice Illinois health plans, or their delegates, had staff with caseloads exceeding the weighted maximum of 600.
- All six MMAI health plans, or their delegates, were compliant with weighted caseloads maximums.
- Two of the six HealthChoice Illinois health plans, or their delegates, had staff with caseloads exceeding the total allowed for high risk or moderate risk enrollees.
- All six MMAI health plans, or their delegates, were compliant with total caseload maximums.

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

- Follow up with those health plans employing CC/CM staff who do not meet qualification requirements for managing waiver caseloads.
- Follow up with health plans employing CC/CM staff who do not meet the related experience requirements for staff managing HIV/acquired immune deficiency syndrome (AIDS) waiver caseloads.
- Provide direction to the health plans related to caseload requirements for CC/CMs managing HIV and BI waiver members. Discussion with health plans identified that the health plans interpret the contract to mean that the 30-caseload limit pertains only to HIV and/or BI caseloads, as opposed to CC/CM total caseload (which may include other waiver and nonwaiver cases).
- Follow up with health plans with noncompliant findings related to managing weighted caseloads above 600.
- Follow up with health plans with noncompliant findings related to caseload volumes.

Training Findings and Recommendations

During SFY 2019, the training review found that, for most health plans, training materials and completion of mandatory training did not meet contract requirements. The training review was conducted prior to Harmony's enrollees being transitioned to Meridian; therefore, Harmony was included in the training review. The training review found that:

- Five of the nine health plans, or their delegates, did not have general training content developed to meet contract requirements.

- Four of the nine health plans, or their delegates, did not have waiver training content developed to meet contract requirements.
- Seven of the nine health plans, or their delegates, had staff managing Elderly (ELD) waiver caseloads without evidence of ELD waiver-required training.
- Four of the nine health plans, or their delegates, had staff managing BI waiver caseloads without evidence of BI waiver-required training.
- Five of the nine health plans, or their delegates, had staff managing HIV waiver caseloads without evidence of HIV waiver-required training.
- Eight of the nine health plans, or their delegates, had staff managing Supported Living Facility (SLF) waiver caseloads without evidence of SLF waiver-required training.
- Seven of the nine health plans, or their delegates, had staff managing waiver caseloads without evidence of the required 20 hours (or prorated based on hire date) of annual training.

In addition, HSAG identified that, for most health plans, there was opportunity to ensure that all care coordination staff received annual required general and waiver topic-based training.

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

- Follow up with those health plans who had not yet developed all required training content, both general and waiver-specific.
- Follow up with health plans who have CC/CMs without evidence of required general training.
- Follow up with health plans who have CC/CMs without evidence of required waiver-specific training.
- Follow up with health plans who have CC/CMs without evidence of the required annual waiver training hours.
- Consider requesting that health plans develop an audit process to ensure that required annual trainings, including general, waiver-specific, and waiver-specific hours, are completed for all staff.

Key Leadership Positions

HealthChoice Illinois Key Leadership Position Analysis

HSAG analyzed each health plan's compliance with contract requirements in the areas described below:

- Key leadership positions occupied
- Residency requirements
- FTE requirements
- Licensure/credentials requirements

For SFY 2019, six of the seven health plans reviewed had a deficiency in one or more key leadership positions, such as noncompliance with FTE requirements.

Findings and Recommendations

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

- Review contractual licensure requirements to identify whether revisions are needed for specific key leadership positions (e.g., quality management coordinator).
- Examine implications for health plans not meeting requirements for key leadership positions.
- Review staffing analysis findings against other available data to determine additional improvement opportunities for specific health plans.

Health, Safety, and Welfare (HSW) Monitoring Review

HSAG was contracted by HFS to conduct an HSW/critical incident (CI) review of state-selected requirements for the Medicaid managed care plans. The HSW/CI monitoring activity included review of system effectiveness, the contract requirements for the HealthChoice Illinois and MMAI waiver and nonwaiver programs, and HFS' *Critical Incident Guide* and health plan policy related to CI reporting.

HSAG reviewed compliance within the following domains:

- Reporting of incident
- Compliance with investigating authority decisions
- Case management activities

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.

Findings and Recommendations

During file review, HSAG assessed each health plan and identified the following overall findings across health plans:

- The reporting of incident domain performed at 93 percent for HealthChoice Illinois and 96 percent for MMAI.
- The compliance with investigating authority decisions domain performed at 80 percent for HealthChoice Illinois and 73 percent for MMAI.
- The case management activities domain performed at 93 percent for HealthChoice Illinois and 69 percent for MMAI.

Based on the findings of the HSW/CI monitoring review across health plans, HSAG identified the following recommendations for HFS:

- HFS should consider further refining CI definitions in order to ensure consistent reporting by the health plans.
- HFS should provide direction to MMAI health plans related to abuse, neglect, and exploitation (ANE) education for nonwaiver enrollees and those enrollees not engaged in care coordination. HFS may consider revising member handbook template language to ensure education is provided to all enrollees. Alternatively, HFS may consider approving health plan action plans to address this finding.
- HFS should consider providing guidance, or a formal approval of health plan process, on appropriate actions required to consider an incident closed/resolved if the enrollee is unable to reach post-event.
- HFS should consider providing guidance to the health plans on whether fraud cases should be included in HSW/CI reporting or only included in compliance/FWA reporting. If HFS intends for

the health plans to include fraud cases in reporting, HFS should consider including the category in the *Critical Incident Guide* and providing additional direction related to appropriate reporting processes.

- HFS should consider providing education or guidance to the health plans on expected processes that must be documented to consider an incident closed/resolved.

Illinois Department of Healthcare and Family Services (HFS) Meetings

HSAG met regularly with HFS throughout the term of its EQRO contract to partner effectively and efficiently with the State, including bimonthly EQRO activities meetings and health plan operational meetings. The purpose of these meetings was to review all current and upcoming EQR activities, discuss any barriers or progress, design solutions or a course of action, and review the goals of the quality strategy. The meetings included discussion of compliance with the State's quality strategy, ongoing monitoring of performance of Medicaid programs, program changes or additions, readiness reviews, and future initiatives.

For the bimonthly meetings, HSAG prepared a progress report that documented the status of all EQRO activities, key findings and issues to be resolved, and areas of focus or follow-up for HFS. These meetings were instrumental in implementing new programs and making program changes and ensuring timely communication and follow-up.

For health plan operational meetings, HSAG was responsible for consulting with HFS in selecting meeting content, preparing the agenda and any necessary meeting materials, forwarding materials to participants in advance of the meeting, and facilitating the meeting. Meeting materials included worksheets, Microsoft (MS) PowerPoint presentations, slide handouts, or technical demonstrations. Subject matter experts, including clinical and analytical staff, were involved in the development of meeting content, as required, and appropriate staff provided the instruction and/or facilitation, as appropriate. Following each meeting, HSAG prepared meeting minutes and, after HFS approval, forwarded them to all meeting participants. As part of this process, HSAG created an action item list and then followed up with the health plans and HFS to ensure timely completion of those items. HSAG provided status updates to HFS so it could track health plan progress on completing follow-up items.

Quality Forums

During SFY 2019, HFS continued to identify focus areas for improvement in quality forums, with a continued focus on breast cancer screening for innovation in practice, with goals to:

- Realize an improvement in the number of Medicaid women screened for breast cancer.
- Identify and reduce or eliminate identified disparities and barriers to screening and follow-up through engagement of community partners and Medicaid members.
- Improve appropriate and efficient follow-up treatment for improved outcomes.
- Identify successful quality improvement initiatives that improve screening and follow-up and implement those initiatives statewide.

The purpose of the quality forum was to build a partnership for improvement through communication and collaboration and enact strategies that would improve breast cancer screening for women at risk. The forum included expert clinician, community partner, and survivor presentations, and provided the

health plans the opportunity to collaborate on best practices, barrier identification, and targeted solutions.

HSAG, in collaboration with HFS, developed an intervention work plan to assist the health plans with their performance improvement initiative. The work plan included actions following the Plan-Do-Study-Act quality framework, culminating in a remeasurement of screening rates to evaluate the effectiveness of the interventions, with reporting at the October 2018 quality forum. At this session, health plans described their breast cancer screening initiatives; member, provider, and stakeholder outreach; feedback; barriers; results; and best practices.

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, pay-for-performance (P4P) program measures, health plan compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, HCBS waiver program requirements, and much more.

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 2019.

Designing New P4P Program

HFS contracted with HSAG to develop a scoring mechanism for the managed care P4P Program. For the P4P, each plan is evaluated on several HEDIS and non-HEDIS measures. The P4P calculation methodology and measures for HEDIS reporting years (RYs) 2020 and 2021 describe the mechanism through which HealthChoice Illinois' performance will be evaluated and scored and final payments will be calculated. HSAG conducted a thorough analysis to recommend a measure set, which was refined by HFS and then reviewed by the health plans. The P4P measures selected included alignment with IHH outcome-based payment measures and HFS priority measures and are representative of the HealthChoice Illinois managed care populations. In SFY 2020, the HealthChoice Illinois health plans will be subject to P4P payments or withholds based on measure rate performance collected during CY 2019, HEDIS rate year (RY) 2020, data collection CY 2020, and HEDIS RY 2021. HSAG anticipates conducting additional TA to refine the P4P methodology, conduct training with the health plans, and assist HFS in developing reporting mechanisms.

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

In addition, HSAG developed the HealthChoice Illinois Managed Care Program NCQA Medicaid Healthcare Maintenance Organization Accreditation status sheet (status sheet), which succinctly displays each health plan's accreditation date and status, along with a description of the NCQA accreditation levels. HFS features this status sheet on its website to make the information public. The most recent version can be accessed at https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2018HFSWebsiteNCQAAccreditationDoc052218.pdf.

Throughout SFY 2020, HSAG will update the NCQA tracking spreadsheet for HFS' reference periodically and any time there is an update to a health plan's status. HSAG will also keep the status sheet updated through accessing the most recent accreditation information on NCQA's website.

IHH Implementation

The IHH program is a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. Each member in the Medicaid population will be linked to an IHH provider, based on their level of need and the provider's ability to meet those needs. HFS aims to enhance true integration of behavioral and physical healthcare by developing the IHH program, which promotes accountability, rewards team-based integrated care, and shifts toward a system that pays for value and outcomes. Illinois' vision for integration is ambitious because the current provider delivery system is not structured to support it. Today, behavioral and physical healthcare providers often operate in siloes and fail to exchange information, let alone collaborate as part of a seamlessly integrated care team. The development of IHHs and a payment model that will sustainably support them will be a significant but challenging step. Illinois recognizes that IHHs will not materialize without considerable planning and intends to use extensive stakeholder input, allow flexibility for multiple models to emerge across the State, and allow for continued provider innovation. HFS allows for a phased approach, under which all providers are encouraged to make progress, by creating greater incentives for those who can move more quickly toward a higher degree of integration. Therefore, HSAG anticipates providing TA to HFS and health plans during IHH implementation.

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. In SFY 2019, HSAG provided TA in the development and selection of performance measures for the IHH program and the MLTSS program.

FOIA Requests

FOIA is found in Title 5 of the United States Code, §552. It was enacted in 1966 and states that any person has the right to request access to federal agency records. CMS frequently receives FOIA requests for payment and other information relating to state Medicaid claims or activities. HFS frequently requests assistance from HSAG in responding to CMS and providing documentation regarding FOIA requests. In addition, under the Illinois Freedom of Information Act (5 ILCS 140), records in possession of public agencies may be accessed by the public upon written request; therefore, HFS may receive FOIA requests directly and request HSAG's assistance in responding to the submitter. FOIA requests arise frequently and are sometimes highly time-sensitive (response required within 24 to 48 hours). Responses to FOIA requests range from simply answering a question to providing ad hoc analysis and submitting data. HSAG responds to HFS' needs in a timely and thorough manner to ensure compliance with FOIA requirements.

HFS and Health Plan 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. Other examples of training topics that HSAG developed for HFS include:

- Appeals, CIs, and HSW.
- Transitions of Care.
- NCQA Accreditation Requirements.
- HEDIS Updates for States.
- Quality Assurance (QA)/Utilization Review (UR)/Peer Review (PR) Annual Report Evaluation.

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. In SFY 2017, HSAG helped develop an updated template for the health plans to use to ensure their annual submissions contained all the required data and information in a standardized format.

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

Research

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

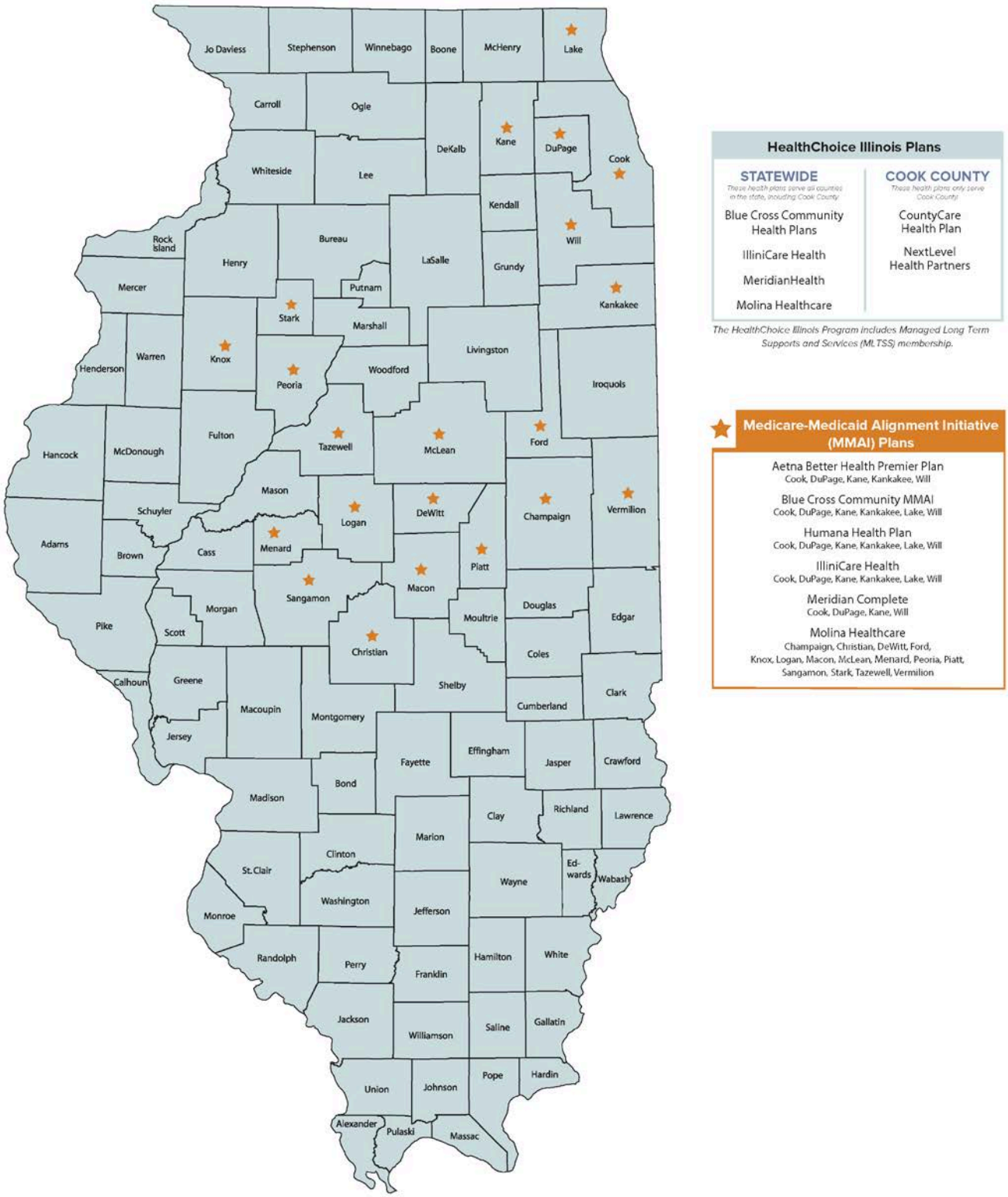
Presentations to the Illinois Legislature and HFS Administration

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 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 2019, HSAG provided ongoing TA to periodically update the map to reflect up-to-date expansion. Figure 7-1 represents the map as of July 1, 2019.

Figure 7-1—Illinois Medicaid Managed Care Expansion Map



Appendix A1. Executive Summary of Performance Measure Results

Performance Measures

Table A1-1 displays a snapshot of health plan performance for measures selected by the HFS in domains of care that it prioritizes for improvement. Performance for HEDIS 2019 measures is compared to the NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018, when available, which is an indicator of health plan performance on a national level. For most measures, two years of data (HEDIS 2018 and HEDIS 2019) are trended. Due to changes in the technical specifications for one measure in HEDIS 2019 (i.e., *Controlling High Blood Pressure*), NCQA does not recommend trending between 2019 and prior years or comparisons to benchmarks; therefore, this measure is not displayed below. Additionally, *Ambulatory Care* is a utilization measure and is provided for information only. As noted previously, performance measure results are shown for only the six health plans that will continue to serve Illinois Medicaid beneficiaries in 2019. A key and notes for Table A1-1 are listed in the table below.

Table A1-1—Summary of Performance Measures Results

Measure	# Plans Reporting 2019	Plan Performance 2019				Statewide Avg. 2019/Trended 2018–2019	Improved Performance 2018–2019	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Access to Care								
Adults' Access to Preventive/Ambulatory Health Services								
Total	6	3	2	0	1	<25th ↑	4 of 6 plans	A
Adult BMI Assessment								
Adult BMI Assessment	6	3	2	1	0	<25th ↑	4 of 6 plans	Q
Ambulatory Care (per 1,000 Member Months)								
ED Visit—Total	6	0	3	3	0	50th–74th ↓	3 of 6 plans	Not Applicable (NA)
Outpatient Visit—Total	6	4	1	1	0	<25th ↓	3 of 6 plans	NA
Annual Dental Visits[1]								
Annual Dental Visits	5	0	2	2	1	50th–74th/NA	NA	A

Executive Summary of Performance Measure Results

Measure	# Plans Reporting 2019	Plan Performance 2019				Statewide Avg. 2019/Trended 2018–2019	Improved Performance 2018–2019	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Keeping Kids Healthy								
Childhood Immunization Status								
Combination 2	6	3	0	2	1	<25th ↑	4 of 6 plans	Q
Combination 3	6	3	1	2	0	<25th ↑	4 of 6 plans	Q
Immunization for Adolescents								
Combination 1 (Meningococcal, Tdap)	6	1	1	3	1	50th–74th ↑	4 of 6 plans	Q
Combination 2 (Meningococcal, Tdap, HPV)	6	1	1	2	2	50th–74th ↑	4 of 6 plans	Q
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile Documentation—Total	6	0	3	2	1	25th–49th ↑	4 of 6 plans	Q
Counseling for Nutrition—Total	6	0	4	1	1	25th–49th ↑	5 of 6 plans	Q
Counseling for Physical Activity—Total	6	0	4	1	1	50th–74th ↑	5 of 6 plans	Q
Well-Child Visits in the First 15 Months of Life								
Six or More Well-Child Visits	6	1	4	1	0	25th–49th ↑	3 of 6 plans	Q
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life								
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	6	1	2	2	1	50th–74th ↓	2 of 6 plans	Q
Women's Health								
Breast Cancer Screening								
Breast Cancer Screening	6	2	3	0	1	25th–49th ↓	3 of 5 plans[2]	Q
Cervical Cancer Screening								
Cervical Cancer Screening	6	3	1	2	0	25th–49th ↓	2 of 6 plans	Q
Chlamydia Screening in Women								
Total	6	0	1	4	1	50th–74th ↑	2 of 6 plans	Q

Executive Summary of Performance Measure Results

Measure	# Plans Reporting 2019	Plan Performance 2019				Statewide Avg. 2019/Trended 2018–2019	Improved Performance 2018–2019	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Prenatal and Postpartum Care								
Timeliness of Prenatal Care	6	1	2	1	2	50th–74th ↑	4 of 6 plans	Q, T, A
Postpartum Care	6	1	3	2	0	50th–74th ↓	4 of 6 plans	Q, T, A
Living With Illness								
Annual Monitoring for Patients on Persistent Medications[1]								
ACE Inhibitors or ARBs	5	1	1	2	1	50th–74th ↑	5 of 5 plans	Q
Diuretics	5	2	1	2	0	25th–49th ↑	5 of 5 plans	Q
Total	5	2	1	1	1	25th–49th ↑	5 of 5 plans	Q
Comprehensive Diabetes Care								
HbA1c Testing	6	1	1	4	0	50th–74th ↑	4 of 6 plans	Q
Eye Exam (Retinal) Performed	6	1	3	2	0	25th–49th ↑	3 of 6 plans	Q
Medical Attention for Nephropathy	6	2	2	1	1	50th–74th ↑	3 of 6 plans	Q
Medication Management for People With Asthma								
Medication Compliance 50%—Total[3]	6	2	4	0	0	25th–49th ↓	4 of 6 plans	Q
Medication Compliance 75%—Total	6	2	4	0	0	25th–49th ↓	4 of 6 plans	Q
Statin Therapy for People With Diabetes								
Received Statin Therapy	6	1	0	1	4	≥75th ↑	5 of 6 plans	Q
Statin Adherence 80%	6	1	2	2	1	50th–74th ↑	4 of 6 plans	Q
Behavioral Health								
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	6	4	2	0	0	<25th ↓	2 of 6 plans	Q, T, A
30-Day Follow-Up—Total	6	4	2	0	0	<25th ↓	2 of 6 plans	Q, T, A

Executive Summary of Performance Measure Results

Measure	# Plans Reporting 2019	Plan Performance 2019				Statewide Avg. 2019/Trended 2018–2019	Improved Performance 2018–2019	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Initiation and Engagement of AOD Abuse or Dependence Treatment								
Initiation of AOD Treatment—Total	6	0	1	3	2	50th–74th ↑	2 of 6 plans	Q, T, A
Engagement of AOD Treatment—Total	6	0	3	3	0	50th–74th ↑	4 of 6 plans	Q, T, A
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Total	6	1	0	5	0	50th–74th ↑	4 of 5 plans[2]	Q

↑ *indicates performance improved from HEDIS 2018 to HEDIS 2019.*

↓ *indicates performance declined from HEDIS 2018 to HEDIS 2019.*

[1] *One health plan did not have a reportable rate in HEDIS 2019 for this measure; therefore, only five health plans had rates that could be compared to benchmarks in HEDIS 2019 and trended from HEDIS 2018 to HEDIS 2019, where applicable.*

[2] *One health plan did not have a reportable rate in HEDIS 2018 for this measure; therefore, only five health plans had rates that could be trended from HEDIS 2018 to HEDIS 2019.*

[3] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

Appendix A2. Executive Summary Appendix

Federal Requirements for EQR Technical Report

This report addresses the following for each EQR-related activity conducted in accordance with 42 CFR §438.358:

- Objectives
- Technical methods of data collection and analysis
- Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
- Conclusions drawn from the data

As described in the CFR, the report also offers:

- An assessment of each health plan's strengths and weaknesses for the quality and timeliness of, and access to, healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each health plan, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to, healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all health plans, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each health plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

This report also offers recommendations for improving the quality of healthcare services furnished by each health plan, makes comparisons of plan performance, and describes performance improvement efforts. Information released in this technical report does not disclose the identity of any beneficiary, in accordance with §438.350(f) and §438.364(a)(b).

Scope of Report

Mandatory activities for SFY 2019 included:

- Compliance Monitoring—As set forth in 42 CFR §438.356(b)(1)(iii), the state or its designee conducts a review within the previous three-year period to determine the health plan's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.
- Validation of Performance Measures—In accordance with §438.356(b)(1)(ii), the EQR technical report must include information on the validation of health plan performance measures (as required by the state) or health plan performance measures calculated by the state during the preceding 12 months.

- Validation of PIPs—In accordance with §438.356(b)(1)(i), HSAG validated PIPs conducted by the health plans regarding compliance with requirements set forth in 42 CFR §438.330(b)(1).
- Validation of network adequacy—As described in 42 CFR §438.356(b)(1)(iv), HSAG validated health plan network adequacy during the preceding 12 months to comply with requirements set forth in §438.68.

Optional activities, as described in 42 CFR §438.356(c), for SFY 2019 included:

- Validation of encounter data reported by health plans (described in 42 CFR §438.310(c)(2)).
- Administration or validation of consumer or provider surveys of quality of care.
- Evaluation of the Managed Care State Quality Strategy (Quality Strategy) as described in 42 CFR §438.340(c)(2)(i).
- Validation of Performance Measures—HSAG conducted a review of the PCCM and CHIPRA programs for a select set of performance measures, following the PMV protocol outlined by CMS.[A2-1]
- CMS HCBS Waiver Performance Measures Record Reviews—To monitor the quality of services and supports provided to the HCBS waiver program enrollees, HSAG continued on-site record reviews for health plans to monitor performance on the HCBS waiver performance measures.
- Assistance with the development of a Medicaid managed care quality rating system as set forth in 42 CFR §438.334.
- Provision of technical guidance to health plans and HFS to assist them in conducting activities related to the mandatory and optional activities.

HealthChoice Illinois Health Plan Enrollment

Table A2-1 identifies the health plans, their counties of operation, and the SFY 2019 enrollment for each health plan.

Table A2-1—HealthChoice Illinois Health Plans for SFY 2019

Health Plan Name	Counties	June 2019 Enrollment
BCBSIL	All Counties	390,897
CountyCare	Cook County	317,846
IlliniCare	All Counties	343,104
Meridian	All Counties	790,741
Molina	All Counties	214,293
NextLevel	All Counties	46,079
Total		**2,102,960**

[A2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Mar 13, 2018.

Medicaid Managed Care Programs

MMAI

The MMAI was a groundbreaking joint effort to reform the way care is delivered to clients eligible for both Medicare and Medicaid Services (called "dual eligibles"). The MMAI demonstration project began providing coordinated care to Medicare-Medicaid enrollees in the Chicagoland area and Central Illinois beginning in March 2014. The MMAI program continues to operate under a separate three-way contract between HFS, the federal CMS, and the health plans and was not expanded to additional counties in 2018.

MLTSS

MLTSS and waiver services (including Elderly waiver and Supportive Living program and Division of Rehabilitation waiver services) were expanded as part of HealthChoice Illinois. MLTSS services were expanded statewide to all counties when CMS approved Illinois' MLTSS waiver amendment, effective July 1, 2019. The HealthChoice Illinois MLTSS program provides waiver and other services to individuals who qualify for both Medicare and Medicaid, but who are not part of the Medicare-Medicaid Alignment Initiative.

HCBS

Dual-eligible adults who are receiving LTSS in an institutional care setting or through a HCBS waiver, excluding those receiving partial benefits who are enrolled in the MMAI, are served through HealthChoice Illinois. All HealthChoice Illinois health plans serve HCBS enrollees.

DCFS Youth

Children in the care of the DCFS, including those formerly under this care who have been adopted or who entered into a guardianship, will be covered under statewide managed care Medicaid expansion. In SFY 2019, the transition of DCFS Youth to IlliniCare Health Plan as part of HealthChoice Illinois began. Full implementation is expected for 2020.

IHHs

Building on a managed care system that carved behavioral health into the medical program, HFS aims to enhance true integration of behavioral and physical healthcare through an ambitious integrated behavioral and physical health home program (IHHs) that promotes accountability, rewards team-based integrated care, and shifts toward a system that pays for value and outcomes. The IHH program is a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. Each member in the Medicaid population will be linked to an IHH provider based on their level of need and the provider's ability to meet those needs. The IHH will be responsible for care coordination for members across their physical, behavioral, and social care needs. The development of IHHs and the

payment model to sustainably support them is a significant but challenging step. HealthChoice Illinois recognizes that these IHHs will not materialize without considerable planning and appreciates that different providers are at different stages in their evolutions toward becoming IHHs, so HFS is allowing for a phased approach under which all providers are encouraged to make progress by creating greater incentives for those who can move more quickly toward a higher degree of integration.

Quality Strategy

The Quality Strategy provides a framework to accomplish HFS' mission of empowering individuals enrolled in the Medicaid program to improve their health status while simultaneously containing costs and maintaining program integrity. HFS worked with stakeholders and identified the following goals for quality improvement.[A2-2]

Better Care

1. Improve population health.
2. Improve access to care (including community based long-term services and supports).
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 health care.
6. Create consumer-centric healthcare delivery system.

Affordable Care

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

Performance Domains

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which a managed care organization (MCO) or prepaid impatient health plan (PIHP) increases the likelihood of desired

[A2-2] Illinois Department of Healthcare and Family Services. FY 2016 Annual Report: Medical Assistance Program; March 31, 2017. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/HFS2016AnnualReportFINAL33117.pdf. Accessed on: Mar 19, 2018.

> health outcomes of its enrollees through its structural and operational characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement.[A2-3]

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).[A2-4]

Timeliness

The NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A2-5] In the final 2016 federal healthcare managed care regulations, CMS recognizes the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206(a) and by requiring states, at 42 CFR §438.68(b), to develop time and distance standards for network adequacy.

Performance Measure Domains

Table A2-2 shows HSAG's assignment of the HEDIS 2018 performance measures HFS prioritized for improvement into the domains of quality, timeliness, and access. *Ambulatory Care* does not fall into these domains, as this is a utilization measure; therefore, this measure is not included in the table below.

Table A2-2—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measure	Quality	Timeliness	Access
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Adult BMI Assessment	✓		
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total and *Outpatient Visits—Total*	NA	NA	NA
Annual Dental Visits			✓

[A2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

[A2-4] Ibid.

[A2-5] National Committee for Quality Assurance. 2013 Standards and Guidelines for Managed Behavioral Health Organizations (MBHOs) and MCOs.

Performance Measure	Quality	Timeliness	Access
Keeping Kids Healthy			
Childhood Immunization Status—Combination 2 and *Combination 3*	✓		
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living With Illness			
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Diuretics, and *Total*	✓		
Comprehensive Diabetes Care—HbA1c Testing, Eye Exam (Retinal) Performed, and *Medical Attention for Nephropathy*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	✓		
Statin Therapy for People With Diabetes—Received Statin Therapy and *Statin Adherence 80%*	✓		
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	✓		

Appendix A3. Follow-Up on Prior Year EQR Recommendations

Section Contents

Prior Recommendations

The tables in this section identify recommendations for quality improvement made in the SFY 2018 EQR Technical Report and an assessment of the degree to which each health plan has addressed the recommendations effectively.

Table A3-1—Recommendations for Health Plans from Prior EQR Report

Focused Populations and Processes Targeted for Improvement			
Behavioral Health (BH)	**Health Plan Customer Service[i]**	**Appropriate Care—Chronic Conditions**	**Preventive Ambulatory Health Services**
Quality, Access, and Timeliness	**Quality**	**Quality**	**Access**
• Evaluate effectiveness of transitions of care from inpatient settings to HCBS settings. • Evaluate effectiveness of CC/CM for beneficiaries with complex healthcare needs. • Evaluate effectiveness of CC/CM for children with BH conditions. • Continue participation in the quarterly monitoring and reporting of the BH Transitions of Care Quality Improvement Plan implemented in 2018. • Continue collaboration with community BH organizations. • Provide easy access to prior-authorization, pharmacy, and claims data for CC/CM staff.	• Evaluate the need for a service recovery program, complaints and grievances (C/G) tracking system, and standards and service level reporting for customer service. • Evaluate C/G data to identify failure points/root causes. • Track trends and use data to improve service processes. • Train and empower frontline employees to resolve C/G quickly and effectively.	• Consider a focused project to analyze commonalities and barriers to achieving hypertension control. • Use CACs to identify barriers to care and factors that motivate beneficiaries to seek care. • Examine barriers for women to access prenatal care, including appointment availability and wait times for obstetrics and gynecology providers. • Examine methods used for finding pregnant women. • Evaluate outreach and engagement programs to find pregnant members. • Evaluate the effectiveness of established prenatal/ pregnancy programs.	• Conduct a root cause analysis to identify barriers to obtaining appointments. • Consider targeted outreach campaigns. • Identify frequent/high ED users and connect them with CC/CM programs. • Evaluate provider compliance with appointment availability and after-hours access. • Gain access to real-time ED visit and discharge data from hospitals for timely follow-up. • Evaluate “gaps in care” and “unable to reach” programs. • Use the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE) immunization registry to obtain access to immunization records in an effort to supplement immunization data. • Follow up with parents of children who have missed appointments and assist with rescheduling. • Identify providers who have evening/weekend clinics to accommodate working parents. • Develop incentive programs to entice parents to get their children immunized. • Increase awareness about the importance of immunizations through culturally appropriate education campaigns. • Use health fairs and mobile vans to enhance immunization education.

Overall Improvement Opportunities for Compliance Monitoring
Quality, Access, and Timeliness
Improve health plan monitoring and oversight of access and availability by: • Monitoring providers' open and closed panels, compliance with Americans with Disabilities Act, and network adequacy—remains an area for continued improvement by the health plans. • Using results of provider access and availability survey results to improve monitoring of PCP appointment availability. • Improving the accuracy of the provider directory through regular audits and timely updates when changes are identified—remains an area of continued improvement for the health plans. • Improving the accuracy of provider network reporting for pediatric specialty and LTSS providers. • Developing time and distance standards for LTSS providers where the enrollee is required to travel to the provider to receive services. • Developing a list of Medicaid-approved HCBS providers to enhance the EQRO validation of the health plan-contracted HCBS providers. • Conducting root cause analysis of beneficiary access-related grievances to identify barriers in accessing care and services. Improve compliance with CC/CM requirements by: • Evaluating effectiveness of the CC/CM program and enhancing training and oversight of CC/CM activities. • Evaluating and strengthening transition of care programs and improving communication with hospitals to improve transitions of care. • Evaluating effectiveness of CC/CM for children with BH conditions. • Improving CC/CM documentation systems, unable-to-reach programs, and compliance with HCBS training requirements. Improve compliance with subcontracts and delegation contract requirements by: • Improving oversight of delegated vendors through monthly operations meetings and quarterly review of delegate performance. • Improving performance feedback to delegated vendors and monitoring remediation actions. • Completing delegation agreements and implementing oversight of the BH crisis line. Improving compliance with CI requirements by: • Improving systems used for the intake, processing, tracking, and reporting of CIs. Improve network provider satisfaction through: • Implementing systems and processes for timely resolution of provider complaints. • Using the results of provider satisfaction surveys to identify root causes of provider dissatisfaction. • Streamlining and standardizing the prior-authorization process across managed care plans.

Health Plan Follow-Up

Table A3-2—Follow-Up from Health Plans on Recommendations from Prior EQR Report

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
BCBSIL	
BH	BCBSIL has an outpatient provider incentive and a facility incentive for mental health follow-up. BCBSIL partnered with a contracted community health provider to offer an intensive case management program (ICM) for our highest admitting and most acute adult population to create a higher level for intervention with top readmitting members and to provide additional supports and housing solutions to aid in treatment engagement and stabilization. BCBSIL terminated relationship with BH vendor, Threshold, due to noncompliance with HRA completion, poor transition of care, lack of follow-up with the mobile crisis response processes, and untimely completion of documentation.
Health Plan Customer Service	Initiatives implemented during SFY 2019 included using a vendor to assist with locating difficult to find members; implementing Central Support, which can respond to urgent member calls and provider inquiries; ensuring the knowledge base for Customer Service Representations is up-to-date; posting educational CAHPS handout on the BCBSIL website for providers; implementing process improvements to the authorization process; continuing to conduct the Secret Shopper survey; continuing to evaluate Geo-Access along with grievance to assess geographical distribution of PCPs and specialists; and providing custom reporting to the top 10 provider groups on their members' CAHPS responses. Due to poor performance by the member service and provider service call centers, BCBSIL put the call center on a CAP to address the root cause of the missed metrics. The customer service vendor, TMG Health (TMG)/Cognizant, addressed their staffing model, capacity planning, and training program.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
BCBSIL	
Appropriate Care—Chronic Conditions	For prescribers, BSBSIL has a program called Guided Health, where provider communications are sent quarterly, alerting them of patients with less than 80% medication adherence in the following categories: cholesterol, diabetes, and hypertension. BCBSIL used the Institute's Community Health Management CHM Hub® of 25 data sets to visualize and connect geography-linked claims, social and environmental data, and proprietary health resource deserts, including PCP, nutritional, and pharmacy deserts, to identify local barriers to conduct analysis on the social determinants of health. During an analysis of the top 5 counties of DuPage, Cook, Kane, Lake, and Will, hypertension had the highest prevalence of 12.2%. Therefore, PAVE® and Living365® programs were implemented to address hypertension. However, additional initiatives will be developed in SFY 2020. PAVE engages with community pharmacists to talk to nonadherent patients about taking their medications as prescribed and the importance of refilling their medications. BCBSIL is working with Davis Vision to conduct outreach calls to diabetic members who are noncompliant for their dilated eye exam.
Preventive Ambulatory Health Services	HealthChoice Illinois members receive incentives for completing the following services: *Breast Cancer Screening*, *Comprehensive Diabetes Care–Dilated Eye Exam*, and *Well Child Visits in the First 15 Months of Life (6+ visits)*. CareNet conducts outreach calls to members who are noncompliant for *Breast Cancer Screening* and *Well Child Visits*. CareNet also makes outbound calls to members who have not had an office visit or a BMI completed in 2019. CareNet assists members with scheduling appointments and transportation for all 3 services. BCBSIL has provider rewards for *Well Visits in the First Fifteen Months of Life*, *Breast Cancer Screening*, and *Comprehensive Diabetes Care–Dilated Eye Exam*.
Compliance Monitoring	CC/CM program: updated policies and procedures, enhanced staff and management training, implementation of an Activation Team for HRA and care plan completion, implementation of an oversight process for the Activation Team, enhanced reporting logic to better capture data on newly eligible members, continued improvement on CI reporting and submission through weekly CI workshops, additional training, and care coordination clinics for all staff; and enhanced monitoring of waiver queues and creation/completion of Guiding Care activities to ensure all transitional waiver members are seen within the contractual time frames. HCBS: implemented new documentation templates (Guiding Care templates) for staff to use while working with waiver members to help care coordinators track the services that waiver members receive and deployed a Guiding Care activity enhancement to improve and assist the Care Coordination team with documentation of care coordination efforts to assist waiver members. CAPs: closed all remediation items in the CAPs with HFS that focused on appeals and grievances, delegation oversight, and quality improvement and oversight. Meeting with HFS on a biweekly basis to reconcile provider portal CAP tickets against the CAP. Closed all remediation items for the HCBS waiver CAP.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
BH	CountyCare developed a partnership and invested $1 million in the Chicago and Cook County Flexible Housing Pool (FHP), a program that uses data to identify and house persons experiencing homelessness who are high-cost users of hospital, jail, and/or homeless systems. Additionally, CountyCare implemented a program of targeted home visits to members who lack valid phone numbers and began a pilot program to integrate care managers with physician appointments at Cook County clinics. Lastly, CountyCare expanded its team of dedicated Transition of Care Team (TOC) staff who work in BH and medical teams assigned to specific hospitals to provide members on-site transition support. CountyCare applied for and was selected to be 1 of 7 teams in the nation for the Advancing Health Equity Learning Collaborative to support payment innovations to address health disparities. CountyCare upgraded the CommunityCare Connect platform to allow for bidirectional messaging between a member's CME and the BH agency. This is a key step toward interdisciplinary communication to improve shared decision making and support transitions of care. Additionally, ACCESS Community Health Network has a BH TOC that facilitates posthospital provider appointments.
Health Plan Customer Service	The retention and growth team was developed in SFY 2019 and launched in July 2019. The retention and growth team makes outbound calls to members who are up for redetermination to assist them with the redetermination process. The Customer Service Quality Management Committee was launched. The committee will focus on analyzing data obtained from CAHPS, member grievances and appeals, and access and availability surveys, among other things related to customer satisfaction, and use the data to find opportunities to improve the member experience. The "Find A Provider" tool was revamped to make it more user-friendly and provide more information about providers for members. CountyCare also revised the list of services requiring prior authorization to reduce the delay in providing members with needed services and improve the rating of healthcare.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
Preventive Ambulatory Health Services	CountyCare launched "Brighter Beginnings," a new program designed to help expectant families and babies stay healthy during pregnancy and after the baby is born, including a new member incentive for families to earn coupons for diapers by maintaining updated immunizations for children under 2 years of age. Through care coordination, the program will guide members through prenatal and postpartum appointments and assist families with adding the newborn to the family's Medicaid coverage. In January 2019, CountyCare revamped its provider incentive program to align with the HealthChoice Illinois P4P program. The primary areas of focus include preventive care and screenings and medication management per HEDIS specifications. CountyCare added a universal provider incentive for claims for all prenatal and postpartum visits and all metabolic screening for children on antipsychotics. CountyCare launched a robust outreach and scheduling initiative to encourage members to get a mammogram, resulting in improved performance on the *Breast Cancer Screening* measure, reaching the 75th percentile. The CountyCare Rewards Program entered its second year with members earning more rewards for services provided to close care gaps. CountyCare also revised its P4P program to incentivize providers to meet targets on HEDIS measures where improvement is needed.
Appropriate Care—Chronic Conditions	CountyCare partnered with Canary Telehealth, a vendor to provide in-home diabetic retinal exams to members with diabetes, which eliminates the transportation barrier that members face for getting to appointments. From February through June 2019, 1800 members benefitted from this initiative. During SFY 2019, many network PCPs added retinal cameras to their practice sites as well. CountyCare continues to offer its comprehensive member incentive program (MIP). The MIP program, now in its second year, rewards members for managing chronic conditions like diabetes and attending prenatal visits.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
Compliance Monitoring	CountyCare initiated CAPs on DentaQuest/EyeQuest, the dental and vision vendor, regarding gaps identified in the online provider directory. A CAP was also initiated for Independent Living Systems (ILS), a delegated CME, to address low performance on completing key required care management activities. A deficiency action plan was also initiated for the third party administrator, Evolent Health, to address a number of compliance deficiencies. ACCESS embedded care managers in 2 hospital EDs to manage transitions of care. CountyCare developed the Master Performance Report to provide new Provider Performance Reports (PPRs) to support the oversight of the value-based arrangements above and monitoring of large provider groups and CMEs. The PPR shows provider performance on key utilization and quality metrics compared to CountyCare overall, with trended data and extensive filters to identify successful interventions and opportunities for improvement in the upcoming year. To improve the HEDIS data collection methods, CountyCare is pursuing the delivery of electronic medical record (EMR) data directly to CountyCare from major provider groups. Additionally, CountyCare is working with provider groups to obtain direct access to their EMR systems. Both will assist CountyCare with obtaining standard and nonstandard supplemental data and enable medical record retrieval support during chart chase season. CountyCare initiated the inclusion of data from the I-CARE.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
IlliniCare	
BH	IlliniCare significantly expanded its behavioral healthcare programs and network provider partnerships, including contracting with the Illinois Health Practice Alliance (IHPA), a BH provider association, to improve provider access for high-risk members after mental health hospital discharge, and to implement a collaborative model of care coordination that includes BH specialists. This partnership increased the number of in-network BH providers by 847 statewide, closing significant health professional shortage area (HPSA) gaps, particularly in rural and downstate areas.
Health Plan Customer Service	IlliniCare implemented organization-wide member experience standards for all staff and managers.
Appropriate Care—Chronic Conditions	IlliniCare enhanced chronic condition and disease management programs by implementing telemonitoring services to members diagnosed with heart failure and diabetes, by deploying in-home respiratory therapists who act as health coaches and conducting health and environmental safety visits, and by providing treatment to vulnerable members following hospitalization. IlliniCare implemented community-based workers and mobile health vehicles statewide who act as trusted resources in the community for outreach to members, education, informal counseling, referrals, and social supports.
Preventive Ambulatory Health Services	Plan to initiate: targeted member incentives, allowing point of services rewards for closing care gaps and completing preventive health services, and full implementation and network-wide user support for a provider-facing, web-based, and real-time HEDIS reporting tool that provides daily updates for claims at the provider level for surveillance of care gaps in member panels.
Compliance Monitoring	lliniCare developed a multi-tiered structure, "Accountable Care Communities," for multiple levels of outreach and engagement to meet members and providers "where they are" and facilitate care coordination when members are most in need. These communities are embedded and IlliniCare is using this model in 15 provider offices and 26 medical and BH facilities statewide. IlliniCare deployed innovative member outreach strategies, including text messaging and auto-dialed Proactive Outreach Manager (POM) calls that improved membership redetermination efforts, collection of health risk screening data, and novel methods for member communication to improve the HEDIS gap closure. IlliniCare's new Provider Performance business initiated key innovations to support network provider performance. These tools include substantive analytics at the practitioner level, drilling down to aspects of practice management, such as utilization and cost, which are critical to improving member engagement; effective delivery of preventive care; and better management of outcomes. IlliniCare has a robust, network-wide communication strategy reaching over 1,000 provider practices monthly on key topics in quality, providing specific messaging and education on P4P program performance and earning opportunities, quality dashboards, member gap lists, key strategies, and support for gap closure.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Meridian	
BH	Meridian established a relationship with vendor Best Foot Forward (BFF) to assist in outreach efforts for difficult to engage and unable to reach enrollees. Meridian developed Community Health Outreach Workers (CHOW) presence across the state to support the telephonic care coordinators providing a presence in the field to locate hard to reach enrollees. Meridian enhanced their BH Care Coordination team to focus on improving enrollee transition of care outcomes and related HEDIS performance. Meridian established on-site staff presence at safety net hospitals and discharge facilities to increase engagement and improve provider relations.
Health Plan Customer Service	Meridian expanded their outreach hours beyond regular business hours to engage with more enrollees. Meridian plans to implement member feedback from Member Advisory Committees (MACs) and CACs and reestablish an interdepartmental CAHPS workgroup designed to identify key drivers for member satisfaction and implement initiatives. The grievance and appeals department collaborated with the care coordination department to identify and resolve access grievances reported by members. Specifically, community care coordinators conduct home visits and discuss provider grievances with members before escalating issues to provider network development representatives. Meridian's provider network team launched comprehensive provider meetings and educational campaigns targeted to providers in rural and new counties. In addition, Meridian conducts monthly meetings with large health systems, medical groups, and PCP groups as an ongoing initiative that is a part of the organization's strategic outreach goal.
Appropriate Care—Chronic Conditions	A member clinical profile tool has been created as a tool for care coordinators, and several pilot programs are in progress to improve health outcomes in high-risk and chronically ill member populations. Meridian's Quality Improvement team revamped a new disease management program that targets members with chronic medical and behavioral conditions. The program will engage in multiple activities to improve member self-efficacy in managing their chronic conditions.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Meridian	
Preventive Ambulatory Health Services	Meridian partnered with a third party vendor, HealPros, to schedule appointments in high noncompliant areas for *Comprehensive Diabetes Care–Eye Exam (CDC DRE)*. HealPros was able to complete mobile eye exams in member residences and address identified gaps in care for diabetic members. The partnership with HealPros positively impacted Medicaid rates and contributed to an overall 3.69% rate increase from HEDIS 2018 to HEDIS 2019 for the CDC DRE measure. Meridian implemented several population health management initiatives that will be evaluated for performance in SFY 2020. Meridian developed high-risk maternity and Medicaid-specific teams to further ensure populations are managed appropriately. The Progeny First Year of Life Program is a partnership between Meridian and ProgenyHealth. Through the First Year of Life program, ProgenyHealth provides ICM services for members who have babies admitted into a neonatal intensive care unit (NICU) or special care nursery up to their first birthday. The Illinois Quality Improvement PPC Incentive Program strives to positively impact PPC-postpartum performance through the implementation of targeted incentives that encourage members to complete appointments and improve health outcomes.
Compliance Monitoring	Meridian has implemented 9 electronic data interchange (EDI) feeds and began the process with a few other providers and provider groups in SFY 2019. Lack of EDI was a barrier for HEDIS improvement and will continue to be an area of opportunity for SFY 2020 to improve data collection and HEDIS measure performance.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Molina	
BH	Molina joined with a key community health provider, Thresholds, in an effort to increase member engagement in healthcare and recovery education. Through Thresholds, high-need Molina members received additional support from localized resources to secure timely follow-up appointments following hospitalization and to link members with severe mental illness to appropriate outpatient services. Molina launched a program in August 2018 with the Illinois Behavioral Health Home Coalition (IBHHC), a group of 6 mental and behavioral health center providers that is well-equipped to treat members with complex BH and physical comorbidities. Molina launched a Behavioral Health Excellence Program for providers to offer preferred provider status and potentially reduced authorization review for BH providers that meet readmission and follow-up benchmark goals.
Health Plan Customer Service	A new team dedicated to FQHCs and RHCs provider network management is being established to become more aware of and closely dedicated to those issues that specifically impact encounter clinics. Molina has planned the following initiatives related to improving member satisfaction: create a blinded scorecard with provider specific CAHPS results to show performance against peers, conduct an off-season CAHPS Survey to drill down on specific measures, and disseminate provider tip sheets and CAHPS reminders.
Appropriate Care—Chronic Conditions	Molina's Targeted Case Management Programs have been redesigned for members with one or more of the following diagnoses: diabetes, asthma, chronic obstructive pulmonary disease (COPD), depression, congestive heart failure (CHF), and schizophrenia. Molina targets any presenting member, regardless of acuity, for outreach to provide support and education around tools for medication and treatment adherence. To direct the care management for membership with chronic conditions, Molina has formed a dedicated team, the Strategic Triage Assessment Team (STAT), composed of nurse care coordinators and member health assessors. This team engages, assesses, and creates care plans for high-risk and potentially high-risk members. Employed a respiratory specialist to support hospital discharges and develop respiratory care plans for members to be distributed to their PCPs.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Molina	
Preventive Ambulatory Health Services	Molina incorporated a community needs assessment into our community connector program, with the goal to complete the assessment as part of every successful community connector outreach to a member. That assessment will encompass social determinants of health and identify immediate needs, such as shelter and food, to assist in developing a holistic view of members' lives. Molina implemented a member incentive for completing a mammogram every 2 years. Molina also conducted outreach to members at several times of the year and partnered with key providers across the state to host mammogram events to close breast screening gaps. Molina enhanced methods for identifying pregnant members and incorporated evidence-based practices into the Well Mom Program of incentives and education for members during and after pregnancy.
Compliance Monitoring	Molina formed a Delegation Oversight Committee to serve an advisory role to review reporting and audit results to provide any recommendations on actions the health plan should take, including CAPs that may need to be enacted.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
NextLevel	
BH	NextLevel added depression, anxiety, and trauma screens to its suite of BH assessments, and more extensive assessments of depression and anxiety specifically have been included in the HRA. NextLevel is seeking partnerships to expand its successful housing pilot initiative with Trilogy, a community BH provider partner, to expand housing options for persons with serious mental illness with a history of high inpatient utilization. NextLevel is planning a pilot program for the use of government-issued telephones with members with BH needs who are hospitalized, to assist in maintaining contact, particularly following a hospital stay. NextLevel has a care coordination agreement with ACCESS (see more details in appropriate care section). NextLevel is expanding network choices for its members who prefer to receive treatment in less stigmatizing primary care settings (like FQHCs) and is working to educate and incentivize providers to become Medication Assist Treatment (MAT) providers.
Health Plan Customer Service	NextLevel implemented a robust Community Communications Strategy that included, but was not limited to, leveraging content across multiple channels.
Appropriate Care—Chronic Conditions	NextLevel entered into an agreement with ACCESS FQHCs to delegate the care coordination functions of members receiving primary and/or behavioral healthcare at ACCESS locations. This provider has 40% NextLevel population and has 31 clinics located throughout the Chicago area. The ACCESS care coordination model is multidisciplinary, with behavioral and medical providers working side-by-side in care management and care delivery. NextLevel works with this delegated provider on routine census and complex cases weekly to ensure collaboration with NextLevel priority strategies. NextLevel worked to establish a TOC to engage with hospital discharge planners and social workers to ensure members are successfully discharged to the most appropriate level of care and with all of the necessary services in place to enhance recovery, reduce the likelihood of readmission, and reduce the length of stay in the hospital setting. Initiatives included a daily census of all hospital admissions and embedding case managers at partnering facilities.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Preventive Ambulatory Health Services	NextLevel launched the Tiger Team in 2017 to address members with high inpatient and/or ED utilization who would benefit from enhanced case management. In 2018, this team evolved into a unit of embedded care managers located at acute inpatient facilities conducting daily rounds on current census information. Focused teams created based on health information exchange allowing population health management to become proactive versus reactive making the Tiger Team in 2019 much more robust in managing overutilization. NextLevel improved collaborations with Metropolitan Breast Cancer Task Force to outreach to and engage members and resulted in NextLevel Health branding of materials with "Big or Small-Save Them All®" to promote awareness of breast cancer screenings and initiatives. In order to increase NextLevel Health's attempts to outreach to new members, the plan entered into 23 separate agreements with vendors who provide HRS/HRA services for hard to reach members. The NextLittle Steps® program was established in January 2018 to address an identified need to better engage pregnant members and support maternal and infant wellness.
Compliance Monitoring	NextLevel made improvements to the care management software to align with NCQA specifications and assist care managers with efficiency of documentation. NextLevel migrated to a new utilization management platform that allows for more robust data-sharing capabilities. NextLevel integrated bidirectional flow of clinical integration through EMR access with institutions and provider groups. NextLevel implemented a weekly plan-wide Integrated Care Management meeting to review gaps in care, screening completion, and other improvement factors and established a series of operational huddles twice weekly to focus on authorization trends and deliverables. NextLevel implemented an electronic platform (Compliance 360) for internal and external reporting of quality of care or service, safety incidents.

CAPs

When health plans are found to not be meeting expected performance levels or standards, a CAP is developed. The CAP details the identified deficiencies and provides a reporting structure for the health plan to demonstrate progress toward improvement, including the goals of the corrective action; the timelines associated with the actions; the identified changes in processes, structure, and internal and external education; the type of follow-up monitoring, evaluation, and improvement required; and the identified improvements and enhancements of existing outreach and care-management activities, if applicable. HSAG monitors and evaluates corrective actions taken to assure that appropriate changes have been made and are effective and conducts reevaluations to assess the sufficiency of the health plan's interventions, activities, and timelines to determine whether the actions can reasonably bring the health plan's performance into full compliance with the requirements.

During SFY 2019, the following plan-specific CAPs were developed, reviewed, and remediated:

- Aetna: grievances and appeals
- BCBSIL: grievances and appeals and HCBS
- CountyCare: HCBS
- Humana: HCBS

Aetna

Aetna's findings included:

- Noncompliance with timely processing of grievances and appeals and written acknowledgment to the enrollee of the receipt of a grievance and/or appeal.
- Staffing shortages within the grievances and appeals department, resulting in untimely processing and a backlog of grievances and appeals.
- System issues in the grievances and appeals documentation system.
- Lack of oversight by the Quality Management Oversight Committee and the compliance officer to monitor and evaluate corrective actions to assure that appropriate changes were made to resolve noncompliance with the processing of grievances and appeals.
- Unclear handoff of quality of care grievances between the quality department and the grievances and appeals department resulting in untimely processing and closure of quality of care grievances.

BCBSIL

BCBSIL's HCBS findings included:

- Noncompliance with timely care management activities, including enrollee outreach, HRA, care planning, and waiver service planning.
- Lack of process for accurate identification of newly eligible waiver beneficiaries.

BCBSIL was placed on a focused CAP for significant noncompliance with timely acknowledgement and resolution of both grievances and appeals and with oversight of their delegated vendors contracted to process appeals. The focused CAP resulted in data and narrative submissions that required HSAG analysis and multiple on-site reviews with health plan leadership and department staff. BCBSIL made substantial process improvements, resulting in finalization of closure of its CAP in SFY 2020.

CountyCare

CountyCare's findings included:

- Lack of oversight of its delegated entity related to HCBS care management.
- Noncompliance with care management activities, including risk stratification, waiver service planning, enrollee outreach, and ICT activities.
- Lack of care coordination staff access to claims and utilization data to validate delivery of waiver services.
- Lack of follow-up to HSW concerns identified during HSAG quarterly HCBS reviews.

Humana

Humana's findings included:

- Lack of waiver service validation process.
- Lack of oversight of delegated entity related to HCBS care management.
- Lack of care coordination staff access to claims and utilization data to validate delivery of waiver services.

Appendix B1. 2018–2019 Performance Measure Methodology

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 and HFS-defined 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 2018 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS 2019, 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 plan. All of HSAG's lead auditors were Certified HEDIS Compliance Auditors (CHCAs). The audit involved three phases: off-site, on-site, and post-on-site. The following provides a summary of HSAG's activities with the health plans, as applicable, within each of the validation phases:

Off-Site Validation Phase (October 2018 through May 2019)

- Forwarded HEDIS 2019 Record of Administration, Data Management, and Processes (Roadmap) 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 on-site visit dates.
- Conducted kick-off calls to introduce the audit team, discussed the on-site agenda, provided guidance on HEDIS audit processes, and ensured that health plans were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the health plan used a vendor whose measures were certified by NCQA.
- Reviewed source code used for calculating the HFS-defined performance measure rates to ensure compliance with the specifications required by the State.
- Conducted validation for all supplemental data sources (SDS) intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation (MRRV) to ensure the integrity of MRR processes for performance measures that required medical record data for HEDIS reporting.

On-Site Validation Phase (January 2019 through April 2019)

- Conducted on-site audits to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Post-On-Site Validation Phase (May 2019 through July 2019)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS 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 2018 Audit Means, Percentiles, and Ratios. The report also included requests for clarification on any notable changes in rates, eligible populations, or measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result for 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. These included:

- HEDIS Roadmap.
- Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- Supporting documentation, such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Reabstraction 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 and by 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 for validation through the NCQA HEDIS Compliance Audits are listed in the table below. For measures that had an administrative and hybrid methodology, HFS allowed the health plans to choose the methodology (i.e., admin or hybrid) that worked best for its health plan.

Table B1-1—Measures Selected for Validation

HEDIS 2019 Performance Measures Selected by HFS			
	Performance Measure Name	**Acronym**	**Methodology**
1	*Adult BMI Assessment*	*ABA*	Hybrid
2	*Ambulatory Care*	*AMB*	Admin
3	*Childhood Immunization Status*	*CIS*	Hybrid
4	*Follow-Up After Hospitalization for Mental Illness*	*FUH*	Admin
5	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	*IET*	Admin
6	*Medication Management for People With Asthma*	*MMA*	Admin
7	*Metabolic Monitoring for Children and Adolescents on Antipsychotics*	*APM*	Admin
8	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*	*WCC*	Hybrid
9	*Movement of Members Within Service Populations (HFS-defined measure)*	*IL 3.6*	Admin

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 2019 Roadmap, published by NCQA as Appendix 2 to NCQA's *HEDIS 2019, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*, and updated information communicated by NCQA to the audit team directly.
- On-site meetings in the health plans' offices, 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, programming logic review and inspection of dated job logs, computer database and file structure review, and discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.
- If the hybrid method 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 2019 (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 B1-2.

Table B1-2—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 (<30) to report a valid rate. a. For Effective ness 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, except Plan All-Cause Readmissions (PCR) and Hospitalization for Potentially Preventable Complications (HPC), when the denominator is <150.
NB	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
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 applies only to a limited set of measures (e.g., Board Certification).

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than five 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., *Medication Management for People with Asthma* and *Initiation* and *Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*). 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 MRR staff qualifications, training, 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 and training materials to verify that all key HEDIS 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 reabstracted 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.

Plan-Specific Findings for HealthChoice Illinois Health Plans

NCQA HEDIS Compliance Audit Results for BCBSIL

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for BCBSIL's HealthChoice Illinois population. The audit indicated that BCBSIL was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B1-3—BCBSIL 2019 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 full compliance with the HEDIS IS standards was based on the findings summarized below. 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 used Cognizant (formerly TMG) as a third-party administrator to process medical services data. Cognizant used Facets to process claims. Cognizant received approximately 95 percent of claims in standard 837 format and the remaining 5 percent on paper. Cognizant converted paper claims to 837 format by scanning and using optical character recognition (OCR) technology. All 837 files received through the clearinghouse via Cognizant's scanning process were loaded into Facets through the applications translator. Standard validations and business rules were applied.

Cognizant's Quality Team conducted audits on a random sample of claims to monitor processor proficiency and accuracy. During the on-site visit, Cognizant reviewed the audit program and performance results for 2018, which showed over 90 percent accuracy. The audits assessed timeliness, compliance with State processing requirements, potential fraud and abuse, technical accuracy, and financial accuracy. BCBSIL reimbursed providers on a fee-for-service (FFS) basis. The plan reinforced this point during the on-site visit. During the on-site visit, 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.

BCBSIL had a very close relationship with Prime Therapeutics. Oversight included routine meetings and analytics reports.

BCBSIL provided data for the Query 2—Data Loading Checks request, documenting the monthly medical and pharmacy claim counts for 2018. Monthly medical claim counts provided demonstrated a reasonable, consistent volume and trend over the year, with a slight decrease in the last two months of the year. Monthly pharmacy claim counts were consistent across all of 2018.

BCBSIL was fully compliant with IS Standard 1.0.

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

BCBSIL experienced approximately a 25 percent increase in membership during 2018. The increase was primarily caused by changes to Medicaid contracts with HFS, including the merging of populations and a reduction in the number of contracted health plans.

BCBSIL used Cognizant to process enrollment data. Cognizant continued using the Facets system for enrollment data. BCBSIL received daily enrollment files with additions, terminations, and PCP information. Monthly 834 audit files were also received from the State and were reconciled with the information received in the daily files and then loaded into Facets via the TMG Enroll application. Nearly all records in the State files loaded without any issues, with only 20 to 30 records in a load being identified as needing manual work. The most common issue causing records to require manual intervention included discrepancies in member contact information (e.g., name, phone number).

The Cognizant Quality Team monitored the accuracy of the enrollment data, in part, through the Cognizant Monthly Enrollment Recon Report. BCBSIL conducted routine oversight of membership data processed by TMG through a set of "Absent on Recon" (AOR) with a rereview monthly. AOR identified members who failed to load into Facets. BCBSIL investigated issues and provided updated information to TMG for correction. Facets enrollment screens and the process for editing enrollment data were demonstrated during the on-site visit. All data elements required to support HEDIS and HFS reporting were present in the Facets system. Member eligibility history was present and long-term care identifiers were confirmed during the demonstration.

BCBSIL provided monthly enrollments counts by sex for 2018 (Query 1—Overall Demographics). Query results showed a modest increase during the second quarter of 2018, with a slow decreasing trend throughout the rest of the 2018.

BCBSIL was fully compliant with IS Standard 2.0.

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

BCBSIL maintained practitioner data in Premier Provider and Facets. Credentialing and contracting data were maintained in the Premier Provider system. Daily files were exported and transferred to TMG via a file transfer protocol (FTP) site. Weekly reports (Control 77 Premier—Facets Error Report) were produced and reviewed to ensure concordance between the two systems. The report compared the full set of practitioner data in each system. The concordance rate between the two systems was consistently over 95 percent. In 2018, the primary errors found by BCBSIL through the routine monitoring was related to affiliation configuration. During the on-site, system demonstrations were conducted for both

the Premier Provider and Facets provider systems. Two behavioral health providers were reviewed in both systems to verify the concordance of the data in the systems. All data elements, including specialty and active contract segments, matched across the two systems.

BCBSIL was fully compliant with IS Standard 3.0.

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

BCBSIL sampled for the *ABA*, *CIS*, and *WCC* measures according to the HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined to be sound. The MRR project configuration and data were reviewed through a walk-through of the MRR application.

BCBSIL used internal staff to conduct MRRs and QA. Staff members were sufficiently qualified and trained on the HEDIS Technical Specifications and the use of Inovalon's Quality Spectrum Hybrid Reporter (QSHR) abstraction tool for the measures under review. BCBSIL 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 completed, but oversight of random samples for each abstractor is recommended for future years.

BCBSIL was required to submit a convenience sample. The audit scope included three hybrid measures (*ABA*, *WCC*, and *CIS*), and two cases were reviewed for each measure. No critical errors were identified in any of the measures.

BCBSIL successfully passed the final MRRV.

BCBSIL was fully compliant with IS Standard 4.0.

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

BCBSIL presented several standard SDS from several lab data sources for HEDIS 2019 reporting. These supplemental lab sources included the following:

- Advocate Lab
- Boncura
- EMSI
- LabCorp
- Little Company of Mary
- Quest Diagnostics
- Swedish Hospital

All SDS met the requirements for standard SDS and were exempt from PSV. BCBSIL provided a walk-through of the supplemental data collection warehousing and extraction process in addition to the Roadmap documentation. All sources were reviewed and approved prior to the on-site visit.

BCBSIL was fully compliant with IS Standard 5.0.

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 in the Data Quality Report (DQR). BCBSIL's process included a monthly calculation and reporting of HEDIS measures to support internal quality improvement activities and to provide ongoing monitoring and comparison for the production of HEDIS performance measure calculations.

During the on-site visit, BCBSIL provided a walk-through of the process for data extraction from the Enterprise Data Warehouse (EDW) to the Quality Spectrum Insight (QSI)®-XL™ load and validation process. The most recent DQR was also reviewed. No issues were identified during the walk-through or DQR review.

BCBSIL was fully compliant with IS Standard 6.0.

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

BCBSIL used Inovalon's QSI 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 on-site visit, PSV for Query Group 3 was conducted for five members in each of the following measures: *FUH*, *ABA*, and *IL 3.6*. For each member, enrollment, administrative, and practitioner data in the QSI repository and source systems were reviewed to confirm compliance with measure specifications and system concordance. All five members for each of the selected measures were found to be compliant with the measure specification requirements.

In addition to the on-site query review, data for additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers, and loads into the QSI repository. Membership and enrollment data were assessed through Query Group 1—Overall Demographics query for which BCBSIL provided monthly membership counts for 2018 by product and stratified by gender.

BCBSIL data load logs claims and pharmacy data were reviewed as part of the Query Group 2—Data Loading Checks. No issues were identified in the documentation.

BCBSIL was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for CountyCare

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for CountyCare's HealthChoice Illinois population. The audit indicated that CountyCare was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B1-4—CountyCare 2019 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 full compliance with the HEDIS IS standards was based on the findings summarized below. 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 delegated most health plan operations during 2018 and initiated a contract for delegated health plan operations with Evolent, including claims processing. Evolent used Aldera as its claims transactional system and received more than 95 percent of claims through electronic submission for both facility and professional claims. CountyCare reimbursed providers through a FFS delivery system, with few exceptions for individual providers. Claims for behavioral health services were received and processed through the standard claim process in Aldera.

Evolent only accepted standard claim forms. In addition, Evolent did not accept any nonstandard coding schemes. Evolent provided a system demonstration during which original claims were compared with data in the Aldera system and all HEDIS-related fields were traced through into the Aldera system.

The relatively small number of paper claims received were scanned and converted into electronic claims files using OCR technology. Oversight of the scanning and conversion process was appropriate.

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, member validation, code edit checks, and required field checks within the Aldera system.

Evolent received pharmacy data from Optum daily and with monthly reconciliation files. Routine oversight and monitoring of pharmacy data for completeness and accuracy were appropriate for HEDIS reporting. No performance issues were identified with Optum during 2018.

CountyCare provided data for the Query Group 2—Data Loading Checks request, documenting the monthly medical and pharmacy claim counts for 2018. The provided monthly medical claim counts demonstrated a reasonable consistent volume and trend over the year, with a slight decrease in the last two months of the year. Monthly pharmacy claim counts were consistent across all of 2018.

CountyCare was fully compliant with IS Standard 1.0.

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

CountyCare experienced an increase in enrollment during 2018 as a result of HFS combining the FHP/ACA and ICP populations and reduced the number of participating health plans. 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.

Evolent provided an on-site system demonstration of the Aldera enrollment system. All HEDIS-relevant data elements were observed in the system, including the capture of historical enrollment spans and long-term care flags.

CountyCare provided monthly enrollments counts by sex for 2018 (Query Group 1—Overall Demographics). Query results showed a modest decrease during the first quarter of 2018 with a consistent member count throughout the rest of 2018.

CountyCare was fully compliant with IS Standard 2.0.

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

CountyCare provided Evolent daily provider files which were 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; data elements included provider specialty.

The provider type-to-specialty was reviewed and approved prior to the on-site visit; however, the Query Group 3 review found that the provider type-to-specialty crosswalk in the Change Healthcare software had not been updated to the version provided with the Roadmap and mapped rehabilitation facilities to mental health providers. CountyCare corrected the mapping and provided documentation of remediation prior to production of the final rate submission. CountyCare submitted revised provider mapping, which was reviewed and approved.

Evolent provided a demonstration of the Aldera provider system, and no issues were identified.

CountyCare was fully compliant with IS Standard 3.0.

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

CountyCare continued to contract with Change Healthcare as its medical record project vendor. HSAG reviewed the Change Healthcare tools, instructions, and training manuals. HSAG approved the medical record tool and MRR training manual prior to the on-site audit. Change Healthcare had appropriate training and conducted routine evaluation of abstractor accuracy. Abstractor oversight included overreads of 5 percent of each abstractor's charts; a minimum of 95 percent accuracy must be maintained. CountyCare conducted close oversight along with weekly oversight meetings to ensure complete and accurate data collection.

CountyCare was required to submit a convenience sample. The audit scope included three hybrid measures (*ABA*, *WCC*, and *CIS*), and two cases were reviewed for each measure. No critical errors were identified in any of the measures.

CountyCare successfully completed the final MRRV.

CountyCare was fully compliant with IS Standard 4.0.

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

CountyCare presented several standard SDS and one nonstandard data source for HEDIS 2019 reporting. All SDS were reviewed and approved prior to the on-site visit.

Standard SDS included the following:

- Care Coordination Claims Data (CCCD) State Encounter File
- HFS Immunization Registry
- LabCorp
- Mount Sanai Lab Data
- Quest Diagnostics
- Stroger Lab

These SDS met the requirements for standard SDS and were exempt from PSV.

One nonstandard supplemental data source was presented and used: Medical Home EHR Data. PSV was performed on a sample of 30 records, and all records were found to be compliant.

CountyCare provided a walk-through of the supplemental data collection warehousing and extraction process in addition to the Roadmap documentation. All sources were reviewed and approved prior to the on-site visit.

CountyCare was fully compliant with IS Standard 5.0.

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. Data from the January and April warehouses were exported to text files and provided to Change Healthcare. Change Healthcare loaded the text files into the repository and conducted valuations that included repository-to-source record count reconciliation, integrity checks, and field-level validations. Evolent did not accept nonstandard coding schemes, and no crosswalks were used or reviewed.

The provider type-to-specialty crosswalk was reviewed and approved prior to the on-site visit; however, the Query Group 3 review found that the provider type-to-specialty crosswalk in the Change Healthcare software had not been updated to the version provided with the Roadmap and mapped rehabilitation facilities to mental health providers. CountyCare corrected the mapping and provided documentation of remediation prior to production of the final rate submission. CountyCare submitted revised provider mapping, which was reviewed and approved.

During the on-site visit, CountyCare provided a walk-through of the process for data extraction from its claims system and the Change Healthcare load and validation process.

CountyCare was fully compliant with IS Standard 6.0.

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

CountyCare maintained its relationship with Change Healthcare for HEDIS 2019 performance measure production. All HEDIS measures within the scope of the audit were included in Change Healthcare's measure certification. The process for calculating the *IL 3.6* measure was reviewed during the on-site visit, and no issues were identified.

Query Group 3 validation testing was performed on five members from each of the following measures: *FUH*, *ABA*, and *IL 3.6*. Data in source and Change Healthcare systems were reviewed for compliance with measure requirements and concordance between systems. All members selected from the *ABA* population were found to meet the specification requirements for denominator inclusion and numerator compliance. All members selected from the *IL 3.6* population were found to meet the requirements of the specification. All members selected from the *FUH* population were found to meet the measure requirements for denominator inclusion and numerator compliance.

In addition to the on-site query review, data for additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers, and loads into the Change Healthcare repository. Membership and enrollment data were assessed through the Group 1—Overall Demographics query for which CountyCare provided monthly membership counts for 2018 by product and stratified by gender.

CountyCare was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Harmony

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Harmony's HealthChoice Illinois population. The audit indicated that Harmony was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B1-5—Harmony 2019 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	Not Applicable*	Fully Compliant	Fully Compliant	Fully Compliant

* Harmony elected to use the administrative methodology for all measures under the scope of the audit; therefore, MRR was not applicable.

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. 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

All claims are processed through Xcelys for Harmony. HSAG reviewed Harmony's claims process during the on-site audit and determined that no significant changes occurred in Xcelys or in the overall claim process since the prior year. Documentation provided in the Roadmap tables were reviewed in Xcelys as they were in historical audits. Harmony staff indicated that there were no processing changes during the year. Harmony's Xcelys system captured primary and secondary procedure and diagnosis codes without any issues. The claims system also had the capability to capture as many codes as were billed on a claim. Paper claims transactions were mailed to a Tampa, Florida mailbox, Change Healthcare (Relay Health), where they were then captured by Imagenet. Imagenet scanned the claims, converted them to an 837 format, and verified all data were captured. Imagenet's quality control center ensured data were captured appropriately. Harmony monitored the Imagenet claims on a daily basis to ensure all values were captured on the scanned claims. Audits were conducted on 3 percent of all claims submitted. Close to 100 percent of claims were processed offshore with exceptions. Approximately 84 percent of all claims were auto-adjudicated. In addition to the edits conducted in the preprocessing steps, Harmony utilized edits within Xcelys. Xcelys looked for provider, member, and payment errors to ensure members existed and payments were accurate. Harmony indicated that there were no issues with claims processing in 2018. Ninety-nine percent of all claims were captured within one day and 100 percent within two days. Harmony also captured encounter data from capitated vendors. Encounters included dental, transportation, and vision. While these encounters were not captured in Xcelys, they underwent edits in Edifecs (Exengine) which looked for valid billing codes and member information.

There were no changes to the process in 2018. Harmony was fully compliant with IS Standard 1.0.

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

Harmony received daily enrollment files from the State. This process has been in place over the last several years. Harmony received the daily enrollment files in a standard HIPAA-compliant 834 electronic format and loaded the files directly into Xcelys. Harmony reconciled the daily files with a monthly file, also provided by the State, to ensure data were accurate prior to enrolling the member. HSAG reviewed the Xcelys system during the on-site audit and confirmed that each enrollment span was captured. Additionally, HSAG reviewed several enrollment records to ensure that all HEDIS-required data elements were present and accurate. HSAG conducted on-site queries of average member enrollments and did not find any issues. The average member was continuously enrolled for approximately 11 months or more. There was a program change with the State that required members to select a plan for a full year, rather than being able to change health plans once per month.

There were no changes to the process in 2018. Harmony was fully compliant with IS Standard 2.0.

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

Harmony utilized Xcelys to capture all of its provider data for claims processing. Harmony utilized both direct contracted and delegated entities to enroll providers. Harmony used an internal software tracking mechanism (Omniflow) to manage its provider information. Omniflow was used to send provider data to Harmony's credentialing department for provider management prior to loading into Xcelys. Once the provider information flowed through Omniflow, the data were then loaded into Xcelys. A unique provider identifier was created along with provider specialties. Harmony's credentialing staff ensured provider specialties were appropriate by validating the provider's education and specialty assignment authorized by the issuing provider board. HSAG verified that the required HEDIS reporting elements were present in Xcelys and that provider specialties were accurate based on the provider mapping documents submitted with Harmony's Roadmap. Additionally, HSAG conducted on-site queries around provider specialties and did not find any issues.

Harmony credentialed all FQHCs. HSAG reviewed Harmony's process and determined it to be compliant with NCQA's requirements for FQHCs. Harmony's FQHCs were mapped to PCPs appropriately and were not mapped to any other specialty.

There were no changes to the process from the previous year. Harmony was fully compliant with IS Standard 3.0.

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

Harmony elected to use the administrative methodology for all measures under the scope of the audit; therefore, IS standard 4.0 for Medical Record Review Processes was not applicable.

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

Harmony used several standard SDS such as laboratory (lab) results and immunization and encounter files from HFS. Harmony also used one nonstandard supplemental database that required PSV. All SDS met the HEDIS requirements for supplemental data use. Harmony provided file layouts, coding transformation documents, and training documents with its HEDIS 2019 Roadmap submission. All nonstandard data sources passed the POS validation with no significant errors identified. There were no

changes to the SDS since the previous year's audit. Harmony invested a lot of time and effort ensuring data in the SDS were accurate and processed timely. Harmony conducted audits on its supplemental data intermittently throughout the year to ensure there were minimal errors or issues. When issues were discovered, they were promptly rectified.

HSAG did have some concerns with the Roadmap submission for SDS. Since WellCare, Harmony's parent company, completed the Roadmap Section 5, SDS that were not applicable to the scope of the audit were included. HSAG requests that for future audits, Harmony clearly indicates the SDS that are applicable to Harmony for the HSAG audit scope to make it simpler to identify all data sources being used. The audit team further recommends that like SDS be combined into one standard supplemental source. For example, Harmony has several lab vendors that can be combined into one standard supplemental source. Another example of combining sources is the CCCD files. Since all of these files come from the same State source, they should be combined into one CCCD standard supplemental data source.

Harmony was fully compliant with IS Standard 5.0.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Harmony continued to use its internal data warehouse to combine all files for extraction into the Inovalon certified measures software. The internal data warehouse combined all systems and external data into tables for consolidation prior to loading into Inovalon's file layouts. The majority of information was derived from the Xcelys system while external data, such as supplemental and vendor files, were loaded directly into the data warehouse tables. HSAG conducted a review of the HEDIS data warehouse and found it to be compliant. Harmony had several staff involved with the process who have many years of experience in dealing with data extractions, transformations, and loading. The warehouse was managed well, and access was only granted when required for job duties. HSAG conducted PSV and did not encounter any issues during the validation. Member data matched Xcelys, the data warehouse, and Inovalon numerator events. HSAG also conducted a series of NCQA-required queries during the on-site audit and did not identify any issues. HSAG reviewed Harmony's preliminary rates and did not identify any immediate issues. There were no changes to Harmony's systems or data integration processes since the previous year's HEDIS review.

Harmony was fully compliant with IS Standard 6.0.

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

Harmony contracted with Inovalon to use Inovalon's QSI software for HEDIS 2019 certified measure production. Inovalon was responsible for maintaining all aspects of the QSI application. Data transfers between Harmony and Inovalon were continually monitored through quality data reporting. Each file submitted to Inovalon underwent loading and validation checks. Harmony inspected each file load to determine if records failed. When records did fail, Harmony reviewed the individual records and remediated any issues. HSAG inspected record load errors during the on-site audit and found that record failures were due to members no longer being active.

There were no concerns with data following on-site review and PSV.

Harmony was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for IlliniCare

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for IlliniCare's HealthChoice Illinois population. The audit indicated that IlliniCare was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B1-6—IlliniCare 2019 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 full compliance with the HEDIS IS standards was based on the findings summarized below. 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

IlliniCare's claims processing remained the same as the previous year's review, with the exception of annual updates to the procedure and diagnosis coding.

IlliniCare continued to use AMISYS Advance to capture all medical claims. The audit team verified that the AMISYS system appropriately captured the required fields used to produce all HEDIS measures under the scope of the review. AMISYS Advance captured the claim receipt date, primary and secondary procedure codes, and unique member and provider identifiers.

IlliniCare continued to receive encounters from its vendor, Envolve HealthCare, Inc. (Envolve). Envolve was Centene's vendor for pharmacy, vision, and behavioral health services. Vendor data from Envolve were used to calculate some of the measures under review. Envolve was wholly owned and operated by Centene, IlliniCare's parent company. Encounters were received regularly from Envolve and data were captured in IlliniCare's EDW. Encounter data were captured in the same manner as traditional medical claims through standard 837 transactions. All encounters were subjected to the same preprocessing edits as direct billed claims, which required valid standard coding, valid membership, and provider information.

IlliniCare conducted routine audits of claims and encounter data weekly. IlliniCare also met with the vision and behavioral health vendors to discuss issues and transactional processes. IlliniCare continually assessed the data completeness of external encounters through trending reports and regular oversight meetings.

IlliniCare's audits included a 0.5 percent random sample of adjudicated claims, which were reviewed for financial accuracy. In addition, production standards were monitored daily and monthly by claims operations management to ensure compliance with standards.

Encounters were reviewed weekly for medical and vendor claims data. The response files (999, 837 Proprietary Response and National Council for Prescription Drug Programs [NCPDP] format) were reviewed for completeness and acceptance. The acceptance performance was tracked and reported weekly, while rejections were reviewed for resubmission. Encounter compliance standards were present in each vendor contract. HSAG reviewed the service level agreements and did not find any issues.

IlliniCare continued to use incurred but not received (IBNR) reports to determine claims/encounter completeness.

HSAG did not have any concerns with IlliniCare's ability to capture the relevant information required to produce any of the measures under review.

IlliniCare was fully compliant with IS Standard 1.0.

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

IlliniCare's process for capturing enrollment data did not change from the previous year's review. IlliniCare used AMISYS Advance to capture enrollment information from the State's secure file transfer protocol (SFTP) site daily, in electronic 834 format. The EDI team at Centene, the parent company for IlliniCare, processed the enrollment files on behalf of IlliniCare at its headquarters in St. Louis, Missouri. IlliniCare also received a monthly file to use for reconciliation of the daily files.

HSAG reviewed the enrollment information in AMISYS and concluded that IlliniCare captured the data accurately. HSAG verified that the AMISYS system contained sufficient fields for maintaining enrollment spans and member eligibility history. IlliniCare had sufficient processes in place to ensure that members had only one unique identifier and that no member was duplicated in the AMISYS system.

HSAG conducted PSV on member enrollment data to ensure the enrollment spans met the specification guidelines for inclusion in the various measures. There were no issues found during the primary source enrollment verification process.

IlliniCare's enrollment process also captured the subpopulation information required for categorizing the denominators. HSAG reviewed this enrollment process, interviewed staff on-site, and did not encounter any issues with the capture of enrollment information.

IlliniCare was fully compliant with IS Standard 2.0.

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

IlliniCare's provider data systems contained all relevant HEDIS fields required for reporting. PORTICO was the source system that updated AMISYS. When a change occurred on a provider record, the record was first updated in PORTICO and then submitted to AMISYS. Reconciliations were conducted on

provider systems daily through electronic means. IlliniCare frequently audited the two systems to manage any discrepancies.

IlliniCare's AMISYS system contained all relevant information for HEDIS reporting. All specialties and provider identifiers were captured and documented appropriately with the exception of FQHCs. HSAG reviewed IlliniCare's mapping for FQHCs and found that FQHCs were mapped to both PCPs and behavioral health specialists. HSAG advised IlliniCare that it can only map FQHCs to PCPs and must remove the FQHCs mapped to behavioral health providers from its mapping. IlliniCare provided documentation showing that the FQHCs did not have any impact on the *FUH* numerator compliant members. This issue was resolved without further action.

IlliniCare was fully compliant with IS Standard 3.0.

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

HSAG reviewed IlliniCare's IS 4 Roadmap pertaining to the policies and procedures for IS Standards 4.1, 4.2, 4.3, 4.4, and 4.5. The Roadmap review found these policies and procedures to be consistent with NCQA's *HEDIS 2019, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. IlliniCare demonstrated it sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample.

Provider chase logic was reviewed and determined appropriate across all hybrid measures. For HEDIS 2019, IlliniCare brought all medical record abstraction in-house using Inovalon's abstraction tools. HSAG participated in a live vendor demonstration of Inovalon's tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2019, Volume 2, Technical Specifications for Health Plans.* IlliniCare provided documentation that supported its processes, including maintaining QA reviews, over-reads, and random record selection reviews of numerator negatives. IlliniCare successfully passed convenience sample and final MRRV.

IlliniCare was fully compliant with IS Standard 4.0.

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

IlliniCare submitted several standard SDS and one nonstandard supplemental data source for review. The standard SDS included labs and State historical claims data. All data files were submitted in standard file layouts. IlliniCare mapped all files to Inovalon's standard supplemental data file layouts. Data files from the external entities were continuously monitored each month to ensure data submissions met standard reporting requirements.

The nonstandard data source, HEDIS User Interface (HUI) database, required POS documentation review. HSAG selected 50 randomly selected records for review, and no issues were found. All standard and nonstandard data sources were approved for use in HEDIS 2019.

Final impact reports were submitted following the final data refreshes prior to final rate reporting. There were no concerns.

IlliniCare was fully compliant with IS Standard 5.0.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

IlliniCare used Inovalon, a software vendor with NCQA-certified HEDIS measures. IlliniCare used several external data sources that it integrated into the HEDIS repository. External sources included pharmacy claims, lab results, dental encounters, and behavioral health claims. All external sources were wholly owned and operated by Centene, the parent company of IlliniCare. All vendor data were monitored on a regular basis through various trending reports and annual vendor audits. Data from the different source systems were loaded and integrated into the EDW.

Extracts were created by the Information Technology (IT) team using the SQL package to create flat files. The flat files were loaded into Inovalon's QSI software, which was housed at Centene. The data were mapped using a static SQL package. Initial mapping was completed with input and guidance from Inovalon and expert knowledge of the data within the EDW. Validation occurred to determine the accuracy of the mapping. Benchmarking over the past three years have supported the accuracy of the mapping. HSAG also conducted queries along with PSV during the on-site audit. PSV data were uploaded to the HSAG FTP site post-on-site. There were no issues discovered during the query and PSV review.

IlliniCare was fully compliant with IS Standard 6.0.

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

Inovalon's QSI software continued to be used for HEDIS 2019 certified measure production. Inovalon was responsible for maintaining all aspects of the QSI application; however, no data were transferred between IlliniCare and Inovalon. IlliniCare loaded its own data in their entirety and monitored the processes as described in IS Standard 6.0. IS Standard 7.0 components were appropriately handled via oversight of the vendor.

IlliniCare was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Meridian

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Meridian's HealthChoice Illinois population. The audit indicated that Meridian was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B1-7—Meridian 2019 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 full compliance with the HEDIS IS standards was based on the findings summarized below. 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

Meridian processed all nonpharmacy claims during 2018 using Managed Care Systems (MCS), an internally developed transaction system. Approximately 96 percent of claims were received and loaded electronically during 2018 and were subjected to Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance edits. Providers were paid FSS and were required to submit claims for services provided using industry-standard formats and industry-standard coding. All data submitted were captured, and primary diagnosis codes were distinguishable from secondary diagnosis codes. All data needed for reporting were available in MCS. Approximately 75 percent of claims were auto-adjudicated during 2018. Due to an expected increase in membership, Meridian contracted with Jacobson until November 2018 to adjudicate claims in MCS. Jacobson's staff participated in the same training and audit process as in-house examiners.

The standard for timeliness of claims processing of 95 percent of claims processed within 30 days was exceeded during 2018. The accuracy of claims processing during 2018 was 98.5 percent.

Meridian used MeridianRX during 2018 to manage pharmacy benefits and pay pharmacy claims. Member benefit data were automatically loaded from MCS to Merlin, MeridianRX's internal claims processing system, at regular intervals throughout the day. MeridianRX used Relay Health Systems for the transfer of point of sale transactions to Merlin. Pharmacy claims were automatically loaded from Merlin to MCS daily. All data needed for reporting were available in MCS.

Meridian was fully compliant with IS Standard 1.0.

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

During 2018, HFS obtained Medicaid member enrollment data and provided them to Meridian. Meridian received an 834 monthly audit file containing prospective membership for the upcoming month. This file was used to determine members that were terming at the end of the month as well as prospective members for the next month. Meridian also received a daily 834 file reflecting current changes in member enrollment data. Meridian processed member demographic and enrollment data internally in MCS within five business days of receipt for all enrollments during 2018. All data needed for reporting were available in MCS. Benefit plan code contained the data needed to identify members to be included in the HealthChoice Illinois reporting population.

Beginning January 2018, HFS rebranded its Medicaid managed care program as HealthChoice Illinois. With the rebranding, HFS expanded and made mandatory Medicaid managed care available to Illinois residents eligible for Medicaid. HealthChoice Illinois includes Illinois residents who meet one of the following criteria: families and children eligible for Medicaid through Title XIX or Title XXI (CHIP); ACA expansion Medicaid-eligible adults; Medicaid-eligible adults with disabilities who are not eligible for Medicare; Medicaid-eligible older adults who are not eligible for Medicare; dual-eligible adults receiving LTSS in an institutional care setting or through an HCBS waiver; SNC, defined as Medicaid-eligible enrollees under the age of 21 who are covered under SSI, a disability category of eligibility, or are receiving services from the Division of Specialized Care for Children (DSCC); and children formerly under the care of DCFS who have opted out of the DCFS-specific managed care program. As a result of these changes, Meridian's Medicaid enrollment increased significantly in 2018. Enrollment increased significantly in January 2018 due to acquisition of members from managed care plans that were no longer contracted to provide coverage to Illinois Medicaid participants. Enrollment increased significantly again in April 2018 due to Illinois' expansion of managed care to all Illinois Medicaid participants statewide–an increase from 12 to 102 counties. 2018 was the first year members and providers in the southern region of Illinois were exposed to Medicaid managed care. Significant efforts were made to increase the provider network to ensure access to healthcare.

Query 1 review assessed changes in Meridian's Medicaid enrollment from January 2016 through December 2018. Changes in enrollment reflected changes in the Illinois Medicaid program.

Meridian was fully compliant with IS Standard 2.0.

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

The State was responsible for credentialing and recredentialing all Illinois Medicaid providers. Providers enrolled in the Illinois Medicaid program using the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system. Meridian used IMPACT reports to confirm that providers were valid Illinois Medicaid providers. Meridian obtained provider demographic information directly from providers using the State roster template. Before November 2018, provider data had been manually entered in both the MCS and eVips credentialing systems. Beginning November 2018, data were manually entered in eVips and integrated electronically in MCS. Although the State was responsible for credentialing all Illinois Medicaid providers, the plan validated key data elements while entering the data into its systems. For example, Meridian validated the National Provider Identifier (NPI) using the

National Plan and Provider Enumeration System (NPPES) and used the American Board of Medical Specialties or American Osteopathic Association to validate specialties for physicians. There were no significant changes in 2018 to MCS or the processing of provider data that would impact reporting.

All data entry was audited by Meridian and all data required for reporting were captured. The NPI and specialty for the billing and rendering provider were required fields for both in- and out-of-network claims. NPPES was used to determine provider specialty for out-of-network claims.

Meridian was fully compliant with IS Standard 3.0.

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

Meridian conducted MRR internally using an internally developed system, Quality Management System (QMS). Meridian staff used the HEDIS Mobile Application to capture medical record images from provider offices. Images obtained were abstracted off-site using QMS. The measures under the scope of this audit that were reported using the hybrid methodology were *ABA*, *WCC*, and *CIS*.

HSAG reviewed Meridian's abstraction tool (QMS) and training manual and participated in a live demonstration of the tool. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2019, Volume 2, Technical Specifications for Health Plans.* Following completion of reviews, HSAG approved Meridian's medical record abstraction tool and training manual.

Abstractors entered data directly into QMS. Accuracy of abstraction was evaluated during training and throughout the abstraction period. All numerator positive events and exclusions were audited. All abstractors met the minimum accuracy standard of 95 percent.

Meridian passed both the convenience sample and MRRV process.

No concerns were noted with the chase logic. Medical record retrieval and abstraction were significantly complete.

Meridian was fully compliant with IS Standard 4.0.

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

Fourteen SDS were submitted for audit approval for 2019 reporting. Six of the sources were audited and approved for use in 2018 reporting as standard sources. These six SDS were lab results; Illinois Historical Claims, which included Medicaid FFS medical and pharmacy claims and Cornerstone and I-CARE immunizations; and four provider EMR data feeds. Three of the four provider EMR data feeds (Centegra, OSF, and Oak Street) were based on provider-programmed extractions of their EMR data using Meridian's internal file layout with mapping of EMR codes to Meridian's internal service type. One of the providers, Athena, provided CCCD records that the plan mapped to its internal file layout. The only new data feed received during 2018 for these existing provider EMR sources was from Centegra. All supplemental data used for 2019 reporting for OSF, Oak Street, and Athena were included in last year's audit.

During Q4 of 2018, Meridian added two new provider EMR data feeds, Lawndale Christian Health Center and IL Visiting Nurse Association. During 2019, Meridian attempted to add six new provider EMR feeds: Access Community Health Center, Memorial Health Partners, Shawnee Health Services, Infant Welfare Society of Chicago, Erie Family Health Center, and PCC Community Wellness Center. These six new provider EMR feeds in 2019 were not approved for 2019 reporting since they were not implemented by March 29.

All SDS reviewed for 2019 reporting were standard, except for Athena. Athena was classified as a nonstandard source this year because documentation on how the CCCD records were created was not provided and due to NCQA's decision that CCCD records are considered nonstandard supplemental data.

Mapping of nonstandard codes to standard codes was required for Cornerstone and I-CARE immunizations and provider EMR data sources. Meridian used mapping documents provided by Cornerstone and I-CARE to map its proprietary codes to CVX and Current Procedural Terminology (CPT™) codes. Providers submitting EMR data to Meridian in Meridian's file layout were required to use a mapping document provided by Meridian to map their services to Meridian service type codes. Meridian was required to map Athena CCCD records to its file format and to map industry-standard codes to its internal service type code.

Review of SDS impact reports found that most of the data sources had little to no impact on rates for measures under the scope of this audit. The exception was Cornerstone and I-CARE Immunization data. Cornerstone is an Illinois statewide information system used to capture maternal and child health services provided by the Illinois Department of Human Services, while I-CARE is the Illinois State immunization registry. Only one source, Illinois Historical claims, impacted required exclusions.

Meridian was fully compliant with IS Standard 5.0.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

The scope of this audit was limited to nine measures; *ABA*, *CIS*, *WCC*, *MMA*, *FUH*, *APM*, *IET*, *AMB*, and *IL 3.6* (state-defined measure). Meridian reported all measures using internally developed programs. These programs reside in MCS and are referred to as the HEDIS engine. The programs access tables in MCS that were populated directly without manipulation from underlying tables in MCS. These tables were updated as changes were made in source date and therefore reflected current data at the time the HEDIS engine was run.

The only nonstandard coding schemes that required mapping were for SDS.

Service and practitioner data were linked using the Meridian Provider Identification Number. Service and member data were linked using member identification (ID). Error reports were created with each load and monitored to ensure referential integrity.

Query 2 and Query 6 assessed completeness of medical, pharmacy, and lab result data. No issues were found.

Measures selected for Query 3 were based on prior year final rates, since current year rates were not provided prior to the on-site visit. *MMA* and *AMB–ED Visits* measures were selected for PSV since they benchmarked above the national 90th percentile. Query 3 could not be completed during the on-site visit due to time limitations and a lack of access to key transaction systems. In a review of detailed data for five members that were numerator positive for *MMA*, 75 percent were found to include rejected pharmacy claims, resulting in duplicate claims and causing a material overstatement of rates. The plan corrected its programming logic to use final paid claims only. Review of detailed data for one member with a large volume of *AMB–ED Visits* found that the logic allowed counting of multiple claims and/or claim lines for the same visit. The plan corrected its programming logic to count each episode of care as one visit, regardless of duration or intensity of visit.

Meridian was fully compliant with IS Standard 6.0.

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

Reporting was accomplished using internally developed programs that reside within MCS. Programs were reviewed and updated to reflect any changes in the reporting requirements. Source code peer review, QA testing, and user acceptance testing were performed on all changes. QA testing consisted of validating results member-by-member for all measures against the engine output by reconstructing the engine logic outside of the engine and comparing the results to what the engine produced for each measure. In addition, measure results were compared to previous years and State and national averages.

HSAG reviewed and approved programs used for reporting.

Meridian was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Molina

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Molina's HealthChoice Illinois population. The audit indicated that Molina was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. All selected HEDIS measures received an *R* designation.

Table B1-8—Molina 2019 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 full compliance with the HEDIS IS standards was based on the findings summarized below. 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

Molina used QNXT, an industry-standard claims adjudication system, to process FFS claims during 2018. This system has been in place at Molina for several years and did not undergo any significant changes during the measurement year. HSAG confirmed that QNXT had integrated logic that verified valid procedure and diagnosis codes as part of the adjudication process. HSAG also verified that QNXT captured a sufficient number of diagnosis and procedure codes to meet HEDIS reporting requirements. Molina did not employ nonstandard coding or use nonstandard claims forms. Molina received encounter data from several external sources during 2018 and did not report any issues. Molina continued to monitor and track independent practice association (IPA) encounter submissions on a monthly basis to ensure complete encounters were captured. All encounter data were directly fed into the corporate Operational Data Store (ODS) for use with HEDIS integration. The ODS encounter data were in a standard 837 format. Molina had sufficient processes in place to capture and validate encounter data submissions. Molina validated data submissions against financial reports with the State to ensure accuracy of reporting.

Molina regularly monitored submissions from all external capitated providers and delegated entities to ensure encounters were received regularly and on time.

Molina was fully compliant with IS Standard 1.0.

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

Molina's enrollment process had not changed since the previous year's review. Eligibility files were received from the State in an 834 file format. Preprocessing of eligibility files was performed in the Molina Eligibility Gateway (MEG) module. With the exception of babies, all records were loaded into QNXT. Babies required manual processing and linkage to the mother's record until Molina received identification numbers for the babies. This process of linking babies to mothers was only conducted if the State did not submit a Medicaid number for the baby. In most instances, claims were not processed until Molina received an update on the enrollment files from the State. All enrollment processes were conducted in the QNXT system. QNXT had appropriate fields to capture all vital information required for claims processing and HEDIS reporting. QNXT allowed for several identification numbers in order 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.

Molina sent daily enrollment files to delegated entities and external vendors as needed. This ensured seamless care with contracted and delegated entities.

Molina was fully compliant with IS Standard 2.0.

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

There were no changes to Molina's provider processing systems during the measurement year. HSAG reviewed the provider mapping documents provided in the Roadmap and found no issues during the on-site review. There were several newly added PCPs during the measurement year, mainly to accommodate the growing membership. 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 was able to capture multiple provider 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. On a monthly basis, Molina audited the provider data in QNXT to ensure completion of specialties, license type, and professional degree. This internal audit included 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 2018.

Molina was fully compliant with IS Standard 3.0.

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

Molina sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Medical record pursuit and data collection are conducted by Molina staff using Inovalon's QSHR hybrid tools. HSAG reviewed and approved the hybrid tools and corresponding abstraction instructions. Provider chase logic was reviewed and determined to be appropriate across the hybrid measures. Reviewer qualifications, training, and oversight were appropriate. Due to changes in

the 2018 MRR process, a convenience sample was required. No issues were identified during the validation process.

Molina successfully passed the final MRRV process for HEDIS 2019. Measures selected included the following:

- *Adult BMI Assessment*
- *WCC—BMI Percentile—Total*
- *WCC—Nutrition—Total*
- *WCC—Physical Activity—Total*
- *CIS—Hepatitis B (Hep B)*
- *CIS—Haemophilus influenzae type b (HiB)*
- *CIS—Measles, mumps and rubella (MMR)*

Molina was fully compliant with the IS Standard 4.0 requirements.

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

Molina submitted several SDS in the Roadmap. Two were nonstandard supplemental sources and the remaining were standard sources. Standard supplemental sources included lab results, prior year's audited medical records, and historical claims from the State and immunization registries. There were no issues identified with the standard supplemental sources.

The nonstandard SDS required POS review for verification of service results and dates. A selection of 50 records from each data source (prior medical record review [PMRR] and supplemental data capturing tool [SDCT]) were chosen at random. The random selection was reviewed and approved by the HSAG supplemental data review team and all records passed inspection. Both nonstandard data sources were approved to use for HEDIS 2019 reporting.

Molina also submitted 12 standard supplemental databases, which comprised mostly laboratory data from independent laboratories. All standard data sources were approved to use for HEDIS 2019 reporting.

Final impact reports were submitted after the final data refresh of its HEDIS repository and no concerns were found.

Molina was fully compliant with IS Standard 5.0.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Data transfers and mappings were managed appropriately, as demonstrated during the on-site audit. Molina monitored data transfers through matching data loads to its data extracts from ODS into Inovalon's system. Data that fell out were quickly identified to ensure that critical errors were corrected.

During the on-site audit, the examination of the data transfer and consolidation did not reveal any issues. HSAG conducted PSV and did not encounter any issues. Nonstandard coding was mapped appropriately for a select number of state-required codes.

Molina was fully compliant with IS Standard 6.0.

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

Molina continued to use Inovalon's software for the HEDIS 2019 rate calculation. Molina worked with Molina Corporate for the management of the Inovalon product. Corporate processes were reviewed during the on-site visit and were found to be sufficient for HEDIS 2019 processing. Molina's staff were proficient in data warehousing and demonstrated during the on-site visit that record counts and volumes were monitored. Molina continued to meet with Inovalon on a regular basis to discuss file loading and processing. There was significant improvement from the prior year with Molina's oversight of vendor file submissions. Molina began monitoring provider submissions and tracked the volume for each submission over time. These volumes were compared to expected per member per month (PMPM) counts to determine if data were missing. Molina will continue to monitor its oversight of external entities. The mapping was reviewed and approved by HSAG.

Molina was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for NextLevel

HSAG conducted a 2019 NCQA HEDIS Compliance Audit of the data collection and reporting processes for NextLevel's HealthChoice Illinois population. The audit indicated that NextLevel was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. All selected HEDIS measures received an *R* designation.

Table B1-9—NextLevel 2019 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 full compliance with the HEDIS IS standards was based on the findings summarized below. 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

NextLevel contracted with DST Systems, Inc. (DST), for medical claims processing until June 1, 2018. The DST contract was terminated due to performance issues related to implementation of the fee schedule and processing authorizations. NextLevel contracted with Envolve to process claims as of June 1, 2018. Envolve delegated claims processing to Centene, which used the AMISYS system.

The initial plan was for DST to process claims that had a date of service prior to June 1, 2018, and were received after June 1, 2018; however, due to concerns about DST performance, these claims were processed by Centene.

NextLevel reached out to providers to ensure that no claims were lost during the conversion process. NextLevel reported that, based on internal analysis and monitoring conducted during the conversion, no claims were lost. Claims processing backlogs that occurred due to the conversion and DST performance issues were alleviated by the end of 2018. NextLevel provided the study that was completed in 2018 to confirm data completeness following the system conversion. No significant issues were identified.

The auditor confirmed that all necessary fields were captured in the systems. There was no use of nonstandard coding. DST and Envolve had adequate policies in place to validate electronic claim transmissions, paper claim OCR, and data entry.

NextLevel reported there were no issues receiving the claims data files from its ancillary vendors during 2018.

NextLevel was fully compliant with IS Standard 1.0.

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

NextLevel contracted with DST for enrollment data processing until June 1, 2018. DST used the Membership and Billing (MAB) and Exeter/AMISYS systems for processing enrollment data. NextLevel contracted with Envolve for enrollment data processing as of June 1, 2018. Envolve delegated enrollment processing to Centene, which used the AMISYS system.

Prior to the conversion of enrollment data, NextLevel provided all prior enrollment files to Envolve. Envolve reconciled the membership data with NextLevel to ensure completeness, and all data were loaded to AMISYS by March 2018. There were no issues converting the membership data to the new system.

There were no issues receiving or processing the State enrollment files during the measurement year.

The auditor confirmed that all necessary fields were captured in AMISYS.

NextLevel membership counts increased from 51,514 on December 31, 2017, to approximately 81,000 on January 1, 2018, due to expansion of the State of Illinois Medicaid eligibility requirements. However, many members were termed during the year due to redetermination of eligibility status, and the December 31, 2018 enrollment count was 48,233 members. NextLevel reported that most members that termed during the year were members added on January 1, 2018, and the demographics of continuously enrolled members did not change from 2017.

There were no issues with timeliness for processing the enrollment files, and time to process standards were met.

NextLevel was fully compliant with IS Standard 2.0.

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

All practitioner data were loaded to AMISYS prior to the June 1, 2018 system conversion. The source of truth for validating the data in AMISYS was the State provider file that was loaded to the PORTICO credentialing system. Prior to the new system implementation date, a reconciliation process was developed to ensure the information in AMISYS matched the information in PORTICO. There were no issues with the conversion of practitioner data to the new system.

NextLevel provided an updated provider specialty mapping document following the on-site visit. The auditor reviewed and approved the document.

NextLevel was fully compliant with IS Standard 3.0.

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

NextLevel contracted with Change Healthcare to conduct MRRs for HEDIS 2019. HSAG reviewed the Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS Standard 4.0 requirements.

NextLevel sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures.

HSAG participated in a live vendor demonstration of Change Healthcare's tool and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2019, Volume 2, Technical Specifications for Health Plans.* HSAG approved Change Healthcare's hybrid tool and instructions.

HSAG reviewed Change Healthcare's abstraction training manual and found no concerns. Reviewer qualifications, training, and oversight by Change Healthcare of its review staff were appropriate.

HSAG required a convenience sample for the following measures because the plan used a new MRR vendor for HEDIS 2019:

- *CIS—Combo 3*
- *WCC—Counseling for Nutrition*
- *WCC—Counseling for Physical Activity*
- *WCC—BMI Percentile Documentation*
- *ABA*

HSAG reviewed the convenience sample and found no errors.

NextLevel provided the chase completion reports following completion of the MRRs. The reports indicated a 99 percent completion rate; representing a considerable higher completion rate relative to the prior year.

No issues were identified during the final MRRV.

NextLevel was fully compliant with IS Standard 4.0.

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

NextLevel received historical claims data from the State of Illinois. The auditor considered these data to be standard supplemental data. Standard coding was used, and no changes were made to the data when reformatting for upload to Inovalon's QSI-XL software. File transmissions were monitored by NextLevel. The auditor did not identify any issues with the State's data and approved the database for use.

NextLevel received lab results data from LabCorp, Quest, and Medical Diagnostics Lab. The auditor considered these data to be standard supplemental data. Standard coding was used, and no changes were made to the data when reformatting for upload to QSI-XL. File transmissions were monitored by Envolve. The auditor did not identify any issues with the data and approved the database for use.

NextLevel was fully compliant with IS Standard 5.0.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Data extracts were validated based on lab and claim load counts. Current claim counts were compared to the previous counts, with the assumption that claim counts should continue to increase.

Enrollment data were validated with NextLevel to ensure completeness.

NextLevel updated Roadmap Section 6 to identify the data sources included in the data extracts. The auditor confirmed that all necessary data sources were included.

NextLevel was fully compliant with IS Standard 6.0.

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

Testing of the Inovalon QSI-XL HEDIS software began in July 2018. Envolve performed parallel testing by comparing the QSI-XL results to the DST Interactive Data Submission System (IDSS) results for HEDIS 2018 rates. No significant issues were identified.

For the data loads, the data files were posted to the Inovalon platform. As the data were loaded to QSI-XL, a data load report was produced showing records submitted and records loaded. The February load indicated that no records were rejected. NextLevel provided the data load sheet for the final May load. Analysts monitored the rates monthly; there were no significant variances.

The auditor conducted Query Group 3 on-site by selecting five compliant cases each for the *WCC—Counseling for Nutrition*, *ABA*, and *FUH—7 Day* measures from QSI-XL. NextLevel demonstrated compliance in the source system for the five *WCC—Counseling for Nutrition* and *ABA* cases. NextLevel demonstrated compliance in AMISYS for two of the *FUH—7 Day* cases. The claims data for the remaining *FUH—7 Day* cases were in the data warehouse because the services occurred prior to the system conversion. NextLevel provided the additional documentation needed to complete the query review, and no issues were identified.

The auditor conducted Query Group 6 on-site by validating that the servicing provider specialty in AMISYS for five *WCC—Counseling for Nutrition* cases met the requirements for the measure. The auditor also confirmed the servicing provider specialty was correct in AMISYS for the five *FUH—7 Day* cases.

The auditor completed Query Group 1 post-on-site by comparing NextLevel member months data extracted from AMISYS to the Enrollment by Product Line (ENP) measure results from QSI-XL. The auditor found a 0.3 percent difference.

The auditor completed Query Group 2 post-on-site by reviewing the DQR for the May load to the HEDIS repository. The auditor did not identify any significant issues.

NextLevel was fully compliant with IS Standard 7.0.

Validation of State Performance Measures for CHIPRA

Introduction

HFS contracts with HSAG to conduct a review of the CHIPRA program for a selected set of performance measures.

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the CMS publication, *EQR Protocol 2, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review,* Version 2.0, September 2012.

Conducting the Review

The primary objectives of the PMV process are to:

- Evaluate the processes used to collect the performance measure data by HFS.
- Determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.

HFS identifies the performance measurement period for validation of the CHIPRA program for the reporting year. HFS selected NCQA HEDIS measures as well as CMS Adult Core Set and Child Core Set performance measures for the CHIPRA program. Most measures used the HEDIS 2019 Technical Specifications. For measures that were both HEDIS and Core Set measures, HSAG reviewed source code according to both the HEDIS 2019 Technical Specifications, the federal fiscal year (FFY) 2019 Adult Core Set, Updated August 2019, and the FFY 2019 Child Core Set, February 2019. This was acceptable since the specifications for most, if not all, of the HEDIS measures were the same as the Core Set, except for the age breakouts. There were also measures which utilized the Maternal and Infant Health Initiative (MIHI) Contraceptive Care Measures technical specifications and the Data Definitions technical specifications produced by HFS. For a list of the validated measures and their corresponding rates, see Appendix B4 of this report.

Preaudit Activities

HSAG requests that HFS submit a list of measures under the scope of the audit, a completed Information Systems Capabilities Assessment Tool (ISCAT), source code for each performance measure, and any additional supporting documentation necessary to complete the audit. A conference call is conducted to answer questions and prepare for the audit.

Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of these data:

- ISCAT: HFS was responsible for completing and submitting the ISCAT document to HSAG. Upon receipt, HSAG conducted a cursory review of the ISCAT to ensure that HFS completed all sections and included all needed attachments. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used the information in the ISCAT to complete the review tools, as applicable.
- Source code (programming language) for performance measures: HSAG requested source code from HFS for all performance measures. HSAG source code reviewers completed a line-by-line code review and evaluation of program logic flow to ensure compliance with the specifications required by HFS. The source code reviewers identified areas of deviation and shared them with HFS for adjustment. The source code reviewers also informed the audit team of any deviations from the measure specifications so the team could evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Supporting documentation: HSAG requested documentation and data queries that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for follow-up.

Performance Measure Validation Findings

To validate the performance measures, data from various sources, including provider data, claims/encounter systems, and enrollment data, must be audited. The auditor scrutinizes these processes and makes a determination as to the validity of the data collected. HSAG uses a variety of audit methods, including analysis of computer programs, PSV, and staff member interviews to determine a result for each measure.

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the designations identified in the CMS PMV Protocol listed below in Table B1-10.

Table B1-10—Performance Measure Audit Results and Definitions

Result	Definition
R	*Reportable.* Measure was compliant with the State's specifications and the rate can be reported.
NR	*Not Reported.* This designation is assigned to measures for which (1) the rate was materially biased, or (2) the rate was not required to be reported.
NB	*No Benefit.* Measure was not reported because the benefit required by the measure was not offered.

HSAG determined that all data supported the elements necessary for reporting and measures were calculated appropriately according to the required measure specifications. Further, all performance measures under the scope of the audit received an *R* designation.

Appendix B2. 2018–2019 Encounter Data Completeness

Encounter Data Completeness

The tables below display the estimate of the administrative data completeness for the CY 2018 (HEDIS 2019) measure rate calculated using the hybrid methodology for each health plan. Health plans were not required to report using the hybrid method; therefore, the measures in the tables may differ between health plans. These measures use administrative encounter data and supplement the results with medical record data. The information provided in the tables below present the percentage of each HEDIS measure rate that was determined using administrative encounter data only.

Table B2-1—Estimated Encounter Data Completeness for Hybrid Measures—BCBSIL

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	50.63%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	40.32%
Combination 3	38.94%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	66.38%
Combination 2 (Meningococcal, Tdap, HPV)	58.17%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	42.90%
Counseling for Nutrition—Total	33.72%
Counseling for Physical Activity—Total	19.37%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	83.78%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	98.73%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	88.18%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.30%
Postpartum Care	95.36%

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.92%
Eye Exam (Retinal) Performed	94.94%
Medical Attention for Nephropathy	99.74%
Controlling High Blood Pressure	
Controlling High Blood Pressure	30.00%

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

Table B2-2—Estimated Encounter Data Completeness for Hybrid Measures—CountyCare

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	49.67%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	51.46%
Combination 3	49.17%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	72.12%
Combination 2 (Meningococcal, Tdap, HPV)	67.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	46.32%
Counseling for Nutrition—Total	34.10%
Counseling for Physical Activity—Total	25.90%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	89.59%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	96.88%

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	95.00%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.67%
Postpartum Care	92.80%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	97.30%
Eye Exam (Retinal) Performed	84.02%
Medical Attention for Nephropathy	99.19%
Controlling High Blood Pressure	
Controlling High Blood Pressure	13.11%

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

Table B2-3—Estimated Encounter Data Completeness for Hybrid Measures—IlliniCare

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	57.85%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	45.50%
Combination 3	45.88%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	80.12%
Combination 2 (Meningococcal, Tdap, HPV)	71.19%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	60.19%
Counseling for Nutrition—Total	42.11%
Counseling for Physical Activity—Total	32.73%

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	90.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	97.94%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	93.87%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	95.08%
Postpartum Care	92.68%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.63%
Eye Exam (Retinal) Performed	98.75%
Controlling High Blood Pressure	
Controlling High Blood Pressure	22.89%

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

Table B2-4—Estimated Encounter Data Completeness for Hybrid Measures—Meridian[1]

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	51.46%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	97.95%
Combination 3	97.82%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	99.44%
Combination 2 (Meningococcal, Tdap, HPV)	98.53%

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	38.91%
Counseling for Nutrition—Total	23.81%
Counseling for Physical Activity—Total	23.11%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	97.17%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	97.63%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	100.00%
Postpartum Care	95.88%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.64%
Eye Exam (Retinal) Performed	88.12%
Medical Attention for Nephropathy	100.00%
Controlling High Blood Pressure	
Controlling High Blood Pressure	12.66%

[1] *Please note, Harmony did not report any measures using the hybrid methodology; therefore, the percentage of numerator positive cases determined by administrative data are only based on Meridian's reported measures.*

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

Table B2-5—Estimated Encounter Data Completeness for Hybrid Measures—Molina

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	46.17%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	98.14%
Combination 3	98.25%

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	97.17%
Combination 2 (Meningococcal, Tdap, HPV)	98.13%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	51.72%
Counseling for Nutrition—Total	39.51%
Counseling for Physical Activity—Total	34.23%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	90.32%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	98.26%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	93.94%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.63%
Postpartum Care	94.84%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	96.91%
Eye Exam (Retinal) Performed	95.50%
Medical Attention for Nephropathy	96.67%
Controlling High Blood Pressure	
Controlling High Blood Pressure	37.97%

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

Table B2-6—Estimated Encounter Data Completeness for Hybrid Measures—NextLevel

2019 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	46.15%
Keeping Kids Healthy	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	55.28%
Counseling for Nutrition—Total	37.41%
Counseling for Physical Activity—Total	30.89%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	67.12%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	99.16%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	91.43%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	89.76%
Postpartum Care	87.96%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	94.62%
Eye Exam (Retinal) Performed	64.84%
Medical Attention for Nephropathy	98.85%
Controlling High Blood Pressure	
Controlling High Blood Pressure	6.45%

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

Appendix B3. 2018–2019 PCCM/CHIPRA PMV Methodology

State PMV for PCCM/CHIPRA

Introduction

HFS contracted with HSAG to conduct a review of the PCCM and CHIPRA programs for a selected set of performance measures.

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the CMS publication, *EQR Protocol 2, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review,* Version 2.0, September 2012. HSAG also uses the NCQA manual, *HEDIS 2019, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures.*

Conducting the Review

The primary objectives of the PMV process are to:

- Evaluate the processes used to collect the performance measure data by HFS.
- Determine the extent to which the specific performance measures calculated by HFS followed the specifications established for each performance measure.

HFS identifies the performance measurement period for validation for each program for the reporting year. HFS selected NCQA HEDIS measures and the CMS Adult Core Set and Child Core Set performance measures for the PCCM and CHIPRA programs. Most measures used the HEDIS 2018 Technical Specifications. For measures that were both HEDIS and Core Set measures, HSAG reviewed source code according to the HEDIS 2018 Technical Specifications, the February 2018 Adult Core Set, and the February 2018 Child Core Set. This was acceptable since the specifications for most, if not all, of the HEDIS measures were the same as the Core Set, except for the age breakouts. There were also measures that used the MIHI Contraceptive Care Measures technical specifications and the Data Definitions technical specifications produced by HFS. For a list of the validated measures and their corresponding rates, see Appendix B4 of this report.

Preaudit Activities

HSAG requests that HFS submit a list of measures under the scope of the audit, a completed ISCAT, source code for each performance measure, and any additional supporting documentation necessary to complete the audit. A conference call is conducted to answer questions and prepare for the audit.

Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG analyzed them:

- ISCAT: HFS was responsible for completing and submitting the ISCAT document to HSAG. Upon receipt, HSAG conducted a cursory review of the ISCAT to ensure that HFS had completed all sections and included all needed attachments. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used the information in the ISCAT to complete the review tools, as applicable.
- Source code (programming language) for performance measures: HSAG requested source code from HFS for all performance measures. HSAG source code reviewers completed a line-by-line code review and evaluation of program logic flow to ensure compliance with the specifications required by HFS. The source code reviewers identified areas of deviation and shared them with HFS for adjustment. The source code reviewers also informed the audit team of any deviations from the measure specifications so the team could evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Supporting documentation: HSAG requested documentation and data queries that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for follow-up.

Performance Measure Validation Findings

To validate the performance measures, data from various sources, including provider data, claims/encounter systems, and enrollment data, must be audited. The auditor scrutinizes these processes and makes a determination as to the validity of the data collected. HSAG uses a variety of audit methods, including analysis of computer programs, PSV, and staff member interviews to determine a result for each measure.

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the designations identified in the CMS PMV Protocol, listed below in Table B3-1.

Table B3-1—Performance Measure Audit Results and Definitions

Result	Definition
R	*Reportable.* Measure was compliant with the State's specifications and the rate can be reported.
NR	*Not Reported.* This designation is assigned to measures for which (1) the rate was materially biased, or (2) the rate was not required to be reported.
NB	*No Benefit.* Measure was not reported because the benefit required by the measure was not offered.

HSAG determined that all data supported the elements necessary for reporting and measures were calculated appropriately according to the required measure specifications. Further, all performance measures under the scope of the audit received an *R* designation.

Appendix B4. CHIPRA PMV Results

Overview

HSAG conducted a review of the CHIPRA program for a select set of performance measures, following the PMV protocol outlined by the CMS. Using the most recent data available at the time, HSAG evaluated the processes HFS used to collect the performance measure data and determined the extent to which the performance measures followed the established specifications. See Appendix B3 for more details regarding the PMV process.

CY 2018 Performance Measures

CY 2018 performance measures selected by HFS included a combination of the HEDIS and non-HEDIS measures. The non-HEDIS measures consisted of Adult Core Set and Child Core Set measures. All HEDIS measures were reviewed for compliance with the HEDIS 2019 technical specifications. The non-HEDIS measures were reviewed for compliance with the August 2019 Adult Core Set, the February 2019 Child Core Set, or specifications that were provided by HFS. For measures that were both HEDIS and Core Set measures, HSAG reviewed the age stratifications required by both the HEDIS and Core Set specifications.

CY 2018 Results

Multiple data sources were validated by the auditor to make a determination as to the validity of the data collected by HFS. HSAG determined that the data supported the elements necessary for reporting, and measures were calculated appropriately according to the required measure specifications. As a result, all performance measures audited received an audit designation of *Reportable* (*R*). Table B4-1 displays the CY 2018 rates for the CHIPRA performance measures validated by HSAG.

Table B4-1—CY 2018 CHIPRA Performance Measures

Performance Measure	CHIPRA Rate
Adult BMI Assessment	
Ages 18 to 64 Years	28.16%
Ages 65 to 74 Years	29.04%
Total	28.18%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	
Initiation Phase	30.90%
Continuation and Maintenance Phase	39.37%

Performance Results

CHIPRA PMV

Performance Measure	CHIPRA Rate
Ambulatory Care (per 1,000 Member Months)	
Outpatient Visits	263.40
*ED Visits**	58.70
Antidepressant Medication Management	
Effective Acute Phase Treatment	40.91%
Effective Continuation Phase Treatment	22.58%
Adolescent Well-Care Visits	
Adolescent Well-Care Visits	47.65%
Breast Cancer Screening	
Ages 50 to 64 Years	53.25%
Ages 65 to 74 Years	48.00%
Total	52.76%
Children and Adolescents' Access to Primary Care Practitioners	
Ages 12 to 24 Months	93.08%
Ages 25 Months to 6 Years	85.86%
Ages 7 to 11 Years	89.14%
Ages 12 to 19 Years	90.59%
Cervical Cancer Screening	
Cervical Cancer Screening	52.81%
Contraceptive Care—All Women Ages 15 to 44 Years	
Were Provided a Most Effective or Moderately Effective Method of Contraception (Ages 15 to 20 Years)	20.75%
Were Provided a Most Effective or Moderately Effective Method of Contraception (Ages 21 to 44 Years)	22.61%
Were Provided a Long-Acting Reversible Method of Contraception (LARC) (Ages 15 to 20 Years)	1.88%
Were Provided a LARC (Ages 21 to 44 Years)	2.76%
Contraceptive Care—Postpartum Women Ages 15 to 44 Years	
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery (Ages 15 to 20 Years)	0.97%
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery (Ages 21 to 44 Years)	7.67%

Performance Measure	CHIPRA Rate
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery (Ages 15 to 20 Years)	24.51%
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery (Ages 21 to 44 Years)	26.16%
Were Provided a LARC Within 3 Days of Delivery (Ages 15 to 20 Years)	0.84%
Were Provided a LARC Within 3 Days of Delivery (Ages 21 to 44 Years)	0.91%
Were Provided a LARC Within 60 Days of Delivery (Ages 15 to 20 Years)	11.38%
Were Provided a LARC Within 60 Days of Delivery (Ages 21 to 44 Years)	10.46%
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	82.97%
Eye Exam (Retinal) Performed	42.66%
Medical Attention for Nephropathy	87.37%
Chlamydia Screening in Women	
Ages 16 to 20 Years	46.57%
Ages 21 to 24 Years	56.60%
Childhood Immunization Status	
Combination 2	62.39%
Combination 3	58.62%
Combination 4	55.19%
Combination 5	49.49%
Combination 6	29.64%
Combination 7	47.05%
Combination 8	28.83%
Combination 9	26.03%
Combination 10	25.39%
Developmental Screening in the First Three Years of Life	
1 Year Old	60.01%
2 Years Old	58.77%
3 Years Old	46.29%
Total	55.12%

Performance Measure	CHIPRA Rate
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Ages 6 to 17 Years	43.56%
7-Day Follow-Up—Ages 18 to 64 Years	21.72%
7-Day Follow-Up—Ages 65 Years and Older	11.88%
30-Day Follow-Up—Ages 6 to 17 Years	69.77%
30-Day Follow-Up—Ages 18 to 64 Years	38.45%
30-Day Follow-Up—Ages 65 Years and Older	18.77%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	
Initiation of AOD Treatment—Alcohol Abuse or Dependence—Ages 18 to 64 Years	34.23%
Initiation of AOD Treatment—Alcohol Abuse or Dependence—Ages 65 Years and Older	30.52%
Initiation of AOD Treatment—Alcohol Abuse or Dependence—Total	34.19%
Initiation of AOD Treatment—Opioid Abuse or Dependence—Ages 18 to 64 Years	44.14%
Initiation of AOD Treatment—Opioid Abuse or Dependence—Ages 65 Years and Older	41.22%
Initiation of AOD Treatment—Opioid Abuse or Dependence—Total	44.09%
Initiation of AOD Treatment—Other Drug Abuse or Dependence—Ages 18 to 64 Years	37.86%
Initiation of AOD Treatment—Other Drug Abuse or Dependence—Ages 65 Years and Older	36.16%
Initiation of AOD Treatment—Other Drug Abuse or Dependence—Total	37.85%
Engagement of AOD Treatment—Alcohol Abuse or Dependence—Ages 18 to 64 Years	11.23%
Engagement of AOD Treatment—Alcohol Abuse or Dependence—Ages 65 Years and Older	3.19%
Engagement of AOD Treatment—Alcohol Abuse or Dependence—Total	11.13%
Engagement of AOD Treatment—Opioid Abuse or Dependence—Ages 18 to 64 Years	21.91%
Engagement of AOD Treatment—Opioid Abuse or Dependence—Ages 65 Years and Older	16.13%
Engagement of AOD Treatment—Opioid Abuse or Dependence—Total	21.83%
Engagement of AOD Treatment—Other Drug Abuse or Dependence—Ages 18 to 64 Years	13.59%
Engagement of AOD Treatment—Other Drug Abuse or Dependence—Ages 65 Years and Older	2.95%
Engagement of AOD Treatment—Other Drug Abuse or Dependence—Total	13.51%
Annual Monitoring for Patients on Persistent Medications	
Total—Ages 18 to 64 Years	82.15%
Total—Ages 65 Years and Older	87.32%

Performance Measure	CHIPRA Rate
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	55.00%
Postpartum Care	55.58%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*	
Ages 18 to 64 Years	16.14
Ages 65 Years and Older	7.38
Total	15.95
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*	
Ages 40 to 64 Years	57.90
Ages 65 and Older Years	113.16
Total	60.92
Well-Child Visits in the First 15 Months of Life	
*Zero Visits**	4.11%
One Visit	3.49%
Two Visits	4.60%
Three Visits	6.45%
Four Visits	9.35%
Five Visits	13.45%
Six or More Visits	58.55%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.26%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Ages 3 to 11 Years	25.77%
BMI Percentile—Ages 12 to 17 Years	27.13%
BMI Percentile—Total	26.29%
Counseling for Nutrition—Ages 3 to 11 Years	17.14%
Counseling for Nutrition—Ages 12 to 17 Years	16.85%
Counseling for Nutrition—Total	17.03%
Counseling for Physical Activity—Ages 3 to 11 Years	12.04%
Counseling for Physical Activity—Ages 12 to 17 Years	17.11%
Counseling for Physical Activity—Total	13.97%

Performance Results

CHIPRA PMV

Performance Measure	CHIPRA Rate
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	82.06%
Combination 2 (Meningococcal, Tdap, HPV)	30.73%
Meningococcal	84.30%
Tdap	89.05%
HPV	34.40%
Live Births Weighing Less Than 2,500 Grams*	
Live Births Weighing Less Than 2,500 Grams	9.88%
Cesarean Section for Nulliparous Singleton Vertex*	
Cesarean Section for Nulliparous Singleton Vertex	21.80%
Percentage of Eligibles Who Received Preventive Dental Services	
Percentage of Eligibles Who Received Preventive Dental Services	44.01%
Heart Failure Admission Rate (per 100,000 Member Months)*	
Ages 18 to 64 Years	25.93
Ages 65 Years and Older	161.00
Total	28.89
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)*	
Total	5.98
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.77%
Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk	
Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk	12.63%

* For this measure, a lower rate may indicate better performance.

Appendix B5. MLTSS PMV Methodology

Introduction

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures for data collected by the health plans during CY 2017. HFS selected two measures for validation:

- MLTSS program Measure 2.2: Moderate- and high-risk members with a comprehensive assessment completed within required time frames.
- MLTSS Measure 3.2: Enrollees with documented discussions of person-centered care goals.

HFS selected one measure for validation of data collected by the health plans during CY 2018:

- MLTSS Measure IL 3.6: Movement of Members within Service Populations (non-HEDIS, state-defined measure).

To ensure full submission of data and complete all validation activities, HFS scheduled the MLTSS Quality Withhold PMV for completion during SFY 2019. Validation of Measure 2.2 and Measure 3.2 was conducted in alignment with CMS protocols, while the validation of Measure 3.6 was completed as part of a separate, NCQA HEDIS compliance audit.

Methodology

Measure 2.2 and Measure 3.2

HSAG validated the data collection and reporting processes used by the health plans to report the quality withhold performance measure data for CY 2017 in accordance with the CMS publication *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[B5-1] HFS provided the specifications and supplemental guidance that the health plans were required to use for reporting the performance measures.

The CMS EQR protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the types of data collected and how HSAG conducted the analysis of these data:

[B5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 4, 2019.

- **ISCAT**—Health plans were required to submit a shortened completed ISCAT. An ISCAT is an information systems assessment tool that allows the organization to provide detailed documentation of its information systems; the protocols used for collecting, managing, and integrating data; and the processes used for performance measure reporting. The ISCAT was modified to include questions related to MLTSS 2.2 and MLTSS 3.2 processes only.
- **Supporting Documentation**—Health plans submitted documentation to HSAG that provided additional information to complete the validation process, including file layouts, system flow diagrams, data collection process descriptions, policies/procedures and plans, and MLTSS 2.2 and 3.2 enrollee-specific data files.

The PMV review of the health plans' reported data consisted of remote validation and post-validation activities focusing on the HRA processes, care plan processes, data integration, and performance measure production. HSAG used the NCQA methodology[B5-2] for the file reviews for both MLTSS Measures 2.2 and 3.2, referred to as the "8 and 30" file sampling procedure.

HSAG's PMV provided a validation result of either of the following:

- Report: Measure data were compliant with CMS' specifications and the data, as reported, were valid.
- Not Reported: Measure data were materially biased.

Measure 3.6

HSAG completed a validation of Measure 3.6, for data collected by the health plans during CY 2018. The validation was conducted via a NCQA HEDIS compliance audit in accordance with NCQA's *HEDIS 2019, Volume 5: HEDIS Compliance Audit Standards, Policies and Procedures* and *HEDIS 2019, Volume 2: Technical Specifications for Health Plans*. The audit process included submission and review of the health plans' HEDIS Roadmap and measure calculation source code and HSAG's review of preliminary and final rates. HSAG used a variety of audit methods, including the analysis of computer programs, medical record abstraction results, data files, data samples, and structured interviews with key staff to derive measure-specific findings. Final measure determinations were consistent with one of the following NCQA categories:

B5-2 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: Feb 4, 2019.

Table B5-1—NCQA Reporting Status Categories

Rate/Result	Comment
R	Reportable. A reportable rate was submitted for the measure.
NA	Small Denominator. The health plan followed the specifications, but the denominator was too small (<30) to report a valid rate. 1. For Effectiveness of Care (EOC) and EOC-like measures, when the denominator is less than 30. 2. For utilization measures that count member months, when the denominator is less than 360 member months. 3. For all risk-adjusted utilization measures, except PCR and HPC, when the denominator is less than 150.
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.
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 applies only to a limited set of measures (e.g., Board Certification).

Appendix B6. MLTSS PMV Detailed Results

Introduction

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

HFS contracted with HSAG, the EQRO for Illinois, to conduct validation of selected measures for data collected by the health plans during CY 2017. HFS selected two measures for validation:

- MLTSS Measure 2.2: Moderate- and high-risk members with a comprehensive assessment completed within required time frames.
- MLTSS Measure 3.2: Enrollees with documented discussions of person-centered care goals.

HFS selected one measure for validation of data collected by the health plans during CY 2018:

- MLTSS Measure IL 3.6: Movement of Members within Service Populations (non-HEDIS, state-defined measure).

To ensure full submission of data and complete all validation activities, HFS scheduled the MLTSS Quality Withhold PMV of Measure 2.2 and Measure 3.2 for completion during SFY 2019. Validation of Measure 2.2 and Measure 3.2 was conducted in alignment with CMS protocols, while the validation of Measure 3.6 was completed as part of a separate, NCQA HEDIS compliance audit.

Results

Measure 2.2 and Measure 3.2

HSAG completed PMV for the four health plans with MLTSS enrollees during CY 2017: Aetna, BCBSIL, IlliniCare, and Meridian.

HSAG's PMV of Measure 2.2 assessed the health plan's compliance with reporting technical specifications related to completion of the HRA for three categories of members:

- The total number of moderate- and high-risk members requiring an HRA within 180 days of enrollment with an HRA completed within 180 days of enrollment
- The total number of moderate- and high-risk members requiring an HRA within 90 days of enrollment with an HRA completed within 90 days of enrollment

- The total number of moderate- and high-risk members requiring an HRA within 15 days of MCO notification of member's waiver eligibility with an HRA completed within 15 days of MCO notification of member's waiver eligibility

HSAG's PMV of Measure 2.2 found that three (Aetna, BCBSIL, and IlliniCare) of the four health plans did not have a process to differentiate enrollees per the technical specifications for the measure or had critical errors that led to incorrect categorization. As a result, only Meridian received a validation categorization of Report (R): measure data were compliant with CMS' specifications, and the data, as reported, were valid.

HSAG's PMV of Measure 3.2 assessed the health plan's compliance with reporting technical specifications related to:

- The total number of members with at least one documented discussion of person-centered care goals in the initial or revised care plan.

HSAG's PMV of Measure 3.2 found that three (Aetna, BCBSIL, and IlliniCare) of the four health plans did not have a process to differentiate enrollees per the technical specifications for the measure or had critical errors that led to incorrect categorization. Two of the health plans were also found to lack compliance with the reporting requirements for the measure. One health plan, Meridian, was able to differentiate enrollees per the technical specifications for the measure; however, the PMV identified a lack of compliance with reporting requirements. As a result, all four health plans received a validation categorization of Not Reported (NR): measure data were materially biased.

Table B6-1—PMV Results of CY 2017 Data: Measures 2.2 and 3.2

Health Plan	Measure 2.2: Moderate- and High-Risk Members With a Comprehensive Assessment Completed Within Required Time Frames	Measure 3.2: Enrollees With Documented Discussions of Person-Centered Care Goals
Aetna	NR	NR
BCBSIL	NR	NR
IlliniCare	NR	NR
Meridian	R	NR

Measure 3.6

HSAG's HEDIS Compliance Audit was completed for all seven health plans with MLTSS enrollees during CY 2018: BCBSIL, CountyCare, Harmony, IlliniCare, Meridian, Molina, and NextLevel. All health plans received a final result categorization of R (Reportable): a reportable rate was submitted for the measure.

Appendix B7. HCBS Record Reviews Methodology

Sampling Methodology

HSAG developed a sampling methodology based on the waiver requirements approved by HFS. HSAG conducted a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selected a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group were determined based on the number of eligible members in each waiver program. Once the required sample sizes were identified, a proportional random sample was selected based on the distribution of the health plans' population within each designated waiver program. Each sample was selected to ensure a 95 percent confidence level and five percent margin of error at the waiver program level, with a maximum sample population of 5,000 cases across the HealthChoice Illinois and MMAI waiver enrollees. Additionally, a ten percent oversample based on the proportional distribution of enrollees across health plans was selected to replace ineligible cases. The samples were selected in April 2018 and included waiver members enrolled as of April 1, 2018. Table B7-1 displays the FY 2019 record review sample size by health plan and waiver program for HealthChoice Illinois, and Table B7-2 displays the SFY 2019 record review sample size by health plan and waiver program for MMAI.

Table B7-1—HealthChoice Illinois Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLF
BCBSIL	11,892	418	103	77	59	76	103
CountyCare	6,985	276	59	78	75	55	9
Harmony	4,550	145	34	18	12	44	37
IlliniCare	10,396	376	81	71	54	86	84
Meridian	10,322	344	83	48	41	84	88
Molina	2,310	88	15	11	13	25	24
NextLevel	505	18	4	5	3	4	2
Statewide Total	**46,960**	**1,665**	**379**	**308**	**257**	**374**	**347**

Table B7-2—MMAI Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			BI	ELD	HIV	PD	SLF
Aetna	983	135	21	37	28	31	18
BCBSIL	4,779	589	65	166	37	131	190
Humana	1,448	136	13	62	4	32	25
IlliniCare	1,052	139	24	38	15	39	23
Meridian	1,101	136	21	40	13	42	20
Molina	712	99	8	21	6	34	30
Statewide Total	**10,075**	**1,234**	**152**	**364**	**103**	**309**	**306**

Limitations to the sampling methodology included known variables, such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g., enrolled as HealthChoice Illinois and transferred to MMAI or previously enrolled as MMAI and transferred to MLTSS). Additionally, due to Harmony's exit from the program after Q2 SFY 2019, its remaining sample was redistributed to the other six health plans.

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this section, including tables and graphs, reflect the quarters in which the health plans were reviewed. The six-month look back periods during SFY 2019 consisted of the following:

- Q1, SFY 2019: December 1, 2017–May 31, 2018
- Q2, SFY 2019: March 1, 2018–August 31, 2018
- Q3, SFY 2019: June 1, 2018–November 30, 2018
- Q4, SFY 2019: September 1, 2018–February 28, 2019

Web-Based Abstraction Tool and Scoring Methodology

HSAG collaborated with HFS to develop an electronic web-based abstraction tool and reporting database, which included requirements set forth in the HealthChoice Illinois and MMAI contracts and the HCBS waivers. The review tool was developed to conduct the review at the individual case level and was modeled after the tool used by the State to monitor the FFS population to ensure waiver enrollees are monitored in a similar manner for similar performance measures. The tool was used to assess compliance to case management activities, including comprehensive assessments, care planning, waiver service planning, beneficiary interaction, and specialized waiver evaluations.

During the on-site review, the HSAG review team reviewed documentation for the selected cases for each review period, consisting of a six-month look-back period from the date of the review. The review team determined evidence of case compliance with each of the HFS-selected scored elements. A score of *Yes*, *No*, or *Not Applicable (NA)* was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Yes* or *No*. These scores indicated the health plan's compliance with the requirements. HSAG also used a designation of *NA* if the requirement was not applicable to a record; *NA* findings were not included in the two-point scoring methodology.

HSAG calculated the score by adding the score from each eligible case and dividing the summed scores by the total number of eligible cases. HSAG aggregated the results across all records by health plan, by waiver population, and by performance measure.

Interrater Reliability (IRR)

In order to ensure accuracy of the reviews, HSAG conducted IRR on all review team members. The IRR reviews were conducted by the HSAG senior project manager for 10 percent of all records completed by each individual reviewer, via an overread of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95 percent was required, with retraining completed if required. Reviews were completed across all waivers, program types, and health plans to ensure continued compliance to the 95 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent during SFY 2019.

Remediation Actions and Tracking

As a result of the on-site reviews, HSAG identified noncompliant performance and contract measures. HSAG's electronic web-based abstraction tool and reporting database included a remediation tracking function that detailed the findings of noncompliance related to waiver performance measures and HealthChoice Illinois contract requirements. Health plans and HFS had access to their respective reports and the remediation tracking database via the HSAG web portal.

HSAG notified HFS of the online availability of each health plan's report of findings within 30 days of each review. Once approved by the State, the report of findings was forwarded to each health plan to complete remediation actions. Remediation actions were defined in the HealthChoice Illinois contract and were specific to each CMS waiver performance measure and contract finding. The remediation-tracking database tracked the date the health plan was notified of findings, the date the health plan reported the remediation action was completed, and the number of days from notification of the finding until the remediation action was completed.

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the HSW of enrollees was maintained. HSAG completes remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans. Results of this process are included in Appendix B6.

Waiver Programs Included in SFY 2019 Reviews

The following HCBS waiver programs were included in the CMS performance measures record reviews:

- **Persons with Physical Disabilities (PD)**: Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility, and can be safely maintained in the home or community-based setting with the services provided in the plan of care. Individuals 60 years or older who began services before age 60 may choose to remain in this waiver.
- **Persons with HIV/AIDS (HIV)**: Persons of any age who are diagnosed with HIV or AIDS and are at risk of placement in a nursing facility.
- **Persons with Brain Injury (BI)**: Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- **Persons who are Elderly (ELD)**: Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are aged 65 and older and those who are physically disabled, ages 60 through 64.
- **Persons in a Supportive Living Facility (SLF)**: Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

Appendix B8. HCBS Record Reviews Detailed Results

CMS Performance Measures Description

For SFY 2019 review, HFS identified 15 CMS waiver performance measures for review. Table B8-1 provides a description of each CMS performance measure, including the identification of waiver-specific measures.

Table B8-1—CMS Waiver Performance Measure Descriptions

Measure #	Measure Description
4A	Overdue service plan was completed within 30 days of expected renewal.
31D	The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.
32D	The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.
33D	The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.
34D	The enrollee reported he/she received the services he/she needed when he/she needed them. ELD Waiver only
35D	The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.
36D	PD and ELD Waiver—The case manager made annual contact with the enrollee or there is valid justification in record.
	HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bimonthly, or valid justification is documented in the enrollee's record.
	BI Waiver—The case manager made valid contact with the enrollee at least one time a month, or valid justification is documented in the enrollee's record.
37D	PD, HIV, SLF, and ELD Waivers—The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)
	BI Waiver—The most recent service plan is in the record and completed in a timely manner. (Completed within 6 months from review date)
38D	The service plan was updated when the enrollee needs changed.
39D	Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.
40D	The enrollee reported he/she received all services listed in the plan of care. ELD Waiver only
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers.
42G	The enrollee is informed how and to whom to report abuse, neglect, and exploitation at the time of assessment/reassessment.
44G	The enrollee reported he/she was being treated well by direct support staff. ELD Waiver only
49G	Most recent service plan includes a backup plan that includes the name of the backup. BI, HIV, PD Waivers

HealthChoice Illinois Detailed Findings

Successes

SFY 2019 represented the second year of review for the HealthChoice Illinois population, and several successes were identified.

- ☑ Ten of the 15 CMS performance measures averaged 90 percent or greater compliance in SFY 2019.
- ☑ Three of the seven health plans averaged 90 percent or greater compliance in SFY 2019.
- ☑ Compared to SFY 2018, CountyCare realized a statistically significant increase in overall performance in SFY 2019 (+6 percentage points, p=<0.0001).
- ☑ Compared to SFY 2018, NextLevel realized a statistically significant increase in overall performance in SFY 2019 (+7 percentage points, p=0.0261).
- ☑ Compared to SFY 2018, measure 39D realized a statistically significant increase in overall performance in SFY 2019 (+9 percentage points, p=<0.0001).
- ☑ The MLTSS subset realized a statistically significant increase in overall performance between Q1 and Q4 SFY 2019 (+6 percentage points, p=<0.0001).

Opportunities for Improvement

Review of SFY 2019 performance identified the following opportunities for improvement:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, averaged 28 percent compliance in SFY 2019. All six health plans with applicable cases (NextLevel did not have any applicable cases for the measure) performed at a rate of less than 50 percent in SFY 2019.
- Measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, averaged 51 percent and 42 percent compliance for the BI and HIV waivers, respectively, in SFY 2019.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, averaged 59 percent compliance in SFY 2019.
- Compared to SFY 2018, BCBSIL demonstrated a statistically significant decrease in overall performance in SFY 2019 (-5 percentage points, p=<0.0001).
- Compared to SFY 2018, Harmony demonstrated a statistically significant decrease in overall performance in SFY 2019 (-28 percentage points, p=<0.0001).

- Compared to SFY 2018, Meridian demonstrated a statistically significant decrease in overall performance in SFY 2019 (-5 percentage points, p=<0.0001).
- Compared to SFY 2018, overall performance on the 15 CMS performance measures combined demonstrated a statistically significant decrease in overall performance in SFY 2019 (-2 percentage points, p=<0.0001).
- Compared to SFY 2018, measure 31D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-7 percentage points, p=<0.0001).
- Compared to SFY 2018, measure 32D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-6 percentage points, p=<0.0001).
- Compared to SFY 2018, measure 33D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-4 percentage points, p=0.0004).
- Compared to SFY 2018, measure 35D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=0.0004).
- Compared to SFY 2018, measure 36D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-9 percentage points, p=<0.0001).
- Compared to SFY 2018, measure 38D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-8 percentage points, p=0.0014).
- Compared to SFY 2018, measure 41D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-2 percentage points, p=0.0350).
- Compared to SFY 2018, measure 42G demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=0.0052).
- Compared to SFY 2018, measure 49G demonstrated a statistically significant decrease in overall performance in SFY 2019 (-5 percentage points, p=<0.0001).
- Compared to SFY 2018, the ELD waiver demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=<0.0001).
- Compared to SFY 2018, the PD waiver demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=<0.0001).
- Compared to SFY 2018, the SLF waiver demonstrated a statistically significant decrease in overall performance in SFY 2019 (-5 percentage points, p=0.0027).

Analysis of HealthChoice Illinois SFY 2019 Performance on SFY 2018 Recommendations for Improvement

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the HealthChoice Illinois health plans to address HSAG recommendations following the conclusion of SFY 2018 reviews, efforts to incorporate TA received during on-site reviews, and efforts to integrate HFS guidance into internal processes. Although it is not possible to definitively determine causal relationships, Table B8-2 documents the results of some of the health plan improvement efforts.

Table B8-2—HealthChoice Illinois Health Plan Interventions and Results

SFY 2018 Recommendation	SFY 2019 Analysis of Performance
Plan-Specific	
BCBSIL should focus efforts on measures 4A, 37D, and 39D. BCBSIL should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. BCBSIL may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. BCBSIL should also identify a process to validate the provision of waiver services for all members.	BCBSIL realized a statistically significant increase in performance in measure 37D from Q1 to Q4 SFY 2019 and demonstrated stable performance from SFY 2018 to SFY 2019. Performance on 37D results in the population for 4A: BCBSIL demonstrated stable performance throughout SFY 2019 but demonstrated a statistically significant decrease when compared to SFY 2018. BCBSIL realized a statistically significant increase in performance in measure 39D from Q1 to Q4 SFY 2019 and demonstrated stable performance from SFY 2018 to SFY 2019, with an overall increase of 8 percentage points.
CountyCare should focus efforts on measures 4A, 37D, and 39D. CountyCare should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. CountyCare may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. CountyCare should also identify a process to validate the provision of waiver services for all members.	CountyCare demonstrated stable performance in performance in measure 37D from Q1 to Q4 SFY 2019 and realized a statistically significant increase from SFY 2018 to SFY 2019. Performance on 37D results in the population for 4A: CountyCare realized statistically significant increases from Q1 to Q4 SFY 2019 and from SFY 2018 to SFY 2019. CountyCare demonstrated stable performance in performance in measure 39D from Q1 to Q4 SFY 2019 and realized a statistically significant increase from SFY 2018 to SFY 2019, with an overall increase of 16 percentage points.
Harmony should focus efforts on measure 39D. Harmony should identify a process to validate the provision of waiver services for all members.	Harmony demonstrated stable performance in measure 39D throughout SFY 2019 but demonstrated a statistically significant decrease in SFY 2019 when compared to SFY 2018, with an overall decrease of 49 percentage points.

SFY 2018 Recommendation	SFY 2019 Analysis of Performance
Plan-Specific	
IlliniCare should focus efforts on measures 4A, 37D, and 39D. IlliniCare should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. IlliniCare should also identify a process to validate the provision of waiver services for all members.	IlliniCare demonstrated stable performance in measure 37D from Q1 to Q4 SFY 2019 and from SFY 2018 to SFY 2019. Performance on 37D results in the population for 4A: IlliniCare demonstrated stable performance throughout SFY 2019 but demonstrated a statistically significant decrease when compared to SFY 2018. IlliniCare realized a statistically significant increase in performance in measure 39D from Q1 to Q4 SFY 2019 and from SFY 2018 to SFY 2019, with an overall increase of 16 percentage points.
Meridian should focus efforts on measures 4A, 37D, and 39D. Meridian should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Meridian should also identify a process to validate the provision of waiver services for all members.	Meridian demonstrated stable performance in performance in measure 37D from Q1 to Q4 SFY 2019 and demonstrated a statistically significant decrease from SFY 2018 to SFY 2019. Performance on 37D results in the population for 4A: Meridian demonstrated stable performance from Q1 to Q4 SFY 2019 and from SFY 2018 to SFY 2019. Meridian realized a statistically significant increase in performance in measure 39D from Q1 to Q4 SFY 2019 and demonstrated stable performance from SFY 2018 to SFY 2019.
Molina should focus efforts on measure 39D. Molina should identify a process to validate the provision of waiver services for all members.	Molina demonstrated stable performance in measure 39D throughout SFY 2019 but realized a statistically significant increase in SFY 2019 when compared to SFY 2018, with an overall increase of 31 percentage points.
NextLevel should focus efforts on measures 4A, 37D, and 39D. NextLevel should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. NextLevel may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. NextLevel should also identify a process to validate the provision of waiver services for all members.	NextLevel demonstrated stable performance in measure 37D from Q1 to Q4 SFY 2019 and from SFY 2018 to SFY 2019, performing at 100 percent in SFY 2019. Performance on 37D results in the population for 4A: NextLevel did not have any applicable cases for 4A in SFY 2019. NextLevel demonstrated stable performance in measure 39D throughout SFY 2019 but realized a statistically significant increase in SFY 2019 when compared to SFY 2018, with an overall increase of 45 percentage points.

SFY 2018 Recommendation	SFY 2019 Analysis of Performance
Waiver-Specific	
BI: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that CCs/CMs have caseloads of no more than 30. Health plans should target efforts for contact to those CCs/CMs managing BI caseloads to ensure contact is completed in a timely manner. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee at least one time a month, resulted in a statistically significant increase in performance from Q1 to Q4 SFY 2019 and demonstrated stable performance from SFY 2018 to SFY 2019. Focused efforts related to measure 36D were recommended during SFY 2019 and remain as a recommendation for SFY 2020.
HIV: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with bimonthly face-to-face contact. Health plans should analyze their staffing to ensure that CCs/CMs have caseloads of no more than 30. Health plans should target efforts for contact to those CCs/CMs managing HIV caseloads to ensure contact is completed in a timely manner. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee once a month, with bimonthly face-to-face contact, demonstrated stable performance from Q1 to Q4 SFY 2019 and from SFY 2018 to SFY 2019. Focused efforts related to measure 36D were recommended during SFY 2019 and remain as a recommendation for SFY 2020.
Performance-Measure Specific	
All health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from following the *Performance Measure-Specific* recommendations.	Overall performance for measure 4A was 28% in SFY 2019. Overall performance for measure 36D averaged 51% and 42% compliance for the BI and HIV waivers, respectively. Overall performance for measure 37D was 82% in SFY 2019. Overall performance for measure 39D was 59% in SFY 2019. Focused efforts will continue to remain as recommendations for measures 4A, 36D, 37D, and 39D.

MMAI Detailed Findings

Successes

SFY 2019 represented the fifth year of review for the MMAI population, and several successes were identified.

- ☑ Ten of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2019.
- ☑ Three of the six health plans averaged 90 percent or greater compliance in SFY 2019.
- ☑ Compared to SFY 2018, Aetna realized a statistically significant increase in overall performance in SFY 2019 (+8 percentage points, p=<0.0001).
- ☑ Compared to SFY 2018, IlliniCare realized a statistically significant increase in overall performance in SFY 2019 (+3 percentage points, p=0.0120).
- ☑ Compared to SFY 2018, measure 34D realized a statistically significant increase in overall performance in SFY 2019 (+5 percentage points, p=0.0007).
- ☑ Compared to SFY 2018, measure 39D realized a statistically significant increase in overall performance in SFY 2019 (+10 percentage points, p=<0.0001).
- ☑ Compared to SFY 2018, measure 40D realized a statistically significant increase in overall performance in SFY 2019 (+4 percentage points, p=0.0033).
- ☑ Compared to SFY 2018, the BI waiver realized a statistically significant increase in overall performance in SFY 2019 (+3 percentage points, p=0.0063).
- ☑ Compared to SFY 2018, the ELD waiver realized a statistically significant increase in overall performance in SFY 2019 (+2 percentage points, p=0.0081).

Opportunities for Improvement

Review of SFY 2019 performance identified the following opportunities for improvement:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, averaged 30 percent compliance in SFY 2019. Four of the six health plans performed at a rate of 50 percent or less in SFY 2019.
- Measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, averaged 63 percent and 58 percent compliance for the BI and HIV waivers, respectively, in SFY 2019.

- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, averaged 65 percent compliance in SFY 2019.
- Compared to SFY 2018, BCBSIL demonstrated a statistically significant decrease in overall performance in SFY 2019 (-2 percentage points, p=0.0035).
- Compared to SFY 2018, measure 31D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=0.0031).
- Compared to SFY 2018, measure 32D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-2 percentage points, p=0.0002).
- Compared to SFY 2018, measure 33D demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=0.0004).
- Compared to SFY 2018, the SLF waiver demonstrated a statistically significant decrease in overall performance in SFY 2019 (-3 percentage points, p=<0.0001).

Analysis of MMAI SFY 2019 Performance on SFY 2018 Recommendations for Improvement

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the MMAI health plans to address HSAG recommendations following the conclusion of SFY 2018 reviews, efforts to incorporate TA received during on-site reviews, and efforts to integrate HFS guidance into internal processes. Although it is not possible to definitively determine causal relationships, Table B8-3 documents the results of some of the health plan improvement efforts.

Table B8-3—Health Plan Interventions and Results

SFY 2018 Recommendation	SFY 2019 Analysis of Performance
Plan-Specific	
Aetna should focus efforts on measures 4A and 39D. Aetna should ensure that overdue service plans are completed within 30 days of the expected date. Aetna may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Aetna should also identify a process to validate the provision of waiver services for all members.	Data reflected that Aetna made significant improvement in measure 4A from SFY 2018 to SFY 2019, resulting in 100% compliance in SFY 2019. Compared to SFY 2018, Aetna realized a statistically significant improvement in measure 39D in SFY 2019 (+35 percentage points, *p*=<0.0001).

SFY 2018 Recommendation	SFY 2019 Analysis of Performance
Plan-Specific	
BCBSIL should focus efforts on measures 4A and 39D. BCBSIL should ensure that overdue service plans are completed within 30 days of the expected date. BCBSIL may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. BCBSIL should also identify a process to validate the provision of waiver services for all members.	BCBSIL realized stable performance in measure 4A throughout SFY 2019 and compared to SFY 2018. Compared to SFY 2018, BCBSIL realized an improvement of 5 percentage points in measure 39D.
Humana should focus efforts on measures 4A and 39D. Humana should ensure that overdue service plans are completed within 30 days of the expected date. Humana may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Humana should also identify a process to validate the provision of waiver services for all members.	Humana realized stable performance in measure 4A throughout SFY 2019 and compared to SFY 2018. Compared to SFY 2018, Humana realized an improvement of 5 percentage points in measure 39D.
IlliniCare should focus efforts on measures 4A, 37D, and 39D. IlliniCare should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. IlliniCare should also identify a process to validate the provision of waiver services for all members.	IlliniCare realized stable performance in measures 4A, 37D, and 39D throughout SFY 2019 and compared to SFY 2018.
Meridian should focus efforts on measures 4A and 39D. Meridian should ensure that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Meridian should also identify a process to validate the provision of waiver services for all members.	Meridian realized stable performance in measure 4A throughout SFY 2019 and compared to SFY 2018. Compared to SFY 2018, Meridian realized an improvement of 5 percentage points in measure 39D.
Molina should focus efforts on measures 4A and 39D. Molina should ensure that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Molina should identify a process to validate the provision of waiver services for all members.	Molina realized stable performance in measure 4A throughout SFY 2019 and compared to SFY 2018. Compared to SFY 2018, Molina realized a statistically significant improvement in measure 39D in SFY 2019 (+19 percentage points, p=0.0068).

SFY 2018 Recommendation	SFY 2019 Analysis of Performance
Waiver-Specific	
BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that CCs/CMs have caseloads of no more than 30. Health plans should target efforts for contact at those CCs/CMs managing BI caseloads to ensure contact is completed in a timely manner. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee at least one time a month, increased in SFY 2019 compared to SFY 2018 (+5 percentage points). Focused efforts related to measure 36D were recommended during SFY 2019 and remain as a recommendation for SFY 2020.
HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with bimonthly face-to-face contact. Health plans should analyze their staffing to ensure that CCs/CMs have caseloads of no more than 30. Health plans should target efforts for contact at those CCs/CMs managing HIV caseloads to ensure contact is completed in a timely manner. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee once a month, with bimonthly face-to-face contact, increased in SFY 2019 compared to SFY 2018 (+13 percentage points). Focused efforts related to measure 36D were recommended during SFY 2019 and remain as a recommendation for SFY 2020.
Performance-Measure Specific	
All health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from following the *Performance Measure-Specific* recommendations.	Overall performance for measure 4A was 30% in SFY 2019. Overall performance for measure 36D averaged 63% and 58% compliance for the BI and HIV waivers, respectively. Overall performance for measure 37D was 83% in SFY 2019. Overall performance for measure 39D was 65% in SFY 2019. Focused efforts will continue to remain as recommendations for measures 4A, 36D, and 39D.

Remediation Validation

Remediation validation for the health plans was conducted on-site during the Q2 and Q4 SFY 2019 waiver performance measure reviews. A random sample was drawn in two groupings: by health plan and by performance measure, using only members for whom remediation actions were completed. For health plans with an initial sample of at least 32 cases, a validation sample of 16 cases was completed. For health plans with an initial sample of fewer than 32 cases, a full validation sample was completed. Table B8-4 indicates the number of cases reviewed per health plan.

All health plans received their remediation sample 10 days prior to on-site remediation validation review and were responsible for ensuring all necessary remediation documentation was available during the on-site review. Remediation validation included review of each record in the sample and supporting documentation, to ensure the action taken and completion date documented in the remediation tracking database were consistent with the information in the health plan's care management record and/or staff training records.

HealthChoice Illinois Remediation Validation

Harmony did not have remediation validation in Q4 due to its exit from the managed care program. Table B8-4 indicates the number of cases reviewed per HealthChoice Illinois health plan.

Table B8-4—HealthChoice Illinois Remediation Validation Review Totals

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	10/13	16/17
CountyCare	20/32	25/32
Harmony	2/2	NA
IlliniCare	12/26	15/23
Meridian	20/20	23/23
Molina	17/18	19/22
NextLevel	10/10	2/2

Overall remediation validation for the seven HealthChoice Illinois health plans averaged 80 percent. Three health plans, Harmony, Meridian, and NextLevel, demonstrated 100 percent compliance with remediation validation. Of the remaining four health plans, multiple causative factors for noncompliance were identified, including incorrect data entry into the HSAG database, lack of documentation to validate completion of remediation actions, and lack of documentation of care coordinator training.

MMAI Remediation Validation

Table B8-5 indicates the number of cases reviewed per MMAI health plan.

Table B8-5—MMAI Remediation Validation Review Totals

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Aetna	32/32	21/22
BCBSIL	15/19	14/15
Humana	31/31	32/32
IlliniCare	1/6	7/9
Meridian	12/12	9/9
Molina	13/14	10/10

Overall remediation validation among the six MMAI health plans averaged 93 percent. Multiple causative factors for noncompliance were identified, including incorrect data entry into the HSAG database and lack of documentation to validate completion of care coordinator training.

TA

HSAG provided TA and database training to each health plan to mitigate future noncompliance. TA included:

- Health plan-specific database user training, including an overview of the report availability and documentation requirements for the remediation process.
- Overview of required elements to validate care coordinator training specific to each performance measure as outlined by the HealthChoice Illinois and MMAI contracts.

As a result of the findings of the remediation validation process, HSAG recommended the following health plan actions:

- Implementation of internal processes to monitor remediation actions to ensure timely and accurate remediation of record review findings.
- Implementation of internal process and staff training to ensure remediation actions are entered correctly into the HSAG database.

Remediation validation reviews will continue in SFY 2020 and will include review of any records that were found to be not fully remediated during the SFY 2019 reviews.

HCBS Program Recommendations for Improvement

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Plan-specific, waiver-specific, and performance measure-specific recommendations are identified below.

HealthChoice Illinois Plan-Specific

BCBSIL should focus efforts on measures 4A, 36D, 37D, and 39D. BCBSIL should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. BCBSIL may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of timely contacts and service plans. BCBSIL should ensure consistent application of a process to validate the provision of waiver services for all members. BCBSIL may benefit from following the *Performance Measure-Specific* recommendations below.

CountyCare should focus efforts on measures 4A, 36D, and 39D. CountyCare should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. CountyCare may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of timely contacts and service plans. CountyCare should ensure consistent application of a process to validate the provision of waiver services for all members. CountyCare may benefit from following the *Performance Measure-Specific* recommendations below.

IlliniCare should focus efforts on measures 4A, 36D, 37D, and 39D. IlliniCare should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of timely contacts and service plans. IlliniCare should ensure consistent application of a process to validate the provision of waiver services for all members. IlliniCare may benefit from following the *Performance Measure-Specific* recommendations below.

Meridian should focus efforts on measures 4A, 36D, 37D, and 39D. Meridian should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of timely contacts and service plans. Meridian should ensure consistent application of a process to validate the provision of waiver services for all members. Meridian may benefit from following the *Performance Measure-Specific* recommendations below.

Molina should focus efforts on measures 4A, 36D, 37D, and 39D. Molina should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service

plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of timely contacts and service plans. Molina should ensure consistent application of a process to validate the provision of waiver services for all members. Molina may benefit from following the *Performance Measure-Specific* recommendations below.

NextLevel should focus efforts on measure 39D. NextLevel should ensure consistent application of a process to validate the provision of waiver services for all members. NextLevel may benefit from following the *Performance Measure-Specific* recommendations below.

MMAI Plan-Specific

Aetna performed at 90 percent or greater for 14 of the 15 CMS performance measures. The one performance measure with results lower than 90 percent was 39D, which averaged 89 percent during SFY 2019 and realized a statistically significant improvement from SFY 2018 (+35 percentage points, p=<0.0001). HSAG will continue to review Aetna's SFY 2020 performance to ensure gains are sustained and identify any best practices.

BCBSIL should focus efforts on measures 4A, 37D, and 39D. BCBSIL should ensure that overdue service plans are completed within 30 days of the expected date. BCBSIL may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. BCBSIL should also identify a process to validate the provision of waiver services for all enrollees. BCBSIL may benefit from following the *Performance Measure-Specific* recommendations below. In addition, BCBSIL should focus efforts on measures 31D, 32D, and 33D, especially for SLF waiver enrollees, as those three measures demonstrated statistically significant decreases in performance in SFY 2019 when compared to SFY 2018.

Humana should focus efforts on measures 4A and 39D. Humana should ensure that overdue service plans are completed within 30 days of the expected date. Humana may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Humana should also identify a process to validate the provision of waiver services for all members. Humana may benefit from following the *Performance Measure-Specific* recommendations below.

IlliniCare should focus efforts on measures 4A and 39D. IlliniCare should ensure that service plans are completed on time and, if not completed within the required time frame, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. IlliniCare should also identify a process to validate the provision of waiver services for all members. IlliniCare may benefit from following the *Performance Measure-Specific* recommendations below.

Meridian should focus efforts on measures 4A and 39D. Meridian should ensure that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Meridian should also identify a process to validate the provision of waiver services for all members. Meridian may benefit from following the *Performance Measure-Specific* recommendations below.

Molina should focus efforts on measures 4A and 39D. Molina should ensure that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific time frames for completion of service plans. Molina should identify a process to validate the provision of waiver services for all members. Molina may benefit from following the *Performance Measure-Specific* recommendations below.

Waiver-Specific

BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that CCs/CMs have caseloads of no more than 30. Health plans should target efforts for contact to those CCs/CMs managing BI caseloads to ensure contact is completed in a timely manner. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with bimonthly face-to-face contact. Health plans should analyze their staffing to ensure that CCs/CMs have caseloads of no more than 30. Health plans should target efforts for contact to those CCs/CMs managing HIV caseloads to ensure contact is completed in a timely manner. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

All waivers: HSAG will conduct review of all CMS-approved waivers to determine changes to reportable performance measures. Based on the review, HSAG will recommend to HFS any applicable revisions to the evaluation criteria.

Performance Measure-Specific

All HealthChoice Illinois and MMAI health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from following the *Performance Measure-Specific* recommendations below.

For measure 4A and 37D, efforts might include:

- Ensuring that internal audit processes focus on review of these measures, with immediate feedback and discussion with CCs/CMs to identify opportunities for improvement.
- Considering system enhancements to alert CCs/CMs of time frames to update waiver service plans.
- Educating care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

For measure 36D, efforts might include:

- Forming 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.

- Analyzing staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conducting staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensuring that internal audit processes focus on review of this measure, with immediate feedback and discussion with CCs/CMs to identify opportunities for improvement.
- Considering system enhancements to alert CCs/CMs of time frames to contact beneficiaries.

For measure 39D, efforts might include:

- Establishing a process to complete ongoing claims validation of the waiver service plan.
- Conducting root cause analysis to determine service providers who may benefit from outreach and education regarding claims submission.
- Ensuring completion of education with beneficiaries related to approved hours for personal assistants.
- Conducting staff training to ensure timely follow-up with beneficiaries who have a change in service provider. Training should include a component for review of claims to validate service provision and steps to ensure there are no gaps in waiver services.
- Ensuring that all appropriate staff are provided access and trained on navigation of waiver agency portals to review beneficiary information.
- Developing relationships with service providers to ensure timely communication to the health plan when services cannot be provided per the waiver service plan and ensure documentation of the communication in the beneficiary's record.

Appendix C. 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.

MLTSS Readiness Review Methodology

Process

HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[C-1] Desk review activities included developing readiness review tools, preparing and forwarding to PIHPs a customized desk review form with instructions for submitting documentation to HSAG, providing a cover letter with detailed instructions about the desk review, conducting desk review of documents, data aggregation and analysis, and preparation of findings.

Data Collection and Analysis

To ensure health plan readiness to serve the MLTSS population, HSAG incorporated and built upon the results of the HealthChoice Illinois Pre-Implementation Readiness Reviews and the corrective actions performed by the plans as a result of those reviews. As many of the requirements assessed in that review were applicable to the MLTSS program, HSAG conducted a crosswalk between the following documents:

- CMS' *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs*
- State of Illinois Contract between the Department of Healthcare and Family Services and Model Contract for Furnishing Health Services by a Managed Care Organization, 2018-24-001
- Illinois' *Section 1915(b) Waiver Proposal For PIHPs, MMA Amendment Version,* 2nd Revision September 18, 2018 (MLTSS waiver)
- HealthChoice Illinois Pre-Implementation Readiness Review tool

The crosswalk was used to determine key requirements applicable to MLTSS programs and select the criteria for the MLTSS Readiness Reviews in order to evaluate health plan readiness to provide services to MLTSS beneficiaries for the statewide expansion.

HSAG developed data collection tools to document the MLTSS review. The requirements in the tools were based on applicable federal and State regulations and laws and on the requirements set forth in the documents described above in the crosswalk process. To assess the plans' ability and capacity to deliver MLTSS services consistent with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the health plans. The MLTSS

[C-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: May 23, 2019.

Readiness Review Evaluation Tool contained 10 standards and 44 elements. HSAG aggregated all information obtained.

Additional Components of Review

Network adequacy activities were also conducted to evaluate and report on the capacity of the health plan MLTSS provider network, as described in Section 5 of this report.

To further assesses the plans' capacity to serve MLTSS beneficiaries for the statewide expansion, HSAG also conducted a review of state-selected requirements for CC/CM staff training, qualifications, and caseloads. The CC/CM staff review included evaluation of the contract requirements for the MLTSS program. HSAG reviewed the training, educational qualifications, related experience, FTE allocation, and caseloads of CC/CM staff serving the MLTSS population against contract requirements. Plans were required to follow up on any required actions associated with noncompliant elements to ensure compliance.

Scoring

Based on the results and conclusions from the readiness review activities, HSAG assigned each element within the standards in the compliance monitoring tool a score of *Met* or *Not Met* to document whether the plan complied with the requirements. HSAG used a designation of *NA* when a requirement was not applicable to an organization during the period covered by the review.

Appendix D. PIPs Methodology

Objective

As part of the State's quality strategy, each MCO is required to conduct PIPs 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 Balanced Budget Act of 1997 (BBA), HSAG, as the State's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows validation guidelines established in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[D-1] Additionally, HSAG's PIP process facilitates frequent communication with the MCOs. HSAG provides written feedback after each module is validated and provides TA for further guidance. HSAG conducts webinar trainings prior to each module submission and progress check-ins while MCOs test interventions.

HFS requires its MCOs to conduct two PIPs annually. The topics initiated in SFY 2019 were:

- *Follow-Up After Hospitalization for Mental Illness Within 30 Days*
- *Transitions of Care–Patient Engagement After Inpatient Discharge*

The topics selected by HFS addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, the MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

[D-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 14, 2018.

Approach to PIP Validation

In SFY 2019, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Module 1 and Module 2.

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus on the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, FMEA, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act**: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the health plan summarizes key findings and outcomes and presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

The MCOs submitted each module according to the approved timeline. After the initial validation of each module, the MCOs received HSAG's feedback and TA and resubmitted the modules until all validation criteria were achieved. This process ensures that the methodology is sound before the MCOs progress to the next phase of the PIP process.

The goal of HSAG's PIP validation is to ensure that HFS and key stakeholders have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound improvement project and confirmed that any achieved improvement can be clearly linked to the quality improvement strategies implemented by the MCO.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*NA*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Appendix E1. 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.

Post-Implementation Monitoring Methodology

In SFY 2018–2019, HSAG continued network monitoring activities as follow-up to the HealthChoice Illinois Post-Implementation Reviews. The methodology for the monitoring process is detailed below.

Network Data Submission Process

HSAG developed a *Provider Network Data Submission Instruction Manual* (manual) to provide health plans with detailed guidance for the completion and quarterly submission of accurate network capacity data. The health plans were required to follow the instructions and definitions for provider types within the manual to submit network capacity data in a standardized Provider File Layout (PFL), MS Excel workbook. The manual included the following sections:

- Section 1—Introduction, describes the purpose of the manual and its organization and provides an overview of the PFL
- Section 2—PFL 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 follow to submit the provider network data
- Appendix A—Data Dictionary, contains definitions for all provider types required for submission
- Appendix B—HCBS Waiver Definitions, defines HCBS service types required for submission
- Appendix C—PFL MS Excel workbook template

Health plans were required to upload their provider network data files to a secure HSAG file transfer protocol site. These files included PCPs, specialists, pediatric providers, dental providers, hospitals, facilities, pharmacies, HCBS and MLTSS providers (including substance abuse providers), FQHCs, CMHCs, RHCs, nursing facilities, SLFs, exceptional care providers, and transportation providers within each managed care service area.

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 post-implementation reviews, 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 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 quarterly provider network capacity reports to ensure compliance with HFS' specifications. The provider network capacity reports included:

- Regional Dashboard Report—review of the health plans' contracting status with hospitals, FQHCs, CMHCs, and RHCs in the services regions, as well as contiguous counties, if applicable.
- Hospital Analysis Report—hospitals listed by name and region to show contracted and pended hospitals across health plans.
- HealthChoice Illinois Network Development—snapshot of the health plans' network development progress between each submission.
- PCP Network Capacity Report—review of each health plan's PCP capacity within each county and region.
- PCP Open & Closed Panels—number and percent of PCPs with open and closed panels by health plan.
- No Contracted Providers Across Statewide Health Plans—review of provider types the health plans were least successful contracting in rural counties.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.
- Division of Alcoholism and Substance Abuse (DASA) Provider Network Review—high-level review of each health plan's current and future network for DASA providers within each region.

MLTSS Readiness Review Methodology

Similar network data completion and submission processes outlined above were followed by the health plans for the MLTSS Readiness Reviews prior to the implementation of the MLTSS statewide expansion. The MLTSS network reviews included all providers listed in Attachment I: Service Package II Covered Services and MLTSS Covered Services of the Medicaid Model Contract. HSAG used the health plan data file submissions to identify any potential network gaps and monitor compliance toward maintaining an adequate provider network for MLTSS.

In preparation for the MLTSS statewide expansion, HSAG completed an analysis of the FFS utilization data to determine the number of enrollees within each service county who received waiver services between March 2018 and April 2019. HSAG used the results of the utilization analysis to evaluate whether each plan was contracted with a sufficient number of the same provider types identified within each of the counties/regions in the service area. Plans must enter into contracts with at least two providers in any county served by more than one provider, as required by the Medicaid Model Contract §5.7.1.4.

HSAG conducted a statewide analysis to evaluate the contracting of nursing facilities and, therefore, determine the number of nursing facilities not contracted by any health plan. Based on the results of this analysis, HFS estimated the number of assigned enrollees within the noncontracted nursing facilities and required all health plans to begin contracting efforts with these facilities to ensure a seamless transition for enrollees residing in these nursing facilities. Plans were required to update the nursing facility contracting workbook to document the status of contracting efforts. In addition, health plans were also required to have single case agreements with each of the noncontracted facilities, whereby they have assigned enrollment until execution of a provider agreement.

Plans must notify HFS within three business days of terminating network providers who serve 100 or more active enrollees, as required by the Medicaid Model Contract §5.7.3. These notices must include an evaluation of the risk the provider termination poses and subsequent provision of MLTSS services. If there is an impact to network adequacy, the health plan is required to submit a plan to ensure continuity of care to affected enrollees.

Reporting and Communication

During the MLTSS readiness review process, 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 plans' compliance toward establishing an adequate provider network for the MLTSS expansion. 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 correct any gaps in the MLTSS network prior to July 1, 2019.

Monitoring Network Adequacy for MLTSS

HSAG collaborated with HFS to develop provider network capacity reports to ensure compliance with HFS' specifications. The provider network capacity reports for MLTSS included:

- MLTSS Network Monitoring Report—review of contracted providers within each region/county for all covered services included in Attachment I: Service Package II Covered Services and MLTSS Covered Services of the Medicaid Model Contract.
- MLTSS Utilization of HCBS Services—review of the health plan provider network to determine network capacity based on utilization data supplied by HFS for waiver providers serving clients in expansion counties. The results of this analysis identified whether each health plan was contracted with a sufficient number of the same provider types as identified within the utilization data file.
- Other MLTSS Services Providers—review of contracted behavioral health providers, transportation providers, CMHCs, FQHCs, exceptional care providers, nursing homes, and SLFs.
- Nursing Facility Provider Contracting Workbook—contracting progress report for noncontracted nursing facilities.

Appendix E2. MLTSS Provider Network Adequacy Reports

This section includes the detailed reports on MLTSS provider network adequacy completed for the MLTSS readiness review.

IL2019 MLTSS Statewide Expansion - Network Readiness - Nursing Facilities (NFs)
Number of Outreach Attempts and Contracting Status
Health Plan Contracting Workbook Submitted on June 24, 2019

		Statewide Health Plans - # of Outreach Attempts & Contracting Status				Cook Only Health Plans	
Region / Facility Name	# of Members within the NF (HFS Estimates)*	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Region 1 - Northwest							
Alpine Fireside Health Center	6	1	2	4	3		
Clayberg, The	22	2	Contracted	4	2		
Elizabeth Nursing Home	7	Contracted	3	4	NF not contracting		
Harbor Crest Home	0	1	2	Contracted	2		
Heritage Square	6	3	3	5	2		
Medina Nursing Center	31	3	2	Contracted	3		
Pine Acres Rehab Living Center	30	4	Contracted	Contracted	Contracted		
Willows Health Center	8	6	NF not contracting	4	2		
Region 2 - Central							
Heartland Manor	15	4	2	Contracted	3		
Sunset Home	68	2	3	3	Pending		
Region 3 - Southern							
Bethalto Care Center	19	1	3	2	3		
Eunice C Smith Home	2	2	2	3	1		
Fairview Nursing Center	21	2	2	Contracted	Pending		
Faith Care Center	9	2	Contracted	4	2		
Memorial Care Center	1	2	2	2	1		
Oak Hill	22	Contracted	2	Contracted	1		
St Pauls Home	22	2	3	3	2		
Three Springs Lodge Nrsg Home	18	2	3	3	1		
Twin Willows Nursing Center	15	2	2	4	2		
United Methodist Village North	0	4	2	Contracted	2		
Region 4 - Cook							
Abington Of Glenview Nursing &	17	1	3	2	1	3	Pending
Montgomery Place	1	1	1	2	1	Contracted	Contracted
Moorings Of Arlington Heights	3	2	1	2	2	Contracted	Contracted
Westminster Place	6	2	1	2	2	Contracted	Contracted

IL2019 MLTSS Statewide Expansion - Network Readiness - Nursing Facilities (NFs)
Number of Outreach Attempts and Contracting Status
Health Plan Contracting Workbook Submitted on June 24, 2019

		Statewide Health Plans - # of Outreach Attempts & Contracting Status				Cook Only Health Plans	
Region / Facility Name	# of Members within the NF (HFS Estimates)*	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Region 5 - Collars							
Alden Estates Cts Of Huntley	0	1	Contracted	Contracted	Contracted		
Fair Oaks Health Care Center	4	5	2	2	1		
Hearthstone Manor	10	1	1	2	2		
Libertyville Manor Ext Care	6	1	2	2	3		
Mercy Harvard Hospital Cr Ctr	3	1	Contracted	2	Contracted		
Radford Green	3	1	Contracted	2	1		
Springs At Monarch Landing	2	1	NF not contracting	2	1		
Valley Hi Nursing Home	49	2	3	4	1		

Notes

• In preparation for the MLTSS Statewide expansion HSAG conducted a statewide analysis to evaluate the contracting of nursing facilities (NFs) and, therefore, determine the number of nursing facilities not contracted by any health plan. HFS directed HSAG to work with the health plans to track contracting efforts with each of the non-contracted nursing facilities identified in the grid above.

The table above shows the following information:

*HFS identified the number of enrollees assigned to each nursing facility (NF).
• "Contracted" shaded in green indicates that the health plan has contracted with the identified NF. HSAG's review of the health plan data identified that the nursing facility was not included in the data or was listed in the data as "pending load". HSAG will follow-up with the health plans for accurate reporting of NFs in the next provider network data file submission.
• "Pending" shaded in blue indicates that the health plan reported that they are in the process of executing a contract with the identified nursing facility.
• "NF not contracting" shaded in pink/red indicates that the nursing facility is not contracting with the identified health plan.
• Numeric values in C through H represent the number of outreach attempts to contract with the identified NF.
• The shaded yellow/orange cells in Columns C through H indicate the projected contract execution date of 7/1/19.

IL2019 HCBS & MLTSS Network Monitoring
Region 1 - Northwest: Contracted Providers
as of May 30, 2019

County / Health Plan	HCBS Enrollment as of March 2019		Contracted HCBS Providers - County Coverage									
	HCI Program	MLTSS Program	Adult Day Services	Day Habilitation	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Metro Counties												
Boone												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	19	0	3+	3+	3+	3+	3+	3+	3+	1	2	1
Meridian	13	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
DeKalb												
BCBS	0	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	0	0	3+	3+	3+	1	3+	3+	3+	1	3+	2
Meridian	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Peoria												
BCBS	2	0	3+	2	3+	2	3+	3+	3+	3+	3+	3+
IlliniCare	14	0	3+	3+	3+	2	3+	3+	3+	3+	3+	3+
Meridian	194	5	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
Molina	124	3	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Rock Island												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	58	2	3+	3+	3+	1	3+	3+	3+	3+	3+	3+
Meridian	79	2	3+	2	2	2	3+	0	1	2	3+	1
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Tazewell												
BCBS	1	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	1	0	3+	3+	3+	1	3+	3+	3+	3+	3+	3+
Meridian	71	4	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
Molina	42	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+

County / Health Plan	HCBS Enrollment as of March 2019		Contracted HCBS Providers - County Coverage									
	HCI Program	MLTSS Program	Adult Day Services	Day Habilitation	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Winnebago												
BCBS	**10**	**0**	2	1	2	2	2	2	2	2	2	2
IlliniCare	**245**	**4**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**178**	**2**	3+	1	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**7**	**0**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Micro Counties												
Henry												
BCBS	**0**	**0**	2	1	2	2	2	2	2	2	2	2
IlliniCare	**15**	**0**	3+	3+	3+	1	3+	3+	3+	3+	3+	2
Meridian	**8**	**0**	3+	2	2	2	3+	3+	3+	3+	3+	3+
Molina	**0**	**0**	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Knox												
BCBS	**1**	**0**	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**1**	**0**	3+	3+	3+	1	3+	3+	3+	1	2	0
Meridian	**41**	**0**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**23**	**3**	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
La Salle												
BCBS	**0**	**0**	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**1**	**0**	3+	3+	3+	1	3+	3+	3+	3+	3+	3+
Meridian	**1**	**0**	3+	3+	2	1	3+	3+	3+	3+	3+	3+
Molina	**0**	**0**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Ogle												
BCBS	**0**	**0**	2	1	2	2	2	2	2	2	2	2
IlliniCare	**0**	**0**	3+	2	2	1	3+	3+	2	0	1	0
Meridian	**0**	**0**	3+	1	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**0**	**0**	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Stephenson												
BCBS	**0**	**0**	2	1	2	2	2	2	2	2	2	2
IlliniCare	**0**	**0**	3+	3+	3+	1	3+	3+	3+	2	3+	1
Meridian	**1**	**0**	2	1	2	3+	3+	3+	3+	3+	3+	3+
Molina	**0**	**0**	3+	3+	3+	3+	3+	3+	3+	3+	3+	2

County / Health Plan	HCBS Enrollment as of March 2019		Contracted HCBS Providers - County Coverage									
	HCI Program	MLTSS Program	Adult Day Services	Day Habilitation	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Whiteside												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	3+	3+	3+	3+	2
Meridian	0	0	3+	2	2	2	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Woodford												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	2	1	2	1	3+	2	3+	1	1	1
Meridian	1	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Rural Counties												
Bureau												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	3+	3+	0	1	1
Meridian	0	0	1	1	2	2	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Carroll												
BCBS	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	0	0	3+	2	2	1	3+	3+	3+	0	2	0
Meridian	0	0	1	1	2	2	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Fulton												
BCBS	0	0	1	1	1	1	1	1	1	1	1	1
IlliniCare	1	0	3+	2	2	1	3+	3+	3+	2	3+	2
Meridian	0	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Henderson												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	3+	1	1	1	1
Meridian	0	0	2	1	2	2	1	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	1	3+	3+	2

County / Health Plan	HCBS Enrollment as of March 2019		Contracted HCBS Providers - County Coverage									
	HCI Program	MLTSS Program	Adult Day Services	Day Habilitation	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Jo Daviess												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	3+	3+	3+	2	3+	3+	2	1	1	0
Meridian	0	0	1	1	2	1	2	1	2	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Lee												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	1	0	3+	3+	3+	1	3+	3+	3+	2	3+	1
Meridian	0	0	3+	2	3+	2	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	1	3+	3+	3+
Marshall												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	3+	2	2	1	3+	3+	3+	0	1	0
Meridian	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	1	3+	3+	2
Mercer												
BCBS	0	0	1	1	1	1	1	1	1	1	1	1
IlliniCare	6	0	3+	3+	3+	1	3+	3+	3+	2	1	1
Meridian	3	0	3+	2	2	1	3+	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	2	3+	3+	3+
Putnam												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	3+	0	0	1	0
Meridian	0	0	1	1	2	1	2	3+	3+	3+	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	0	3+	3+	2
Stark												
BCBS	0	0	2	1	2	2	2	2	2	2	2	2
IlliniCare	0	0	2	1	1	1	3+	2	1	1	1	0
Meridian	3	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+
Molina	2	0	3+	3+	3+	3+	3+	3+	1	3+	3+	3+

County / Health Plan	HCBS Enrollment as of March 2019		Contracted HCBS Providers - County Coverage									
	HCI Program	MLTSS Program	Adult Day Services	Day Habilitation	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Warren												
BCBS	**0**	**0**	1	1	1	1	1	1	1	1	1	1
IlliniCare	**0**	**0**	3+	3+	3+	1	3+	3+	2	0	2	0
Meridian	**1**	**0**	3+	1	2	3+	2	3+	3+	3+	3+	3+
Molina	**0**	**0**	3+	3+	3+	3+	3+	3+	2	3+	3+	2

Notes:

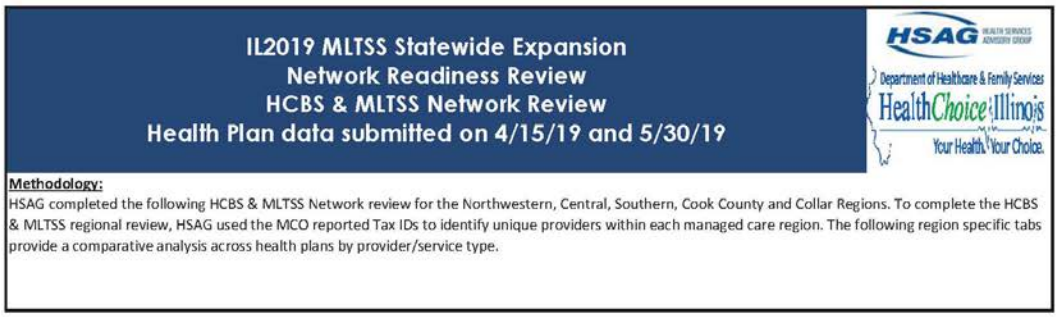
- The table above shows the number of unique providers that were reported by the health plans within each county. Counties that were identified with "zero" (0) providers do not indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service. The analysis above reflects providers that were listed in the health plan data as contracted and loaded.

The figures included in the grid identify the following:

- "3+" - three (3) or more contracted providers
- "2" - two (2) contracted providers
- "1" - one (1) contracted provider
- "0" - no contracted/loaded provider was identified in the health plan provider data
- Health plan provider network data submitted on April 15, 2019 and May 30, 2019.

Health Plan Notes:

- BCBSIL reported that they are in the process of adding a provider group to their network data file that provides services in McLean county. BCBSIL indicated a completion date of 7/1/2019.


IL2019 MLTSS Statewide Expansion
Network Readiness Review
HCBS & MLTSS Network Review
Health Plan data submitted on 4/15/19 and 5/30/19
HSAG
Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.
Methodology:
HSAG completed the following HCBS & MLTSS Network review for the Northwestern, Central, Southern, Cook County and Collar Regions. To complete the HCBS & MLTSS regional review, HSAG used the MCO reported Tax IDs to identify unique providers within each managed care region. The following region specific tabs provide a comparative analysis across health plans by provider/service type.

IL2019 HCBS & MLTSS Provider Network for Northwestern Counties Region 1 MLTSS Statewide Expansion Current Network: Contracted and Loaded Providers Health Plan data submitted on 4/15/19 and 5/30/19				
Enrollment	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
HCBS Enrollment as of March 2019	14	362	594	202
MLTSS Enrollment as of March 2019	0	6	13	8

	Contracted and Loaded			
Facilities	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Exceptional Care	5	23	15	3
Skilled Nursing Facilities	98	88	88	69
Supportive Living Facilities	22	15	17	17

	Contracted and Loaded			
HCBS Providers	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Pre-vocational Services	5	4	5	3
Respite Care Services	7	63	30	24
Specialized Medical Equipment	7	11	15	11

	Contracted and Loaded			
Behavioral Health Services	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Alcohol and Substance Abuse Rehab. Services	23	15	15	24
Licensed Professional/Licensed Clinical Counselor	45	29	80	20
Other Behavioral Health Services	86	26	39	4
Psychologist	26	13	18	7
Social Worker	44	29	47	27
Targeted Case Management Services	9	25	29	21

	Contracted and Loaded			
MLTSS Transportation	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Medicar Transportation	9	33	4	6
Non-Emergency Ambulance Transportation	8	24	1	11
Other Transportation*	5	76	24	23

HSAG Notes:

- HSAG conducted training sessions with each health plan to validate the service capacity of HCBS/MLTSS providers & transportation vendors.
- Health plans reported that some HCBS providers are available to enrollees in multiple counties and that MLTSS transportation vendors have the capacity to provide statewide coverage.

*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

IL2019 HCBS & MLTSS Provider Network for Central Counties Region 2 MLTSS Statewide Expansion Current Network: Contracted and Loaded Providers Health Plan data submitted on 4/15/19 and 5/30/19				
Enrollment	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
HCBS Enrollment as of March 2019	8	32	121	246
MLTSS Enrollment as of March 2019	0	0	1	3

	Contracted and Loaded			
Facilities	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Exceptional Care	1	14	7	21
Skilled Nursing Facilities	90	108	94	77
Supportive Living Facilities	24	16	16	19

	Contracted and Loaded			
HCBS Providers	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Pre-vocational Services	6	3	5	4
Respite Care Services	8	39	26	25
Specialized Medical Equipment	7	16	8	11

	Contracted and Loaded			
Behavioral Health Services	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Alcohol and Substance Abuse Rehab. Services	13	19	18	16
Licensed Professional/Licensed Clinical Counselor	28	29	66	27
Other Behavioral Health Services	68	22	23	9
Psychologist	6	10	14	9
Social Worker	35	36	37	41
Targeted Case Management Services	9	39	16	32

	Contracted and Loaded			
MLTSS Transportation	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Medicar Transportation	9	43	3	6
Non-Emergency Ambulance Transportation	6	38	0	11
Other Transportation	7	103	16	16

HSAG Notes:

- HSAG conducted training sessions with each health plan to validate the service capacity of HCBS/MLTSS providers & transportation vendors.
- Health plans reported that some HCBS providers are available to enrollees in multiple counties and that MLTSS transportation vendors have the capacity to provide statewide coverage.

*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

- **Meridian** reported that non-contracted ambulance providers are reimbursed by Meridian for providing Non-Emergency Ambulance transportation services in the Central and Southern regions regardless of network status (contracted and non-contracted).

IL2019 HCBS & MLTSS Provider Network for Southern Counties Region 3 MLTSS Statewide Expansion Current Network: Contracted and Loaded Providers Health Plan data submitted on 4/15/19 and 5/30/19				
Enrollment	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
HCBS Enrollment as of March 2019	7	14	616	168
MLTSS Enrollment as of March 2019	0	0	12	3

	Contracted and Loaded			
Facilities	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Exceptional Care	2	19	11	1
Skilled Nursing Facilities	64	91	81	54
Supportive Living Facilities	24	14	12	18

	Contracted and Loaded			
HCBS Providers	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Pre-vocational Services	4	1	2	5
Respite Care Services	8	30	13	21
Specialized Medical Equipment	7	8	2	9

	Contracted and Loaded			
Behavioral Health Services	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Alcohol and Substance Abuse Rehab. Services	13	17	13	16
Licensed Professional/Licensed Clinical Counselor	12	15	45	17
Other Behavioral Health Services	40	8	15	11
Psychologist	3	7	8	3
Social Worker	20	21	23	32
Targeted Case Management Services	8	30	3	28

	Contracted and Loaded			
MLTSS Transportation	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Medicar Transportation	8	35	1	2
Non-Emergency Ambulance Transportation	1	27	0	5
Other Transportation	8	83	13	15

HSAG Notes:

- HSAG conducted training sessions with each health plan to validate the service capacity of HCBS/MLTSS providers & transportation vendors.
- Health plans reported that some HCBS providers are available to enrollees in multiple counties and that MLTSS transportation vendors have the capacity to provide statewide coverage.

*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

- **Meridian** reported that non-contracted ambulance providers are reimbursed by Meridian for providing Non-Emergency Ambulance transportation services in the Central and Southern regions regardless of network status (contracted and non-contracted).

IL2019 HCBS & MLTSS Provider Network for Cook County Region 4 MLTSS Statewide Expansion Current Network: Contracted and Loaded Providers Health Plan data submitted on 4/15/19 and 5/30/19						
Enrollment	**BCBS**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
HCBS Enrollment as of March 2019	3,398	2,668	1,919	195	3,722	355
MLTSS Enrollment as of March 2019	4,676	3,084	3,459	332	3,963	334

	Contracted and Loaded					
Facilities	**BCBS**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Exceptional Care	13	52	78	10	10	4
Skilled Nursing Facilities	198	185	188	122	125	149
Supportive Living Facilities	28	30	40	18	32	56

	Contracted and Loaded					
HCBS Providers	**BCBS**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Pre-vocational Services	61	50	7	3	66	1
Respite Care Services	85	147	73	38	11	3
Specialized Medical Equipment	85	48	33	19	123	1

	Contracted and Loaded					
Behavioral Health Services	**BCBS**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Alcohol and Substance Abuse Rehab. Services	23	16	16	26	18	4
Licensed Professional/Licensed Clinical Counselor	56	51	181	49	55	65
Other Behavioral Health Services	152	97	60	20	37	5
Psychologist	67	57	98	40	85	35
Social Worker	93	95	89	77	93	61
Targeted Case Management Services	86	94	56	62	127	1

	Contracted and Loaded					
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Medicar Transportation	58	76	32	15	15	3
Non-Emergency Ambulance Transportation	18	18	4	5	57	11
Other Transportation	91	107	185	35	6	12

HSAG Notes:

- HSAG conducted training sessions with each health plan to validate the service capacity of HCBS/MLTSS providers & transportation vendors.
- Health plans reported that some HCBS providers are available to enrollees in multiple counties and that MLTSS transportation vendors have the capacity to provide statewide coverage.

*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

IL2019 HCBS & MLTSS Provider Network for Collar Counties Region 5 MLTSS Statewide Expansion Current Network: Contracted and Loaded Providers Health Plan data submitted on 4/15/19 and 5/30/19				
Enrollment	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
HCBS Enrollment as of March 2019	932	664	909	65
MLTSS Enrollment as of March 2019	884	824	815	86

	Contracted and Loaded			
Facilities	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Exceptional Care	5	17	46	3
Skilled Nursing Facilities	98	111	104	52
Supportive Living Facilities	22	19	28	18

	Contracted and Loaded			
HCBS Providers	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Pre-vocational Services	21	17	7	2
Respite Care Services	25	112	78	22
Specialized Medical Equipment	25	20	35	13

	Contracted and Loaded			
Behavioral Health Services	**BCBS**	**IlliniCare**	**Meridian**	**Molina**
Alcohol and Substance Abuse Rehab. Services	23	27	25	24
Licensed Professional/Licensed Clinical Counselor	45	34	119	20
Other Behavioral Health Services	86	48	48	4
Psychologist	26	34	51	7
Social Worker	44	42	56	27
Targeted Case Management Services	26	60	52	29

4b-IL2019_Other_MLTSS_Service_Providers_5.30.19 2/13/2020

	Contracted and Loaded			
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina
Medicar Transportation	32	48	22	15
Non-Emergency Ambulance Transportation	11	17	3	4
Other Transportation	43	81	152	37

HSAG Notes:

- HSAG conducted training sessions with each health plan to validate the service capacity of HCBS/MLTSS providers & transportation vendors.
- Health plans reported that some HCBS providers are available to enrollees in multiple counties and that MLTSS transportation vendors have the capacity to provide statewide coverage.

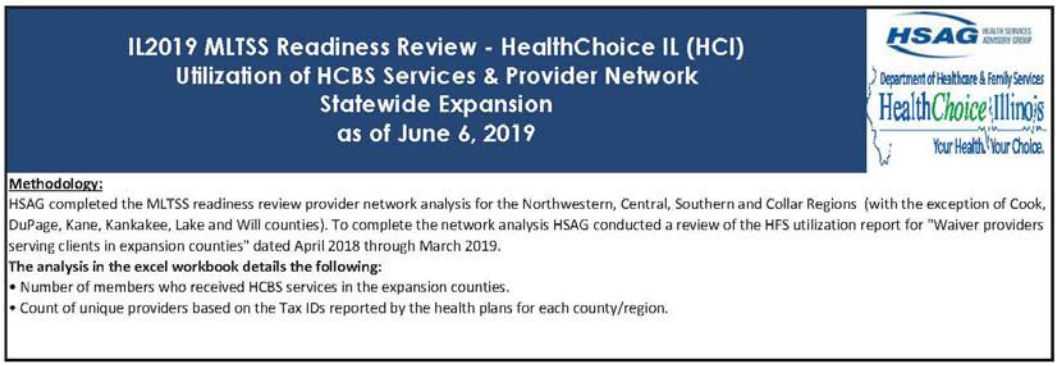
*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

4b-IL2019_Other_MLTSS_Service_Providers_5.30.19 2/13/2020

IL2019 Contracted FQHCs & CMHCs
Statewide Analysis
Health Plan data submitted on 4/15/19

	Region 1 - Northwestern Counties			Region 2 - Central Counties			Region 3 - Southern Counties			Region 4 - Cook County			Region 5 - Collar Counties		
	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***
FQHCs: # of Facilities (Clinics)															
BCBS	31	26	84%	47	26	55%	77	30	39%	207	185	89%	81	79	98%
IlliniCare	31	31	100%	47	44	94%	77	66	86%	207	207	100%	81	81	100%
Meridian	31	28	90%	47	33	70%	77	55	71%	207	158	76%	81	34	42%
Molina	31	23	74%	47	28	60%	77	41	53%	207	139	67%	81	20	25%
CountyCare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	207	167	81%	N/A	N/A	N/A
NextLevel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	207	207	100%	N/A	N/A	N/A
CMHCs: # of Facilities (Clinics)															
BCBS	142	70	49%	180	76	42%	173	81	47%	434	267	62%	232	132	57%
IlliniCare	142	110	77%	180	130	72%	173	114	66%	434	325	75%	232	183	79%
Meridian	142	93	65%	180	119	66%	173	95	55%	434	323	74%	232	169	73%
Molina	142	96	68%	180	113	63%	173	103	60%	434	257	59%	232	108	47%
CountyCare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	434	293	94%	N/A	N/A	N/A
NextLevel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	434	330	76%	N/A	N/A	N/A

*This column shows the overall number of facilities available within the identified region.
**This column shows the number of facilities that were reported by health plans as contracted and loaded.
***This column shows the percentage of contracted facilities over the number of available facilities within the identified region.
* "N/A" - not a service region for the identified health plan.



IL2019 MLTSS Readiness Review - HealthChoice IL (HCI)
Utilization of HCBS Services & Provider Network
Statewide Expansion
as of June 6, 2019

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

Methodology:

HSAG completed the MLTSS readiness review provider network analysis for the Northwestern, Central, Southern and Collar Regions (with the exception of Cook, DuPage, Kane, Kankakee, Lake and Will counties). To complete the network analysis HSAG conducted a review of the HFS utilization report for "Waiver providers serving clients in expansion counties" dated April 2018 through March 2019.

The analysis in the excel workbook details the following:

- Number of members who received HCBS services in the expansion counties.
- Count of unique providers based on the Tax IDs reported by the health plans for each county/region.

IL2019 MLTSS Provider Network Readiness Review
Utilization of HCBS Services - Statewide Expansion
as of June 6, 2019

Region / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Regions & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
Region 1			FFS Members Served in Expansion Regions between April 2018 and March 2019 - Red Font*											
Northwestern Counties			160	128	1	19	124	62	4,658	35	3,318	0	1	48
Health Plan	**Enrollment**	**Enrollment**	Contracted Providers by Health Plan											
BCBS	14	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	362	6	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	594	13	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	202	8	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Region 2			FFS Members Served in Expansion Regions between April 2018 and March 2019 - Red Font*											
Central Counties			62	55	2	8	216	84	5,706	47	4,219	0	0	8
Health Plan	**Enrollment**	**Enrollment**	Contracted Providers by Health Plan											
BCBS	8	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	82	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	121	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	246	3	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Region 3			FFS Members Served in Expansion Regions between April 2018 and March 2019 - Red Font*											
Southern Counties			128	113	8	8	61	7	5,860	40	3,638	12	6	18
Health Plan	**Enrollment**	**Enrollment**	Contracted Providers by Health Plan											
BCBS	7	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	14	0	3+	3+	3+	2	3+	2	3+	3+	3+	1	3+	3+
Meridian	616	12	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	2
Molina	168	3	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Region 5			FFS Members Served in Expansion Regions between April 2018 and March 2019 - Red Font*											
Collar Counties			18	18	0	4	6	0	248	0	181	0	1	5
Health Plan	**Enrollment**	**Enrollment**	Contracted Providers by Health Plan											
BCBS	932	884	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	664	824	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	909	815	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	65	86	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

Notes:
* The table above shows the number of members who received the identified services in the expansion counties between April 2018 through March 2019.
• The table also shows the number of unique providers that were identified by the health plans as contracted and loaded.
The figures included in the grid identify the following:
• "3+" - three (3) or more contracted providers (shaded green)
• "2" - two (2) contracted providers (shaded green)
•"1" - one (1) contracted provider (shaded yellow/orange)
•"0" - no contracted/loaded providers were identified in the health plan network data.
• Health plan provider network data submitted on May 30, 2019.

IL2019 MLTSS Provider Network Readiness Review
Region 1 - Northwest: Utilization of HCBS Services
as of June 6, 2019

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Boone			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	19	0	3+	3+	3+	0	3+	3+	3+	3+	3+	1	3+	1
Meridian	13	0	3+	2	1	3+	3+	3+	3+	3+	3+	0	3+	3+
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
DeKalb			1	1	0	1	3	13	185	0	129	0	0	4
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	2
Meridian	0	0	3+	3+	3+	3+	2	3+	3+	3+	3+	2	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Peoria			18	16	0	2	6	8	551	5	491	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	2	0	3+	3+	2	2	3+	2	3+	3+	3+	2	2	2
IlliniCare	14	0	3+	3+	3+	0	3+	2	3+	3+	3+	2	3+	2
Meridian	194	5	3+	2	2	3+	3+	3+	3+	3+	3+	2	3+	3+
Molina	124	3	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Rock Island			55	50	0	0	2	0	473	0	294	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	58	2	3+	3+	3+	0	3+	1	3+	3+	3+	2	3+	1
Meridian	79	2	3+	2	2	3+	2	2	3+	1	3+	0	3+	0
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Tazewell			5	3	0	3	0	1	263	4	161	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	1	0	3+	3+	3+	1	3+	1	3+	3+	3+	1	3+	1
Meridian	71	4	3+	2	2	3+	3+	3+	3+	3+	3+	1	3+	3+
Molina	42	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Winnebago			13	11	0	9	37	26	1,294	0	905	0	0	2
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	10	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	245	4	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
Meridian	178	2	3+	3+	1	3+	3+	3+	3+	3+	3+	2	3+	3+
Molina	7	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Henry			1	1	0	0	4	1	143	7	77	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	15	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	1
Meridian	8	0	3+	3+	2	3+	2	2	3+	3+	3+	0	3+	2
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Knox			13	12	0	1	2	0	203	0	171	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	1	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	2
Meridian	41	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+
Molina	23	3	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
La Salle			19	9	1	0	5	2	347	6	231	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	1	0	3+	3+	3+	1	3+	1	3+	3+	3+	1	3+	0
Meridian	1	0	3+	3+	3+	3+	2	1	3+	3+	3+	1	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Ogle			0	0	0	1	20	0	252	1	184	0	0	19
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	2	3+	1	3+	0
Meridian	0	0	3+	2	1	3+	3+	3+	3+	3+	3+	0	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Stephenson			29	22	0	0	11	5	235	1	191	0	0	7
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	1	0	2	2	1	3+	2	3+	3+	3+	3+	0	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Whiteside			0	0	0	1	16	6	255	1	191	0	1	14
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	0	0	3+	3+	2	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Woodford			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	3+	1	0	2	1	3+	3+	2	1	2	0
Meridian	1	0	3+	2	2	3+	3+	3+	3+	3+	3+	1	3+	3+
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Bureau			5	3	0	1	6	0	152	1	118	0	0	1
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	1
Meridian	0	0	1	1	1	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Carroll			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	1	3+	3+	3+	3+	3+	3+	1	3+	3+
IlliniCare	0	0	3+	2	2	0	2	1	3+	3+	3+	1	3+	0
Meridian	0	0	1	1	1	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Fulton			0	0	0	0	8	0	199	5	109	0	0	1
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	1	0	3+	3+	2	0	2	1	3+	3+	3+	1	3+	1
Meridian	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	1	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font[4]											
Henderson			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	1	3+	1	3+	1
Meridian	0	0	2	1	1	3+	2	2	1	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font[4]											
Jo Daviess			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	2	3+	2	3+	2	3+	0
Meridian	0	0	1	1	1	3+	2	1	2	2	3+	0	2	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font[4]											
Lee			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	1	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	1
Meridian	0	0	3+	2	2	3+	3+	2	3+	3+	3+	0	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font[4]											
Marshall			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	2	0	2	1	3+	3+	3+	1	3+	0
Meridian	0	0	3+	2	1	3+	3+	3+	3+	3+	3+	1	3+	2
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font[4]											
Mercer			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	6	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	3	0	3+	2	2	3+	2	1	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Putnam			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	0	3+	1	3+	0
Meridian	0	0	1	1	1	3+	2	1	2	3+	3+	0	2	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Stark			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	1	0	1	1	3+	1	3+	1	2	0
Meridian	3	0	3+	2	2	3+	3+	3+	3+	3+	3+	1	3+	3+
Molina	2	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018- Red Font[1]											
Warren			1	0	0	0	4	0	106	4	66	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	2	3+	1	3+	0
Meridian	1	0	3+	1	1	3+	2	3+	2	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+

Notes:

[1] The table above shows the number of members that received the identified services in the expansion counties between April 2018 through March 2019. The table above also shows the number of unique providers that were identified by the health plans as contracted and loaded.

- Counties that were identified with "zero" (0) providers do not indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service.
- The analysis above reflects providers that were listed in the health plan data as contracted and loaded.

The figures included in the grid identify the following:

- "3+" - three (3) or more contracted providers (shaded green)
- "2" - two (2) contracted providers (shaded green)
- "1" - one (1) contracted provider (shaded yellow/orange)
- "0" - no contracted/loaded provider was identified in the health plan provider data
- Health plan provider network data submitted on April 15, 2019 and May 30, 2019.
- Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

Health Plan Notes:

IL2019 MLTSS Provider Network Readiness Review
Region 2 - Central: Utilization of HCBS Services
as of June 6, 2019

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Champaign			5	5	0	0	7	16	394	3	330	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	2	0	3+	3+	1	3+	3+	3+	3+	3+	3+	1	3+	3+
IlliniCare	2	0	3+	3+	3+	3+	3+	2	3+	3+	3+	1	3+	2
Meridian	34	0	3+	3+	1	3+	3+	1	3+	3+	3+	1	3+	3+
Molina	104	3	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Coles			0	0	0	0	14	1	869	8	631	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	2	0	3+	1	3+	3+	3+	2	3+	0
Meridian	1	0	2	1	1	3+	2	2	3+	3+	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Macon			16	13	0	1	46	0	1,070	2	742	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	3	0	1	1	1	0	1	1	3+	3+	3+	1	2	2
Meridian	3	0	3+	3+	2	3+	2	1	3+	3+	3+	1	3+	3+
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
McLean			11	11	0	0	10	7	286	2	230	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	3	0	0	0	0	0	0	0	0	0	3+	0	0	0
IlliniCare	5	0	2	2	2	0	2	1	3+	3+	3+	1	3+	2
Meridian	19	0	3+	3+	1	3+	3+	3+	3+	3+	3+	0	3+	3+
Molina	42	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Sangamon			14	13	0	0	25	0	869	2	713	0	0	2
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	1	0	3+	3+	3+	1	3+	1	3+	3+	3+	1	3+	1
Meridian	5	0	3+	2	2	3+	2	2	3+	3+	3+	1	3+	0
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Adams			12	10	0	0	29	0	527	17	361	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	1	2	3+	2	3+	3+	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	0	3+	3+	3+	0	3+	1
Meridian	1	0	2	2	1	3+	2	1	3+	1	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Jersey			1	0	1	0	17	6	150	0	115	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	3+	3+	1	3+	0
Meridian	0	0	3+	2	1	3+	3+	3+	3+	3+	3+	0	3+	2
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Macoupin			1	1	0	0	17	0	177	0	117	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	0	0	2	1	2	0	3+	1	3+	3+	3+	1	2	1
Meridian	2	0	3+	3+	2	3+	3+	3+	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
McDonough			0	0	1	0	5	0	127	0	71	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	0	0	3+	2	1	3+	2	3+	2	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Morgan			0	0	0	0	32	0	226	0	175	0	0	1
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	2	3+	2	3+	3+	3+	2	3+	2
IlliniCare	0	0	3+	1	2	0	2	2	3+	3+	3+	1	3+	1
Meridian	1	0	3+	3+	2	3+	2	2	3+	3+	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Vermilion			0	0	0	0	0	4	302	11	242	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	13	0	1	1	1	0	1	1	3+	3+	3+	1	2	1
Meridian	43	1	3+	3+	1	3+	3+	1	3+	3+	3+	0	3+	1
Molina	92	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Brown			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	1	1	0	1	0	1	1	2	0	1	0
Meridian	0	0	1	1	1	3+	2	1	2	3+	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Calhoun			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	1	1	0	1	0	1	0	2	0	1	0
Meridian	0	0	3+	2	1	3+	3+	3+	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Cass			0	0	0	0	1	0	124	1	83	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	0	0	3+	3+	2	3+	2	1	3+	3+	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Christian			0	0	0	0	0	0	148	0	128	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	3+	3+	1	3+	1
Meridian	0	0	3+	2	2	3+	2	1	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Clark			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	1	2	1	0	1	1	3+	2	3+	1	2	1
Meridian	1	0	1	1	1	3+	2	0	2	2	3+	0	2	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Cumberland			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	1	1	1	0	1	1	3+	2	2	1	2	0
Meridian	0	0	2	1	1	3+	2	1	2	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
De Witt			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	4	0	1	1	1	0	1	1	3+	2	3+	1	2	0
Meridian	3	0	3+	3+	1	3+	2	3+	3+	3+	3+	0	3+	3+
Molina	2	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Douglas			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	2	1	2	1	3+	3+	3+	1	3+	1
Meridian	0	0	2	2	1	3+	2	1	3+	3+	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Edgar			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	0	0	2	2	1	3+	2	0	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	2	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Ford			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	1	1	0	1	1	3+	3+	2	1	2	0
Meridian	4	0	3+	3+	2	3+	3+	0	2	3+	3+	1	3+	1
Molina	4	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Greene			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	1	0	1	1	3+	1	2	1	2	0
Meridian	1	0	3+	2	1	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Hancock			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	3+	0	2	1	2	3+	3+	0	2	1
Meridian	0	0	3+	3+	1	3+	2	1	3+	3+	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Iroquois			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	1	1	0	1	1	3+	3+	3+	1	2	2
Meridian	0	0	3+	3+	2	3+	3+	0	2	3+	3+	1	3+	2
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Livingston			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	0	1	1	1	1	1	3+	0	1	1
IlliniCare	2	0	0	0	0	0	0	1	2	3+	1	1	1	0
Meridian	0	0	2	2	2	3+	3+	3+	3+	3+	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served In Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Logan			1	1	0	1	4	0	219	1	127	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	3+	3+	2	2	3+	2	3+	3+	3+	2	3+	2
IlliniCare	1	0	3+	2	2	0	2	1	3+	3+	3+	1	3+	1
Meridian	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	0	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Mason			0	0	0	0	1	0	68	0	39	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	2	3+	1	3+	0
Meridian	2	0	3+	1	2	3+	3+	3+	3+	3+	3+	1	3+	2
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Menard			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	0	0	0	0	1	2	1	2	1	1	0
Meridian	0	0	3+	2	2	3+	2	2	3+	3+	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Montgomery			1	1	0	1	8	0	150	0	115	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	0	0	0	0	1	2	3+	3+	2	3+	1
Meridian	0	0	3+	2	3+	3+	2	1	3+	3+	3+	1	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Moultrie			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	2	2	2	2	2	2	3+	2	2	2
IlliniCare	1	0	1	1	1	0	1	2	3+	2	3+	1	2	0
Meridian	0	0	2	1	1	3+	2	1	2	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	2	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Piatt			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	1	1	0	1	1	3+	2	3+	1	2	0
Meridian	0	0	3+	3+	1	3+	2	1	3+	3+	3+	0	3+	2
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Pike			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	2	3+	2	3+	1	3+	0
Meridian	0	0	2	2	1	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Schuyler			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	2	0	2	0	2	2	3+	0	2	0
Meridian	0	0	2	2	1	3+	2	3+	2	3+	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Scott			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	3+	3+	1	3+	2
Meridian	1	0	2	1	1	3+	2	1	2	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Shelby			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	1	1	2	0	1	1	3+	3+	3+	1	2	0
Meridian	0	0	3+	1	1	3+	2	1	2	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	2	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served In Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment

Notes:

* The table above shows the number of members that received the identified services in the expansion counties between April 2018 through March 2019. The table above also shows the number of unique providers that were identified by the health plans as contracted and loaded.

- Counties that were identified with "zero" (0) providers do not indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service.
- The analysis above reflects providers that were listed in the health plan data as contracted and loaded.

The figures included in the grid identify the following:

- "3+" - three (3) or more contracted providers (shaded green)
- "2" - two (2) contracted providers (shaded green)
- "1" - one (1) contracted provider (shaded yellow/orange)
- "0" - no contracted/loaded provider was identified in the health plan provider data
- Health plan provider network data submitted on April 15, 2019 and May 30, 2019.
- Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

Health Plan Notes:

- BCBSIL reported that they are in the process of adding a provider group to their network data file that provides services in McLean county. BCBSIL also reported a completion date of 7/1/2019.

IL2019 MLTSS Provider Network Readiness Review
Region 3 - Southern: Utilization of HCBS Services
as of June 6, 2019

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Jackson			23	23	0	0	0	0	412	0	207	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	2	3+	2	3+	3+	3+	2	3+	3+
IlliniCare	1	0	3+	3+	3+	0	3+	0	3+	2	3+	0	3+	2
Meridian	0	0	2	1	1	3+	2	1	3+	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Madison			15	12	0	7	46	2	986	1	785	0	2	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	2	0	3+	3+	1	3+	3+	3+	3+	3+	3+	1	3+	3+
IlliniCare	3	0	3+	2	1	0	2	1	3+	3+	3+	1	3+	1
Meridian	321	6	3+	3+	2	3+	3+	3+	3+	3+	3+	1	3+	2
Molina	77	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Saint Clair			19	16	2	1	3	0	1,148	3	892	2	2	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	6	0	3+	3+	3+	1	3+	2	3+	3+	3+	1	3+	1
Meridian	276	6	3+	3+	2	3+	3+	3+	3+	3+	3+	1	3+	1
Molina	87	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Williamson			22	19	0	0	0	0	417	23	195	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	1	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	3+
Meridian	2	0	2	1	1	3+	2	1	3+	2	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Clinton			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	3+	3+	1	2	3+	2	3+	3+	3+	1	3+	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	2	3+	1	3+	2
Meridian	10	0	3+	3+	2	3+	3+	3+	3+	3+	3+	0	3+	1
Molina	3	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
Effingham			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	0	3+	3+	3+	0	3+	0
Meridian	0	0	1	0	1	3+	2	2	2	3+	3+	0	2	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Franklin			14	14	0	0	0	0	373	1	167	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	1	2	1	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	0	3+	3+	3+	0	3+	1
Meridian	2	0	2	1	1	3+	2	1	3+	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Jefferson			13	12	0	0	0	4	404	2	219	5	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	2	2	3+	2	3+	3+	3+	2	3+	3+
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	1
Meridian	0	0	2	1	1	3+	2	1	3+	3+	3+	1	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Marion			6	6	0	0	2	0	478	0	352	5	1	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	1	2	3+	2	3+	3+	3+	1	3+	2
IlliniCare	0	0	3+	2	2	1	2	0	3+	3+	3+	0	3+	0
Meridian	2	0	2	1	2	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Massac			0	0	0	0	0	0	101	0	27	0	0	2
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	3+	1	1	0	1	1	3+	3+	3+	1	2	2
Meridian	0	0	0	0	1	3+	2	1	2	0	3+	0	0	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Monroe			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	2	3+	1	3+	0
Meridian	0	0	3+	3+	1	3+	3+	3+	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Randolph			0	0	1	0	0	0	116	0	112	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	2	2	0	2	1	3+	3+	3+	1	3+	0
Meridian	0	0	3+	3+	1	3+	3+	2	3+	3+	3+	0	3+	0
Molina	1	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	2	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Saline			12	7	0	0	2	0	329	7	151	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	0	3+	3+	3+	0	3+	1
Meridian	1	0	2	1	1	3+	2	1	3+	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Wabash			0	0	0	0	0	0	215	0	110	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	1	0	2	3+	2	0	2	1	3+	1	3+	1	3+	0
Meridian	0	0	1	1	1	3+	2	1	3+	2	3+	1	2	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Alexander			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	3+	0	0	0	0	0	3+	1	3+	0	0	0
Meridian	1	0	0	0	0	3+	2	1	1	1	3+	0	1	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Bond			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	1	1	0	1	1	3+	1	3+	1	3+	0
Meridian	0	0	3+	2	2	3+	2	2	3+	3+	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Clay			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	0	3+	3+	3+	0	3+	1
Meridian	0	0	1	0	1	3+	2	2	3+	2	3+	0	2	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Crawford			0	0	0	0	3	0	91	1	54	0	1	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	2	0	2	1	3+	3+	3+	1	3+	0
Meridian	0	0	0	0	0	3+	2	1	1	2	3+	0	0	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Edwards			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	2	0	2	1	3+	1	3+	1	3+	1
Meridian	0	0	1	1	1	3+	2	1	3+	2	3+	0	2	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Fayette			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	1	2	3+	2	3+	3+	3+	1	3+	2
IlliniCare	0	0	3+	3+	3+	0	3+	0	3+	3+	3+	0	3+	0
Meridian	0	0	2	1	0	3+	2	2	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Gallatin			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	0	3+	2	3+	0	3+	1
Meridian	0	0	0	0	0	3+	2	1	1	1	3+	0	0	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Hamilton			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	1	1	0	1	1	2	2	3+	1	2	0
Meridian	0	0	1	1	1	3+	2	1	3+	1	3+	0	3+	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Hardin			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	2	2	2	2	2	2	3+	2	2	2
IlliniCare	0	0	3+	1	1	1	1	0	3+	1	3+	0	1	1
Meridian	0	0	0	0	0	3+	2	1	1	0	3+	0	0	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Jasper			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	3+	2	0	2	1	3+	1	3+	1	3+	0
Meridian	0	0	1	1	1	3+	2	2	3+	3+	3+	0	1	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Johnson			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	3+	1	1	0	1	0	3+	2	3+	0	1	1
Meridian	0	0	2	1	1	3+	2	1	3+	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Lawrence			0	0	0	0	0	0	1	0	1	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	2	0	2	1	3+	2	3+	1	3+	0
Meridian	0	0	1	1	0	3+	2	1	2	2	3+	0	1	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Perry			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	3+	3+	1	3+	3+	3+	3+	3+	3+	1	3+	3+
IlliniCare	1	0	3+	2	2	0	2	0	3+	3+	3+	0	2	1
Meridian	0	0	3+	2	1	3+	2	1	3+	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Pope			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	3+	1	2	0	2	0	3+	0	3+	0	2	1
Meridian	0	0	0	0	1	3+	2	1	2	0	3+	0	0	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Pulaski			1	1	0	0	0	1	192	0	61	0	0	4
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	1	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	0	0	3+	1	1	0	1	0	3+	0	3+	0	1	1
Meridian	1	0	0	0	1	3+	2	1	2	1	3+	0	1	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Richland			0	0	0	0	5	0	365	2	243	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	0	3+	1	3+	3+	3+	1	3+	0
Meridian	0	0	1	1	1	3+	2	1	3+	2	3+	0	2	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Union			3	3	0	0	0	0	232	0	62	0	0	7
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	1	1	1	1	1	1	1	1	3+	1	1	1
IlliniCare	1	0	3+	0	0	0	0	0	3+	3+	3+	0	0	1
Meridian	0	0	2	1	1	3+	2	1	3+	2	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Washington			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	1	0	0	0	0	1	2	2	2	1	1	0
Meridian	0	0	3+	2	2	3+	2	1	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
Wayne			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	3+	3+	3+	1	3+	1	3+	3+	3+	1	3+	1
Meridian	0	0	2	1	1	3+	2	1	3+	3+	3+	0	3+	1
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+
			FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*											
White			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	0	0	2	2	2	0	2	1	3+	3+	3+	1	3+	2
Meridian	0	0	1	1	1	3+	2	1	3+	1	3+	0	2	0
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment

Notes:

* The table above shows the number of members that received the identified services in the expansion counties between April 2018 through March 2019. The table above also shows the number of unique providers that were identified by the health plans as contracted and loaded.
- Counties that were identified with "zero" (0) providers do not indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service.
- The analysis above reflects providers that were listed in the health plan data as contracted and loaded.

The figures included in the grid identify the following:

- "3+" - three (3) or more contracted providers (shaded green)
- "2" - two (2) contracted providers (shaded green)
- "1" - one (1) contracted provider (shaded yellow/orange)
- "0" - no contracted/loaded provider was identified in the health plan provider data
- Health plan provider network data submitted on April 15, 2019 and May 30, 2019.
- Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

Health Plan Notes:

IL2019 MLTSS Provider Network Readiness Review
Region 5 - Collars: Utilization of HCBS Services
as of June 6, 2019

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment
		FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*												
Grundy			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	0	0	2	2	1	2	2	2	2	2	3+	1	2	2
IlliniCare	1	0	3+	3+	3+	0	3+	1	3+	1	3+	1	3+	1
Meridian	1	0	3+	3+	3+	3+	2	2	3+	3+	3+	2	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+
		FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*												
Kendall			0	0	0	0	0	0	0	0	0	0	0	0
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	3	0	3+	3+	2	3+	3+	3+	3+	3+	3+	2	3+	3+
IlliniCare	0	0	3+	3+	3+	0	3+	2	3+	2	3+	1	3+	0
Meridian	2	0	3+	3+	3+	3+	2	3+	3+	3+	3+	2	3+	3+
Molina	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+
		FFS Members Served in Expansion Counties between April 2018 and March 2018 - Red Font*												
McHenry			18	18	0	4	6	0	248	0	181	0	1	5
Health Plan	Enrollment	Enrollment	Contracted Providers by Health Plan											
BCBS	14	0	3+	3+	2	2	3+	2	3+	3+	3+	2	2	2
IlliniCare	37	0	3+	3+	3+	0	3+	2	3+	3+	3+	1	3+	3+
Meridian	68	0	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+
Molina	4	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+

County / Health Plan	Enrollment as of March 2019		Fee-For-Service (FFS) Members Served in Expansion Counties & Provider Network Capacity											
	HCBS Enrollment (without MLTSS)	MLTSS HCBS Enrollment	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment

Notes:
* The table above shows the number of members that received the identified services in the expansion counties between April 2018 through March 2019. The table above also shows the number of unique providers that were identified by the health plans as contracted and loaded.
• Counties that were identified with "zero" (0) providers do not indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service.
• The analysis above reflects providers that were listed in the health plan data as contracted and loaded.
The figures included in the grid identify the following:
• "3+" - three (3) or more contracted providers (shaded green)
• "2" - two (2) contracted providers (shaded green)
•"1" - one (1) contracted provider (shaded yellow/orange)
•"0" - no contracted/loaded provider was identified in the health plan provider data
• Health plan provider network data submitted on April 15, 2019 and May 30, 2019.
• Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

Health Plan Notes:
•BCBSIL reported that they are in the process of adding a provider group to their network data file that provides services in McLean county. BCBSIL also reported a completion date of 7/1/2019.

Appendix E3. DCFS Healthworks Agencies Network Review Report

This section includes the DCFS Healthworks Agencies Network Review Report.

IL2019 YouthCare Network
Contracted HealthWorks Lead Agencies
May 2019

#	HealthWorks Lead Agencies Service Region	Location County	YouthCare Network Contract Status
#	**Region 1 - Northwest Counties**		
1	Rock Island County Health Department	Rock Island	Contracted
	Counties Served: Bureau, Henderson, Henry, Knox, McDonough, Mercer, Putnam, Rock Island, Stark, Warren		
2	LaSalle County Health Department	La Salle	Contracted
	Counties Served: La Salle		
3	TASC Inc (Treatment Alternatives for a Safe Community)	Peoria	Contracted
	Counties Served: Marshall, Peoria,		
4	Winnebago County Health Department	Winnebago	Contracted
	Counties Served: Boone, Carroll, Dekalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago		
#	**Region 2 - Central Counties**		
5	Adams County Health Department	Adams	Contracted
	Counties Served: Adams, Brown, Calhoun, Greene, Hancock, Jersey, Pike, Schuyler		
6	Champaign Urbana Public Health District	Champaign	Contracted
	Counties Served: Champaign, Ford, Iroquois, Vermilion,		
7	Logan County Health Department	Logan	Contracted
	Counties Served: Cass, Christian, Fulton, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Sangamon, Scott, Tazewell, Woodford		
8	Macon County Health Department	Macon	Contracted
	Counties Served: Clark, Coles, Cumberland, Douglas, Edgar, Macon, Moultrie, Shelby		
9	McLean County Health Department	McLean	Contracted
	Counties Served: De Witt, Livingston, McLean, Piatt		
#	**Region 3 - Southern Counties**		
10	Effingham County Health Department	Effingham	Contracted
	Counties Served: Clay, Crawford, Edwards, Effingham, Fayette, Hamilton, Jasper, Jefferson, Lawrence, Marion, Richland, Wabash, Wayne		
11	Jackson County Health Department	Jackson	Contracted
	Counties Served: Franklin, Gallatin, Jackson, Perry, Saline, White, Williamson		
12	Southern Illinois Healthcare Foundation	Saint Clair	Contracted
	Counties Served: Bond, Clinton, Madison, Monroe, Randolph, Saint Clair, Washington		
13	Southern Seven Health Department	Pulaski	Contracted
	Counties Served: Alexander, Hardin, Johnson, Massac, Pope, Pulaski, Union		
#	**Region 4 - Cook County**		
14	Cook-Aunt Martha's Youth Service Center	Cook	Contracted
	Counties Served: Cook		
#	**Region 5 - Collar Counties**		
15	DuPage County Health Department	DuPage	Contracted
	Counties Served: DuPage, Kane, Kendall		
16	Kankakee Health Department	Kankakee	Contracted
	Counties Served: Kankakee		
17	Lake County Health Department	Lake	Contracted
	Counties Served: Lake		
18	McHenry County Health Department	McHenry	Contracted
	Counties Served: McHenry		
19	Will County Health Dept, HealthWorks of Will County	Will	Contracted
	Counties Served: Grundy, Will		

Notes:

- HSAG conducted a review of IlliniCare's provider network data to verify the contracting status for the HealthWorks providers included in the table above.

The table above shows the following information:

- Column A shows the number of approved HealthWorks providers
- Column B & C identifies the HealthWorks Lead Agencies by region, counties served, and location county.
- Column D includes the current contract status.

Appendix E4. Provider Network Time/Distance Analysis

This section includes the Provider Network Time/Distance Analysis.

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

SFY 2018 Provider Network Time/Distance Analysis

April 2019

HSAG HEALTH SERVICES ADVISORY GROUP

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

Table of Contents

1. Executive Summary

Introduction

The Illinois Department of Healthcare and Family Services (HFS) is responsible for the ongoing monitoring and oversight of its contracted HealthChoice Illinois managed care health plans (health plans) that deliver services to HealthChoice Illinois enrollees. As part of its provider network adequacy monitoring activities, HFS requested its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), conduct a time/distance analysis between enrollees and providers in the HealthChoice Illinois health plan networks. Specifically, the purpose of the State Fiscal Year (SFY) 2018 Time/Distance Analysis was to evaluate the degree to which health plans comply with network standards outlined in the Illinois Department of Healthcare and Family Services—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

Validation of network adequacy is a mandatory external quality review (EQR) activity, and states must begin conducting this activity, described in the Centers for Medicare & Medicaid Services (CMS) rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While this protocol is expected to be released in the upcoming months, time/distance analysis described in this report aligns with current federal regulations and will help prepare HFS to meet the network adequacy validation requirements once the provisions go into effect.

This time/distance analysis includes two phases. The first phase, presented in a report finalized in November 2018, was conducted in mid-2018 and included the following seven HealthChoice Illinois health plans:

- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare (CountyCare)[1-1]
- Harmony Health Plan (Harmony)
- IlliniCare Health Plan (IlliniCare)
- Meridian Health (Meridian)
- Molina Healthcare of Illinois (Molina)
- NextLevel Health (NextLevel)[1-1]

The second phase of the analysis, presented in this report, included the five health plans contracted statewide. CountyCare and NextLevel Health, which only serve enrollees in Cook County, were excluded. Future network adequacy analyses will include all health plans.

[1-1] Available only in Cook County.

Beginning January 1, 2019, the HealthChoice Illinois managed care program will include six health plans due to Harmony Health Plan's acquisition of Meridian Health Plan. Harmony members will automatically be enrolled in Meridian on January 1 unless they request enrollment in another health plan. As a result of the acquisition, both health plan provider networks will provide services to one health plan, which will allow for greater network capacity and coverage for Medicaid members.

Statewide Medicaid Managed Care Expansion

On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, which serves approximately 2.5 million residents. Under the managed care program reboot, seven health plans were contracted by HFS to provide care for 80 percent of all Medicaid enrollees statewide. The key objectives of the reboot were to reduce Medicaid program costs, more efficiently manage utilization of healthcare services, and improve healthcare quality and outcomes. The managed care program prior to January 1, 2018, was designed to operate in 30 counties; as of April 1, 2018, expansion included all 102 counties statewide. Five of the seven HealthChoice Illinois managed care health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. This phase of the provider network analysis of the statewide expansion examines the five statewide health plans.

Table 1-1 displays the managed care enrollment for the five statewide health plans as of September 1, 2018.

Table 1-1—Health Plan Managed Care Enrollment

Statewide Health Plans—Enrollment as of September 1, 2018				
BCBSIL	Harmony	IlliniCare	Meridian	Molina
415,700	246,380	342,217	608,433	218,947

Network Adequacy

HSAG is contracted to conduct an analysis of the health plans' provider networks as a key component of pre- and post-implementation readiness reviews for the statewide expansion. The purpose of the provider network review prior to statewide implementation of managed care was to evaluate the progress of each health plan in contracting providers to ensure sufficient network capacity to serve enrollees in the expansion areas. The network analysis allowed HFS to evaluate the provider network across the health plans using a standardized approach. This process ensured that the health plans' networks were reviewed with a consistent methodology that allowed for comparisons, and that each health plan had a broad range of PCPs, specialists, outpatient facilities, and hospitals to provide access to care and services to its enrollees. Once the health plans established provider networks in the expansion counties, HFS contracted with HSAG to complete a time/distance study to validate the provider network adequacy for the provider categories included in the study.

Network Validation—Time/Distance Study

Time/distance standards limit how long and/or how far an enrollee must travel to access a specified type of provider. Time/distance requirements are a common metric for measuring the adequacy of a health plan's provider network.

Geographic network distribution analyses assess whether enrollees in each county are required to travel a reasonable amount of time or distance to reach the nearest provider. HFS has established time/distance standards by provider category for the maximum allowable distance or time an enrollee should be required to travel to receive care as detailed in Section 2 of this report. This report presents the percentage of enrollees with each health plan who have access to providers within the time/distance standards statewide and for each region as well as the percentage of counties per region meeting the contract requirements defined in the HealthChoice Illinois Medicaid model contract.

While the time/distance standards vary by provider category, the contract standard for each provider category requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Overall Statewide Time/Distance Study Findings

Table 1-2 and Table 1-3 display overall health plan compliance with the time/distance standards for all provider categories included in the study for all regions. The overall percentages of health plan compliance with the time/distance standards in urban and rural counties for the five statewide health plans that serve enrollees in regions 1, 2, 3, and 5 are displayed in Table 1-2. Table 1-3 displays health plan compliance with the time/distance standards for Region 4 (Cook County). Overall time/distance results for all five regions are summarized below:

- All five health plans were compliant with the time/distance standards for all provider categories in Region 4 (Cook County).
- Across regions 1,2,3, and 5, BCBSIL was compliant with the time/distance standards for 88.8 percent of provider categories in urban counties and 93.8 percent in rural counties.
- Across regions 1, 2, 3, and 5, Harmony was compliant with the time/distance standards for 80.0 percent of provider categories in urban counties and 91.3 percent in rural counties.
- Across regions 1, 2, 3, and 5, IlliniCare was compliant with the time/distance standards for 93.8 percent of provider categories in urban counties and 96.3 percent in rural counties.
- Across regions 1, 2, 3, and 5, Meridian was compliant with the time/distance standards for 96.3 percent of provider categories in both urban and rural counties.
- Across regions 1, 2, 3, and 5, Molina was compliant with the time/distance standards for 98.8 percent of provider categories in urban counties and 95.0 percent in rural counties.

Table 1-2–Health Plan Compliance With Time/distance Standards for Urban and Rural Counties—Regions 1, 2, 3, and 5 (Northwestern, Central, Southern, and Collar)*

Statewide Health Plans										
Health Plans	**BCBSIL**		**Harmony**		**IlliniCare**		**Meridian**		**Molina**	
Urbanicity	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**
Enrollment Count as of September 1, 2018	139,713	20,555	89,959	67,563	145,429	89,935	319,222	129,114	100,281	49,077
Total Provider Categories	80	80	80	80	80	80	80	80	80	80
Within Time/Distance Standard*	71	75	64	73	75	77	77	77	79	76
Not Within Time/Distance Standard	9	5	16	7	5	3	3	3	1	4
Within Time/Distance Standard (%)	88.8%	93.8%	80.0%	91.3%	93.8%	96.3%	96.3%	96.3%	98.8%	95.0%
Not Within Time/Distance Standard (%)	11.3%	6.3%	20.0%	8.8%	6.3%	3.8%	3.8%	3.8%	1.3%	5.0%

* Provider categories are considered "Within the time/distance standard" if 90.0 percent of enrollees have access to providers within the time/distance standard. Please note this is different from meeting the contract requirements, which requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Table 1-3—Health Plan Compliance With Time/distance Standards for Region 4 (Cook)*

	Statewide Health Plans				
Health Plans	**BCBSIL**	**Harmony**	**IlliniCare**	**Meridian**	**Molina**
Urbanicity	**Urban**	**Urban**	**Urban**	**Urban**	**Urban**
Enrollment as of September 1, 2018	255,432	88,858	106,853	160,097	69,589
Total Provider Categories	20	20	20	20	20
Within Time/Distance Standard*	20	20	20	20	20
Not Within Time/Distance Standard	0	0	0	0	0
Within Time/Distance Standard (%)	100.0%	100.0%	100.0%	100.0%	100.0%
Not Within Time/Distance Standard (%)	0.0%	0.0%	0.0%	0.0%	0.0%

* Provider categories are considered "Within the time/distance standard" if 90.0 percent of enrollees have access to providers within the time/distance standard. Please note this is different from meeting the contract requirement, which requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Overall, the Illinois SFY 2018 Provider Network Time/Distance Phase II Analysis results suggest that the Illinois health plans have comprehensive provider networks in regions 4 and 5, with targeted opportunities for improvement in regions 1, 2, and 3. Enrollees residing in regions 4 and 5 have access to a broad range of providers within the time/distance standards for all health plans.

The comparison of results between Phase I and Phase II revealed that several health plans did not meet the standards in either analytic phase for oral surgery and endocrinology provider networks. For regions 1, 2, and 3, BCBSIL, Harmony, and Meridian consistently did not meet the standards in both analytic phases for oral surgery provider networks. At least one health plan met the standard for endocrinology providers for each region, indicating that endocrinology providers are available for contracting in all regions. No health plans met the time/distance standards for oral surgery in the Southern region (Region 3), which may indicate that not enough oral surgery providers are available for contracting for enrollees in the Southern region. IlliniCare made significant improvement for several provider categories between both analytic phases in regions 2 and 3, and BCBSIL enrollees living in regions 2 and 3 had improved access to endocrinology providers. Harmony consistently had provider networks that provided less than 90.0 percent of enrollees with access to several provider categories in regions 1 and 2 for both analytic phases of the study. Across both phases of the study, enrollees in regions 4 and 5 had access to all provider categories within the time/distance standards.

Recommendations

Based on the results and conclusions presented in this report, HSAG recommends the following for HFS and the health plans to strengthen the HealthChoice Illinois Medicaid managed care provider networks and ensure enrollees' timely access to healthcare services:

- HFS and the health plans should continue to work with their EQRO to ensure that provider data submitted by the health plans accurately reflects the services provided and the populations served by the providers, especially regarding pediatric providers. It is important to ensure that these providers are accurately represented in the health plans' networks so that analysis of time/distance standards may provide the most robust results for the unique needs of the pediatric population.
- HFS should continue to collaborate with the health plans to contract with additional providers, if available, in the areas identified as having excessive travel times or travel distances. Provider categories of concern include Allergy and Immunology, Endocrinology, Infectious Disease, and Oral Surgery.
- HFS should conduct an in-depth review of provider categories in which each plan did not meet the time/distance standards, with the goal of determining whether the health plan's failure to meet the time/distance network access standard(s) was the result of a lack of providers or an inability to contract with providers in the geographic area. Specifically, HFS should work with health plans to investigate changes in provider networks between Phase I and Phase II in which enrollee access to providers decreased substantially. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories in which providers may not be available or willing to contract with the health plans.

- As the time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should consider using appointment availability and utilization analyses to evaluate providers' availability and enrollees' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess enrollees' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- HFS should continue to develop requirements for Long-Term Services and Supports (LTSS) providers that require the enrollee to travel to the provider. LTSS network requirements are included in the new requirements governing network adequacy in the 2016 Medicaid Managed Care Rule.

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2. Methodology

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 analysis. The health plans submitted the provider data as part of their regular, ongoing submissions to HSAG. HSAG submitted a detailed data requirements document to HFS requesting its Medicaid enrollee data, including data which met the following criteria:

- Enrollee demographic data as of September 1, 2018.
- Enrollee eligibility and enrollment data, including start and end dates for enrollment with the health plan.

Data Processing

HSAG cleaned, processed, and used the provided data to define unique lists of providers, provider locations, and enrollees for inclusion in the analysis. HSAG standardized and geocoded all Medicaid enrollee and provider addresses using Quest Analytics Suite software (Quest). Analyses for pediatric dentists were limited to enrollees younger than 18 years of age, and analyses for adult dentists were limited to enrollees 18 years of age and older. Analyses for obstetrics and gynecology (OB/GYN) providers were limited to female enrollees ages 15 years and older. Analyses for all specialist providers were limited to enrollees 18 years of age and older.

Provider offices in the State of Illinois or in counties contiguous to Illinois were included in the time/distance analysis. All provider office locations associated with a provider were included in the analysis. For example, if a single provider practiced at three locations, each location was considered a unique location for the time/distance analysis.

Table 2-1 shows the provider categories included in the time/distance analysis, the enrollee criteria for the time/distance analysis, and the network access standards. For each of the standards presented in Table 2-1, the contract requirements state that the health plans must ensure that 90.0 percent of enrollees in each county of the contracting area have access within the stated time or distance standard. Analyses were conducted by region to illustrate differences by Illinois region.

The time/distance standards are defined separately for enrollees living in urban and rural areas. HSAG used the "urban" and "rural" county definitions from 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 data provided by HFS. For records without a valid county name (about 0.1 percent of records), 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., < 0.1 percent) or were geocoded to a county that did not match the county information in the enrollee demographic data (i.e., 2.8 percent). These enrollees were excluded from the analysis.

Table 2-1—Provider Categories, Enrollee Criteria, and Access Standards

Provider Categories	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Adult Primary Care Provider (PCP)[2]	All adults (on or after 18th birthday) enrolled in a health plan	Access to 2 PCPs within 30 miles or 30 minutes	Access to 1 PCP within 60 miles or 60 minutes
Pediatric PCP[2]	All children (up to 18th birthday) enrolled in a health plan	Access to 2 PCPs within 30 miles or 30 minutes	Access to 1 PCP within 60 miles or 60 minutes
Adult Behavioral Health Service Provider[3]	All adults (on or after 18th birthday) enrolled in a health plan	Access to 2 behavioral health service providers within 30 miles or 30 minutes	Access to 1 behavioral health service provider within 60 miles or 60 minutes
Pediatric Behavioral Health Service Provider[3]	All children (up to 18th birthday) enrolled in a health plan	Access to 2 behavioral health service providers within 30 miles or 30 minutes	Access to 1 behavioral health service provider within 60 miles or 60 minutes
OB/GYN Provider[4]	Female adults (on or after 15th birthday) enrolled in a health plan	Access to 2 OB/GYN providers within 30 miles or 30 minutes	Access to 1 OB/GYN provider within 60 miles or 60 minutes
Pediatric Dentist	All children (up to 18th birthday) enrolled in a health plan	Access to 1 pediatric dentist within 30 miles or 30 minutes	Access to 1 pediatric dentist within 60 miles or 60 minutes
Hospital	All enrollees enrolled in a health plan	Access to 1 general or critical access hospital within 30 miles or 30 minutes	Access to 1 general or critical access hospital within 60 miles or 60 minutes
Specialist[5]			
Allergy and Immunology	All adults (on or after 18th birthday) 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
Dermatology	All adults (on or after 18th birthday) enrolled in a health plan		
Endocrinology	All adults (on or after 18th birthday) enrolled in a health plan		

Provider Categories	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Ear, Nose, and Throat (ENT)/Otolaryngology	All adults (on or after 18th birthday) 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
Infectious Disease	All adults (on or after 18th birthday) enrolled in a health plan		
Nephrology	All adults (on or after 18th birthday) enrolled in a health plan		
Neurology	All adults (on or after 18th birthday) enrolled in a health plan		
Oral Surgery	All adults (on or after 18th birthday) enrolled in a health plan		
Orthopedic Surgery	All adults (on or after 18th birthday) enrolled in a health plan		
Pulmonology	All adults (on or after 18th birthday) enrolled in a health plan		
Urology	All adults (on or after 18th birthday) enrolled in a health plan		
Chiropractor	All adults (on or after 18th birthday) enrolled in a health plan		
Physiatry/ Rehabilitative Medicine	All adults (on or after 18th birthday) enrolled in a health plan		

[1] For this analysis, "urban" and "rural" are defined by Medicaid Model Contract 2018-24-001.

[2] Adult PCPs include providers with a PCP flag indicator and a specialty of general practice, internal medicine, family medicine, family practice, nurse practitioner, or physician assistant. Pediatric PCPs include providers with a PCP flag indicator and a specialty of pediatric medicine, pediatric physician assistant, or pediatric nurse practitioner.

[3] Adult behavioral health service providers include providers with a specialty of psychiatry, psychology, alcohol and substance abuse rehab services, licensed professional/licensed clinical, social worker, or 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, or licensed practitioner of the healing arts.

[4] OB/GYN providers include providers with a specialty of obstetrics, gynecology, obstetrics/gynecology, or nurse midwife.

[5] Only adult providers were included for analyzing adult access to specialty providers (i.e., providers with a pediatric specialty, such as pediatric neurologists, were excluded).

Time/Distance Analysis

HSAG used Quest 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 analyses for each health plan for the provider categories listed in Table 2-1:

- Percentage of enrollees within predefined time/distance standards
  - A higher percentage of enrollees meeting time/distance standards indicates a better geographic distribution of the health plan's providers relative to the Medicaid enrollees.
- Percentage of counties providing at least 90.0 percent of enrollees access to a provider within the predefined time/distance standards
  - A higher percentage of counties meeting the 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[2-1] (driving times in minutes) to the nearest three providers
  - A shorter driving distance or travel time indicates greater accessibility to providers, since enrollees must travel fewer miles or minutes to access care.
  - Results from the average travel distances and travel times to each provider category are presented by health plan in Appendix B.

[2-1] 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.

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3. Findings

Network Accessibility

Geographic network distribution analyses assess whether enrollees in each county are required to travel a reasonable amount of time or distance to reach the nearest provider. HFS has established time/distance standards by provider category for the maximum allowable distance or time an enrollee should be required to travel to receive care (previously presented in Table 2-1). This section presents the percentage of enrollees living within the time/distance standards by region and health plan, as well as the percentage of counties per region meeting the contract requirements defined in the health plan contracts. Since Cook County (i.e., Region 4) is classified as urban, Region 4 results are limited to enrollees living in urban areas.

Region 1—Northwestern

Table 3-1 displays the percentage of enrollees residing within the time/distance standards by health plan and urbanicity in Region 1.

Table 3-1—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 1*

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	2,262	1,827	4,089	9,402	11,475	20,877	36,179	26,923	63,102	94,047	47,358	141,405	23,534	15,161	38,695
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	100.0	100.0	100.0	99.9	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	93.3	97.1	95.8	100.0	98.2	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	77.2	93.3	84.2	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	99.9	100.0	100.0	100.0
OB/GYN Providers	100.0	98.5	99.4	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	97.2	100.0	98.3
Pediatric Dentist	84.7	91.6	87.7	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	85.0	>99.9	93.2	100.0	100.0	100.0	100.0	100.0	100.0	>99.9	100.0	>99.9

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	2,262	1,827	4,089	9,402	11,475	20,877	36,179	26,923	63,102	94,047	47,358	141,405	23,534	15,161	38,695
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Specialists															
Allergy and Immunology	80.0	97.5	87.3	99.0	100.0	99.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dermatology	99.8	100.0	99.9	99.9	100.0	>99.9	100.0	100.0	100.0	99.7	100.0	99.8	100.0	100.0	100.0
Endocrinology	95.5	100.0	97.4	70.2	>99.9	86.0	100.0	100.0	100.0	100.0	100.0	100.0	97.2	100.0	98.3
ENT/Otolaryngology	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
Infectious Disease	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
Nephrology	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
Neurology	100.0	100.0	100.0	99.7	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	72.7	96.2	82.6	70.2	100.0	86.0	89.1	99.3	93.3	64.7	>99.9	76.4	53.1	100.0	70.8
Orthopedic Surgery	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
Pulmonology	100.0	100.0	100.0	70.9	98.3	85.4	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	75.3	100.0	88.4	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractor	100.0	100.0	100.0	99.0	100.0	99.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Physiatry/ Rehabilitative Medicine	100.0	100.0	100.0	66.9	99.9	84.4	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded gray indicate urban or rural counties that did not meet the time/distance standard. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

For Region 1—Northwestern, the overall findings for the regional time/distance analysis for the health plans operating in this region identified that the following health plans and provider categories did not meet the enrollee access time/distance standard:

- **Pediatric Behavioral Health Service Providers**
  - **BCBSIL**—Across all counties, 84.2 percent of enrollees had access to a pediatric behavioral health service provider, and 77.2 percent of enrollees in urban counties had access.
- **Pediatric Dentist**
  - **BCBSIL**—Across all counties, 87.7 percent of enrollees had access to a pediatric dentist, and 84.7 percent of enrollees in urban counties had access.
- **Hospitals**
  - **Harmony**—In urban counties, 85.0 percent of enrollees had access to a hospital.

- **Allergy and Immunology**
  - **BCBSIL**—Across all counties, 87.3 percent of enrollees had access to an allergy and immunology provider, and 80.0 percent of enrollees in urban counties had access.
- **Endocrinology**
  - **Harmony**—Across all counties, 86.0 percent of enrollees had access to an endocrinology provider, and 70.2 percent of enrollees in urban counties had access.
- **Oral Surgery:** Less than 90.0 percent of enrollees residing in urban counties had access to oral surgery providers within the time/distance standards for all health plans.
  - **BCBSIL**—Across all counties, 82.6 percent of enrollees had access to an oral surgery provider, and 72.7 percent of enrollees in urban counties had access.
  - **Harmony**—Across all counties, 86.0 percent of enrollees had access to an oral surgery provider, and 70.2 percent of enrollees in urban counties had access.
  - **IlliniCare—**In urban counties, 89.1 percent of enrollees had access to an oral surgery provider.
  - **Meridian**—Across all counties, 76.4 percent of enrollees had access to an oral surgery provider, and 64.7 percent of enrollees in urban counties had access.
  - **Molina**—Across all counties, 70.8 percent of enrollees had access to an oral surgery provider, and 53.1 percent of enrollees in urban counties had access.
- **Pulmonology**
  - **Harmony**—Across all counties, 85.4 percent of enrollees had access to an endocrinology provider, and 70.9 percent of enrollees in urban counties had access.
- **Urology**
  - **Harmony**—Across all counties, 88.4 percent of enrollees had access to an endocrinology provider, and 75.3 percent of enrollees in urban counties had access.
- **Physiatry/Rehabilitative Medicine**
  - **Harmony**—Across all counties, 84.4 percent of enrollees had access to an endocrinology provider, and 66.9 percent of enrollees in urban counties had access.

Table 3-2 displays the percentage of enrollees residing within the time/distance standards and the percentage of participating counties meeting the contract requirements for Region 1. While the time/distance standards vary by provider category, the contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Table 3-2—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 1

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	97.1	95.8	98.2	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	84.2	91.7	100.0	100.0	100.0	100.0	99.9	95.8	100.0	100.0
OB/GYN Providers	99.4	95.8	100.0	100.0	100.0	100.0	100.0	100.0	98.3	95.8
Pediatric Dentist	87.7	83.3	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	93.2	87.5	100.0	100.0	100.0	100.0	> 99.9	100.0
Specialists										
Allergy and Immunology	87.3	70.8	99.5	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Dermatology	99.9	100.0	> 99.9	100.0	100.0	100.0	99.8	100.0	100.0	100.0
Endocrinology	97.4	95.8	86.0	91.7	100.0	100.0	100.0	100.0	98.3	95.8
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	82.6	70.8	86.0	91.7	93.3	87.5	76.4	91.7	70.8	91.7
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology	100.0	100.0	85.4	83.3	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	88.4	91.7	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractor	100.0	100.0	99.5	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Physiatry/ Rehabilitative Medicine	100.0	100.0	84.4	87.5	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Overall, Region 1 maintained geographically well-distributed provider networks across the provider categories for IlliniCare. BCBSIL, Harmony, Meridian, and Molina each had some provider categories that did not meet the contract requirements. Key results from the Region 1 network time/distance analysis include:

- For IlliniCare, all provider categories met the contract requirements except oral surgery (i.e., 87.5 percent of counties met the contract requirements).
- Meridian and Molina each had at least 90.0 percent of counties meeting the contract requirements for all provider categories. However, only 76.4 percent of Meridian enrollees and 70.8 percent of Molina enrollees had access to an oral surgery provider.
- Harmony did not meet the contract requirements for hospitals, pulmonology, or physiatry/rehabilitative medicine providers, with only 87.5 percent of counties meeting the contract requirements for hospitals and physiatry/rehabilitative medicine providers, and 83.3 percent of counties meeting the contract requirements for pulmonology providers. However, 93.2 percent of enrollees had access to a hospital within the time/distance standard, and only 84.4 percent of enrollees had access to a physiatry/rehabilitative medicine provider.
- For BCBSIL, only 70.8 percent of counties met the contract requirements for allergy and immunology, and oral surgery. Additionally, for pediatric dentists, only 83.3 percent of counties met the contract requirements for this plan.

Appendix A contains a complete list by health plan of counties not meeting the contract requirement for each provider type.

Region 2—Central

Table 3-3 displays the percentage of enrollees residing within the time/distance standards in Region 2 by health plan and urbanicity.

Table 3-3—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 2*

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	7,170	10,197	17,367	19,663	21,548	41,211	22,366	23,491	45,857	40,549	38,766	79,315	37,768	18,060	55,828
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	100.0	100.0	100.0	>99.9	100.0	>99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	98.6	100.0	99.4	78.5	100.0	89.3	100.0	100.0	100.0	99.9	100.0	>99.9	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	62.2	100.0	81.4	99.9	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	7,170	10,197	17,367	19,663	21,548	41,211	22,366	23,491	45,857	40,549	38,766	79,315	37,768	18,060	55,828
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Pediatric Behavioral Health Service Providers	>99.9	97.9	98.8	62.6	100.0	81.5	>99.9	100.0	>99.9	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	96.6	100.0	98.5	100.0	100.0	100.0	99.9	100.0	>99.9	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	1.2	42.1	23.7	100.0	100.0	100.0	>99.9	100.0	>99.9	>99.9	100.0	>99.9	>99.9	100.0	>99.9
Hospitals	>99.9	100.0	>99.9	61.9	100.0	81.2	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists															
Allergy and Immunology	95.6	>99.9	98.1	97.7	100.0	98.9	86.5	99.0	92.4	92.3	>99.9	96.0	100.0	100.0	100.0
Dermatology	95.6	100.0	98.1	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	100.0	100.0	100.0	61.6	100.0	81.1	99.6	100.0	99.8	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	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
Infectious Disease	95.9	99.4	97.9	62.7	87.4	75.2	100.0	94.0	97.1	100.0	83.8	92.1	100.0	100.0	100.0
Nephrology	96.1	100.0	98.3	99.2	100.0	99.6	89.5	100.0	94.5	100.0	100.0	100.0	100.0	100.0	100.0
Neurology	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
Oral Surgery	30.3	85.7	61.5	60.5	100.0	80.6	51.0	86.7	68.0	62.0	91.8	76.5	99.5	97.1	98.7
Orthopedic Surgery	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
Pulmonology	100.0	100.0	100.0	61.6	99.9	81.0	99.6	100.0	99.8	100.0	100.0	100.0	100.0	100.0	100.0
Urology	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
Chiropractor	100.0	100.0	100.0	0.7	81.1	41.6	100.0	100.0	100.0	100.0	100.0	100.0	99.6	100.0	99.7
Physiatry/ Rehabilitative Medicine	100.0	100.0	100.0	60.4	99.9	80.5	87.1	100.0	93.2	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded gray indicate urban or rural counties that did not meet the time/distance standard. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

For Region 2—Central, the overall findings for the regional time/distance analysis for the health plans operating in this region identified that the following health plans and provider categories did not meet the enrollee access time/distance standard:

- **Pediatric PCPs**
  - **Harmony**—Across all counties, 89.3 percent of enrollees had access to a pediatric PCP, and 78.5 percent of enrollees in urban counties had access.

- **Adult Behavioral Health Providers**
  - **Harmony**—Across all counties, 81.4 percent of enrollees had access to an adult behavioral health provider, and 62.2 percent of enrollees in urban counties had access.
- **Pediatric Behavioral Health Service Providers**
  - **Harmony**—Across all counties, 81.5 percent of enrollees had access to a pediatric behavioral health service provider, and 62.6 percent of enrollees in urban counties had access.
- **Pediatric Dentist**
  - **BCBSIL**—Across all counties, 23.7 percent of enrollees had access to a pediatric dentist. In urban counties, 1.2 percent of enrollees had access, and 42.1 percent of enrollees in rural counties had access. In comparison, all other health plans had at least 99.9 percent of enrollees with access to a pediatric dentist.
- **Hospitals**
  - **Harmony**—Across all counties, 81.2 percent of enrollees had access to a hospital, and 61.9 percent of enrollees in urban counties had access.
- **Allergy and Immunology**
  - **IlliniCare**—In urban counties, 86.5 percent of enrollees had access to an allergy and immunology provider.
- **Endocrinology**
  - **Harmony**—Across all counties, 81.1 percent of enrollees had access to an endocrinology provider, and 61.6 percent of enrollees in urban counties had access.
- **Infectious Disease**
  - **Harmony**—Across all counties, 75.2 percent of enrollees had access to an infectious disease provider. In urban counties, 62.7 percent of enrollees had access, and 87.4 percent of enrollees in rural counties had access.
  - **Meridian**—In rural counties, 83.8 percent of enrollees had access to an infectious disease provider.
- **Nephrology**
  - **IlliniCare**—In urban counties, 89.5 percent of enrollees had access to nephrology provider.
- **Oral Surgery:** All health plans except Molina had oral surgery provider networks that did not meet the time/distance standard.
  - **BCBSIL**—Across all counties, 61.5 percent of enrollees had access to an oral surgery provider. In urban counties, 30.3 percent of enrollees had access, and 85.7 percent of enrollees in rural counties had access.
  - **Harmony**—Across all counties, 80.6 percent of enrollees had access to an oral surgery provider, and 60.5 percent of enrollees in urban counties had access.
  - **IlliniCare**—Across all counties, 68.0 percent of enrollees had access to an oral surgery provider. In urban counties, 51.0 percent of enrollees had access, and 86.7 percent of enrollees in rural counties had access.
  - **Meridian**—Across all counties, 76.5 percent of enrollees had access to an oral surgery provider, and 62.0 percent of enrollees in urban counties had access.

- **Pulmonology**
  - **Harmony**—Across all counties, 81.0 percent of enrollees had access to a pulmonology provider, and 61.6 percent of enrollees in urban counties had access.
- **Chiropractor**
  - **Harmony**—Across all counties, 41.6 percent of enrollees had access to a chiropractor. In urban counties, 0.7 percent of enrollees had access, and 81.1 percent of enrollees in rural counties had access. In comparison, all other health plans had at least 99.6 percent of enrollees with access to a chiropractor.
- **Physiatry/Rehabilitative Medicine**
  - **Harmony**—Across all counties, 80.5 percent of enrollees had access to a physiatry/rehabilitative medicine provider, and 60.4 percent of enrollees in urban counties had access.
  - **IlliniCare**—In urban counties, 87.1 percent of enrollees had access to a physiatry/rehabilitative medicine provider.

Table 3-4 displays the percentage of enrollees residing within the time/distance standards and the percentage of participating counties meeting the contract requirements for Region 2. While the time/distance standards vary by provider category, the contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Table 3-4—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 2

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	99.4	97.1	89.3	94.3	100.0	100.0	> 99.9	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	81.4	97.1	99.9	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	98.8	94.3	81.5	97.1	> 99.9	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	98.5	97.1	100.0	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	23.7	31.4	100.0	100.0	> 99.9	100.0	> 99.9	100.0	> 99.9	100.0
Hospitals	> 99.9	100.0	81.2	97.1	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology	98.1	97.1	98.9	100.0	92.4	91.4	96.0	97.1	100.0	100.0

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)
Dermatology	98.1	97.1	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	81.1	97.1	99.8	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	97.9	91.4	75.2	91.4	97.1	97.1	92.1	94.3	100.0	100.0
Nephrology	98.3	97.1	99.6	100.0	94.5	97.1	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	61.5	88.6	80.6	97.1	68.0	68.6	76.5	88.6	98.7	94.3
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology	100.0	100.0	81.0	97.1	99.8	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractor	100.0	100.0	41.6	57.1	100.0	100.0	100.0	100.0	99.7	100.0
Physiatry/ Rehabilitative Medicine	100.0	100.0	80.5	97.1	93.2	97.1	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Overall, Region 2 maintained geographically well-distributed provider networks across the provider categories for Molina. BCBSIL, Harmony, IlliniCare, and Meridian each had provider categories that did not meet the contract requirements. Key results from the Region 2 network time/distance analysis include:

- Molina's provider network met the contract requirements for all provider categories except oral surgery (i.e., 33 out of 35 counties met the contract requirements, and Adams and Hancock counties did not meet the contract requirements).
- Meridian and IlliniCare maintained robust provider networks for all provider categories except oral surgery, for which only 88.6 percent of counties and 68.6 percent of counties, respectively, met the contract requirements.
- Harmony's provider network met the contract requirements for at least 90.0 percent of counties for all provider categories except chiropractors (i.e., only 57.1 percent of counties met the contract requirements). As shown in Table 3-4, several provider categories had less than 90.0 percent of enrollees with access.
- BCBSIL's provider network met the contract requirements for at least 90.0 percent of counties for all provider categories except oral surgery (i.e., only 88.6 percent of counties met the contract requirements) and pediatric dentist (i.e., only 31.4 percent of counties met the contract requirements).

Appendix A contains a complete list by health plan of counties not meeting the contract requirement for each provider type.

Region 3—Southern

Table 3-5 displays the percentage of enrollees residing within the time/distance standards in Region 3 by health plan and urbanicity.

Table 3-5—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 3*

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	337	5,244	5,581	27,300	30,823	58,123	3,614	36,138	39,752	34,707	35,642	70,349	29,430	15,399	44,829
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	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
Pediatric PCPs	100.0	100.0	100.0	>99.9	100.0	>99.9	100.0	100.0	100.0	>99.9	100.0	>99.9	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	99.6	100.0	>99.9	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	94.6	89.5	89.6	100.0	100.0	100.0	100.0	100.0	100.0	99.7	98.8	99.2	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	>99.9	>99.9	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	96.4	62.1	62.9	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	64.1	100.0	97.8	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	100.0	92.9	93.5	100.0	90.2	94.6	100.0	89.4	90.6	100.0	96.1	98.1	100.0	89.5	96.4
Dermatology	100.0	100.0	100.0	100.0	80.8	89.4	100.0	92.5	93.3	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	43.5	100.0	94.9	100.0	100.0	100.0	100.0	99.6	99.7	100.0	95.4	97.8	100.0	75.5	91.6
ENT/Otolaryngology	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
Infectious Disease	100.0	99.7	99.7	100.0	77.5	87.5	100.0	>99.9	>99.9	100.0	97.8	98.9	100.0	92.0	97.2
Nephrology	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
Neurology	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
Oral Surgery	0.0	18.1	16.5	100.0	59.9	77.8	100.0	62.2	66.4	0.0	5.7	2.7	100.0	50.1	82.8
Orthopedic Surgery	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

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	337	5,244	5,581	27,300	30,823	58,123	3,614	36,138	39,752	34,707	35,642	70,349	29,430	15,399	44,829
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Pulmonology	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
Urology	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
Chiropractor	100.0	100.0	100.0	100.0	87.2	92.9	100.0	100.0	100.0	100.0	70.0	85.7	100.0	75.0	91.4
Physiatry/ Rehabilitative Medicine	100.0	100.0	100.0	100.0	80.5	89.2	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded gray indicate urban or rural counties that did not meet the time/distance standard. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

For Region 3—Southern, the overall findings for the regional time/distance analysis for the health plans operating in this region identified that the following health plans and provider categories did not meet the enrollee access time/distance standard:

- **Pediatric Behavioral Health Service Providers**
  - **BCBSIL**—Across all counties, 89.6 percent of enrollees had access to a pediatric behavioral health service provider, and 89.5 percent of enrollees in rural counties had access.
- **Pediatric Dentist**
  - **BCBSIL**—Across all counties, 62.9 percent of enrollees had access to a pediatric dentist, and 62.1 percent of enrollees in rural counties had access.
- **Hospitals**
  - **BCBSIL**—In urban counties, 64.1 percent of enrollees had access to a hospital.
- **Allergy and Immunology**
  - **IlliniCare**—In rural counties, 89.4 percent of enrollees had access to an allergy and immunology provider.
  - **Molina**—In rural counties, 89.5 percent of enrollees had access to an allergy and immunology provider.
- **Dermatology**
  - **Harmony**—Across all counties, 89.4 percent of enrollees had access to a dermatology provider, and 80.8 percent of enrollees in rural counties had access.
- **Endocrinology**
  - **BCBSIL**—In urban counties, 43.5 percent of enrollees had access to an endocrinology provider.
  - **Molina**—In rural counties, 75.5 percent of enrollees had access to an endocrinology provider.

- **Infectious Disease**
  - **Harmony**—Across all counties, 87.5 percent of enrollees had access to an infectious disease provider, and 77.5 percent of enrollees in rural counties had access.
- **Oral Surgery:** All health plans had oral surgery provider networks that did not meet the time/distance standard.
  - **BCBSIL**—BCBSIL enrollees residing in Region 3 had the lowest percentage of enrollees with access to an oral surgery provider compared to BCBSIL enrollees in other regions. Across all counties, 16.5 percent of enrollees had access to an oral surgery provider. In urban counties, 0.0 percent of enrollees had access, and 18.1 percent of enrollees in rural counties had access.
  - **Harmony**—Harmony had the lowest percentage of Region 3 enrollees with access to an oral surgery provider among all health plans. Across all counties, 77.8 percent of enrollees had access to an oral surgery provider, and 59.9 percent of enrollees in rural counties had access.
  - **IlliniCare**—Across all counties, 66.4 percent of enrollees had access to an oral surgery provider, and 62.2 percent of enrollees in rural counties had access.
  - **Meridian**—Across all counties, 2.7 percent of enrollees had access to an oral surgery provider. In urban counties, 0.0 percent of enrollees had access, and 5.7 percent of enrollees in rural counties had access.
  - **Molina**—Across all counties, 82.8 percent of enrollees had access to an oral surgery provider, and 50.1 percent of enrollees in rural counties had access.
- **Chiropractor**
  - **Harmony**—In rural counties, 87.2 percent of enrollees had access to a chiropractor.
  - **Meridian**—Across all counties, 85.7 percent of enrollees had access to a chiropractor, and 70.0 percent of enrollees in rural counties had access.
  - **Molina—**In rural counties, 75.0 percent of enrollees had access to a chiropractor.
- **Physiatry/Rehabilitative Medicine**
  - **Harmony**—Across all counties, 89.2 percent of enrollees had access to a physiatry/ rehabilitative medicine provider, and 80.5 percent of enrollees in rural counties had access.

Table 3-6 displays the percentage of enrollees residing within the time/distance standards and the percentage of participating counties meeting the contract requirements for Region 3. While the time/distance standards vary by provider category, the contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Table 3-6—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 3

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	> 99.9	100.0	100.0	100.0	> 99.9	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	89.6	82.4	100.0	100.0	100.0	100.0	99.2	97.1	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	62.9	64.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	97.8	94.1	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology	93.5	70.6	94.6	79.4	90.6	85.3	98.1	85.3	96.4	88.2
Dermatology	100.0	100.0	89.4	67.6	93.3	88.2	100.0	100.0	100.0	100.0
Endocrinology	94.9	94.1	100.0	100.0	99.7	97.1	97.8	85.3	91.6	67.6
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	99.7	97.1	87.5	64.7	> 99.9	100.0	98.9	91.2	97.2	91.2
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	16.5	8.8	77.8	58.8	66.4	67.6	2.7	8.8	82.8	41.2
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractor	100.0	100.0	92.9	67.6	100.0	100.0	85.7	52.9	91.4	47.1
Physiatry/ Rehabilitative Medicine	100.0	100.0	89.2	64.7	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Overall, Region 3 maintained geographically well-distributed provider networks across the provider categories for IlliniCare and Molina for most provider categories. BCBSIL, Harmony, and Meridian each had more than one provider category that did not meet the contract requirements. Key results from the Region 3 network time/distance analysis include:

- Region 3 had consistently lower percentages of counties meeting the contract requirements for all health plans in comparison to other regions.
- All health plans had a consistently low percentage of counties meeting the contract requirements for oral surgery providers. IlliniCare had the highest percentage meeting the contract requirements for oral surgery providers (i.e., 67.6 percent). BCBSIL and Meridian had the lowest percentages, with only Effingham, Jasper, and Crawford counties meeting the contract requirements for oral surgery providers for both plans.
- Harmony, Meridian, and Molina had low percentages of counties meeting the contract requirements for chiropractors, with 67.6 percent, 52.9 percent, and 47.1 percent meeting the requirements, respectively. While the percentage of counties meeting the contract requirements was low, the overall percentage of enrollees with access to a chiropractor was above 90.0 percent, except for Meridian, which was 85.7 percent.

Appendix A contains a complete list by health plan of counties not meeting the contract requirement for each provider type.

Regions 4 and 5—Cook County and Collar Counties

Table 3-7 displays the percentage of enrollees residing within the time/distance standards in Region 4 by health plan. Results by urbanicity are not displayed, as Region 4 (Cook County) is urban.

Table 3-7—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards in Region 4*

Statewide Health Plans—Region 4					
Enrollment Count as of September 1, 2018	255,432	88,858	106,853	160,097	69,589
Provider Categories	**BCBSIL**	**Harmony**	**IlliniCare**	**Meridian**	**Molina**
Adult PCPs	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0

Statewide Health Plans—Region 4					
Enrollment Count as of September 1, 2018	255,432	88,858	106,853	160,097	69,589
Provider Categories	**BCBSIL**	**Harmony**	**IlliniCare**	**Meridian**	**Molina**
Specialists					
Allergy and Immunology	100.0	100.0	100.0	100.0	100.0
Dermatology	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0
Oral Surgery	100.0	100.0	100.0	100.0	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0
Pulmonology	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0
Chiropractor	100.0	100.0	100.0	100.0	100.0
Physiatry/Rehabilitative Medicine	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

The five statewide health plans were compliant with time/distance standards across all provider categories in Region 4.

Table 3-8 displays the percentage of enrollees residing within the time/distance standards and the percentage of participating counties meeting the contract requirements for Region 4. While the time/distance standards vary by provider category, the contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Since Region 4 consists of one county, a 100.0 percent indicates that Cook County met the contract requirements.

Table 3-8—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 4

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists										
Allergy and Immunology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dermatology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractor	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Physiatry/ Rehabilitative Medicine	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

All enrollees in Cook County had access to all provider types within the time/distance standards.

Table 3-9 displays the percentage of enrollees residing within the time/distance standards in Region 5 by health plan and by urbanicity.

Table 3-9—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity in Region 5*

	BCBSIL			Harmony			IlliniCare			Meridian			Molina		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 1, 2018	129,944	3,287	133,231	33,594	3,717	37,311	83,270	3,383	86,653	149,919	7,348	157,267	9,549	457	10,006
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	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
Pediatric PCPs	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
Adult Behavioral Health 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
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	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	95.8	100.0	95.9
Pediatric Dentist	91.7	100.0	91.8	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	100.0	100.0	100.0
Specialists															
Allergy and Immunology	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
Dermatology	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
Endocrinology	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
ENT/Otolaryngology	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
Infectious Disease	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
Nephrology	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
Neurology	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
Oral Surgery	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
Orthopedic Surgery	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
Pulmonology	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
Urology	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
Chiropractor	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
Physiatry/Rehabilitative Medicine	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

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

The five statewide health plans were compliant with the time/distance standards across all provider categories in Region 5.

Table 3-10 displays the percentage of enrollees residing within the time/distance standards and the percentage of participating counties meeting the contract requirements for Region 5. While the time/distance standards vary by provider category, the contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

Table 3-10—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 5

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	95.9	87.5
Pediatric Dentist	91.8	87.5	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
Specialists										
Allergy and Immunology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dermatology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pulmonology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	BCBSIL		Harmony		IlliniCare		Meridian		Molina	
Provider Categories	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)
Chiropractor	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Physiatry/Rehabilitative Medicine	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard.

For Region 5, Collar Counties, overall findings for the time/distance analysis for the health plans operating in this region identified that all health plans and provider categories met the enrollee access time/distance standards. However, BCBSIL's network of pediatric dentists and Molina's network of OB/GYN providers did not meet the contract requirements for one county (i.e., Kankakee County).

Appendix A contains a complete list by health plan of counties not meeting the contract requirement for each provider type.

Comparison Between Phase I and Phase II Network Accessibility

Table 3-11 through Table 3-15 present the percentage of enrollees by health plan residing within the time/distance standards between Phase I and Phase II.

BCBSIL

Table 3-11 presents the percentage of enrollees with access to a provider within the time/distance standards for BCBSIL.

Table 3-11—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards in Phase I and Phase II—BCBSIL

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II	Phase I	Phase II
Enrollment Count	4,126	4,089	14,051	17,367	4,719	5,581	294,221	255,432	153,097	133,231
Provider Categories	Phase I (%)	Phase II (%)	Phase I (%)	Phase II (%)	Phase I (%)	Phase II (%)	Phase I (%)	Phase II (%)	Phase I (%)	Phase II (%)
Adult PCPs	100.0	100.0	99.8	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	94.8	97.1	97.7	99.4	96.8	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	98.2	100.0	100.0	100.0	90.9	100.0	100.0	100.0	100.0	100.0

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	4,126	4,089	14,051	17,367	4,719	5,581	294,221	255,432	153,097	133,231
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Pediatric Behavioral Health Service Providers	97.8	84.2	97.0	98.8	86.5	89.6	100.0	100.0	100.0	100.0
OB/GYN Providers	96.3	99.4	71.1	98.5	99.9	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	88.7	87.7	35.1	23.7	64.0	62.9	100.0	100.0	91.7	91.8
Hospitals	100.0	100.0	97.0	> 99.9	97.2	97.8	100.0	100.0	100.0	100.0
Endocrinology	91.9	97.4	52.7	100.0	0.0	94.9	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	80.1	82.6	69.4	61.5	51.0	16.5	100.0	100.0	100.0	100.0
Orthopedic Surgery	99.9	100.0	99.8	100.0	94.6	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate overall county results that did not meet the time/distance standard. Only provider categories that were included in both Phase I and Phase II of the report are included in this comparison.

Overall, BCBSIL enrollees maintained access to the provider categories assessed in both analytic phases for at least 90.0 percent of enrollees in regions 4 and 5. Key results from the BCBSIL regional network time/distance analysis between Phase I and Phase II include:

- Enrollees in regions 4 and 5 have access to all provider categories assessed in Phase I and Phase II. A smaller percentage of Region 1 enrollees had access to pediatric behavioral health service providers within the time/distance standards in Phase II.
- In Region 2, the percentage of BCBSIL enrollees with access to OB/GYN providers and endocrinology providers within the time/distance standard improved from Phase I to Phase II.
- In regions 2 and 3, enrollee access to endocrinology providers within the time/distance standard improved between Phase I and Phase II. The substantial increase in the percentage of enrollees with access in regions 2 and 3 is due to newly contracted endocrinology providers in and near these regions.
- BCBSIL enrollees residing in regions 1, 2, and 3 had limited access to oral surgery providers within the time/distance standard in both analytic phases. In Region 3, the percentage of enrollees with access to oral surgery providers within the time/distance standards decreased substantially between the two analytic phases, with 51.0 percent of enrollees having access in Phase I and 16.5 percent having access in Phase II. The decrease in the percentage of enrollees with access in Region 3 is due to a provider in St. Louis who contracted with BCBSIL during the Phase I analyses but was no longer contracted with BCBSIL during the Phase II analyses.

Harmony

Table 3-12 presents the percentage of enrollees with access to a provider within the time/distance standards for Harmony.

Table 3-12—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards in Phase I and Phase II—Harmony

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	25,944	20,877	58,301	41,211	76,542	58,123	84,457	88,858	35,803	37,311
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Adult PCPs	> 99.9	99.9	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	99.8	98.2	64.8	89.3	100.0	> 99.9	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	76.5	81.4	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	88.2	100.0	71.8	81.5	97.5	100.0	100.0	100.0	99.8	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	91.8	93.2	76.8	81.2	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	> 99.9	86.0	100.0	81.1	100.0	100.0	100.0	100.0	100.0	100.0
Neurology	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	89.5	86.0	7.7	80.6	0.0	77.8	100.0	100.0	100.0	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate overall county results that did not meet the time/distance standard. Only provider categories that were included in both Phase I and Phase II of the report are included in this comparison.

Overall, Harmony maintained access for enrollees in regions 4 and 5 between both phases of the time/distance analysis. Key results from the Harmony regional network time/distance analysis between Phase I and Phase II include:

- In Region 1, the percentage of Harmony enrollees with access to endocrinology providers and oral surgery providers decreased between Phase I and Phase II. The percentage of Region 1 enrollees with access to a pediatric behavioral health service provider increased.
- A higher percentage of Harmony enrollees living in Region 2 had access to pediatric PCPs, adult behavioral health providers, pediatric behavioral health service providers, hospitals, and oral surgery providers between Phase I and Phase II. However, these provider networks were still serving less

than 90.0 percent of Harmony enrollees in Region 2. A smaller percentage of Harmony enrollees living in Region 2 had access to an endocrinology provider during Phase II compared to Phase I.

- Less than 90.0 percent of Harmony enrollees in regions 1, 2, and 3 had access to an oral surgery provider in both phases of the analysis. However, regions 2 and 3 had a substantial increase in access (i.e., from 7.7 percent to 80.6 percent and 0.0 percent to 77.8 percent between Phase I and Phase II, respectively).

IlliniCare

Table 3-13 presents the percentage of enrollees with access to a provider within the time/distance standards for IlliniCare.

Table 3-13—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards in Phase I and Phase II—IlliniCare

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	69,070	63,102	53,176	45,857	38,798	39,752	96,392	106,853	84,617	86,653
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	72.5	99.9	100.0	> 99.9	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	> 99.9	100.0	70.3	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	> 99.9	> 99.9	100.0	> 99.9	100.0	100.0	99.9	100.0
Pediatric Dentist	100.0	100.0	> 99.9	> 99.9	> 99.9	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	84.0	100.0	99.8	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	83.2	99.8	54.0	99.7	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	43.9	100.0	100.0	100.0	100.0	100.0
Oral Surgery	95.7	93.3	72.8	68.0	57.5	66.4	100.0	100.0	> 99.9	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	99.7	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate overall county results that did not meet the time/distance standard. Only provider categories that were included in both Phase I and Phase II of the report are included in this comparison.

Overall, IlliniCare maintained access for enrollees in Regions 4 and 5, with at least 99.9 percent of enrollees having access to the provider categories included in both phases of the time/distance analysis. Key results from the IlliniCare regional network time/distance analysis between Phase I and Phase II include:

- Regions 1, 4, and 5 had at least 90.0 percent of IlliniCare enrollees with access to the provider categories that were assessed in both phases of the study.
- Although Region 1 enrollees had a small decrease in access to oral surgery providers, overall access was still above 90.0 percent for both analytic phases.
- In Region 2, IlliniCare enrollees had improved access to adult behavioral health providers, pediatric behavioral health service providers, hospitals, and endocrinology between the two analytic phases. However, these improvements may be a result of the significant decrease in the number of IlliniCare enrollees in Region 2 from Phase I to Phase II.
- A smaller percentage of Region 2 IlliniCare enrollees had access to an oral surgery provider in Phase II compared to Phase I.
- A higher percentage of IlliniCare enrollees in Region 3 had access to endocrinology, neurology, and oral surgery providers in Phase II compared to Phase I. However, despite the higher percentage of enrollees with access to oral surgery providers in Phase II, the percentage of enrollees with access remained less than 90.0 percent in Region 3.

Meridian

Table 3-14 presents the percentage of enrollees with access to a provider within the time/distance standards for Meridian.

Table 3-14—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards in Phase I and Phase II—Meridian

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	137,041	141,405	59,806	79,315	61,759	70,349	141,215	160,097	147,876	157,267
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	99.5	> 99.9	> 99.9	> 99.9	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	99.8	99.9	94.0	100.0	72.8	99.2	100.0	100.0	99.9	100.0
OB/GYN Providers	100.0	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	> 99.9	> 99.9	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
Endocrinology	100.0	100.0	91.6	100.0	89.5	97.8	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	137,041	141,405	59,806	79,315	61,759	70,349	141,215	160,097	147,876	157,267
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Oral Surgery	74.9	76.4	58.2	76.5	2.2	2.7	100.0	100.0	100.0	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate overall county results that did not meet the time/distance standard. Only provider categories that were included in both Phase I and Phase II of the report are included in this comparison.

Overall, Meridian maintained access for enrollees in regions 4 and 5 between both phases of the time/distance analysis. Key results from the Meridian regional network time/distance analysis between Phase I and Phase II include:

- Regions 4 and 5 had at least 99.9 percent of enrollees with access to the provider categories included in both analytic phases.
- In Region 3, a substantially higher percentage of Meridian enrollees had access to pediatric behavioral health service providers and endocrinology providers in Phase II compared to Phase I.
- In regions 1, 2, and 3, a higher percentage of enrollees had access to oral surgery providers in Phase II compared to Phase I. However, less than 90.0 percent of enrollees had access to an oral surgery provider in all three regions, and only 2.7 percent of Region 3 enrollees had access to these providers in Phase II.

Molina

Table 3-15 presents the percentage of enrollees with access to a provider within the time/distance standards for Molina.

Table 3-15—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards in Phase I and Phase II—Molina

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	39,676	38,695	57,722	55,828	44,879	44,829	69,087	69,589	5,572	10,006
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	Region 1		Region 2		Region 3		Region 4		Region 5	
Analytic Phase	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**	**Phase I**	**Phase II**
Enrollment Count	39,676	38,695	57,722	55,828	44,879	44,829	69,087	69,589	5,572	10,006
Provider Categories	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**	**Phase I (%)**	**Phase II (%)**
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	98.8	98.3	100.0	100.0	100.0	100.0	100.0	100.0	97.4	95.9
Pediatric Dentist	99.7	100.0	> 99.9	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	98.7	> 99.9	100.0	100.0	99.0	100.0	100.0	100.0	97.4	100.0
Endocrinology	98.7	98.3	100.0	100.0	96.0	91.6	100.0	100.0	100.0	100.0
Neurology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	> 99.9	70.8	99.1	98.7	88.4	82.8	100.0	100.0	100.0	100.0
Orthopedic Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard. Cells shaded red with red font indicate overall county results that did not meet the time/distance standard. Only provider categories that were included in both Phase I and Phase II of the report are included in this comparison.

Overall, Molina maintained access for enrollees in regions 2, 4, and 5 between both phases of the time/distance analysis. Key results from the Molina regional network time/distance analysis between Phase I and Phase II include:

- At least 95.9 percent of enrollees in regions 2, 4, and 5 had access to all provider categories assessed in both phases of the analysis.
- A substantially smaller proportion of Region 1 enrollees had access to oral surgery providers between Phase I and Phase II (i.e., > 99.9 percent and 70.8 percent, respectively). Much of this decrease is likely the result of an oral surgery provider in Knox County who contracted with Molina during Phase I but was not contracted during Phase II.
- A smaller proportion of Region 3 enrollees had access to an oral surgery provider in Phase II (i.e., 88.4 percent of enrollees with access in Phase I and 82.8 percent with access in Phase II). However, this was not a substantial decrease.

Average Travel Time and Distances

Appendix B presents the average time and distance enrollees would need to travel to reach the nearest providers from each provider category, by urbanicity and health plan. Consistent with findings from comparisons to the contract requirements, results from the average travel time and distance to the nearest three providers indicated that provider networks that were not reasonably accessible to at least 90.0 percent of Medicaid enrollees demonstrated inconsistent geographic distribution. As observed in rural

counties, provider categories with a lower percentage of enrollees meeting the time/distance standard frequently noted average travel time and distance within the access standard to the nearest provider, followed by substantially longer drive times and travel distances associated with the second- and third-nearest providers.

4. Discussion

Conclusions

Overall, the Illinois SFY 2018 Provider Network Time/Distance Phase II Analysis results suggest that the health plans have comprehensive provider networks in regions 4 and 5, with targeted opportunities for improvement in regions 1, 2, and 3. Enrollees residing in regions 4 and 5 generally had access to a broad range of providers within the time/distance standards for all health plans.

Regions 1 and 3 generally had provider networks that met the contract requirements for most provider categories for IlliniCare, Meridian, and Molina; however, BCBSIL and Harmony each had several provider categories in their networks that serve less than 90.0 percent of the enrollee population in these regions. Meridian and Molina enrollees residing in Region 2 had access to a wide range of providers mostly within the time/distance standard. Harmony enrollees living in Region 2 consistently had limited access to several provider categories included in the analysis.

All health plans had at least one county that did not meet the contract requirements for the following provider categories: Allergy and Immunology, Endocrinology, Infectious Disease, and Oral Surgery. Additionally, the following counties did not meet the contract requirements for oral surgery providers for any of the health plans:

- Region 1: Peoria and Tazewell
- Region 3: Alexander, Gallatin, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, and Williamson

The following counties did not meet the contract requirements for BCBSIL, IlliniCare, Meridian, and Molina for allergy and immunology providers:

- Region 3: Edwards, Lawrence, Richland, and Wabash

The comparison of results between Phase I and Phase II revealed that several health plans did not meet the standards in either analytic phase for oral surgery and endocrinology provider networks. BCBSIL, Harmony, and Meridian for regions 1, 2, and 3 consistently did not meet the standards in both analytic phases for oral surgery provider networks. BCBSIL and Harmony, however, demonstrated a substantial increase in the percentage of enrollees with access to an endocrinology provider in regions 2 and 3 due to an increase in contracted providers in and near regions 2 and 3. IlliniCare did not meet the standard for oral surgery provider networks within regions 2 and 3 during both analytic phases. Molina enrollees in Region 3 also had limited access to oral surgery providers, with a smaller percentage of Molina's enrollees with access in Phase II. Across both phases of the study, enrollees in regions 4 and 5 had access to all provider categories within the time/distance standards.

Overall, access to PCPs, hospitals, and OB/GYN provider networks generally provided at least 90.0 of enrollees with access across all health plans except Harmony. Although access to oral surgery providers

improved for some regions and health plans for Phase II of the analysis, oral surgery provider networks continued to provide access to less than 90.0 percent of enrollees living in regions 1, 2, and 3. Regions 1, 2, and 3 have targeted areas for improvement across all health plans.

Study Limitations

- Provider specialty categorizations may not include both adult and pediatric categorizations, even though the provider serves both adult and pediatric populations (e.g., an endocrinologist may not be identified as a pediatric endocrinologist but still provides services to a pediatric population).
- County names included in the enrollment data were used to determine enrollees' urbanicity and region. About 0.1 percent of enrollees did not have a valid county name in the data provided by HFS. As such, county names produced by Quest during geocoding were used to assign urbanicity and region to these enrollees.
- Time/distance metrics represent a high-level measurement of the similarity in geographic distribution of providers relative to enrollees. These raw, comparative statistics do not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) at a specific location or how active the provider is in the Medicaid program. It is likely that some providers are contracted to provide services for multiple health plans. As such, time/distance results only highlight the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations.
- No national distance-based or time-based access standards have been established for Medicaid. While time- and distance-based access standards are defined for the HealthChoice Illinois Medicaid provider categories noted in the methodology, network adequacy cannot be measured against national benchmarks.
- When evaluating the results of these analyses, it is important to note that the reported, average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to enrollees.
- The availability of all provider categories in the expansion counties is currently unknown. These study results may assist HFS in determining if provider contracting deficits in certain counties are due to a lack of providers in the county or an inability of the health plans to contract with existing providers.
- While HSAG conducted both Phase I and Phase II time/distance analyses using Quest, software updates between Phase I and Phase II could result in slight variations in geocoding results between the phases. Such variations are expected as a result of conducting analyses at separate times.
- The Phase I time/distance analyses included provider categories that were excluded from the Phase II analyses, such as cardiologists, pharmacies, and ophthalmologists. The health plans generally had provider networks that met the time/distance standard in Phase I for these provider categories. However, as the health plans continue to build their enrollee and provider networks in the expansion regions, access to these providers may change over time. The Phase I analysis results presented in

this report may not reflect the actual provider networks if the health plans have made substantial changes to either the enrollee or provider networks between Phase I and Phase II.

- 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.

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Appendix A

For each health plan, Appendix A lists counties that did not meet the contract requirements.

BCBSIL

- **Allergy and Immunology:** Crawford, Edwards, Gallatin, Hardin, Henry, Knox, Lawrence, Massac, Mercer, Peoria, Richland, Rock Island, Stark, Tazewell, Vermilion, Wabash, Wayne, White
- **Dermatology:** Vermilion
- **Endocrinology:** Madison, Rock Island, St. Clair
- **Hospitals:** Madison, St. Clair
- **Infectious Disease:** Adams, Crawford, Hancock, Vermilion
- **Nephrology:** Vermilion
- **OB/GYN:** Jo Daviess, Vermilion
- **Oral Surgery:** Alexander, Bond, Clay, Clinton, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Henry, Jackson, Jefferson, Jersey, Johnson, Knox, Lawrence, Macoupin, Madison, Marion, Massac, Mercer, Monroe, Montgomery, Peoria, Perry, Pope, Pulaski, Randolph, Richland, Rock Island, Saline, Sangamon, St. Clair, Stark, Tazewell, Union, Wabash, Washington, Wayne, White, Williamson
- **Pediatric Behavioral Health:** Clark, Crawford, Cumberland, Effingham, Jasper, Jo Daviess, Lawrence, Richland, Wabash, Winnebago
- **Pediatric Dentist:** Adams, Brown, Cass, Champaign, Christian, Clark, Clay, Coles, Crawford, Cumberland, Douglas, Edgar, Edwards, Effingham, Fayette, Fulton, Hancock, Jasper, Jo Daviess, Kankakee, Lawrence, Macon, Marion, Mason, McDonough, Menard, Montgomery, Morgan, Moultrie, Peoria, Pike, Richland, Sangamon, Schuyler, Scott, Shelby, Tazewell, Vermilion, Wabash, Wayne, White
- **Pediatric PCPs:** Champaign, Jo Daviess

Harmony

- **Adult Behavioral Health:** Sangamon
- **Allergy and Immunology:** Gallatin, Hardin, Massac, Pope, Rock Island, Saline, Wayne, White
- **Chiropractor:** Champaign, Clark, Coles, Crawford, Cumberland, De Witt, Douglas, Edgar, Edwards, Ford, Gallatin, Hardin, Jasper, Lawrence, Logan, Macon, Massac, McLean, Moultrie, Piatt, Pope, Richland, Sangamon, Tazewell, Vermilion, Wabash, White
- **Dermatology:** Alexander, Gallatin, Hardin, Johnson, Massac, Pope, Pulaski, Saline, Union, White, Williamson
- **Endocrinology:** Peoria, Sangamon, Tazewell

- **Hospitals:** Peoria, Rock Island, Sangamon, Tazewell
- **Infectious Disease:** Adams, Alexander, Edwards, Gallatin, Hancock, Hardin, Johnson, Massac, Pope, Pulaski, Saline, Sangamon, Union, White, Williamson
- **Oral Surgery:** Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Peoria, Pope, Pulaski, Saline, Sangamon, Tazewell, Union, White, Williamson
- **Pediatric Behavioral Health:** Sangamon
- **Pediatric PCPs:** Macon, McLean, Rock Island
- **Physiatry/Rehabilitative Medicine:** Alexander, Edwards, Gallatin, Hardin, Johnson, Massac, Peoria, Pope, Pulaski, Rock Island, Saline, Sangamon, Tazewell, Union, White, Williamson
- **Pulmonology:** Fulton, Henderson, Peoria, Sangamon, Tazewell
- **Urology:** Peoria, Tazewell

IlliniCare

- **Allergy and Immunology:** Champaign, Crawford, Edwards, Hancock, Lawrence, Richland, Vermilion, Wabash
- **Dermatology:** Edwards, Lawrence, Richland, Wabash
- **Endocrinology:** Alexander
- **Infectious Disease:** Adams
- **Nephrology:** Vermilion
- **Oral Surgery:** Adams, Alexander, Brown, Cass, Gallatin, Hancock, Hardin, Jackson, Johnson, Mason, Massac, McLean, Menard, Peoria, Pike, Pope, Pulaski, Saline, Sangamon, Schuyler, Tazewell, Union, Vermilion, Williamson, Woodford
- **Physiatry/Rehabilitative Medicine:** Vermilion

Meridian

- **Allergy and Immunology:** Crawford, Edwards, Lawrence, Richland, Vermilion, Wabash
- **Chiropractor:** Alexander, Edwards, Gallatin, Hamilton, Hardin, Johnson, Lawrence, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson
- **Endocrinology:** Alexander, Hardin, Massac, Pope, Pulaski
- **Infectious Disease:** Adams, Hancock, Lawrence, Richland, Wabash
- **Oral Surgery:** Alexander, Bond, Clay, Clinton, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Jersey, Johnson, Lawrence, Macoupin, Madison, Marion, Massac, Monroe, Montgomery, Peoria, Perry, Pope, Pulaski, Randolph, Richland, Saline, Sangamon, St. Clair, Tazewell, Union, Wabash, Washington, Wayne, White, Williamson
- **Pediatric Behavioral Health:** Jo Daviess, Wabash

Molina

- **Allergy and Immunology:** Edwards, Lawrence, Richland, Wabash
- **Chiropractor:** Alexander, Clay, Edwards, Gallatin, Hamilton, Hardin, Johnson, Lawrence, Massac, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, Williamson
- **Endocrinology:** Alexander, Gallatin, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Rock Island, Saline, Union, Williamson
- **Infectious Disease:** Lawrence, Richland, Wabash
- **OB/GYN:** Kankakee, Rock Island
- **Oral Surgery:** Adams, Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hancock, Hardin, Jackson, Johnson, Lawrence, Massac, Peoria, Pope, Pulaski, Richland, Saline, Tazewell, Union, Wabash, Wayne, White, Williamson

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Appendix B

For each health plan and provider category, Appendix B presents the average travel time (driving times in minutes) and travel distance (driving distance in miles)[B-1] to enrollees' nearest three providers within rural and urban areas.

Table B-1—BCBSIL Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	3.8	4.2	4.5	4.9	5.1	5.6
Pediatric PCPs	12.2	13.5	14.2	15.8	18.1	20.4
Adult Behavioral Health Providers	7.5	8.3	8.4	9.2	10.7	11.7
Pediatric Behavioral Health Service Providers	25.8	29.3	26.8	30.4	27.8	31.5
OB/GYN Providers	9.5	10.4	13.0	14.5	15.9	17.8
Pediatric Dentist	47.5	58.2	52.2	65.8	68.4	82.9
Hospitals	10.6	11.9	22.8	25.5	29.2	32.7
Specialists						
Allergy and Immunology	39.1	44.0	52.4	60.5	61.4	70.7
Dermatology	18.0	20.0	30.6	34.5	33.3	37.6
Endocrinology	26.4	30.3	38.3	44.4	44.0	50.2
ENT/Otolaryngology	15.7	17.3	20.7	22.9	28.1	31.6
Infectious Disease	31.1	35.4	36.8	42.8	40.6	47.6
Nephrology	20.0	22.6	31.0	34.9	36.5	41.9
Neurology	16.0	18.1	21.5	24.6	26.4	30.1
Oral Surgery	79.1	102.3	116.0	137.1	124.7	159.8
Orthopedic Surgery	12.2	13.6	15.1	16.8	17.1	19.0
Pulmonology	15.8	17.6	20.6	23.4	24.9	28.3
Urology	16.7	18.9	26.6	30.2	32.3	36.7
Chiropractor	28.8	34.0	34.9	40.9	40.4	47.7
Physiatry/Rehabilitative Medicine	23.7	26.8	36.2	41.2	42.9	48.8

[B-1] 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.

Table B-2—BCBSIL Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.0	1.6	1.2	2.0	1.3	2.2
Pediatric PCPs	1.4	2.4	1.8	3.0	2.1	3.5
Adult Behavioral Health Providers	1.5	2.5	1.7	2.9	2.0	3.4
Pediatric Behavioral Health Service Providers	5.4	9.1	5.5	9.1	5.5	9.3
OB/GYN Providers	1.6	2.7	1.9	3.2	2.2	3.6
Pediatric Dentist	6.7	10.7	7.6	12.7	8.2	13.7
Hospitals	3.2	5.5	5.5	9.0	7.7	12.4
Specialists						
Allergy and Immunology	5.0	8.4	7.0	11.7	8.4	14.1
Dermatology	5.1	8.2	6.1	9.9	7.1	11.6
Endocrinology	3.9	6.6	5.6	9.1	6.6	10.7
ENT/Otolaryngology	3.7	6.3	4.6	7.8	5.4	8.9
Infectious Disease	4.0	6.7	4.7	7.9	5.5	9.2
Nephrology	3.5	5.8	4.2	7.0	5.2	8.6
Neurology	3.1	5.3	4.2	7.0	4.9	8.3
Oral Surgery	9.5	16.1	14.3	24.4	15.8	27.3
Orthopedic Surgery	3.5	5.8	4.5	7.3	5.0	8.2
Pulmonology	3.3	5.6	4.0	6.8	4.6	7.9
Urology	4.3	7.2	5.6	9.3	7.0	11.3
Chiropractor	9.9	17.2	13.9	24.2	19.4	34.8
Physiatry/Rehabilitative Medicine	4.8	8.0	6.0	10.2	6.8	11.6

Table B-3—Harmony Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	5.7	6.2	7.0	7.7	8.1	8.9
Pediatric PCPs	15.6	17.1	22.8	25.3	27.6	30.5
Adult Behavioral Health Providers	10.3	11.3	12.5	13.7	15.4	17.0
Pediatric Behavioral Health Service Providers	11.3	12.4	16.3	18.0	20.4	22.6
OB/GYN Providers	11.4	12.6	14.1	15.6	14.9	16.6
Pediatric Dentist	9.7	10.7	12.8	14.0	15.6	17.1
Hospitals	12.5	14.0	26.1	29.0	32.7	36.6
Specialists						
Allergy and Immunology	47.1	53.0	58.3	69.0	64.3	76.8
Dermatology	48.3	54.4	50.0	59.0	57.2	67.9
Endocrinology	31.1	35.1	42.7	48.1	65.2	74.1
ENT/Otolaryngology	21.2	24.0	33.4	38.1	42.1	48.2
Infectious Disease	55.9	62.6	57.5	68.1	64.3	77.5
Nephrology	27.1	30.2	32.0	35.9	37.5	42.7
Neurology	19.5	21.8	27.7	31.0	34.4	38.8
Oral Surgery	60.7	77.3	80.5	96.9	105.4	135.4
Orthopedic Surgery	15.4	17.0	18.8	20.7	21.3	23.5
Pulmonology	32.9	36.4	49.1	55.3	57.7	65.7
Urology	23.0	25.9	32.6	36.5	42.3	47.8
Chiropractor	51.8	57.6	67.0	74.2	74.7	83.3
Physiatry/Rehabilitative Medicine	53.6	61.3	59.9	70.9	61.0	73.8

Table B-4—Harmony Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.9	2.7	2.3	3.3	2.6	3.7
Pediatric PCPs	3.1	4.2	3.6	5.1	4.3	6.1
Adult Behavioral Health Providers	2.1	3.0	4.2	5.6	4.3	5.9
Pediatric Behavioral Health Service Providers	3.7	5.1	4.2	5.9	4.6	6.6
OB/GYN Providers	2.6	3.7	3.0	4.5	3.4	5.0
Pediatric Dentist	1.5	2.1	1.9	2.7	2.2	3.1
Hospitals	7.3	10.4	10.8	15.6	14.7	20.7
Specialists						
Allergy and Immunology	11.7	16.4	14.8	20.9	17.7	25.1
Dermatology	11.7	17.0	15.1	22.3	17.0	24.8
Endocrinology	13.1	18.1	16.1	22.5	18.2	26.1
ENT/Otolaryngology	11.2	15.5	14.2	20.6	16.8	24.4
Infectious Disease	9.0	12.6	10.3	14.8	11.9	17.4
Nephrology	7.3	9.8	8.3	11.2	9.0	12.2
Neurology	9.7	13.7	12.0	17.1	14.2	20.7
Oral Surgery	15.1	21.8	30.9	40.0	34.2	43.7
Orthopedic Surgery	7.1	9.7	9.2	12.8	11.2	15.5
Pulmonology	10.7	14.3	12.1	17.0	13.1	18.8
Urology	9.6	13.9	13.6	18.8	15.5	22.0
Chiropractor	21.7	30.2	26.4	37.6	33.2	46.8
Physiatry/Rehabilitative Medicine	12.0	16.7	13.5	19.4	14.5	21.1

Table B-5—IlliniCare Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	3.7	4.1	4.5	4.9	5.2	5.7
Pediatric PCPs	3.7	4.0	4.7	5.1	5.2	5.6
Adult Behavioral Health Providers	10.5	11.5	12.0	13.2	14.5	16.0
Pediatric Behavioral Health Service Providers	10.5	11.5	11.7	12.9	14.4	15.9
OB/GYN Providers	12.9	14.1	16.5	18.1	18.1	19.9
Pediatric Dentist	11.9	13.0	13.3	14.7	16.5	18.2
Hospitals	9.5	10.5	19.9	22.2	25.9	28.8
Specialists						
Allergy and Immunology	41.7	46.6	51.2	58.6	73.0	86.6
Dermatology	34.1	39.2	39.8	45.6	61.9	74.2
Endocrinology	30.8	34.3	42.5	47.5	53.0	60.2
ENT/Otolaryngology	16.5	18.2	21.4	23.9	26.2	29.2
Infectious Disease	30.7	35.2	38.1	43.9	41.8	48.5
Nephrology	29.0	32.6	40.1	45.8	45.1	51.3
Neurology	26.4	29.1	35.3	39.4	47.5	53.8
Oral Surgery	59.8	70.4	67.5	79.4	76.6	87.6
Orthopedic Surgery	13.6	15.1	16.8	18.7	21.2	23.6
Pulmonology	16.1	17.7	23.6	26.2	27.4	30.6
Urology	21.8	24.2	27.7	30.7	32.9	36.5
Chiropractor	20.9	23.1	31.3	35.1	39.5	44.3
Physiatry/Rehabilitative Medicine	28.4	31.8	34.7	39.3	43.5	49.8

Table B-6—IlliniCare Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.2	1.8	1.4	2.1	1.6	2.4
Pediatric PCPs	1.4	2.0	1.6	2.3	1.8	2.6
Adult Behavioral Health Providers	1.9	2.9	2.3	3.4	2.5	3.8
Pediatric Behavioral Health Service Providers	2.2	3.3	2.7	4.1	3.1	4.6
OB/GYN Providers	2.1	3.1	2.5	3.7	2.7	4.0
Pediatric Dentist	1.6	2.2	1.8	2.5	2.0	2.9
Hospitals	3.9	6.0	8.5	12.7	12.2	17.7
Specialists						
Allergy and Immunology	7.1	10.2	11.9	16.5	15.5	22.4
Dermatology	4.7	7.0	6.6	9.9	10.1	14.3
Endocrinology	5.3	7.9	8.2	12.0	11.7	16.6
ENT/Otolaryngology	4.1	6.1	5.3	7.8	6.0	8.7
Infectious Disease	3.9	6.1	6.4	9.5	7.2	10.7
Nephrology	4.4	6.4	5.5	8.0	6.3	9.1
Neurology	5.3	8.0	6.9	10.4	7.5	11.3
Oral Surgery	13.3	18.6	14.8	20.4	16.6	22.9
Orthopedic Surgery	4.3	6.5	6.0	8.8	6.5	9.6
Pulmonology	4.6	6.9	5.4	8.1	6.2	9.2
Urology	7.9	11.6	9.7	14.3	11.9	17.3
Chiropractor	12.1	18.9	16.8	25.3	20.0	30.5
Physiatry/Rehabilitative Medicine	5.8	8.2	7.2	10.5	9.6	13.9

Table B-7—Meridian Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	3.2	3.5	3.7	4.1	4.6	5.0
Pediatric PCPs	8.0	8.8	11.2	12.3	12.9	14.2
Adult Behavioral Health Providers	6.0	6.5	6.0	6.6	8.1	8.8
Pediatric Behavioral Health Service Providers	19.1	21.1	21.6	23.8	23.6	26.1
OB/GYN Providers	8.2	9.1	10.0	11.0	11.2	12.4
Pediatric Dentist	10.2	11.2	11.5	12.7	12.9	14.3
Hospitals	8.1	8.9	21.2	23.8	26.8	30.2
Specialists						
Allergy and Immunology	29.3	32.5	47.6	55.1	54.1	62.6
Dermatology	17.7	20.0	24.9	28.3	30.8	34.5
Endocrinology	31.6	35.3	37.4	42.4	50.1	58.7
ENT/Otolaryngology	15.5	17.2	21.1	23.6	28.2	31.9
Infectious Disease	31.7	37.0	47.6	56.8	50.8	60.0
Nephrology	15.8	17.4	20.2	22.6	29.6	33.5
Neurology	10.3	11.3	15.3	16.8	18.7	20.6
Oral Surgery	73.8	93.1	95.6	126.2	118.5	148.1
Orthopedic Surgery	15.7	17.4	25.7	28.7	27.5	30.8
Pulmonology	13.6	15.2	18.6	20.9	21.6	24.3
Urology	14.8	16.3	20.7	23.0	27.1	30.5
Chiropractor	41.1	46.4	60.3	69.4	71.6	82.6
Physiatry/Rehabilitative Medicine	17.5	19.4	24.6	27.4	29.0	33.0

Table B-8—Meridian Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.4	1.9	1.7	2.3	1.9	2.6
Pediatric PCPs	2.0	2.9	2.4	3.5	2.7	3.9
Adult Behavioral Health Providers	1.9	2.6	2.0	2.8	2.1	3.0
Pediatric Behavioral Health Service Providers	3.3	4.8	3.6	5.4	4.0	5.9
OB/GYN Providers	2.5	3.5	2.9	4.1	3.2	4.6
Pediatric Dentist	1.8	2.5	2.1	2.9	2.3	3.3
Hospitals	4.0	6.0	7.5	10.9	10.6	15.1
Specialists						
Allergy and Immunology	7.1	9.8	11.3	15.3	13.6	18.5
Dermatology	9.4	13.1	12.2	17.3	14.5	20.1
Endocrinology	5.3	7.5	11.0	14.6	13.0	17.4
ENT/Otolaryngology	6.2	9.1	8.5	12.1	9.8	14.1
Infectious Disease	5.4	7.7	6.8	9.7	9.8	13.7
Nephrology	4.3	6.1	5.9	8.1	6.7	9.2
Neurology	3.0	4.3	3.6	5.3	4.4	6.3
Oral Surgery	28.6	37.1	34.3	51.3	39.7	58.1
Orthopedic Surgery	4.1	6.0	5.5	8.1	6.4	9.3
Pulmonology	4.1	5.9	5.1	7.5	5.8	8.6
Urology	5.0	7.5	5.9	9.0	7.6	11.4
Chiropractor	13.3	20.2	19.9	28.9	30.8	43.9
Physiatry/Rehabilitative Medicine	4.1	6.0	6.3	9.0	7.8	10.8

Table B-9—Molina Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	4.2	4.5	4.9	5.3	5.7	6.1
Pediatric PCPs	4.3	4.6	4.7	5.1	5.4	5.9
Adult Behavioral Health Providers	7.1	7.7	10.6	11.6	13.2	14.4
Pediatric Behavioral Health Service Providers	8.6	9.4	12.5	13.6	14.9	16.3
OB/GYN Providers	10.7	11.8	12.0	13.3	14.7	16.2
Pediatric Dentist	10.2	11.2	12.7	13.9	15.4	17.0
Hospitals	10.1	11.2	20.1	22.4	26.8	30.4
Specialists						
Allergy and Immunology	31.5	35.4	39.1	44.2	46.8	53.6
Dermatology	20.6	22.7	25.4	28.2	30.2	33.8
Endocrinology	44.7	50.2	49.5	56.2	54.5	62.8
ENT/Otolaryngology	12.5	13.9	17.7	19.9	24.4	27.3
Infectious Disease	29.8	33.3	36.0	41.2	39.2	45.6
Nephrology	23.2	25.9	31.2	35.2	33.7	38.1
Neurology	17.1	18.8	24.0	26.7	27.2	30.7
Oral Surgery	59.2	75.6	64.9	82.6	71.1	90.3
Orthopedic Surgery	17.9	19.8	21.7	24.1	26.9	29.8
Pulmonology	17.5	19.5	22.9	25.7	24.9	28.1
Urology	20.6	23.3	27.8	31.2	31.4	36.2
Chiropractor	45.8	52.6	56.0	67.9	80.8	93.0
Physiatry/Rehabilitative Medicine	20.8	23.2	31.1	34.8	36.3	40.6

Table B-10—Molina Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.5	2.0	1.8	2.5	2.1	2.8
Pediatric PCPs	1.4	2.0	1.7	2.3	1.9	2.7
Adult Behavioral Health Providers	2.3	3.1	2.6	3.6	3.0	4.0
Pediatric Behavioral Health Service Providers	2.3	3.2	2.6	3.6	2.9	4.0
OB/GYN Providers	2.8	3.8	3.2	4.5	3.7	5.1
Pediatric Dentist	2.0	2.7	2.3	3.1	2.5	3.5
Hospitals	4.6	6.9	9.3	13.1	15.0	20.6
Specialists						
Allergy and Immunology	7.2	10.1	10.2	14.4	13.3	18.3
Dermatology	7.3	10.1	8.8	12.6	9.9	14.6
Endocrinology	7.7	10.5	9.6	13.0	12.4	16.9
ENT/Otolaryngology	3.9	5.7	4.9	7.2	7.1	10.4
Infectious Disease	4.2	5.9	7.1	10.3	8.0	11.5
Nephrology	4.6	6.4	5.7	8.0	9.2	12.5
Neurology	5.1	7.1	7.1	9.9	8.1	11.6
Oral Surgery	20.1	29.7	26.2	38.6	27.0	39.8
Orthopedic Surgery	4.1	5.9	4.6	6.6	5.7	8.1
Pulmonology	4.7	6.9	6.8	9.9	7.4	11.0
Urology	4.8	7.1	6.9	9.9	9.7	14.0
Chiropractor	12.2	17.7	17.2	24.8	33.1	44.4
Physiatry/Rehabilitative Medicine	5.1	7.3	7.0	9.9	9.9	13.6

Appendix F1. Beneficiary Satisfaction 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. BCBSIL, CountyCare , IlliniCare, Meridian, Molina, and NextLevel were responsible for contracting with a CAHPS vendor to administer the CAHPS surveys on their behalf.[F1-1,F1-2] Results for all six 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. In 2018, both the adult and child Medicaid populations were surveyed under the FHP/ACA and the adult Medicaid population was surveyed under the ICP for BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel.[F1-3] In 2019, both the adult and child Medicaid populations were surveyed under HealthChoice Illinois for BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel.[F1-4] Under the Statewide Survey, a statewide sample of child members enrolled in the All Kids and Illinois Medicaid programs were surveyed.[F1-5]

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on the levels of members' experience with their healthcare.

Overview

Previously, HFS operated four managed care programs: the FHP/ACA program, ICP, MMAI, and MLTSS. In the fall of 2017, HFS announced that seven health plans would provide the full spectrum of

F1-1 With statewide Medicaid expansion (HealthChoice Illinois) beginning in January 2018, HFS contracted with seven health plans to provide healthcare services to HealthChoice Illinois beneficiaries. However, in 2019, Harmony merged with Meridian; therefore, HSAG only presents 2018 and 2019 results in this report for the six health plans that continued to serve Illinois Medicaid beneficiaries in SFY 2019. However, HSAG included Harmony, along with the six health plans that reported CAHPS data for SFY 2019 in the 2018 aggregate; therefore, caution should be exercised when comparing the 2019 and 2018 aggregate results.

F1-2 In 2018, SPH Analytics administered the CAHPS surveys on behalf of CountyCare and Molina. Morpace administered the CAHPS surveys on behalf of BCBSIL, IlliniCare, Meridian, and NextLevel. In 2019, SPH Analytics administered the CAHPS surveys on behalf of CountyCare, Meridian, and Molina. Morpace administered the CAHPS surveys on behalf of BCBSIL, IlliniCare, and NextLevel.

F1-3 HSAG combined the 2018 results for the FHP/ACA and ICP adult Medicaid populations presented in this report.

F1-4 Please exercise caution when evaluating Meridian's 2019 results, since Harmony merged with Meridian in 2019.

F1-5 The Illinois statewide program aggregate results presented in this report represent the results of the All Kids and Illinois Medicaid programs combined.

Medicaid covered services through HealthChoice Illinois. HealthChoice Illinois included the State's existing Medicaid managed care population and the statewide expansion of managed care. HealthChoice Illinois also consolidated previous programs (FHP/ACA, ICP, and MLTSS) and reduced the number of contracted health plans. On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, launching HealthChoice Illinois to serve approximately 2.7 million residents. HFS contracted with seven health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Five of the HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. However, in 2019 Harmony merged with Meridian, so HealthChoice Illinois is served by six health plans.

Technical Methods of Data Collection and Analysis

FHP/ACA and ICP Health Plans

The technical method of data collection was through the administration of the CAHPS 5.0H Adult Medicaid Survey to the adult populations and the CAHPS 5.0H Child Medicaid Survey to the child populations. All health plans used a mixed-mode methodology for data collection, which included both mail and telephone surveys for data collection, with the option to complete the surveys in English and Spanish.[F1-6]

All Kids and Illinois Medicaid Statewide Survey

The technical method of data collection was through the administration of the CAHPS 5.0 Child Medicaid Survey with the Children with Chronic Conditions (CCC) measurement set to a statewide sample of the child population enrolled in each program. For All Kids and Illinois Medicaid, a sample representing the general child population and a 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.

[F1-6] In 2018 BCBSIL and IlliniCare used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.0H Adult Medicaid Survey and CAHPS 5.0H Child Medicaid Survey. In 2019, BCBSIL, IlliniCare, and NextLevel used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.0H Adult Medicaid Survey and CAHPS 5.0H Child Medicaid Survey. This protocol allowed sampled members the option to complete the survey via the Internet.

Survey Measures for CAHPS

The survey questions were categorized into nine measures of experience. These measures included four global ratings and five 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.

The 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 fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2e "No" and "Yes." For four of the composites (*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." For one composite (*Shared Decision Making*), a positive, or top-box, response was defined as a response of "Yes." 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 Car* (*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 2018 top-box scores were compared to NCQA's 2017 Quality Compass Benchmark and Compare Quality Data, and the resulting 2019 top-box scores were compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data.[F1-7,F1-8] 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 F1-1.

Table F1-1—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

F1-7 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2017*. Washington, DC: NCQA. September 2017.

F1-8 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018*. Washington, DC: NCQA. September 2018.

Adult CAHPS Medicaid Survey

Adult Plan-Specific Findings and Comparisons

The 2018 and 2019 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 (i.e., all health plans combined).

Composite Measures

Table F1-2—2018 and 2019 Adult Plan-Specific Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2018	76.5% ★	76.5% ★	94.5% ★★★★★	87.6% ★★	83.0% ★★★★
	2019	83.6% ★★★	81.5% ★★	93.8% ★★★★	90.3% ★★★★	81.0% ★★★
CountyCare	2018	78.7% ★	80.5% ★★	92.1% ★★★	91.2% ★★★★	75.1% ★
	2019	81.2% ★★	82.3% ★★	93.6% ★★★★	94.3% ★★★★★	78.1% ★★
IlliniCare	2018	72.6% ★	75.7% ★	88.4% ★	82.3% ★	77.4% ★
	2019	82.7% ★★	83.0% ★★★	93.0% ★★★	89.1% ★★★	78.8% ★★
Meridian	2018	80.1% ★★	79.5% ★	92.3% ★★★	88.9% ★★★	73.7% ★
	2019	83.4% ★★★	82.9% ★★★	92.2% ★★★	89.5% ★★★	77.8% ★
Molina	2018	77.8% ★	77.7% ★	91.4% ★★	89.5% ★★★	73.7% ★
	2019	78.5% ★	79.6% ★★	91.2% ★★	84.6% ★	82.5% ★★★★
NextLevel	2018	61.3% ★	68.9% ★	90.0% ★	67.3%+ ★+	73.6%+ ★+
	2019	71.1%+ ★+	74.0%+ ★+	92.5%+ ★★★+	88.0%+ ★★+	69.0%+ ★+
Statewide Aggregate	2018	75.8% ★	77.5% ★	91.8% ★★★	87.0% ★★	76.7% ★
	2019	82.1% ★★	82.0% ★★	92.9% ★★★	89.8% ★★★	78.9% ★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Global Ratings

Table F1-3—2018 and 2019 Adult 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
BCBSIL	2018	54.2% ★★	66.2% ★★	69.3% ★★★	61.1% ★★★
	2019	54.1% ★★	67.2% ★★	71.4% ★★★★	60.9% ★★★
CountyCare	2018	50.3% ★	67.5% ★★★	63.1% ★	64.8% ★★★★
	2019	52.6% ★★	66.2% ★★	64.3% ★★	61.8% ★★★
IlliniCare	2018	49.7% ★	57.5% ★	58.7% ★	47.6% ★
	2019	55.3% ★★★	71.9% ★★★★	70.6% ★★★★	57.2% ★★
Meridian	2018	53.5% ★★	64.4% ★★	70.2% ★★★★	59.5% ★★
	2019	56.9% ★★★	69.2% ★★★	67.2% ★★	61.4% ★★★
Molina	2018	51.6% ★★	63.3% ★★	68.8% ★★★	53.0% ★
	2019	53.2% ★★	68.9% ★★★	68.0% ★★★	57.1% ★★
NextLevel	2018	54.1% ★★	63.3% ★★	59.0%+ ★+	39.1% ★
	2019	47.0%+ ★+	65.0%+ ★★+	51.5%+ ★+	47.2% ★
Statewide Aggregate	2018	51.9% ★★	64.1% ★★	65.1% ★★	56.9% ★★
	2019	54.6% ★★	69.0% ★★★	68.1% ★★★	59.3% ★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Child CAHPS Medicaid Survey

Child Plan-Specific Findings and Comparisons

The 2018 and 2019 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 (i.e., all health plans combined).

Composite Measures

Table F1-4—2018 and 2019 Child Plan-Specific Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2018	75.6% ★	82.2% ★	93.8% ★★	86.4% ★★	71.7% ★
	2019	77.0% ★	82.3% ★	94.6% ★★★	87.0% ★	79.7%+ ★★★+
CountyCare	2018	81.1% ★★	83.2% ★	93.8% ★★	89.4% ★★★	84.8%+ ★★★★★+
	2019	83.8% ★★	81.8% ★	92.9% ★★	85.6% ★	76.3%+ ★★+
IlliniCare	2018	75.2%+ ★+	82.1% ★	92.1% ★	79.8% ★	76.6%+ ★+
	2019	77.1% ★	90.0% ★★★	92.5% ★★	89.3% ★★★	81.2%+ ★★★★+
Meridian	2018	78.1% ★	86.2% ★★	94.6% ★★★	88.6% ★★★	83.5% ★★★★★
	2019	79.6% ★	87.4% ★★	94.2% ★★★	87.9% ★★	81.6%+ ★★★★+
Molina	2018	80.4% ★	83.9% ★	92.0% ★	82.8% ★	74.3% ★
	2019	83.8% ★★	87.5% ★★	93.0% ★★	84.4% ★	82.1%+ ★★★★+
NextLevel	2018	70.0%+ ★+	76.1%+ ★+	85.6%+ ★+	80.6%+ ★+	83.3%+ ★★★★★+
	2019	75.4% ★	80.9% ★	90.2% ★	86.0% ★	65.1%+ ★+
Statewide Aggregate	2018	77.7% ★	83.9% ★	93.2% ★★	86.4% ★★	78.6% ★★
	2019	79.7% ★	85.6% ★	93.6% ★★	87.1% ★	80.1% ★★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Global Ratings

Table F1-5—2018 and 2019 Child 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
BCBSIL	2018	74.2% ★★★★	77.9% ★★★	76.7%+ ★★★+	75.2% ★★★★
	2019	74.6% ★★★★	77.7% ★★★	75.7% ★★★	75.3% ★★★
CountyCare	2018	73.1% ★★★★	84.6% ★★★★★	75.0%+ ★★★+	74.1% ★★★
	2019	70.0% ★★	78.6% ★★★	76.8%+ ★★★+	74.2% ★★★
IlliniCare	2018	54.8% ★	71.7% ★	74.1%+ ★★★+	61.5% ★
	2019	63.8% ★	74.4% ★	63.0%+ ★+	62.8% ★
Meridian	2018	72.3% ★★★	79.9% ★★★★	74.0% ★★★	72.1% ★★★
	2019	71.8% ★★★	77.4% ★★★	74.7%+ ★★★+	69.1% ★★
Molina	2018	69.0% ★★	75.6% ★★	74.2% ★★★	66.1% ★
	2019	69.1% ★★	77.0% ★★★	69.4%+ ★+	62.6% ★
NextLevel	2018	59.3%+ ★+	60.7%+ ★+	61.5%+ ★+	47.1%+ ★+
	2019	65.0% ★	73.6% ★	61.2%+ ★+	64.0% ★
Statewide Aggregate	2018	69.9% ★★	78.2% ★★★	75.3% ★★★	71.0% ★★★
	2019	70.6% ★★★	77.1% ★★★	72.9% ★★	69.7% ★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Statewide Survey Findings and Comparisons

The 2018 and 2019 general child and 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.[F1-9]

General Child Population

Table F1-6—2018 and 2019 Statewide Survey General Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2018	82.7% ★★	82.5% ★★	82.7% ★★
	2019	85.0% ★★★	85.5% ★★★	84.9% ★★★
Getting Care Quickly	2018	85.9% ★	83.7% ★	86.1% ★
	2019	88.1% ★★	86.2% ★	88.4% ★★
How Well Doctors Communicate	2018	92.1% ★	95.1% ★★★★	91.8% ★
	2019	93.6% ★★	94.3% ★★★	93.5% ★★
Customer Service	2018	85.1% ★	81.8% ★	85.4% ★
	2019	87.1% ★	87.6% ★★	87.0% ★
Shared Decision Making	2018	78.2% ★★	80.4% ★★★	78.0%+ ★★+
	2019	73.2% ★	76.4% ★★	72.8%+ ★+
Global Ratings				
Rating of All Health Care	2018	63.2% ★	66.7% ★★	62.8% ★
	2019	70.0% ★★	73.0% ★★★★	69.6% ★★

[F1-9] 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 Personal Doctor	2018	74.6% ★★	74.4% ★★	74.7% ★★
	2019	77.0% ★★★	78.5% ★★★	76.8% ★★★
Rating of Specialist Seen Most Often	2018	76.6% ★★★	71.6% ★★	77.1%+ ★★★+
	2019	80.2% ★★★★★	82.1% ★★★★★	80.0%+ ★★★★★+
Rating of Health Plan	2018	61.3% ★	61.3% ★	61.3% ★
	2019	63.1% ★	64.7% ★	62.9% ★
+ Indicates that results for this measure did not meet the minimum number of 100 responses.				

CCC Child Population

Table F1-7—2018 and 2019 Statewide Survey CCC Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2018	84.8% ★★	86.0% ★★	83.1% ★★
	2019	83.1% ★	83.3% ★	82.8% ★
Getting Care Quickly	2018	88.8% ★	89.9% ★★	87.3% ★
	2019	88.7% ★	87.3% ★	90.2% ★
How Well Doctors Communicate	2018	94.3% ★★	94.8% ★★★	93.6% ★★
	2019	93.7% ★★	94.6% ★★	92.7% ★
Customer Service	2018	81.7% ★	81.7% ★	81.8% ★
	2019	83.8% ★	84.3% ★	83.1% ★
Shared Decision Making	2018	83.2% ★	81.5% ★	85.4% ★★★
	2019	82.4% ★	81.9% ★	83.0% ★

Experience of Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Global Ratings				
Rating of All Health Care	2018	61.7% ★	65.6% ★★	56.5% ★
	2019	62.2% ★	62.4% ★	62.0% ★
Rating of Personal Doctor	2018	71.4% ★	72.8% ★	69.6% ★
	2019	75.0% ★★	75.9% ★★	73.8% ★
Rating of Specialist Seen Most Often	2018	72.8% ★★★	74.6% ★★★	70.5% ★★
	2019	74.8% ★★★	75.7% ★★★	73.6% ★★
Rating of Health Plan	2018	53.4% ★	52.4% ★	54.6% ★
	2019	56.0% ★	55.1% ★	57.0% ★
CCC Composites and Items				
Access to Specialized Services	2018	72.8% ★	68.5%+ ★+	76.9%+ ★★+
	2019	68.9% ★	69.5%+ ★+	68.0%+ ★+
Family-Centered Care: Personal Doctor Who Knows Child	2018	90.1% ★★	91.0% ★★★	89.1% ★★
	2019	91.1% ★★	92.5% ★★★	89.5% ★
Coordination of Care for Children with Chronic Conditions	2018	79.4% ★★★	78.8% ★★★	80.1%+ ★★★+
	2019	77.7% ★★★	79.2% ★★★	76.9% ★★
Access to Prescription Medicines	2018	87.8% ★	88.5% ★	86.8% ★
	2019	88.2% ★	87.2% ★	89.5% ★
Family-Centered Care: Getting Needed Information	2018	90.5% ★★	93.0% ★★★★	87.1% ★
	2019	90.1% ★	90.7% ★	89.3% ★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Appendix F2. Beneficiary Satisfaction With Care Detailed Results

Adult CAHPS Medicaid Survey

Response Rates

The 2019 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 F2-1—2019 Adult Response Rates

BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Aggregate
19.38%	23.08%	20.99%	25.85%	23.83%	9.00%	20.83%

Adult Plan-Specific Findings and Comparisons

The 2018 and 2019 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 F2-2—2018 and 2019 Adult Plan-Specific Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2018	76.5% ★	76.5% ★	94.5% ★★★★★	87.6% ★★	83.0% ★★★★
	2019	83.6% ★★★	81.5% ★★	93.8% ★★★★	90.3% ★★★★	81.0% ★★★
CountyCare	2018	78.7% ★	80.5% ★★	92.1% ★★★	91.2% ★★★★	75.1% ★
	2019	81.2% ★★	82.3% ★★	93.6% ★★★★	94.3% ★★★★★	78.1% ★★
IlliniCare	2018	72.6% ★	75.7% ★	88.4% ★	82.3% ★	77.4% ★
	2019	82.7% ★★	83.0% ★★★	93.0% ★★★	89.1% ★★★	78.8% ★★
Meridian	2018	80.1% ★★	79.5% ★	92.3% ★★★	88.9% ★★★	73.7% ★
	2019	83.4% ★★★	82.9% ★★★	92.2% ★★★	89.5% ★★★	77.8% ★

Experience of Care

Statewide Adult Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Molina	2018	77.8% ★	77.7% ★	91.4% ★★	89.5% ★★★	73.7% ★
	2019	78.5% ★	79.6% ★★	91.2% ★★	84.6% ★	82.5% ★★★★
NextLevel	2018	61.3% ★	68.9% ★	90.0% ★	67.3%+ ★+	73.6%+ ★+
	2019	71.1%+ ★+	74.0%+ ★+	92.5%+ ★★★+	88.0%+ ★★+	69.0%+ ★+
Statewide Aggregate	2018	75.8% ★	77.5% ★	91.8% ★★★	87.0% ★★	76.7% ★
	2019	82.1% ★★	82.0% ★★	92.9% ★★★	89.8% ★★★	78.9% ★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Notable

- Compared to national benchmarks, 2019 experience survey results indicated that adult BCBSIL and CountyCare members reported top-box scores above the 75th percentile for *How Well Doctors Communicate* and *Customer Service*. Also, adult Molina members reported top-box scores above the 75th percentile for *Shared Decision Making*.
- Star ratings for BCBSIL improved from 2018 to 2019 for *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that adult members in four of the six MCOs reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, and *Shared Decision Making*.

Global Ratings

Table F2-3—2018 and 2019 Adult 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
BCBSIL	2018	54.2% ★★	66.2% ★★	69.3% ★★★	61.1% ★★★
	2019	54.1% ★★	67.2% ★★	71.4% ★★★★	60.9% ★★★
CountyCare	2018	50.3% ★	67.5% ★★★	63.1% ★	64.8% ★★★★
	2019	52.6% ★★	66.2% ★★	64.3% ★★	61.8% ★★★
IlliniCare	2018	49.7% ★	57.5% ★	58.7% ★	47.6% ★
	2019	55.3% ★★★	71.9% ★★★★	70.6% ★★★★	57.2% ★★
Meridian	2018	53.5% ★★	64.4% ★★	70.2% ★★★★	59.5% ★★
	2019	56.9% ★★★	69.2% ★★★	67.2% ★★	61.4% ★★★
Molina	2018	51.6% ★★	63.3% ★★	68.8% ★★★	53.0% ★
	2019	53.2% ★★	68.9% ★★★	68.0% ★★★	57.1% ★★
NextLevel	2018	54.1% ★★	63.3% ★★	59.0%+ ★+	39.1% ★
	2019	47.0%+ ★+	65.0%+ ★★+	51.5%+ ★+	47.2% ★
Statewide Aggregate	2018	51.9% ★★	64.1% ★★	65.1% ★★	56.9% ★★
	2019	54.6% ★★	69.0% ★★★	68.1% ★★★	59.3% ★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Notable

- Star ratings and top-box scores improved from 2018 to 2019 for IlliniCare for all four global ratings.
- Compared to national benchmarks, 2019 experience survey results indicated that adult BCBSIL and IlliniCare members reported top-box scores at or between the 75th and 89th percentiles for at least one measure.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that adult members in four of the six MCOs reported top-box scores below the 50th percentile for *Rating of All Health Care*.
- Compared to national benchmarks, 2019 experience survey results indicated that adult NextLevel members reported top-box scores below the 50th percentile for all four global ratings.

Child CAHPS Medicaid Survey

Response Rates

The 2019 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 F2-4—2019 Child Response Rates

BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Aggregate
17.33%	24.93%	14.38%	24.32%	21.47%	7.99%	16.80%

Child Plan-Specific Findings and Comparisons

The 2018 and 2019 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 F2-5—2018 and 2019 Child Plan-Specific Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
BCBSIL	2018	75.6% ★	82.2% ★	93.8% ★★	86.4% ★★	71.7% ★
	2019	77.0% ★	82.3% ★	94.6% ★★★	87.0% ★	79.7%+ ★★★+
CountyCare	2018	81.1% ★★	83.2% ★	93.8% ★★	89.4% ★★★	84.8%+ ★★★★★+
	2019	83.8% ★★	81.8% ★	92.9% ★★	85.6% ★	76.3%+ ★★+
IlliniCare	2018	75.2%+ ★+	82.1% ★	92.1% ★	79.8% ★	76.6%+ ★+
	2019	77.1% ★	90.0% ★★★	92.5% ★★	89.3% ★★★	81.2%+ ★★★★+
Meridian	2018	78.1% ★	86.2% ★★	94.6% ★★★	88.6% ★★★	83.5% ★★★★★
	2019	79.6% ★	87.4% ★★	94.2% ★★★	87.9% ★★	81.6%+ ★★★★+

Experience of Care

Statewide Child Results

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Molina	2018	80.4% ★	83.9% ★	92.0% ★	82.8% ★	74.3% ★
	2019	83.8% ★★	87.5% ★★	93.0% ★★	84.4% ★	82.1%+ ★★★★+
NextLevel	2018	70.0%+ ★+	76.1%+ ★+	85.6%+ ★+	80.6%+ ★+	83.3%+ ★★★★★+
	2019	75.4% ★	80.9% ★	90.2% ★	86.0% ★	65.1%+ ★+
Statewide Aggregate	2018	77.7% ★	83.9% ★	93.2% ★★	86.4% ★★	78.6% ★★
	2019	79.7% ★	85.6% ★	93.6% ★★	87.1% ★	80.1% ★★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Notable

- Compared to national Medicaid percentiles, 2019 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores between the 74th and 89th percentiles for *Shared Decision Making* for IlliniCare, Meridian, and Molina.
- Star ratings improved from 2018 to 2019 for four of the five composite measures for IlliniCare and Molina, with three of those measures increasing by at least two stars for IlliniCare.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores below the 50th percentile for *Getting Needed Care* and *Getting Care Quickly* for all MCOs, with the exception of IlliniCare.
- Additionally, parents/caretakers of child members from the general child population reported top-box scores below the 50th percentile for *How Well Doctors Communicate* and *Customer Service* for at least four of the six MCOs.
- Star ratings declined from 2018 to 2019 for *Customer Service* for the following MCOs: BCBSIL, CountyCare, and Meridian.

Global Ratings

Table F2-6—2018 and 2019 Child 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
BCBSIL	2018	74.2% ★★★★	77.9% ★★★	76.7%+ ★★★+	75.2% ★★★★
	2019	74.6% ★★★★	77.7% ★★★	75.7% ★★★	75.3% ★★★
CountyCare	2018	73.1% ★★★★	84.6% ★★★★★	75.0%+ ★★★+	74.1% ★★★
	2019	70.0% ★★	78.6% ★★★	76.8%+ ★★★+	74.2% ★★★
IlliniCare	2018	54.8% ★	71.7% ★	74.1%+ ★★★+	61.5% ★
	2019	63.8% ★	74.4% ★	63.0%+ ★+	62.8% ★
Meridian	2018	72.3% ★★★	79.9% ★★★★	74.0% ★★★	72.1% ★★★
	2019	71.8% ★★★	77.4% ★★★	74.7%+ ★★★+	69.1% ★★
Molina	2018	69.0% ★★	75.6% ★★	74.2% ★★★	66.1% ★
	2019	69.1% ★★	77.0% ★★★	69.4%+ ★+	62.6% ★
NextLevel	2018	59.3%+ ★+	60.7%+ ★+	61.5%+ ★+	47.1%+ ★+
	2019	65.0% ★	73.6% ★	61.2%+ ★+	64.0% ★
Statewide Aggregate	2018	69.9% ★★	78.2% ★★★	75.3% ★★★	71.0% ★★★
	2019	70.6% ★★★	77.1% ★★★	72.9% ★★	69.7% ★★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Experience of Care

Statewide Child Results

Notable

- BCBSIL was the only MCO where parents/caretakers of child members from the general child population reported a top-box score for one measure, *Rating of All Health Care*, at or above the 74th percentile compared to national Medicaid percentiles.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores below the 25th percentile for all four global ratings for NextLevel and IlliniCare.
- Overall, star ratings declined or remained the same from 2018 to 2019 for all four global ratings for all MCOs, except for *Rating of Personal Doctor* for Molina.

Statewide CAHPS Medicaid Survey

Response Rates

The table below presents the 2019 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 F2-7—2019 Statewide Survey Response Rates

Program Name	2019 Response Rate
All Kids	39.21%
Illinois Medicaid	27.86%
Illinois Statewide Aggregate	33.53%

General Child Population Findings and Comparisons

The 2018 and 2019 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.[F2-1]

Table F2-8—2018 and 2019 Statewide Survey General Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2018	82.7% ★★	82.5% ★★	82.7% ★★
	2019	85.0% ★★★	85.5% ★★★	84.9% ★★★
Getting Care Quickly	2018	85.9% ★	83.7% ★	86.1% ★
	2019	88.1% ★★	86.2% ★	88.4% ★★

[F2-1] 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 of Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
How Well Doctors Communicate	2018	92.1% ★	95.1% ★★★★	91.8% ★
	2019	93.6% ★★	94.3% ★★★	93.5% ★★
Customer Service	2018	85.1% ★	81.8% ★	85.4% ★
	2019	87.1% ★	87.6% ★★	87.0% ★
Shared Decision Making	2018	78.2% ★★	80.4% ★★★	78.0%+ ★★+
	2019	73.2% ★	76.4% ★★	72.8%+ ★+
Global Ratings				
Rating of All Health Care	2018	63.2% ★	66.7% ★★	62.8% ★
	2019	70.0% ★★	73.0% ★★★★	69.6% ★★
Rating of Personal Doctor	2018	74.6% ★★	74.4% ★★	74.7% ★★
	2019	77.0% ★★★	78.5% ★★★	76.8% ★★★
Rating of Specialist Seen Most Often	2018	76.6% ★★★	71.6% ★★	77.1%+ ★★★+
	2019	80.2% ★★★★★	82.1% ★★★★★	80.0%+ ★★★★★+
Rating of Health Plan	2018	61.3% ★	61.3% ★	61.3% ★
	2019	63.1% ★	64.7% ★	62.9% ★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Notable

- Compared to national Medicaid percentiles, 2019 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores at or above the 90th percentile for *Rating of Specialist Seen Most Often* for All Kids and Illinois Medicaid. In addition, parents/caretakers of child members reported top-box scores at or between the 74th and 89th percentiles for *Rating of All Health Care* for All Kids.
- Star ratings improved from 2018 to 2019 for All Kids and Illinois Medicaid on the following measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores below the 25th percentile for *Rating of Health Plan* for All Kids and Illinois Medicaid, which is a consistent finding from the MCOs' results.

CCC Child Population Findings and Comparisons

The 2018 and 2019 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.[F2-2]

Table F2-9—2018 and 2019 Statewide Survey CCC Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2018	84.8% ★★	86.0% ★★	83.1% ★★
	2019	83.1% ★	83.3% ★	82.8% ★
Getting Care Quickly	2018	88.8% ★	89.9% ★★	87.3% ★
	2019	88.7% ★	87.3% ★	90.2% ★

[F2-2] 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).

Experience of Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
How Well Doctors Communicate	2018	94.3% ★★	94.8% ★★★	93.6% ★★
	2019	93.7% ★★	94.6% ★★	92.7% ★
Customer Service	2018	81.7% ★	81.7% ★	81.8% ★
	2019	83.8% ★	84.3% ★	83.1% ★
Shared Decision Making	2018	83.2% ★	81.5% ★	85.4% ★★★
	2019	82.4% ★	81.9% ★	83.0% ★
Global Ratings				
Rating of All Health Care	2018	61.7% ★	65.6% ★★	56.5% ★
	2019	62.2% ★	62.4% ★	62.0% ★
Rating of Personal Doctor	2018	71.4% ★	72.8% ★	69.6% ★
	2019	75.0% ★★	75.9% ★★	73.8% ★
Rating of Specialist Seen Most Often	2018	72.8% ★★★	74.6% ★★★	70.5% ★★
	2019	74.8% ★★★	75.7% ★★★	73.6% ★★
Rating of Health Plan	2018	53.4% ★	52.4% ★	54.6% ★
	2019	56.0% ★	55.1% ★	57.0% ★
CCC Composites and Items				
Access to Specialized Services	2018	72.8% ★	68.5%+ ★+	76.9%+ ★★+
	2019	68.9% ★	69.5%+ ★+	68.0%+ ★+

Experience of Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Family-Centered Care: Personal Doctor Who Knows Child	2018	90.1% ★★	91.0% ★★★	89.1% ★★
	2019	91.1% ★★	92.5% ★★★	89.5% ★
Coordination of Care for Children with Chronic Conditions	2018	79.4% ★★★	78.8% ★★★	80.1%+ ★★★+
	2019	77.7% ★★★	79.2% ★★★	76.9% ★★
Access to Prescription Medicines	2018	87.8% ★	88.5% ★	86.8% ★
	2019	88.2% ★	87.2% ★	89.5% ★
Family-Centered Care: Getting Needed Information	2018	90.5% ★★	93.0% ★★★★	87.1% ★
	2019	90.1% ★	90.7% ★	89.3% ★

+ Indicates that results for this measure did not meet the minimum number of 100 responses.

Notable

- Star ratings improved from 2018 to 2019 for *Rating of Personal Doctor* for All Kids.

Needs Work

- Compared to national benchmarks, 2019 experience survey results indicated that parents/caretakers of child members from the CCC population reported top-box scores below the 50th percentile for both populations on all measures except *Rating of Specialist Seen Most Often*, *FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions* for All Kids.
- Star ratings declined or remained the same from 2018 to 2019 for All Kids and Illinois Medicaid on all measures except *Rating of Personal Doctor*.

Recommendations

According to the NCQA, a minimum of 100 responses on each item is required to obtain a reportable CAHPS survey result. Higher response rates minimize the potential effects of nonresponse bias and provide more reliable results. To achieve this targeted number of completed surveys, HSAG recommends the following:

- The MCOs should oversample their sample sizes to ensure that there are sufficient members surveyed to obtain enough responses for each measure. The MCOs can determine an appropriate oversampling rate by considering the CAHPS results that did not meet the minimum number of responses (indicated by +).
- HFS and the MCOs may want to evaluate the quality of member data in their system by ensuring they have the most accurate and up-to-date information when pulling sample frame files. The MCOs should keep in mind that maintaining accurate member contact information in their systems should help eliminate a high number of undeliverables or members that cannot be contacted during survey administration.
- The MCOs should continue using a mixed-mode survey administration protocol (i.e., allow two methods by which the surveys can be completed). Research has shown that a mixed-mode methodology has the greatest potential to increase response rates, since members can be reached via mail or telephone.

Appendix G1. HSW Review Methodology

Introduction

HFS provides quality oversight of State Medicaid managed care health plans (health plans) that provide services for HealthChoice Illinois, MLTSS, and MMAI populations. To provide feedback and analysis on the health plans' compliance with HSW and CI requirements, HFS requested that HSAG, the EQRO for Illinois, conduct quarterly reviews of HSW/CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

The HSW/CI review evaluated the health plans' compliance with all HSW/CI requirements required by contract, State and federal statutes and regulations, and 1915(b) and 1915(c) waiver conditions. The applicable contract citations are included in the HSW/Critical Incidents Monitoring Review reports (available upon request).

For the Q1 and Q2 CY 2019 review, assessment included cases reported in each health plan's internal critical incident reporting system during CY 2018. This report provides a summary of the health plans' compliance with the HSW/CI requirements.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

HSAG developed a sampling methodology based on the requirements approved by HFS. For the Q1/Q2 CY 2019 review, HSAG selected one random sample across all health plans and populations (HealthChoice Illinois and MMAI) combined, consisting of 412 cases with an HSW/CI, with a 20 percent oversample. The sample is designed to ensure a 95 percent confidence level and 5 percent margin of error for annualized results of the population targeted by the sample. This sampling method is designed to ensure that when the samples are combined there is sufficient statistical power to meet any applicable CMS reporting requirements. The 412 cases were equally distributed across all plans to establish baseline data. For those plans serving both HealthChoice Illinois and MMAI, their sample was distributed between the two populations. Table G1-1 displays the CY 2018 record review sample size by health plan.

Table G1-1—Sample Size by Health Plan and Population CY 2018 Incidents

Health Plan	HealthChoice Illinois		MMAI	
	Eligible Population	Sample Size	Eligible Population	Sample Size
Aetna			38	38
BCBSIL	693	26	150	26
CountyCare	229	51		
Humana			95	51
IlliniCare	125	26	16	16
Meridian	1,535	26	108	26
Molina	71	26	42	26
NextLevel	131	51		
Total	**2,784**	**206**	**449**	**183**

Shaded cells represent populations that are not served by the health plan.

The population and resulting sample included both nonwaiver beneficiaries and HCBS waiver beneficiaries. The following HCBS waiver programs were included in the sample:

- **PD:** Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility and can be safely maintained in the home or community-based setting with the services provided in the plan of care. Individuals 60 years or older who began services before age 60 may choose to remain in this waiver.
- **HIV:** Persons of any age who are diagnosed with HIV or AIDS and are at risk of placement in a nursing facility.
- **BI:** Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- **ELD:** Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are aged 65 and older and those who are physically disabled, ages 60 through 64.
- **SLF:** Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

Limitations to the sampling methodology included known variables, such as health plans that did not have enough cases to meet the sample size (in which case, the entire population was reviewed) or identification by the health plan after receipt of sample that the case was not categorized correctly as an HSW/CI.

Methodology for Data Collection

HSAG reviewed the specifications described in the HealthChoice Illinois and MMAI contracts, the MLTSS waiver, and the HFS policies (*Critical Incident Guide* and *MCO-002 – Adult Protective Services Reporting*) to define the scope of the review. HSAG developed a file review tool to assess a sample of HSW/CI cases. HSAG used the tool to assess compliance in each of the following domains:

- Reporting of incident
- Compliance with investigating authority decisions
- Case management activities

HSAG also used the tool to assess additional data related to the incident.

Scoring Methodology

During the file review, the HSAG review team reviewed documentation for the selected cases for the review period. The review team determined evidence of case compliance with each of the scored elements. A score of *Met*, *Not Met*, or *NA* was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Met* or *Not Met* according to the criteria identified below. HSAG also used a designation of *NA* if the requirement was not applicable to a record; *NA* findings were not included in the two-point scoring methodology.

Met 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.

Not Met indicates noncompliance, defined as either of the following:

- Not all documentation was present.
- Cases reviewed did not have documentation that met "Due Diligence" criteria.

NA indicates a requirement that will not be scored for compliance based on the criteria listed for the specific element in the Evaluation Criteria document.

HSAG calculated the overall percentage-of-compliance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, 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.

Remediation Actions

Health plans will be required to complete remediation of any findings. HSAG will complete review of remediation actions within 30 days after the findings are identified to the health plans.

Appendix G2. Staffing Reviews Methodology

Introduction

CMS requires HFS to provide quality oversight of health plans that provide HCBS waiver services for the HealthChoice Illinois and MMAI population. HSAG, the EQRO for Illinois, is contracted by HFS to conduct a semiannual review of the health plans' compliance with waiver staffing contract requirements related to:

- Qualifications by waiver type.
- Related experience.
- Caseload assignments.

As part of the staffing review, HSAG also evaluated contract requirements related to CC/CM staffing. This report provides a summary of the health plans' compliance with the staffing requirements for CC/CM staff. This report also identifies non-contractually-required data and information relative to CC/CM management positions and CM/CC staff. This review included assessment of internal health plan staff and any delegated entities performing CC/CM services.

Additional details about the requirements and results of the staffing reviews are included in Care Management/Care Coordination Bi-Annual Staffing report (available upon request).

Methodology for Data Collection

HSAG reviewed the staffing specifications described in the HealthChoice Illinois and MMAI contracts to define the scope of the staffing analysis for CY 2019, with staffing data effective as of April 30, 2019. HSAG developed an Excel workbook tool that each health plan was required to complete for analysis. HSAG used the tool to assess contract compliance in each of the following domains:

- Waiver member caseloads per contract type
- Weighted caseloads total per contract type
- Staff qualifications
- Staff-related experience

HSAG also used the tool to assess non-contractually-required data related to management and staff positions.

The tool HSAG provided included several spreadsheets requiring health plans to identify their CC/CM staffing, as described below.

Internal CC/CM Management Positions

Health plans were required to identify their internal CC/CM management staff. The CC/CM Management Staffing worksheet identified the names, positions, residency, date of hire, FTE, and credentials of each CC/CM managerial position. CC/CM managerial staffing levels are not directed by contract; however, data was collected to provide information regarding oversight of the CC/CM program.

Delegated CC/CM Management Positions

The health plans were also required to identify delegated CC/CM management staff. For those health plans that delegated CC/CM services, HSAG performed an evaluation of the delegated entity's management against the same standards as the health plan's internal CC/CM management staff.

Internal CC/CM Staff

Health plans were required to provide case management type (telephonic or field), positions, qualifications and related experience of the internal CC/CM staff. Additionally, health plans were required to list each CC/CM's member caseload assignments by waiver, nonwaiver, and risk stratification level and by the FTE assigned.

Delegated CC/CM Staff

Those health plans that delegated CC/CM services were required to identify all delegated CC/CM staff. HSAG performed an evaluation of the delegated entity's CC/CM staff against the same standards as the health plan's internal CC/CM staff.

Methodology for Analysis

HSAG analyzed each health plan's compliance with contract requirements in the areas described below for both internal and delegated staff, as applicable:

- CC/CM staff qualifications for staff managing waiver caseloads
- CC/CM-related experience for staff managing HIV waiver caseloads
- CC/CM staff caseload assignment for staff managing HIV and/or BI waiver caseloads
- CC/CM staff weighted caseload by contract
- CC/CM staff total caseload by contract

HSAG also analyzed the following non-contractually-required data:

- CC/CM management positions
  - Total dedicated FTE
  - Ratio of total dedicated managerial staff to total CC/CM staff
  - Residency of management staff
  - Qualifications of management staff

- CC/CM staff
  - Total dedicated FTE
  - Qualifications of CC/CM staff
  - Type of care management provided (telephonic or field-based)