



**HFS**

Illinois Department of  
Healthcare and Family Services

# EXTERNAL QUALITY REVIEW ANNUAL REPORT

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Illinois Department of Healthcare  
and Family Services  
Division of Medical Programs

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# 1. Executive Summary

## Report Purpose and 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.

## Illinois Medicaid Managed Care

HFS provides a statewide managed care model to deliver integrated and quality managed care to enrollees. During calendar year (CY) 2025, HFS operated three distinct medical programs: HealthChoice Illinois (HealthChoice), Medicare-Medicaid Alignment Initiative (MMAI), and YouthCare Specialty Plan (YouthCare).

### HealthChoice

HealthChoice is the statewide Medicaid managed care program, covering all counties in Illinois and providing the full spectrum of Medicaid-covered services to the general Medicaid population, including children through the Children’s Health Insurance Program (CHIP). HealthChoice offers most Medicaid enrollees enhanced healthcare coordination and quality services, including the following populations: families and children; adults eligible for Medicaid under the Affordable Care Act (ACA); seniors and adults with disabilities who are not eligible for Medicare; dual Medicare-Medicaid eligible adults receiving certain long-term services and supports (LTSS), referred to as the Managed Long-Term Services and Supports (MLTSS) population; and special needs children (SNC), which includes Former Youth in Care (FYiC) and Youth in Care (YiC).

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

**Table 1—HealthChoice Health Plans**

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Community Health Plans	BCBSIL

Health Plan Name	Abbreviation
CountyCare (serves Cook County only)	CountyCare
Meridian	Meridian
Molina Healthcare of Illinois	Molina

## MMAI

MMAI is a partnership among HFS, the Centers for Medicare & Medicaid Services (CMS), and health plans, which provides coordinated care to dually eligible enrollees (seniors and persons with disabilities who have full Medicaid and Medicare benefits). HFS contracted with five Medicare-Medicaid Plans (MMPs) to administer the MMAI. The MMAI program sunsetted on December 31, 2025. Table 2 displays the MMPs.

**Table 2—MMAI Health Plans**

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

## YouthCare

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

## Quality Strategy

In 2024, in accordance with 42 CFR §438.200 et seq., HFS updated its Comprehensive Medical Programs Quality Strategy (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level. The Quality Strategy framework includes five pillars of improvement: Adult Behavioral Health, Child Behavioral Health, Maternal and Child Health, Equity, and Improving Community and Health Promotion. To support health equity and HFS’ mission, HFS strives to drive progress in the five pillars of improvement. HFS identified six goals that fall within the five pillars, as

shown in Table 3. HFS prioritizes equity across all goals by analyzing data to strategically pinpoint improvement needs and efforts.

**Table 3—Quality Strategy Goals**

<b>Pillar: Adult Behavioral Health</b>
1. Improve the health outcomes and management of behavioral health services and supports for adults.
<b>Pillar: Child Behavioral Health</b>
2. Improve the health outcomes and management of behavioral health services and supports for children.
<b>Pillar: Maternal and Child Health</b>
3. Improve the health outcomes of birthing persons, babies, and children.
<b>Pillar: Equity</b>
4. Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.
<b>Pillar: Community and Health Promotion</b>
5. Provide person-centered services and supports to ensure care is delivered in the least restrictive care setting.
6. Promote whole person wellness, preventive care, and management of chronic conditions.

## Aggregating and Analyzing Statewide Data

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

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

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

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




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

Detailed information about each activity’s methodology is provided in Appendix A of this report. For a comprehensive discussion of the strengths, opportunities for improvement, conclusions, and recommendations, please refer to the results of each activity in Sections 2 and 3, as well as in Section 4 for health plan-specific analyses.

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

### Performance Domains

CMS has identified the domains of quality, timeliness, and access as keys to evaluating plan performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the plans in each of these domains.

		
<h2>Quality</h2> <p>as it pertains to EQR, means the degree to which a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.*</p>	<h2>Timeliness</h2> <p>as it pertains to EQR, is described by the NCQA to meet the following criteria: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”^ It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).</p>	<h2>Access</h2> <p>as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCPs 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). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.*</p>
<p>* Department of Health and Human Services, Centers for Medicare &amp; Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program External Quality Review, Final Rule.</p>		
<p>^ National Committee for Quality Assurance (NCQA). <i>2025 Standards and Guidelines for Accreditation of Health Plans</i>.</p>		

### Scope of EQR

HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS.<sup>1</sup> The purpose of these activities, in general, is to improve states’ ability to oversee and manage plans they contract with for services and help health plans improve their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate state efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and CHIP members. For this technical report, HSAG used findings from the mandatory EQR activities displayed in Table 4 below and the optional activities described in Section 2, as well as the additional activities described in Section 3 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each health plan.

**Table 4—EQR Mandatory Activities**






Activity	Description	CMS Protocol
<b>Mandatory Activities</b>		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.	<b>Protocol 1.</b> Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures (PMs) calculated by a health plan are accurate based on the measure specifications and State reporting requirements.	<b>Protocol 2.</b> Validation of Performance Measures
Compliance With Standards	This activity determines the extent to which a Medicaid and CHIP health plan is in compliance with federal standards and associated state-specific requirements, when applicable.	<b>Protocol 3.</b> Review of Compliance With Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity includes validating data to determine whether the network standards, as defined by the state, were met.	<b>Protocol 4.</b> Validation of Network Adequacy

<sup>1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 3, 2026.










## Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the most current 12-month period to comprehensively assess the health plans’ performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP members. No health plans were exempt from mandatory EQR activities. For each health plan reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the health plan’s performance, which can be found in Sections 2 through 4 of this report. The overall findings and conclusions for all health plans were also compared and analyzed to develop overarching conclusions and recommendations. Table 5 highlights substantive findings and Table 6 identifies actionable state-specific recommendations, when applicable, for HFS to further promote its Quality Strategy goals and objectives.









**Table 5—Substantive Findings**



Program Strengths	Domain(s) <sup>2</sup>
<b>Quality Strategy Pillar: Adult Behavioral Health</b>	
Improvements continued in following up with members after high-intensity treatment for substance use disorder (SUD). Statewide averages for all submeasures of <i>Follow-Up After High-Intensity Care for Substance Use Disorder</i> were above the national 50th percentile, and five of six submeasures demonstrated improved performance from MY 2023 to MY 2024.	
<b>Quality Strategy Pillar: Child Behavioral Health</b>	
In the <i>Follow-Up After Emergency Department Visit for Mental Illness</i> measure, the statewide average for the <i>7-Day Follow-Up—6–17 Years</i> submeasure was at or above the national 90th percentile, and the statewide average for the <i>30-Day Follow-Up—6–17 Years</i> submeasure performed between the national 75th and 89th percentiles.	
<b>Quality Strategy Pillar: Maternal and Child Health</b>	
The statewide average for the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> submeasure performed between the national 75th and 89th percentiles in MY 2024. The statewide average for the <i>Postpartum Care</i> submeasure performed above the national 50th percentile.	
The health plans made progress in ensuring children and adolescents received important checkups and assessments as statewide rates improved for <i>Child and Adolescent Well-Care Visits</i> , <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> , and <i>Well-Child Visits in the First 30 Months of Life</i> .	
<b>Quality Strategy Pillar: Equity</b>	
All HealthChoice health plans determined that a disparity existed for the <i>Improving Timeliness of Prenatal Care</i> PIP and implemented one or more interventions to address the disparity.	

<sup>2</sup>  = Quality,  = Timeliness,  = Access

Program Strengths	Domain(s) <sup>2</sup>
All health plans conducted appropriate data analyses to identify a disparity for the <i>Improving Transportation Services</i> Quality Improvement Project (QIP). Three of five MMAI health plans and four of five HealthChoice health plans identified a disparity in services and implemented at least one intervention to address the disparity.	
<b>Quality Strategy Pillar: Community and Health Promotion</b>	
The statewide average for measures related to diabetes management demonstrated improvement: <i>Blood Pressure Control for Patients With Diabetes, Eye Exam for Patients With Diabetes, Glycemic Status Assessment for Patients With Diabetes, and Statin Therapy for Patients With Diabetes</i> (one submeasure).	
<b>Other Program Effectiveness Areas</b>	
For the Child Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS <sup>®</sup> ) <sup>3</sup> survey, the Illinois statewide aggregate 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, <i>Rating of All Health Care</i> .	
For the All Kids Children with Chronic Conditions (CCC) population survey, the 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, <i>Rating of Health Plan</i> .	
For the Illinois Medicaid CCC population survey, the 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, <i>Coordination of Care for Children with Chronic Conditions</i> .	
Compared to NCQA national percentiles, parents/caretakers of general child members reported higher levels of experience for <i>How Well Doctors Communicate</i> . Additionally, parent/caretaker respondents of CCC members reported high levels of experience with <i>Rating of Specialist Seen Most Often, Coordination of Care for Children with Chronic Conditions, and Family Centered Care (FCC): Getting Needed Information</i> .	
All health plans established and maintained robust processes to ensure their enrollee and provider data remained accurate and up-to-date and demonstrated strong methodologies for monitoring adequacy of their provider networks in accordance with State standards.	
HSAG has high confidence in the health plans' ability to produce accurate results to support their own and the State's network adequacy monitoring efforts.	
All HealthChoice enrollees residing in most Illinois counties had access to pharmacies within the State's standard regardless of their health plan.	



<sup>3</sup> CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).




Program Opportunities for Improvement	Domain(s)
<b>Quality Strategy Pillar: Adult Behavioral Health</b>	
<p>The health plans struggled to follow up with adults after a visit to the emergency department (ED) for SUD. In the <i>Follow-Up After Emergency Department Visit for Substance Use</i> measure, the statewide average for both submeasures fell below the national 50th percentile.</p>	
<p>Most health plans struggled to follow up with adults after hospitalization for mental illness. In the <i>Follow-Up After Hospitalization for Mental Illness</i> measure, statewide averages for all submeasures remained below the national 50th percentile.</p>	
<b>Quality Strategy Pillar: Child Behavioral Health</b>	
<p>A majority of adolescents struggling with SUD did not engage in ongoing treatment or receive follow up treatment after visiting the ED for substance abuse. The statewide averages for both submeasures of <i>Initiation and Engagement of Substance Use Disorder Treatment</i> performed below the national 50th percentile and decreased by over 7 percentage points for the <i>Initiation of SUD Treatment</i> submeasure. In the <i>Follow-Up After Emergency Department Visit for Substance Use</i> measure, the statewide averages for both submeasures decreased and dropped below the national 50th percentile.</p>	
<p>The health plans struggled to follow up with children and adolescents after hospitalization for mental illness. In the <i>Follow-Up After Hospitalization for Mental Illness</i> measure, statewide averages for both submeasures remained below the national 50th percentile.</p>	
<b>Quality Strategy Pillar: Maternal and Child Health</b>	
<p>Children between 15 and 30 months of age did not receive recommended well-child visits. The <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> submeasure fell below the national 50th percentile, with two health plans (Aetna and Molina) performing below the national 25th percentile.</p>	
<p>Many women did not receive important screenings.</p> <ul style="list-style-type: none"> <li>The <i>Chlamydia Screening</i> measure statewide average declined and remained below the national 50th percentile.</li> <li>The <i>Breast Cancer Screening</i> measure statewide average and four of the five plans performed below the national 50th percentile.</li> </ul>	
<b>Quality Strategy Pillar: Equity</b>	
<p>No opportunities for improvement were identified.</p>	
<b>Quality Strategy Pillar: Community and Health Promotion</b>	
<p>In the <i>Adults' Access to Preventive/Ambulatory Health Services</i> measure, the statewide average and performance rates for all health plans fell below the national 50th percentile.</p>	
<p>In the <i>MLTSS Successful Transition After Long-Term Facility Stay—Observed Discharge Rate and Expected Discharge Rate</i>, all five health plans' observed rates continued to be lower than the expected rates for both MY 2023 and MY 2024.</p>	




Program Opportunities for Improvement	Domain(s)
<b>Other Program Effectiveness Areas</b>	
<p>While most health plans met the contract time and distance standards for most provider categories and showed improvement over last year’s results, all statewide health plans failed to meet the time and distance standard for at least one provider category. The primary category of concern remains oral surgeons for both the adult and pediatric populations.</p>	
<p>Compared to NCQA national percentiles, parent/caretaker respondents of general child members reported low levels of experience for <i>Rating of Health Plan</i>, <i>Rating of All Health Care</i>, <i>Rating of Personal Doctor</i>, <i>Rating of Specialist Seen Most Often</i>, <i>Getting Needed Care</i>, <i>Getting Care Quickly</i>, <i>Customer Service</i>, and <i>Coordination of Care</i>. Additionally, parent/caretaker respondents of CCC members reported low levels of experience with <i>Rating of Health Plan</i>, <i>Rating of All Health Care</i>, <i>Rating of Personal Doctor</i>, <i>Getting Needed Care</i>, <i>Getting Care Quickly</i>, <i>How Well Doctors Communicate</i>, <i>Customer Service</i>, <i>Coordination of Care</i>, <i>Access to Specialized Services</i>, <i>FCC: Personal Doctor Who Knows Child</i>, and <i>Access to Prescription Medicines</i>.</p>	

### Recommendations for Targeting Goals and Objectives in the Quality Strategy

Table 6—Recommendations

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	<p>The health plans’ care management teams should establish admission, discharge, and transfer (ADT) feeds with hospitals and EDs to monitor visits with a mental illness diagnosis and assist members with coordinating and scheduling follow-up appointments. The health plans should partner with behavioral health providers to expand access, including telehealth options, and receive timely referrals. The health plans can consider strategies focused on building capacity among pediatric providers (e.g. use of the Illinois DocAssist program).</p>	<p><b>Pillar: Adult Behavioral Health</b>  <b>Goal 1:</b> Improve the health outcomes and management of behavioral health services and supports for adults.  <b>Pillar: Child Behavioral Health</b>  <b>Goal 2:</b> Improve the health outcomes and management of behavioral health services and supports for children.</p>
	<p>The health plans should evaluate current care coordination for members with SUD. The health plans should leverage ADT feeds from EDs to engage discharged members in follow-up care. The health plans should consider enhancing existing or developing new partnerships with SUD treatment providers and expanding telehealth options to support timely access to care, the availability of care, and the receipt of referrals from facilities. The health plans’ case management teams should follow up with eligible members to assist with facilitating and coordinating appointments to initiate treatment if necessary.</p>	<p><b>Pillar: Adult Behavioral Health</b>  <b>Goal 1:</b> Improve the health outcomes and management of behavioral health services and supports for adults.  <b>Pillar: Child Behavioral Health</b>  <b>Goal 2:</b> Improve the health outcomes and management of behavioral health services and supports for children.</p>

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	<p>The health plans should work with HFS to determine where provider and member incentives could be considered to support timely well-care visits. The health plans should evaluate current member and provider education to determine opportunities for enhancing messaging with community stakeholders and revise materials to emphasize the importance of well-care visits and preventive health care. The health plans could consider alternative methods of member outreach and healthcare reminders based on advancements in technology, such as text messaging preventive care reminders and partnering with school-based health clinics to complete well-child visits.</p>	<p><b>Pillar: Maternal and Child Health</b>  <b>Goal 3:</b> Improve the health outcomes of birthing persons, babies, and children.</p>
	<p>To improve women’s health screening rates, HSAG recommends that the health plans:</p> <ul style="list-style-type: none"> <li>• Evaluate the effectiveness of existing interventions and consider employing alternative strategies or soliciting best practices for high performing plans to improve their performance and address timely access to care barriers.</li> <li>• Include standing orders and reduce structural barriers by offering non-traditional clinic hours, mobile screenings, patient navigators, and streamlined administrative procedures.</li> <li>• Consider whether disparities/social determinants of health (SDOH) factors within the health plans’ populations contributed to lower access to care. Implement appropriate interventions to reduce barriers to care upon identifying root causes.</li> <li>• Address sexually transmitted infection (STI) stigma among physicians and patients.</li> <li>• Clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update.</li> <li>• Use multi-modal approaches to contact members and promote women’s screenings. Offer incentives to providers to provide screenings, increase access, and conduct outreach to eligible members in their panels.</li> </ul>	<p><b>Pillar: Maternal and Child Health</b>  <b>Goal 3:</b> Improve the health outcomes of birthing persons, babies, and children.  <b>Pillar: Equity</b>  <b>Goal 4:</b> Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.</p>
	<p>The health plans should work with HFS on potential incentive options to support timely preventive health visits and evaluate the effectiveness of interventions for options for further spread and sustainability (or adapt and modify). Further, the health plans’ care management teams should</p>	<p><b>Pillar: Community and Health Promotion</b></p>

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	support coordination and facilitation of appointment scheduling to address barriers as needed. Finally, the health plans should evaluate provider access and availability and consider where alternative hours could be offered to improve performance on the <i>Adults' Access to Preventive/ Ambulatory Health Services</i> measure.	
	For <i>MLTSS Successful Transition After Long-Term Facility Stay—Observed Discharge Rate and Expected Discharge Rate</i> , HSAG recommends that the health plans analyze and further stratify results on members who were expected to be discharged to identify any trends in any subpopulation (e.g., geography, age, or medical condition). Each health plan also should share its approaches to tailor clinical or provider-focused interventions based on the characteristics of the population.	<b>Pillar: Community and Health Promotion</b>
<b>Other Program Effectiveness Areas</b>		
	HSAG recommends that the health plans maintain current levels of access to care and continue to address network gaps for access to provider categories where standards were not met.	<b>Pillar: Equity</b> <b>Goal 4:</b> Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.
	The results of the general child and CCC CAHPS survey indicated that parents/caretakers of child members perceived an overall lack of quality of care and service within their child's providers and health plans. HSAG recommends that the health plans (1) obtain feedback from parents/caretakers of child members regarding their recent experiences with their health plan through follow-up phone calls or emails, with the objective of identifying opportunities for improvement; (2) encourage providers to prioritize patient healthcare experiences; (3) identify obstacles parents/caretakers of child members may experience when trying to obtain required care, testing, or treatment for their child; and (4) enhance customer service training efforts to ensure patients receive accurate information and support.	<b>Pillar: Maternal and Child Health</b> <b>Goal 3:</b> Improve the health outcomes of birthing persons, babies, and children.

## 2. Comparative Statewide Results

### Mandatory EQR Activities

#### Validation of PIPs

##### Overview

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

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

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* (CMS EQR Protocol 1), February 2023.<sup>4</sup> Please note, MMPs use the terminology QIP instead of PIP.

##### Objectives

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that a health plan serves. This structured method of assessing and improving the quality of clinical and nonclinical healthcare can have a favorable effect on member health outcomes and satisfaction.

##### Statewide Mandatory Topics

The health plans and MMPs continued the nonclinical HFS-mandated *Improving Transportation Services* PIP. HFS mandated a new clinical PIP for *Improving Timeliness of Prenatal Care*. The topics addressed CMS' requirements related to quality outcomes, specifically the timeliness of and access to care and services. The health plans updated their submission form and included Steps 7 and 8 with Remeasurement 2 data and interventions for the *Improving Transportation Services* PIP. For the

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<sup>4</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 3, 2026.

*Improving Timeliness of Prenatal Care* PIP, the health plans and MMPs completed a new submission form with Steps 1 through 8 which included baseline data and interventions.

### Technical Methods of Data Collection and Analysis

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

### Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan’s PIP Submission Form. Each health plan completed the form for PIP activities conducted during the measurement year (MY) and submitted it to HSAG for validation. The PIP Submission Form and accompanying PIP Completion Instructions present instructions for documenting information related to each of the steps in CMS EQR Protocol 1. The health plans could also attach relevant supporting documentation with the PIP Submission Form. Table 7 illustrates the data source for each health plan and PIP topic.

**Table 7—Health Plan and PIP-Specific Data Source**

Health Plan	Data Source
<b><i>Improving Timeliness of Prenatal Care (HealthChoice)</i></b>	
Aetna	HEDIS <sup>®</sup> , <sup>5</sup> <i>Prenatal and Postpartum Care (PPC)</i> Measure: Administrative data through claims/encounters
BCBSIL	HEDIS <i>PPC</i> Measure: Administrative data through claims/encounters
CountyCare	HEDIS <i>PPC</i> Measure: Administrative data through claims/encounters
Meridian	HEDIS <i>PPC</i> Measure: Administrative data through claims/encounters
Molina	HEDIS <i>PPC</i> Measure: Administrative data through claims/encounters, supplemental data
<b><i>Improving Transportation Services (HealthChoice and MMAI)</i></b>	
Aetna	Transportation vendor data
BCBSIL	Transportation vendor data
CountyCare	Transportation vendor data
Humana	Transportation vendor data
Meridian (includes YouthCare)	Transportation vendor data: telephone service and call center data, appointment data, and access data
Molina	Transportation vendor data: telephone service and call center data, appointment data, and access data

<sup>5</sup> Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) is a registered trademark of the NCQA.

## Improving Timeliness of Prenatal Care PIP

### PIP Validation Results

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 8 displays the validation scores and confidence levels HSAG assigned to each health plan’s *Improving Timeliness of Prenatal Care* PIP submissions.

**Table 8—Improving Timeliness of Prenatal Care PIP Validation Results**

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met <sup>6</sup>	Percentage Score of Critical Elements Met <sup>7</sup>	Confidence Level <sup>8</sup>	Percentage Score of Evaluation Elements Met <sup>6</sup>	Percentage Score of Critical Elements Met <sup>7</sup>	Confidence Level <sup>8</sup>
Aetna	100%	100%	High Confidence	Not Assessed <sup>9</sup>		
BCBSIL	100%	100%	High Confidence	Not Assessed <sup>9</sup>		
CountyCare	100%	100%	High Confidence	Not Assessed <sup>9</sup>		
Meridian	100%	100%	High Confidence	Not Assessed <sup>9</sup>		
Molina	100%	100%	High Confidence	Not Assessed <sup>9</sup>		

As shown in Table 8 above, for the *Timeliness of Prenatal Care* PIP, for Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology for all five health plans. The *Timeliness of Prenatal Care* PIP cannot be assessed for the overall confidence of significant improvement until the PIP has had a remeasurement period.

### PIP Outcomes

The performance indicator for the *Improving Timeliness of Prenatal Care* PIP is the HEDIS *PPC* measure, which assesses the percentage of deliveries who received timely prenatal care visits during the

<sup>6</sup> **Percentage Score of Evaluation Elements Met**—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

<sup>7</sup> **Percentage Score of Critical Elements Met**—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

<sup>8</sup> **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

<sup>9</sup> **Not Assessed**—HSAG did not assess Validation Rating 2 as the health plan reported the baseline data for each PIP.

first trimester, on or before the enrollment date, or within 42 days of enrollment in the health plan during the MY. Table 9 displays the baseline and remeasurement data as reported by the health plans.

**Table 9—Outcomes for the *Timeliness of Prenatal Care* PIP**

Performance Indicator Results			
Health Plan	Baseline (1/1/2024–12/31/2024)	Remeasurement 1 (1/1/2025–12/31/2025)	Remeasurement 2 (1/1/2026–12/31/2026)
Aetna	84.4%		
BCBSIL	86.6%		
CountyCare	81.7%		
Meridian	83.7%		
Molina	91.0%		

↑ Designates statistically significant improvement over the baseline measurement period ( $p$  value  $< 0.05$ ).

↔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant ( $p$  value  $\geq 0.05$ ).

↓ Designates statistically significant decline over the baseline measurement period ( $p$  value  $< 0.05$ ).

HSAG rounded percentages to the first decimal place.

As shown in Table 9 above, the baseline results ranged from 81.7 percent to 91.0 percent.

### Improving Transportation Services PIP

The *Improving Transportation Services* PIP focuses on the administration of the transportation benefit, specifically focusing on the rate of scheduled trips resulting in the member arriving to a scheduled appointment on time. For this PIP, the health plans were provided HFS-defined specifications to follow.

### PIP Validation Results

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 10 displays the validation scores and confidence levels HSAG assigned to each health plan’s *Improving Transportation Services* PIP submissions. The health plans reported each population served in one PIP Submission Form; however, each population reported was validated independently with validation scores and outcomes.

**Table 10—Improving Transportation Services PIP Validation Results**

Health Plan Name and Population	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met <sup>10</sup>	Percentage Score of Critical Elements Met <sup>11</sup>	Confidence Level <sup>12</sup>	Percentage Score of Evaluation Elements Met <sup>10</sup>	Percentage Score of Critical Elements Met <sup>11</sup>	Confidence Level <sup>12</sup>
<b>Aetna</b>						
HealthChoice	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
MLTSS	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
SNC	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
<b>BCBSIL</b>						
HealthChoice	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
MLTSS	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
SNC	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
<b>CountyCare</b>						
HealthChoice	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
MLTSS	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
SNC	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
<b>Meridian (Includes YouthCare)</b>						
HealthChoice	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>

<sup>10</sup> **Percentage Score of Evaluation Elements Met**—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

<sup>11</sup> **Percentage Score of Critical Elements Met**—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

<sup>12</sup> **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Health Plan Name and Population	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met <sup>10</sup>	Percentage Score of Critical Elements Met <sup>11</sup>	Confidence Level <sup>12</sup>	Percentage Score of Evaluation Elements Met <sup>10</sup>	Percentage Score of Critical Elements Met <sup>11</sup>	Confidence Level <sup>12</sup>
MLTSS	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
SNC	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
<b>Molina</b>						
HealthChoice	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
MLTSS	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
SNC	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>

As shown in Table 10 above, the *Improving Transportation Services* PIP, for Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology for all 15 populations. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement for 12 of 15 populations.

**PIP Outcomes**

Table 11 displays the baseline and Remeasurement data as reported by the health plans for each population.

**Table 11—Outcomes for the *Improving Transportation Services* PIP**

Performance Indicator Results			
Health Plan and Population	Baseline (1/1/2022–12/31/2022)	Remeasurement 1 (1/1/2023–12/31/2023)	Remeasurement 2 (1/1/2024–12/31/2024)
<b>Aetna</b>			
HealthChoice	94.2%	95.1% ↑	96.5% ↑
MLTSS	93.9%	94.8% ↑	97.3% ↑
SNC	93.1%	97.2% ↑	97.8% ↑

Performance Indicator Results			
Health Plan and Population	Baseline (1/1/2022–12/31/2022)	Remeasurement 1 (1/1/2023–12/31/2023)	Remeasurement 2 (1/1/2024–12/31/2024)
<b>BCBSIL</b>			
HealthChoice	81.9%	90.4% ↑	93.3% ↑
MLTSS	82.7%	91.1% ↑	92.4% ↑
SNC	86.1%	93.3% ↑	93.9% ↑
<b>CountyCare</b>			
HealthChoice	83.5%	86.2% ↑	94.2% ↑
MLTSS	88.6%	90.4% ↑	95.0% ↑
SNC	89.4%	85.5% ↓	94.7% ↑
<b>Meridian (includes YouthCare)</b>			
HealthChoice	89.0%	81.2% ↓	87.2% ↓
MLTSS	89.8%	82.6% ↓	89.1% ↓
SNC	85.2%	77.8% ↓	86.9% ↔
<b>Molina</b>			
HealthChoice	84.7%	85.5% ↑	89.2% ↑
MLTSS	86.9%	86.1% ↔	90.7% ↑
SNC	92.1%	91.8% ↔	95.0% ↑

↑ Designates statistically significant improvement over the baseline measurement period ( $p$  value < 0.05).

↔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant ( $p$  value ≥ 0.05).

↓ Designates statistically significant decline over the baseline measurement period ( $p$  value < 0.05).

HSAG rounded percentages to the first decimal place.

As shown in Table 11 above, the Remeasurement 2 results ranged from 86.9 percent to 97.8 percent. Twelve of 15 populations demonstrated statistically significant improvement for Remeasurement 2. Two populations did not demonstrate improvement in performance. One population demonstrated a non-statistically significant improvement.

### Improving Transportation Services QIP

The *Improving Transportation Services* QIP focuses on the administration of the transportation benefit, specifically focusing on the rate of scheduled trips resulting in the member arriving to a scheduled appointment on time. For this QIP, the MMPs were provided HFS-defined specifications to follow.

### QIP Validation Results

Based on its technical review, HSAG determined the overall methodological validity of the QIP. Table 12 displays the validation scores and confidence levels HSAG assigned to each MMP’s *Improving Transportation Services* QIP submissions.

**Table 12—Improving Transportation Services QIP Validation Results**

MMP Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the QIP			Overall Confidence That the QIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met <sup>13</sup>	Percentage Score of Critical Elements Met <sup>14</sup>	Confidence Level <sup>15</sup>	Percentage Score of Evaluation Elements Met <sup>13</sup>	Percentage Score of Critical Elements Met <sup>14</sup>	Confidence Level <sup>15</sup>
Aetna	100%	100%	High Confidence	100%	100%	High Confidence
BCBSIL	100%	100%	High Confidence	100%	100%	High Confidence
Humana	100%	100%	High Confidence	100%	100%	High Confidence
Meridian	94%	100%	High Confidence	100%	33%	No Confidence
Molina	100%	100%	High Confidence	100%	100%	High Confidence

<sup>13</sup> **Percentage Score of Evaluation Elements Met**—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

<sup>14</sup> **Percentage Score of Critical Elements Met**—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

<sup>15</sup> **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the QIP Validation Tool.

As shown in Table 12 above, for the *Improving Transportation Services* QIP, for Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable QIP methodology for all five MMPs. For Validation Rating 2, HSAG assigned a *High Confidence* level that the QIP achieved significant improvement for four of five MMPs.

**QIP Outcomes**

Table 13 below displays the baseline and Remeasurement data as reported by the MMPs.

**Table 13—Outcomes for the Improving Transportation Services QIP**

Performance Indicator Results			
MMP	Baseline (1/1/2022–12/31/2022)	Remeasurement 1 (1/1/2023–12/31/2023)	Remeasurement 2 (1/1/2024–12/31/2024)
Aetna	80.3%	90.1% ↑	90.8% ↑

Performance Indicator Results			
MMP	Baseline (1/1/2022–12/31/2022)	Remeasurement 1 (1/1/2023–12/31/2023)	Remeasurement 2 (1/1/2024–12/31/2024)
BCBSIL	83.3%	92.7% ↑	93.3% ↑
Humana	79.3%	80.6% ↑	85.1% ↑
Meridian	90.0%	82.1% ↓	89.8% ↓
Molina	89.9%	90.0% ↔	91.4% ↑

↑ Designates statistically significant improvement over the baseline measurement period ( $p$  value < 0.05).

↔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant ( $p$  value  $\geq$  0.05).

↓ Designates statistically significant decline over the baseline measurement period ( $p$  value < 0.05).

HSAG rounded percentages to the first decimal place.

As shown in Table 13 above, the Remeasurement 2 results ranged from 85.1 percent to 93.3 percent. Four of five QIPs (Aetna, BCBSIL, Humana and Molina) demonstrated statistically significant improvement for Remeasurement 2. One MMP, (Meridian), had a decline in performance from baseline.

### Aim Statements and Interventions

An aim statement is clear, concise, measurable, and answerable if the statement specifies measurable variables and analytics for a defined improvement strategy, population, and time period. The aim statement identifies the focus of the PIP/QIP and establishes the framework for data collection and analysis. HSAG assessed the appropriateness and adequacy of each health plan’s aim statement.

A health plan’s success in achieving significant improvement in PIP/QIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP/QIP. As part of the PIP/QIP validation process, HSAG reviewed the interventions employed by the health plans for appropriateness to the barriers identified, and timeliness of the implementation of the interventions.

A description of each health plan’s and MMP’s aim statement and interventions can be found in Appendix B.

### PIP Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to PIPs/QIPs were included in Table 5 and recommendations for improvement were included in Table 6. Health plan/MMP-specific strengths, opportunities for improvement, and recommendations are included in Section 4.

## PMV

### Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by the health plans and to determine the extent to which performance measures reported by the health plans follow State specifications and reporting requirements and validate the data collection and reporting processes the health plans used to calculate the performance measure rates.

### HealthChoice and YouthCare Compliance Audit

HFS required the HealthChoice and YouthCare health plans to contract with an NCQA-licensed audit organization to conduct a MY 2024 NCQA HEDIS Compliance Audit. HSAG reviewed the Final Audit Report, provided by the plans, to confirm no notable findings and performance measure result designations. HFS also contracted with HSAG to conduct a MY 2024 PMV of the HealthChoice and YouthCare health plans’ data collection and reporting processes. Health plan specific PMV reports were produced summarizing key findings and final validated results. Table 14 displays the health plans included in MY 2024 PMV activities.

**Table 14—Health Plans Included in PMV**

Health Plan
Aetna
BCBSIL
CountyCare
Meridian
Molina
YouthCare

### Technical Methods of Data Collection and Analysis

The MY 2024 PMV measures were selected by HFS from NCQA *HEDIS Measurement Year 2024, Volume 2 Technical Specifications, CMS Adult and Child Core Set, CMS MLTSS*, and HFS custom measures. HSAG conducted PMV in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.<sup>13</sup> Additional details about the methodology and measure selection for PMV are in Appendix A—Methodology.

<sup>13</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jan 26, 2026.

**Results**

As shown in Table 15 below, HSAG determined the health plans were fully compliant with all HEDIS IS standards and received *Reportable* (R) measure designations across all measures reported through the MY 2024 HEDIS Compliance Audit. Several aspects involved in the calculation of performance measure data were crucial to the validation process. These included data integration, data control, and documentation of performance measure calculations. For the current reporting period, HSAG determined that the data collected and reported by all health plans followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.

**Table 15—MY 2024 NCQA HEDIS Compliance Audit\* Results for All Health Plans**

IS Capabilities Assessment			
Administrative Data	Medical Record Review Processes	Clinical and Care Delivery Data	Data Management and Reporting
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

\*HSAG was not the contracted NCQA-licensed audit organization for MY2024 HEDIS Compliance Audit.

**HealthChoice Pay-for-Reporting (P4R)**

Table 16 below shows the summary of validation results for the HealthChoice health plans on the P4R performance measures selected for MY 2024 PMV activities. All measures resulted in a *Reportable* designation.

**Table 16—Review Designations by Measure for all HealthChoice Health Plans**

Measure	Specifications	Validation Rating
<i>Breast Cancer Screening</i>	HEDIS	R
<i>Colorectal Cancer Screening</i>	HEDIS	R
<i>Contraceptive Care—All Women</i>	CMS Adult Core Set	R
<i>Follow-Up After Mobile Crisis Response Services</i>	HFS Custom	R
<i>Gap in HIV Medical Visits</i>	HFS Custom	R
<i>HIV Viral Load Suppression</i>	HFS Custom	R
<i>MLTSS Minimizing Facility Length of Stay</i>	CMS MLTSS	R
<i>MLTSS Successful Transition After Long-Term Facility Stay</i>	CMS MLTSS	R
<i>Prescription of HIV Antiretroviral Therapy</i>	HFS Custom	R
<i>Screening for Depression and Follow-Up Plan</i>	CMS Child Core Set	R
<i>Unexpected Complications in Term Newborns</i>	Joint Commission National Quality Measures	R

**YouthCare Performance Measures**

Table 17 shows the summary of validation results for YouthCare on the performance measures selected for MY 2024 PMV activities. All measures resulted in a *Reportable* designation.

**Table 17—Review Designations by Measure for YouthCare**

Measure	Specifications	Validation Rating
<i>Emergency Department Visits that Result in an Inpatient Admission for Children and Adolescents—Total</i>	HFS Custom	R
<i>Follow-Up After Mobile Crisis Response Services—Not Hospitalized and Linked to Community Services—Total</i>	HFS Custom	R
<i>Follow-Up After Mobile Crisis Response Service—Hospitalized and Linked to Community Services—Total</i>	HFS Custom	R
<i>Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Inpatient BH Utilization—Total</i>	HFS Custom	R
<i>Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Average Length of Stay—Total</i>	HFS Custom	R
<i>Repeat Behavioral Health Hospitalizations for Children and Adolescents—Percent of Members with Repeat BH Hospitalization—Total</i>	HFS Custom	R
<i>Repeat Behavioral Health Hospitalizations for Children and Adolescents—Average Number of Repeat BH Hospitalizations Per Member—Total</i>	HFS Custom	R

**MMAI PMV**

**Technical Methods of Data Collection and Analysis**

HFS contracted with HSAG to conduct an audit for Humana. HFS selected a specific set of MMAI measures for HSAG’s validation based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. HSAG conducted PMV in accordance with Protocol 2. Additional details about the methodology and measure selection for PMV are in Appendix A—Methodology.

**Results**

Table 18 shows the summary of validation results for Humana on the performance measures selected for MY 2024 PMV activities. All measures resulted in a *Reportable* designation.

**Table 18—Review Designations by Measure for Humana**

Performance Measure	Specifications	Validation Rating
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>	HEDIS	R
<i>Initiation and Engagement of SUD Treatment</i>	HEDIS	R

**MMAI IL 3.6**

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

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

HSAG validated the data collection and reporting processes used by the MMPs to report the quality withhold performance measure data for Demonstration Year 10 (January 1, 2024, through December 31, 2024) in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 2).<sup>14</sup> Table 19 displays HSAG’s validation finding for all MMPs.

**Table 19—MMAI IL 3.6 PMV Audit Results**

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

**PMV Statewide Strengths, Opportunities for Improvement, and Recommendations**

Statewide strengths and opportunities for improvement related to PMV were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 4.

**Performance Measure Results**

Validated performance measure data results for HealthChoice, YouthCare, and MMAI are reported in Appendix C.

<sup>14</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023*. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 3, 2026.

## Compliance Monitoring

### Compliance Review

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

In CY 2025, the first year of a new three-year review cycle, HSAG conducted an Evaluation of Administrative Processes and Compliance Review (Compliance Review) in accordance with §438.358 by evaluating a subset of standards selected by HFS for the health plans serving HealthChoice and YouthCare. Due to the sunset of the MMAI program on December 31, 2025, and the transition to a fully integrated dual eligible special needs plan (FIDE SNP) program on January 1, 2026, HFS deferred the compliance review for the MMAI MMPs and elected to complete a readiness review for the FIDE SNP health plans.

### Objectives

The Compliance Review assessed each health plan’s compliance with the federal standards and the State contract requirements found in HFS Model Contract 2018-24-001, the YouthCare contract, and subsequent amendments. HSAG used information and data derived from Compliance Reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care of Medicaid services provided to Medicaid enrollees.



### Technical Methods of Data Collection and Analysis

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

For any elements that remained out of compliance following remediation, the health plan is required to submit a corrective action plan to HFS. HFS and HSAG will monitor each health plan’s progress toward correcting deficiencies. Additional details about the methodology are in Appendix A—Methodology.

**Standards**

The CY 2025 Compliance Review included a subset of requirements that address federal Medicaid managed care regulations and State standards. For HealthChoice and YouthCare, a total of eight standards were assessed in CY 2025, and the remaining standards will be reviewed in CY 2026, thereby completing the required evaluation of the administrative and compliance process once in a three-year period. Table 20 displays the standards reviewed for each health plan in the three-year cycle.

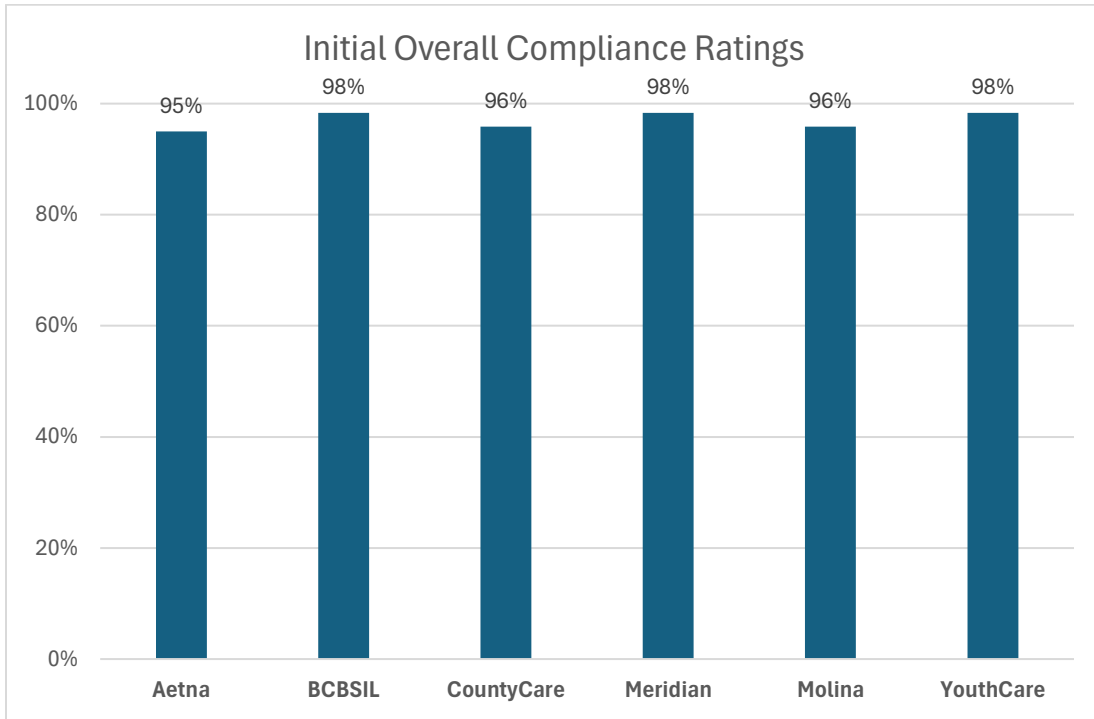
**Table 20—Review Standards for the Three-Year Period: SFY 2023–SFY 2025**

#	CFR	Standard Name	All HealthChoice and YouthCare Health Plans	
			CY 2025	CY 2026
I	438.56	Enrollment and Disenrollment		✓
II	438.100	Enrollee Rights Requirements		✓
III	438.114	Emergency and Post-Stabilization of Services		✓
IV	438.206	Availability of Services		✓
V	438.207	Assurances of Adequate Capacity and Services		✓
VI	438.208	Coordination and Continuity of Care (including Transitions of Care)	✓	
VII	438.210	Coverage and Authorization of Services	✓	
VIII	438.214	Provider Selection	✓	
IX	438.224	Confidentiality		✓
X	438.228	Grievance and Appeal Systems	✓	
XI	438.230	Subcontractual Relationships and Delegation	✓	
XII	438.236	Practice Guidelines		✓
XIII	438.242	Health Information Systems		✓
XIV	438.330	QAPI Program	✓	
XV	438.608	Program Integrity		✓
XVI	N/A	Children’s Behavioral Health	✓	
XVII	N/A	Organization and Governance	✓	

### Compliance Review Results

The CY 2025 Compliance Review included a subset of requirements that addressed federal Medicaid managed-care regulations and State standards. Figure 1 displays the overall initial health plan-specific compliance scores for all eight standards reviewed during the CY 2025 compliance review.

**Figure 1—Overall Compliance Ratings by Health Plan**



As shown in Figure 1, all health plans achieved an initial overall compliance score greater than 90 percent. At the time of reporting, the health plans were remediating findings from the initial results. Final results for both the standards presented above and the remaining standards will be included in the next technical report.

### Readiness Review

HFS requested HSAG conduct a focused readiness review to assess its FIDE SNP awardee health plans’ readiness to receive enrollees in the FIDE SNP program as of January 1, 2026. HSAG conducted the readiness review to assess the FIDE SNP health plans’ structural and operational capacity to perform the managed care functions described in the FIDE SNP model contract. Table 2 displays the FIDE SNPs.

**Table 21—FIDE SNP Health Plans**

Health Plan Name	Abbreviation
Aetna Medicare FIDE	Aetna
Humana Dual Fully Integrated	Humana

Health Plan Name	Abbreviation
Molina Medicare Complete Care Plus	Molina
Wellcare Meridian Dual Align	Meridian

All four health plans demonstrated compliance with no critical findings impacting the ability to receive FIDE SNP enrollees.

### Compliance Review Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to compliance review were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 4.

## NAV

### Objectives

Title 42 of the CFR §438.350(a) requires that the State develop and enforce network adequacy standards, and have a qualified EQRO perform an annual EQR of each plan that includes NAV.<sup>15</sup> The purpose of the NAV is to assess the health plans’ compliance with the State-defined network adequacy standards by evaluating their collection of provider data, the reliability and validity of their network adequacy data, and the methods, systems, and processes they use to monitor their network adequacy. The EQRO is required to determine a validation rating that reflects its overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by the State.

### Technical Methods of Data Collection and Analysis

HSAG used the methodologies approved by HFS to conduct the NAV activity. There were two main components to the activity: an Information Systems Capabilities Assessment (ISCA) for all health plans and an independent time and distance study of the HealthChoice, MMAI, and YouthCare health plans.

Through the ISCA, HSAG examined the health plans’ activities and confirmed that they used reasonable methodologies and produced accurate results to guide their network activities and to monitor their compliance. HSAG confirmed that these activities included regular time and distance analyses, regular provider surveys to assess appointment availability, and a methodology for limiting the maximum panel size for primary care providers (PCPs).

<sup>15</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity, February 2023*. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 3, 2026.

The health plans also submitted their own time and distance data and results to HSAG for review. HSAG conducted an independent time and distance study of the health plans' provider network data to confirm compliance with the access standards incorporated in the health plan contracts, calculating the percentage of each health plan's enrollees who had a provider located within the required access standards. HSAG analyzed results at several levels to identify access issues and compared its results to those submitted by the health plans and considered the similarity in assigning validation scores. Data for point-in-time studies were collected as of March 31, 2025.

Finally, HSAG synthesized all of these results to arrive at a validation scoring following the methodology defined by CMS.

## Results

**ISCA findings:** All seven health plans cooperated fully with the ISCA process and provided HSAG with the requested documentation and access to their information systems. After reviewing health plan documentation of their methodologies, HSAG confirmed in virtual review sessions that the health plans used geospatial analysis software to conduct time and distance studies. HSAG confirmed that the health plans conducted regular surveys to monitor appointment availability, discussed their methodologies for selecting survey samples, and observed how they captured and preserved survey results and assigned PCP panel size.

HSAG requested time and distance studies from the health plans for comparison to the results of its independent time and distance study. Across all health plans, the time and distance results they submitted to HSAG matched the HSAG calculated results within reasonable margins.

Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has *high confidence* in the health plans' data systems, methodologies, and the accuracy and reliability of their results. HSAG identified no concerns regarding system data processing procedures; enrollment data systems; or provider data systems, methodologies, or results for any of the health plans.

Overall, after reviewing the health plans' information system capacities, HSAG has high confidence in their ability to collect and report accurate and valid data, using appropriate methods, and produce accurate and valid results used in monitoring their network adequacy.

**Time and distance findings:** HSAG's time and distance study results were presented for each health plan as the percentage of enrollees and the percentage of counties with access meeting standards, stratified by region. Across provider type and urbanicity, the health plans met or exceeded the vast majority of HFS' time and distance standards.

- **Aggregated statewide findings:** Overall, 99 percent to 100 percent of HealthChoice enrollees, whatever their choice of health plan, had necessary providers located within the required time and distance from their residence for all provider standards except for oral surgeons. The percentage of enrollees with the required access to adult and pediatric oral surgeons was lower, but still exceeded the 90 percent standard when viewed on a statewide level.

- **Health equity:** Stratification of the findings found little indication of disparities in access for enrollees related to race, ethnicity, age, sex, and disproportionately impacted area (DIA) status. The complete results were presented in an aggregate report. Deficits in access were similar across urbanicity, age, sex, race, and ethnicity. Enrollees residing in DIA ZIP Codes were more likely to have access to care within standards than those residing in non-DIA ZIP Codes, but this may be due to a correspondence between DIA status and urbanicity, and may or may not be a function of disparity. Where standards were not met for a provider in a county or region, all enrollees who lived there were impacted, regardless of race, ethnicity, or any of the other factors examined. Deficits in access were limited to the two provider categories of pharmacies and oral surgeons.
- **Provider networks:** All health plans met standards for all enrollees and counties in all provider categories assessed except pharmacies and oral surgeons.
- **Pharmacies:** HFS holds access to pharmacies to a higher standard than other provider categories, requiring that 100 percent of enrollees have access within 15 minutes or 15 miles in urban counties, or within 60 minutes or 60 miles in rural counties. All health plans met this standard in all rural counties, but in some urban counties, some plans did not meet that 100 percent standard. Aetna and BCBSIL both met the standard for 94.1 percent of enrollees, Meridian and Molina each for 95.1 percent of enrollees, and YouthCare for 96.1 percent of enrollees.
- **Oral surgeons:** Access to oral surgeons for the adult and pediatric populations continued to present issues for the Illinois health plans, although it improved from last year. The standard requires that 90 percent of enrollees have access to an oral surgeon within 60 minutes or 60 miles in urban counties, or within 90 minutes or 90 miles in rural counties. When results were analyzed statewide by the percentage of enrollees with the required access and by the percentage of counties where the standard for access was met, two plans met all applicable standards: Aetna, which was active statewide, and CountyCare, which operated only in Cook County. Each of the remaining health plans failed to provide the required access to oral surgeons for adult and pediatric enrollees in some areas. The failing results were predominantly found in rural counties located in Region 3, and scattered results in the western portion of Region 2. These findings were consistent with prior years, and continued to show year-over-year improvement. The health plans have attributed this finding to the lack of provider availability in certain areas of the state and/or provider unwillingness to accept Medicaid rates.
- **Nursing facilities:** HFS requires that MMAI enrollees have access to two nursing facilities within 15 miles or 30 minutes from enrollees' ZIP Code of residence within each county. All of the MMAI plans met the standard for above 99 percent of enrollees in each region and for more than 91 percent of counties in each region. However, county-specific analysis identified that in one rural county, Alexander, four of the five MMAI plans did not meet the HFS standard. In several additional counties, one or two health plans did not meet the standard.

HSAG also noted the following study limitations:

- Time and distance results summarize the geographic distribution of a provider network relative to enrollee residences and may not fully reflect the availability of providers (or appointments) at given office locations. These general statistics do not take into account other issues known to impact

access, such as whether a specific provider is accepting new Medicaid patients at a specific location, or how active the provider is in the Medicaid program.

- The analyses were based on reported average drive times and may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to enrollees.
- When evaluating the results presented, note that provider data supplied by the health plans may not include providers contracted with the health plans under limited use contracts or single case agreements.

### Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG’s overall confidence that the health plans used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 22 through Table 28 summarize HSAG’s validation ratings for each health plan by indicator type for all access and availability, network capacity, and time and distance indicators.

**Table 22—Summary of Aetna’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability HCI (N=7)	100%	0%	0%	0%
Time and distance HCI (N=36)	100%	0%	0%	0%
Maximum provider panel size HCI (N=4)	100%	0%	0%	0%
Access and availability MMAI (N=18)	100%	0%	0%	0%
Time and distance MMAI (N=1)	100%	0%	0%	0%
Maximum provider panel size MMAI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois  
 N = the number of indicators of that type.

**Table 23—Summary of BCBSIL’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability HCI (N=7)	100%	0%	0%	0%
Time and distance HCI (N=36)	100%	0%	0%	0%
Maximum provider panel size HCI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois  
 N = the number of indicators of that type.

**Table 24—Summary of CountyCare’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability HCI (N=7)	100%	0%	0%	0%
Time and distance HCI (N=18)	100%	0%	0%	0%
Maximum provider panel size HCI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois

N = the number of indicators of that type.

**Table 25—Summary of Humana’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability MMAI (N=18)	100%	0%	0%	0%
Time and distance MMAI (N=1)	100%	0%	0%	0%
Maximum PCP panel size MMAI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois

N = the number of indicators of that type.

**Table 26—Summary of Meridian’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability HCI (N=7)	100%	0%	0%	0%
Time and distance HCI (N=36)	100%	0%	0%	0%
Maximum provider panel size HCI (N=4)	100%	0%	0%	0%
Access and availability MMAI (N=18)	100%	0%	0%	0%
Time and distance MMAI (N=1)	100%	0%	0%	0%
Maximum provider panel size MMAI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois

N = the number of indicators of that type.

**Table 27—Summary of Molina’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability HCI (N=7)	100%	0%	0%	0%
Time and distance HCI (N=36)	100%	0%	0%	0%
Maximum provider panel size HCI (N=4)	100%	0%	0%	0%
Access and availability MMAI (N=18)	100%	0%	0%	0%
Time and distance MMAI (N=1)	100%	0%	0%	0%
Maximum provider panel size MMAI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois  
 N = the number of indicators of that type.

**Table 28—Summary of YouthCare’s Validation Findings**

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and availability HCI (N=7)	100%	0%	0%	0%
Time and distance HCI (N=36)	100%	0%	0%	0%
Maximum provider panel size HCI (N=4)	100%	0%	0%	0%

HCI = HealthChoice Illinois  
 N = the number of indicators of that type.

Health plan performance results are provided in Appendix D.

**Network Adequacy Review Statewide Strengths, Opportunities for Improvement, and Recommendations**

Statewide strengths and opportunities for improvement related to network adequacy were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 4.

**Optional EQR Activities**

**Beneficiary Experience With Care**

A key HFS strategy for the oversight of health plans is to conduct an annual experience of care survey of Medicaid members. The CAHPS surveys are designed to capture members’ perspectives on healthcare quality. The CAHPS surveys were administered to the HealthChoice adult and child Medicaid populations.

## Objectives

HFS uses CAHPS results to monitor health plan and provider performance, measure members’ experiences with services and access to care, and evaluate program characteristics.

## Technical Methods of Data Collection and Analysis

HSAG administers a CAHPS survey on behalf of HFS for some child populations and health plans are required to independently administer adult and child surveys which provide HFS with important feedback on performance and are used to initiate changes to improve members’ experiences with the managed care programs. Additional details about CAHPS methodology are presented in Appendix A—Methodology.

## CAHPS Measures

CAHPS survey questions were categorized into measures of experience. 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. Additionally, the CAHPS survey also included the children with chronic conditions (CCC) measurement set of survey questions for the statewide child (i.e., All Kids and Illinois Medicaid) and special needs children (SNC) surveys, 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. Member experience is assessed through the evaluation of these performance measures.

HSAG calculated top-box scores and performed two separate analyses on the survey results: national comparisons and a trend analysis. HSAG performed a trend analysis that compared the 2025 top-box scores to the corresponding 2024 top-box scores. Top-box score results that were statistically significantly higher in 2025 than in 2024 are noted with upward triangles (▲). Top-box scores that were statistically significantly lower in 2025 than in 2024 are noted with downward triangles (▼). Top-box scores in 2025 that were not statistically significantly higher or lower than scores in 2024 are not noted with triangles.

In addition to the trend analysis, HSAG compared the top-box scores for each measure to national Medicaid percentiles. HSAG used the percentile distributions shown in Table 29 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 29—Star Ratings**

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles

Stars	Percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

**Adult CAHPS Medicaid Results**

HFS requires health plans to use an NCQA-certified CAHPS survey vendor to administer CAHPS surveys to a sample of their adult enrollees. The 2024 and 2025 adult Medicaid CAHPS top-box scores, trend analyses, and overall member experience ratings (i.e., star ratings) are presented in Table 30 and Table 31 for each health plan and the statewide aggregate.

**Table 30—2024 and 2025 Adult Health Plan-Specific Results: Composite Measures**

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Aetna	2024	75.52% ★	77.42% ★★	92.38% ★★	87.49% ★
	2025	78.30% ★	80.25% ★★	93.80% ★★★	86.02% ★
BCBSIL	2024	82.41% ★★★	81.63% ★★★	93.65% ★★★	91.16% ★★★★
	2025	77.97% ★	75.95% ★	91.97% ★★	86.84% ★
CountyCare	2024	80.02% ★★	78.17% ★★	91.23% ★	90.15% ★★★
	2025	80.81% ★★	81.39% ★★★	93.13% ★★★	89.41% ★★★
Meridian	2024	83.71% ★★★	82.61% ★★★	95.90% ★★★★★	92.08% ★★★★★
	2025	82.79% ★★★	79.45% ★★	93.78% ★★★	91.01% ★★★★
Molina	2024	86.12% ★★★★	78.62% ★★	95.32% ★★★★★	87.07% <sup>+</sup> ★
	2025	87.42% ★★★★★	81.75% ★★★	95.16% ★★★★	90.00% ★★★

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Illinois Statewide Aggregate	2024	81.61% ★★	79.90% ★★	94.04% ★★★★	89.85% ★★★
	2025	81.00% ★★	79.19% ★★	93.31% ★★★	88.71% ★★

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.  
 ▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.  
 + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

**Table 31—2024 and 2025 Adult Health Plan-Specific Results: Global Ratings**

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
Aetna	2024	50.84% ★	65.70% ★★	64.68% ★★	49.83% ★
	2025	45.65% ★	67.79% ★★	54.07%▼	52.21% ★
BCBSIL	2024	56.06% ★★★★	74.78% ★★★★★	67.77% ★★★★	67.76% ★★★★
	2025	57.41% ★★★★	69.68% ★★★★	65.19% ★★	64.01% ★★★★
CountyCare	2024	61.14% ★★★★	70.82% ★★★★	73.55% ★★★★★	68.15% ★★★★
	2025	60.07% ★★★★	71.82% ★★★★	63.31% ★	70.75% ★★★★★
Meridian	2024	60.32% ★★★★	70.99% ★★★★	66.91% ★★★★	62.26% ★★★★
	2025	57.14% ★★★★	68.95% ★★	72.81% ★★★★	65.03% ★★★★
Molina	2024	69.50% ★★★★★	76.22% ★★★★★	70.10% <sup>+</sup> ★★★★	63.64% ★★★★
	2025	59.92% ★★★★	74.52% ★★★★★	69.33% ★★★★	65.25% ★★★★
Illinois Statewide Aggregate	2024	59.99% ★★★★	70.81% ★★★★	68.41% ★★★★	61.26% ★★
	2025	56.48% ★★	70.19% ★★★★	65.89% ★★	64.00% ★★★★

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.  
 ▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.  
 + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

As shown in Table 30 and Table 31 above, none of the 2025 top-box scores were statistically significantly higher than the 2024 top-box scores for any measure; therefore, no substantial strengths were identified.

Aetna’s 2025 top-box scores were statistically significantly lower than the 2024 top-box score for one measure, *Rating of Specialist Seen Most Often*, which indicates a lack of quality of care.

### Child CAHPS Medicaid Results

HFS requires health plans to use an NCQA-certified CAHPS survey vendor to administer CAHPS surveys to a sample of their child enrollees. The 2024 and 2025 child Medicaid CAHPS top-box scores, trend analyses, and overall member experience ratings (i.e., star ratings) are presented in Table 32 and Table 33 for each child health plan and the statewide aggregate.

**Table 32—2024 and 2025 Child Health Plan-Specific Results: Composite Measures**

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Aetna	2024	81.82% ★★	84.50% ★★	93.73% ★★	90.09% ★★★★
	2025	82.23% ★★	84.79% ★★	93.40% ★★	86.70% ★★
BCBSIL	2024	73.32% ★	75.28% ★	92.38% ★★	84.80% ★
	2025	74.17% ★	80.26% ★	91.16% ★	82.63% ★
CountyCare	2024	79.36% ★★	82.03% ★	93.00% ★★	87.87% ★★★★
	2025	76.72% ★	81.19% ★	93.51% ★★	90.01% ★★★★
Meridian	2024	83.06% ★★★★	85.93% ★★	94.05% ★★★★	84.07% <sup>+</sup> ★
	2025	84.09% ★★★★	89.17% ★★★★	94.63% ★★★★	89.38% <sup>+</sup> ★★★★
Molina	2024	81.41% ★★	79.83% ★	94.21% ★★★★	84.41% ★
	2025	83.84% ★★	86.37%▲	92.22% ★	89.70% ★★★★
Illinois Statewide Aggregate	2024	79.71% ★★	81.78% ★	93.45% ★★	85.60% ★
	2025	80.07% ★★	84.76% ★★	93.11% ★★	87.40% ★★

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.

▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

**Table 33—2024 and 2025 Child Health Plan-Specific Results: Global Ratings**

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
Aetna	2024	67.12% ★★	70.57% ★	68.53% ★★	61.39% ★
	2025	63.30% ★	70.57% ★	68.67% ★★	60.18% ★
BCBSIL	2024	67.97% ★★	74.35% ★★	63.16% <sup>+</sup> ★	73.50% ★★★★
	2025	72.84% ★★★★	77.03% ★★★★	76.83% <sup>+</sup> ★★★★	75.57% ★★★★★
CountyCare	2024	77.16% ★★★★★	75.59% ★★	75.26% <sup>+</sup> ★★★★★	78.56% ★★★★★
	2025	69.06%▼ ★★	73.67% ★★	77.88% ★★★★★	75.20% ★★★★★
Meridian	2024	65.98% ★★	75.89% ★★★★	69.44% <sup>+</sup> ★★	67.21% ★
	2025	75.48% ★★★★★	80.89% ★★★★★	74.58% <sup>+</sup> ★★★★	70.90% ★★
Molina	2024	63.21% ★	75.00% ★★	75.47% ★★★★★	61.31% ★
	2025	74.50%▲ ★★★★★	80.86% ★★★★★	78.57% <sup>+</sup> ★★★★★	69.46%▲ ★★
Illinois Statewide Aggregate	2024	67.95% ★★	74.70% ★★	69.29% ★★	69.08% ★★
	2025	72.35%▲ ★★★★	77.62% ★★★★	75.49% ★★★★	71.47% ★★

▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.  
 ▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.  
 + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

As shown in Table 32 and Table 33 above, the Illinois Statewide Aggregate 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, *Rating of All Health Care*. Additionally, Molina’s 2025 top-box scores were statistically significantly higher than the 2024 top-box scores for the following measures: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*.

CountyCare’s 2025 top-box scores were statistically significantly lower than the 2024 top-box score for one measure, *Rating of All Health Care*, which indicates a lack of quality of care.

## Statewide CAHPS Child Medicaid Survey

### General Child Population

HSAG administered a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. The standardized survey instrument selected was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. Results are calculated for the population of children identified as having a chronic condition and for the general child population. HFS does not require the health plans to administer the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set; however, HSAG uses this survey for Illinois Medicaid and All Kids.

Table 34 shows the 2024 and 2025 general child populations’ CAHPS top-box scores, trend analyses, and overall member experience ratings (i.e., star ratings) for the Illinois statewide aggregate, All Kids, and Illinois Medicaid.

**Table 34—2024 and 2025 Statewide Survey General Child Population Results**

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
<b>Composite Measures</b>				
<i>Getting Needed Care</i>	2024	81.64% ★★	82.03% ★★	81.14% ★★
	2025	78.22% ★	78.37% ★	78.00% ★
<i>Getting Care Quickly</i>	2024	84.18% ★★	83.63% ★★	84.91% ★★
	2025	85.67% ★★	86.39% ★★	84.84% ★★
<i>How Well Doctors Communicate</i>	2024	94.01% ★★★★	93.68% ★★	94.44% ★★★★
	2025	94.41% ★★★★	96.06% ★★★★★	92.23% ★
<i>Customer Service</i>	2024	83.41% ★	82.36% <sup>+</sup> ★	84.67% <sup>+</sup> ★
	2025	88.04% ★★	87.80% <sup>+</sup> ★★	88.31% <sup>+</sup> ★★★★

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
<b>Global Ratings</b>				
<i>Rating of All Health Care</i>	2024	66.76% ★★	67.68% ★★	65.56% ★★
	2025	67.84% ★★	73.54% ★★★★	60.57% ★
<i>Rating of Personal Doctor</i>	2024	71.09% ★	72.30% ★	69.44% ★
	2025	73.90% ★★	75.09% ★★	72.37% ★
<i>Rating of Specialist Seen Most Often</i>	2024	69.72% ★★	72.13% <sup>+</sup> ★★★★	66.67% <sup>+</sup> ★★
	2025	68.38% ★	63.08% <sup>+</sup> ★	75.00% <sup>+</sup> ★★★★
<i>Rating of Health Plan</i>	2024	63.47% ★	63.93% ★	62.88% ★
	2025	64.38% ★	67.17% ★	60.97% ★

- ▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.
- ▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.
- + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results

As shown in Table 34, none of the 2025 top-box scores were statistically significantly higher than the 2024 top-box scores for any measure; therefore, no substantial strengths were identified.

None of the 2025 top-box scores were statistically significantly lower than the 2024 top-box scores for any measure; therefore, no substantial weaknesses were identified.

### CCC Population

Table 35 shows the 2024 and 2025 CCC populations’ CAHPS top-box scores, trend analyses, and overall member experience ratings (i.e., star ratings) for Illinois statewide aggregate, All Kids, and Illinois Medicaid.

**Table 35—2023 and 2024 Statewide Survey CCC Child Results**

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
<b>Composite Measures</b>				
<i>Getting Needed Care</i>	2024	82.30% ★★	84.79% ★★	79.40% ★
	2025	81.66% ★★	83.81% ★★	79.24% ★
<i>Getting Care Quickly</i>	2024	88.17% ★★	89.21% ★★	87.00% ★
	2025	87.81% ★★	88.15% ★★	87.46% ★★
<i>How Well Doctors Communicate</i>	2024	93.25% ★★★★	95.17% ★★★★	91.22% ★
	2025	93.30% ★★	94.44% ★★★★	91.96% ★
<i>Customer Service</i>	2024	83.33% ★	80.99% <sup>+</sup> ★	85.62% <sup>+</sup> ★
	2025	87.25% ★★	89.61% <sup>+</sup> ★★	84.72% <sup>+</sup> ★
<b>Global Ratings</b>				
<i>Rating of All Health Care</i>	2024	62.57% ★★	64.06% ★★	60.84% ★★
	2025	66.57% ★★	71.84% ★★★★	60.65% ★
<i>Rating of Personal Doctor</i>	2024	73.27% ★★	74.46% ★★	71.92% ★★
	2025	75.13% ★★	77.78% ★★★★	72.25% ★★
<i>Rating of Specialist Seen Most Often</i>	2024	71.11% ★★	74.60% ★★★★	66.67% <sup>+</sup> ★★
	2025	72.02% ★★★★	71.72% <sup>+</sup> ★★	72.34% <sup>+</sup> ★★★★
<i>Rating of Health Plan</i>	2024	57.30% ★	56.28% ★	58.45% ★
	2025	62.76% ★★	68.49%▲ ★★★★	56.73% ★

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
<b>CCC Composites and Items</b>				
<i>Access to Specialized Services</i>	2024	62.93% ★	63.92% <sup>+</sup> ★	61.84% <sup>+</sup> ★
	2025	65.80% ★★	66.97% <sup>+</sup> ★★	65.24% <sup>+</sup> ★★
<i>FCC: Personal Doctor Who Knows Child</i>	2024	91.48% ★★★★	92.14% ★★★★	90.73% ★★
	2025	89.80% ★	92.90% ★★★★★	86.72% ★
<i>Coordination of Care for Children with Chronic Conditions</i>	2024	76.08% ★★	78.70% <sup>+</sup> ★★★★	73.26% <sup>+</sup> ★
	2025	81.97% ★★★★★	77.79% <sup>+</sup> ★★★★	84.95% <sup>+</sup> ▲ ★★★★★
<i>Access to Prescription Medicines</i>	2024	88.15% ★★	89.34% ★★	86.75% ★
	2025	88.36% ★★	88.96% ★★	87.74% ★★
<i>FCC: Getting Needed Information</i>	2024	91.34% ★★★★	93.75% ★★★★★	88.55% ★
	2025	94.22% ★★★★★	94.83% ★★★★★	93.55% ★★★★★

- ▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.
- ▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.
- + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

As shown in Table 35 above, the All Kids 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, *Rating of Health Plan*. Additionally, the Illinois Medicaid 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, *Coordination of Care for Children with Chronic Conditions*.

None of the 2025 top-box scores were statistically significantly lower than the 2024 top-box scores for any measure; therefore, no substantial weaknesses were identified.

### Special Needs Children (SNC) Survey

HSAG administered a CAHPS survey on behalf of HFS for Illinois’ special needs children (SNC) health plans and the Former Youth in Care (FYiC) population. The standardized survey instrument selected was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the

CCC measurement set. Results are calculated for the population of children identified as having a chronic condition and for the general child population.

**SNC General Population**

Table 36 shows the 2024 and 2025 general child populations’ CAHPS top-box scores, trend analyses, and overall member experience ratings (i.e., star ratings) for the SNC health plans and FYiC.

**Table 36—2024 and 2025 SNC and FYiC General Child Population Results**

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
<b>Composite Measures</b>								
<i>Getting Needed Care</i>	2024	84.60% ★★★	77.59% ★	78.90% ★	84.37% ★★★	89.18% ★★★★★	89.22% <sup>+</sup> ★★★★★	81.48% ★★
	2025	81.03% ★★	80.33% ★★	84.41% ★★★	86.96% ★★★★★	86.93% ★★★★★	79.60% <sup>+</sup> ▼ ★	84.49% ★★★
<i>Getting Care Quickly</i>	2024	87.06% ★★★	80.71% ★	84.58% ★★	87.16% ★★★	91.01% <sup>+</sup> ★★★★★	93.16% ★★★★★	90.15% ★★★★★
	2025	88.63% ★★★	85.38% ★★	82.28% ★	90.23% ★★★★★	87.47% <sup>+</sup> ★★★	90.00% ★★★	90.90% ★★★★★
<i>How Well Doctors Communicate</i>	2024	89.75% ★	93.09% ★★	88.92% ★	92.04% ★★	91.37% ★	96.70% ★★★★★	96.68% ★★★★★
	2025	91.74% ★	90.90% ★	94.80%▲ ★★★	92.77% ★★	92.27% ★	97.14% ★★★★★	96.48% ★★★★★
<i>Customer Service</i>	2024	90.22% <sup>+</sup> ★★★★★	86.81% ★★	85.44% ★	89.84% ★★★	88.19% <sup>+</sup> ★★★	85.34% <sup>+</sup> ★	87.88% <sup>+</sup> ★★★
	2025	87.18% <sup>+</sup> ★★	88.57% <sup>+</sup> ★★★	92.63%▲ ★★★★★	91.07% <sup>+</sup> ★★★★★	90.32% <sup>+</sup> ★★★	96.55% <sup>+</sup> ▲ ★★★★★	88.15% <sup>+</sup> ★★
<b>Global Ratings</b>								
<i>Rating of All Health Care</i>	2024	66.47% ★★	65.63% ★★	65.84% ★★	63.64% ★	69.57% ★★★	70.37% ★★★	67.25% ★★
	2025	67.38% ★★	67.48% ★★	74.36% ★★★★★	64.74% ★	63.50% ★	63.43% ★	62.94% ★
<i>Rating of Personal Doctor</i>	2024	68.61% ★	76.12% ★★★	75.28% ★★	74.90% ★★	74.37% ★★	76.70% ★★★	80.27% ★★★★★
	2025	75.12% ★★	75.60% ★★	79.90% ★★★★★	75.73% ★★	74.29% ★★	68.26% ★	74.30% ★★

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
<i>Rating of Specialist Seen Most Often</i>	2024	75.21% ★★★★★	78.79% ★★★★★	77.60% ★★★★★	81.36% ★★★★★	80.00% <sup>+</sup> ★★★★★	76.79% <sup>+</sup> ★★★★★	66.32% <sup>+</sup> ★
	2025	69.31% ★★	81.63% <sup>+</sup> ★★★★★	84.04% <sup>+</sup> ★★★★★	73.47% <sup>+</sup> ★★★	72.22% <sup>+</sup> ★★	57.69% <sup>+</sup> ▼ ★	68.67% <sup>+</sup> ★★
<i>Rating of Health Plan</i>	2024	59.76% ★	65.45% ★	69.58% ★★	62.73% ★	59.45% ★	59.90% ★	54.49% ★
	2025	63.91% ★	67.36% ★	74.68% ★★★	60.53% ★	61.93% ★	57.78% ★	54.40% ★

- ▲ Indicates the 2025 score is statistically significantly higher than the 2024 score.
- ▼ Indicates the 2025 score is statistically significantly lower than the 2024 score.
- + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

As shown in Table 36 above, CountyCare’s 2025 top-box scores were statistically significantly higher than the 2024 top-box scores for two measures, *How Well Doctors Communicate* and *Customer Service*. YouthCare’s 2025 top-box score was statistically significantly higher than the 2024 top-box score for one measure, *Customer Service*.

YouthCare’s 2025 top-box scores were statistically significantly lower than the 2024 top-box score for two measures, *Getting Needed Care* and *Rating of Specialist Seen Most Often*, which indicates a lack of quality of care.

**SNC CCC**

Table 37 shows the 2024 and 2025 CCC populations’ CAHPS top-box scores, trend analyses, and overall member experience ratings (i.e., star ratings) for the SNC and FYiC populations.

**Table 37—2024 and 2025 SNC and FYiC CCC NCQA Comparisons**

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
<b>Composite Measures</b>								
<i>Getting Needed Care</i>	2024	86.01% ★★	79.14% ★	81.40% ★★	83.90% ★★	87.35% ★★★	83.11% ★★	81.57% ★★
	2025	81.69% ★★	84.70%▲ ★★★	86.55% ★★★	86.68% ★★★	86.70% ★★★	82.55% ★★	85.90% ★★★
<i>Getting Care Quickly</i>	2024	87.74% ★★	81.80% ★	84.05% ★	86.66% ★	89.99% ★★★	92.29% ★★★★	90.80% ★★★
	2025	90.18% ★★★	87.79%▲ ★★	83.00% ★	90.03% ★★★	88.94% ★★	92.02% ★★★	90.77% ★★★

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
<i>How Well Doctors Communicate</i>	2024	91.54% ★	92.23% ★★	89.76% ★	91.18% ★	92.11% ★	96.24% ★★★★★	96.80% ★★★★★
	2025	93.35% ★★	92.31% ★	94.10%▲ ★★	94.36%▲ ★★	93.45% ★★	96.54% ★★★★★	97.29% ★★★★★
<i>Customer Service</i>	2024	90.71% ★★★★	87.72% ★★	86.83% ★★	90.49% ★★★★	89.20%+ ★★	83.94% ★	85.77% ★
	2025	88.94% ★★	90.21% ★★	92.92%▲ ★★★★★	90.27% ★★	91.94%+ ★★★★	89.09% ★★	87.13% ★★
<b>Global Ratings</b>								
<i>Rating of All Health Care</i>	2024	65.92% ★★★★	67.76% ★★★★	68.86% ★★★★	61.84% ★★	65.19% ★★★★	60.62% ★	61.18% ★★
	2025	68.00% ★★★★	68.39% ★★★★	74.38% ★★★★★	63.28% ★★	62.65% ★★	60.30% ★	62.17% ★★
<i>Rating of Personal Doctor</i>	2024	69.34% ★	76.26% ★★★★	73.85% ★★	71.40% ★★	72.76% ★★	74.14% ★★	81.03% ★★★★★
	2025	77.24%▲ ★★★★	77.18% ★★★★	83.12%▲ ★★★★★	77.69%▲ ★★★★	74.41% ★★	73.66% ★★	75.93% ★★★★
<i>Rating of Specialist Seen Most Often</i>	2024	74.34% ★★★★	81.53% ★★★★★	78.41% ★★★★★	74.23% ★★★★	76.39% ★★★★★	64.49% ★	64.35% ★
	2025	70.45% ★★	83.63% ★★★★★	81.02% ★★★★★	78.40% ★★★★★	74.31% ★★★★	60.40% ★	68.21% ★★
<i>Rating of Health Plan</i>	2024	60.27% ★	66.53% ★★	67.73% ★★★★	60.12% ★	56.60% ★	54.09% ★	47.38% ★
	2025	64.15% ★★	68.37% ★★★★	76.67%▲ ★★★★★	61.19% ★	59.91% ★	51.88% ★	52.39% ★
<b>CCC Composites and Items</b>								
<i>Access to Specialized Services</i>	2024	68.49% ★★	62.95% ★	63.93% ★	64.32% ★	71.13%+ ★★	68.21% ★★	62.60% ★
	2025	69.93%+ ★★★★	64.47% ★★	67.04%+ ★★	68.70% ★★	73.58%+ ★★★★	68.40%+ ★★	67.39% ★★
<i>FCC: Personal Doctor Who Knows Child</i>	2024	89.20% ★	91.49% ★★★★	91.36% ★★★★	89.21% ★	88.80% ★	89.71% ★	91.25% ★★★★
	2025	90.80% ★★	91.19% ★★	92.41% ★★★★	91.96% ★★★★	91.42% ★★★★	93.15% ★★★★★	91.52% ★★★★

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
<i>Coordination of Care for Children with Chronic Conditions</i>	2024	84.67% ★★★★★	80.02% ★★★★★	87.16% ★★★★★	78.84% ★★★★	84.65%+ ★★★★★	72.27% ★	71.94% ★
	2025	84.90%+ ★★★★★	78.07% ★★★★	85.76%+ ★★★★★	81.69% ★★★★★	84.24%+ ★★★★★	72.97%+ ★	67.81% ★
<i>Access to Prescription Medicines</i>	2024	90.74% ★★★★	85.42% ★	89.31% ★★	86.85% ★	89.29% ★★	77.68% ★	83.79% ★
	2025	89.32% ★★	91.08%▲ ★★★★★	90.82% ★★★★	88.36% ★★	87.43% ★	81.87% ★	84.54% ★
<i>FCC: Getting Needed Information</i>	2024	89.73% ★★	89.05% ★★	89.42% ★★	90.28% ★★	92.27% ★★★★	90.79% ★★	92.01% ★★★★
	2025	91.48% ★★★★	90.24% ★★	88.67% ★	90.52% ★★	91.57% ★★★★	92.50% ★★★★	93.22% ★★★★★

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.  
 ▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.  
 + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

As shown in Table 37 above, the following 2025 top-box scores were statistically significantly higher than the 2024 top-box scores:

- Aetna: *Rating of Personal Doctor*.
- BCBSIL: *Getting Needed Care, Getting Care Quickly, and Access to Prescription Medicines*.
- CountyCare: *How Well Doctors Communicate, Customer Service, Rating of Personal Doctor, and Rating of Health Plan*.
- Meridian: *How Well Doctors Communicate and Rating of Personal Doctor*.

None of the 2025 top-box scores were statistically significantly lower than the 2024 top-box scores for any measure; therefore, no substantial weaknesses were identified.

### CAHPS Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to CAHPS were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 4.

### Encounter Data Validation

Accurate and complete encounter data are critical to the success of a managed care program. HFS contracted HSAG to conduct an encounter data validation (EDV) study. In alignment with the most recently published CMS EQR Protocol 5, *Validation of Encounter Data Reported by the Medicaid and*

*CHIP Managed Care Plan*,<sup>16</sup> HSAG will conduct a medical record review (MRR) activity, which is an analysis of the State’s electronic encounter data completeness and accuracy by comparing the State’s electronic encounter data to the information documented in the corresponding customers’ medical records. The goal of the EDV study is to examine the completeness and accuracy of the outpatient institutional encounter data submitted to HFS by the health plans through a review of medical records. HSAG will assess the encounter data submitted by the following six health plans:

- Aetna Better Health (Aetna)
- Blue Cross Community Health Plans (BCBSIL)
- CountyCare-serves Cook County only (CountyCare)
- Meridian (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare HealthChoice Illinois (YouthCare)

In CY 2025, HSAG collaborated with HFS to develop the methodology and timeline for the MRR and assisted the health plans with medical record procurement. As the study was not completed at the time of this report, results will be presented in a future technical report.

### **Quality Rating System**

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

In 2025, HSAG was tasked with developing a report card to evaluate the performance of health plans serving HealthChoice beneficiaries.

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

Health plan performance was evaluated in six separate reporting categories, identified as important to consumers.<sup>17</sup> 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:

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<sup>16</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jan 26, 2026.

<sup>17</sup> National Committee for Quality Assurance. “Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers.” October 1998.

- **Doctors' Communication:** Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate and overall ratings of personal doctors. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access to Care:** Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' access to care and children's and adolescents' access to dentists.
- **Living With Illness:** Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions, such as diabetes and hypertension.
- **Behavioral Health:** Includes HEDIS measures that assess if members with behavioral health conditions received appropriate follow-up after hospitalization, ED visit, or high intensity care, as well as measures that assess pharmacotherapy for opioid use disorder and the initiation and engagement of SUD treatment. In addition, this category includes a HEDIS measure that assesses if children and adolescents using antipsychotic prescriptions receive appropriate metabolic testing.
- **Women's and Children's Health:** Includes HEDIS measures that assess how often women-specific services are provided (e.g., breast cancer, cervical cancer, and chlamydia screenings, as well as prenatal and postpartum care), as well as HEDIS measures that assess how often preventive services for children are provided (e.g., child and adolescent immunizations, well-child visits, and weight assessment and counseling for children/adolescents).

HFS, in collaboration with HSAG, chose measures for the 2025 (CY 2024) Report Card based on a number of factors, such as measures that best approximate the reporting categories that are useful to consumers; using data that are available; and using nationally recognized, standardized measures of Medicaid and/or managed care. Sixty-two measures were chosen: 11 CAHPS and 51 HEDIS. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contributed equally to the derivation of the final results.

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 2024 Quality Compass national Medicaid benchmarks. In addition, HSAG provided consumers with category-level trending information for the selected categories (Doctor's Communication, Access to Care, Living With Illness, Behavioral Health, and Women's and Children's Health) to indicate whether the MCOs' average rating in each category improved, declined, or stayed the same from 2024 to 2025 based on comparisons to national Medicaid benchmarks. HSAG computed five reporting category summary scores for each MCO. HSAG compared each measure to national benchmarks and assigned star ratings for each measure.

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

## 3. Additional EQR Activities

This section presents a description of activities HSAG conducted as additional EQR activities, as requested by HFS.

### Network Monitoring

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

HSAG conducted various activities related to NAV, as described below. For objectives and methodology for each activity, please see Appendix A—Methodology.

#### *Network Adequacy Monitoring Results*

HFS and HSAG have established a process for health plans to submit a Provider File Layout that includes a range of provider types and HSAG analyzes the number of contracted providers within each health plan’s service areas to provide meaningful information on the scope of the provider network.

Analyses and monitoring of the HealthChoice, MLTSS, and MMAI provider network throughout CY 2025 verified that the health plans contracted with a sufficient number of required provider types within each service region.

#### *Access and Availability Telephone Survey*

##### Introduction

As part of its provider network adequacy monitoring activities, HFS requested that HSAG conduct an access and availability survey to evaluate the accuracy of provider information and appointment availability for Illinois Medicaid enrollees with a primary care or outpatient mental health (MH) or SUD provider. To support HFS’ goal to identify and prioritize reducing health disparities, the focus of the study was on providers serving adult and child patients in disproportionately impacted areas (DIAs) and non-DIAs.<sup>18</sup> DIAs are defined as ZIP Codes that meet the following criteria:<sup>19</sup>

- Severely affected by coronavirus disease 2019 (COVID-19) based on positive case per capita rates

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<sup>18</sup> The list of DIA ZIP Codes can be found at: Illinois Department of Commerce and Economic Opportunity. *Zip Codes that Qualify as Disproportionately Impacted Areas for the Illinois Back to Business (B2B) Grant Program*. <https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipodelist.pdf>. Accessed on: Feb 6, 2026.

<sup>19</sup> Illinois Department of Commerce and Economic Opportunity. *QCT-DIA Map*. Illinois workNet Center. Available at: <https://www.illinoisworknet.com/qctdiamap>. Accessed on: Feb 6, 2026.

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

According to the managed care plans' contracts with HFS, each health plan is required to maintain provider network capacity to ensure that primary care visits are available within five weeks (i.e., 35 calendar days) and MH/SUD appointments are available within 10 business days.

### Objectives

The goal of the survey was to evaluate Illinois' Medicaid managed care network of primary care and MH/SUD locations. Specific survey objectives included the following:

- Determine if the contact information (i.e., phone number and address) was accurate for contracted primary care or MH/SUD providers reported by the health plans.
- Determine whether the service locations offered the requested services.
- Determine whether service locations accepted patients enrolled with an Illinois Medicaid health plan.
- Determine whether service locations accepted new patients.
- Determine appointment availability with the sampled service locations for routine primary care and MH/SUD visits.

### Methodology

To address the study objectives described above, HSAG used an HFS-approved methodology and script to conduct a statewide secret shopper telephone survey of primary care and MH/SUD provider offices to collect information on enrollees' access to providers. The health plans assessed in this analysis included the following: Aetna, BCBSIL, CountyCare, Meridian, Molina, and YouthCare.

### Study Limitations

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

### Key Findings

Overall, the provider information maintained and provided by the plans is poor, which could impact access to care due to the inability of members to find a provider that delivers the requested services. Table 38 below provides a summary of the findings from the study.

**Table 38—Summary of Findings**

Concerns	Findings
Contact information was inaccurate.	<p>Overall, 49.9 percent of locations could be contacted, with 55.2 percent of primary care locations and 45.2 percent of MH/SUD locations contacted. Generally, locations in non-disproportionately impacted areas (DIAs) had lower response rates across plans and provider types. However, none of the Meridian child cases in DIAs could be reached.</p> <p>Of the cases unable to be contacted, 20.9 percent were disconnected, 5.6 percent reached a location that was not a medical facility, and 3.3 percent reached a fax machine.</p>
Address information was inaccurate.	<p>Overall, 23.0 percent of primary care locations and 19.7 percent of MH/SUD locations indicated the sampled address was incorrect.</p>
Specialty information was inaccurate.	<p>Overall, 20.0 percent of primary care locations and 19.3 percent of MH/SUD locations indicated the location did not offer the requested services.</p>
Acceptance of the Medicaid health plan was low.	<p>Among cases that could be reached, 44.8 percent of locations reported accepting the requested Medicaid health plan.</p>
Acceptance of new patients was low.	<p>Among cases that could be reached, 40.9 percent of locations accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.</p>
Appointment availability was low.	<p>Among cases that could be reached, 24.3 percent offered a new patient primary care appointment, and 11.9 percent offered an MH/SUD appointment.</p> <p>Overall, 24.6 percent of locations in DIAs and 16.8 percent of locations in non-DIAs offered an adult primary care appointment. Additionally, 28.2 percent of locations in DIAs and 25.6 percent of locations in non-DIAs offered a child primary care appointment.</p> <p>Overall, 14.9 percent of locations in DIAs and 14.5 percent of locations in non-DIAs offered an adult MH/SUD appointment. Additionally, 8.5 percent of locations in DIAs and 5.3 percent of locations in non-DIAs offered a child MH appointment.</p>

Concerns with data accuracy need to be addressed, as this is preventing most callers from reaching a provider’s office. Overall, accuracy of address information and offered services, and acceptance of the

Medicaid health plan and new patients were low. While MH/SUD cases reported a lower response rate, they generally exhibited a greater level of accuracy for the key survey indicators (i.e., address, specialty, Medicaid plan acceptance, and new patients) than the primary care cases. Additionally, MH/SUD cases had a lower rate of appointment availability when compared to primary care cases.

Overall, providers in DIAs performed better for both primary care and MH/SUD for response rates, acceptance of the Medicaid health plan and new patients, appointment availability, and overall wait times. Child primary care cases generally performed better than adult primary care cases across the survey indicators, while adult MH/SUD cases generally performed better than child MH cases across the survey indicators.

When compared to the 2023 Access and Availability Survey of dental and primary care locations in DIAs and the 2024 Access and Availability Survey of behavioral health and prenatal care locations in DIAs, the primary care and MH/SUD group generally performed better than the 2023 and 2024 provider groups. Please note, the 2023 and 2024 surveys were conducted in a revealed survey format where the caller indicated he or she was calling on behalf of HFS, while the 2025 survey was conducted in a secret shopper format where the caller pretended to be an Illinois Medicaid enrollee seeking an appointment.

### Recommendations

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

- **Provider information (i.e., phone number, address, specialty, Medicaid health plan affiliation, and new patient acceptance status) contained in the provider data provided by the plans was incorrect**—Overall, HSAG was unable to reach 44.8 percent of sampled primary care cases and 54.8 percent of MH/SUD cases. Of the nonresponsive cases, 20.9 percent reached a disconnected number, 5.6 percent reached a nonmedical facility, and 3.3 percent reached a fax number. Of note, HSAG was unable to reach any of the Meridian child locations within DIAs, resulting in no results for this population.
- Additionally, 23.0 percent of primary care and 19.7 percent of MH/SUD respondents indicated the sampled address was incorrect, 20.0 percent of primary care and 19.3 percent of MH/SUD locations did not provide the requested services, 14.8 percent of primary care and 13.3 percent of MH/SUD locations did not accept the Medicaid health plan, and 5.3 percent of primary care and 2.5 percent of MH/SUD locations were not accepting new patients.
  - **Recommendation:** Since the health plans supplied HSAG with the provider data used for this survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls (e.g., disconnected telephone numbers or telephone numbers and addresses that do not correspond to the sampled provider location).

- **Recommendation:** The health plans should routinely run address data through the United States Postal Service (USPS) Coding Accuracy Support System (CASS) software program to standardize addresses and identify incorrect addresses that require follow up and/or correction.
- **Recommendation:** The health plans should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.
- **Recommendation:** To further evaluate data inconsistencies, HFS could consider conducting a network validation survey (NVS) to evaluate each health plan’s provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the health plan’s provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the plan-submitted data and the online provider directory, a call would be placed to the provider location to verbally confirm the directory information and request appointment availability.
- **Enrollees seeking primary care and MH/SUD appointments are experiencing limited appointment availability**—Of the cases reached, HSAG was only able to obtain an appointment date with 24.3 percent of the sampled primary care locations and 11.9 percent of the MH/SUD locations. Overall, 24.6 percent of locations serving adults in DIAs and 16.8 percent of locations serving adults in non-DIAs offered a primary care appointment. However, 28.2 percent of locations serving children in DIAs and 25.6 percent of locations serving children in non-DIAs offered a primary care appointment. Additionally, 14.9 percent of locations serving adults in DIAs and 14.5 percent of locations serving adults in non-DIAs offered an MH/SUD appointment. However, 8.5 percent of locations serving children in DIAs and 5.3 percent of locations serving children in non-DIAs offered an MH appointment. Overall, child patients in DIAs seeking a primary care appointment experienced the highest rate of appointment availability at 28.2 percent. However, child patients in non-DIAs seeking an MH appointment experienced the lowest rate of appointment availability at 5.3 percent.
- The survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (e.g., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral). While some barriers pose unique limitations since the caller cannot provide the office personal information, other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments.
  - **Recommendation:** HFS and the health plans should consider conducting a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment.
  - **Recommendation:** The health plans should provide insurance acceptance education to provider office staff.
  - **Recommendation:** The health plans should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.
- **New patients seeking MH/SUD services are experiencing wait times beyond the appointment compliance standards**—Overall, wait times for MH/SUD appointments varied by visit type, with

all visit types, except adults in a DIA, exceeding the wait time standard of 10 business days. Average wait time results are 14 days for an adult in a non-DIA, 15 days for a child in a DIA, and 21 days for a child in a non-DIA. Additionally, appointment availability compliance rates varied by visit type, with 79.5 percent of adult MH, 55.6 percent of child MH, and 75.0 percent of adult SUD appointments meeting the appointment availability compliance standard. Overall, 76.9 percent of adult MH/SUD appointments and 50.0 percent of child MH appointments in DIAs met the appointment availability compliance standard. Similarly, 78.1 percent of adult MH/SUD appointments and 62.5 percent of child MH appointments in non-DIAs met the appointment availability standard.

- **Recommendation:** The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
- **Recommendation:** In coordination with ongoing outreach and network management activities, the health plans should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.
- **Recommendation:** HFS should continue to monitor the health plans' compliance with existing State standards for appointment availability. Additionally, HFS should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability.
- **Recommendation:** The health plans should regularly review enrollee and provider grievances related to access to care concerns and implement processes to address grievances as needed.

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

### ***Time and Distance Analysis***

Annually, HSAG conducts an analysis of the travel time or distance between enrollees and providers in the health plans' networks. The Time and Distance Analysis examines the geographical distribution of each health plan's provider network in relation to its enrollees and calculates the percentage of each health plan's enrollees who have a provider located within the required access standards. During the technical report period, the Time and Distance Analysis was conducted concurrently with the NAV activity. The results of the Time and Distance Analysis can be reviewed in the NAV section of this report.

### **Case Management Staffing and Training Reviews**

HSAG is contracted by HFS to conduct a biannual CY review of the health plans' compliance with case management staffing and training requirements. HFS requires that case managers meet certain staffing and training requirements listed in the health plans' contracts.

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

For the health plans statewide, the following conclusions were made:

- Caseload weighting is a way to balance a case manager’s workload based on the intensity of management expected to support a customer. HFS requires the health plans to manage the number of customers on each case manager’s caseload to ensure that customers receive the attention they need. Most health plans were compliant with all caseload requirements throughout the CY.
- Most health plans met qualification and education requirements for all waiver case managers.

For the health plans statewide, the following recommendations were identified:

- Some health plans did not meet qualification/education requirements for case managers with SNC or HCBS waiver caseloads. The health plans should review the qualification/education requirements for the SNC and HCBS waivers to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plans may consider submitting exemption requests to HFS for consideration.
- The health plans should ensure that all case managers, internal and delegated, receive required trainings by the end of CY 2025.

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

- Most health plans and MMPs achieved significant compliance with staffing and training requirements. HSAG recommends that HFS continue biannual reviews to ensure continued compliance.

## Critical Incident Monitoring Review

To provide feedback and analysis on the health plans’ compliance with and critical incident (CI) requirements, HFS requested that HSAG conduct quarterly reviews of CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Ongoing performance is monitored through quarterly record reviews, health plan-specific feedback, and remediation of review findings. The CI review evaluated the health plans’ compliance with all CI requirements required by contract, State and federal statutes and regulations, and 1915(b) and 1915(c) waiver conditions. All HealthChoice, YouthCare, and MMAI health plans were included in the CY 2025 reviews.

## System Effectiveness and File Review Findings

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

For the health plans statewide, the following conclusions were made:

- File reviews demonstrated that the health plans were compliant with ensuring the health, safety, and welfare (HSW) of the enrollee after the CI occurred. The enrollee was contacted (or the health plan completed attempts to contact the enrollee), and the health plan mitigated the enrollee's needs, risks, and/or situation.
- File reviews demonstrated that the health plans effectively identified and reported CIs to the appropriate investigating authority.
- File reviews demonstrated that the health plans have a thorough CI oversight process that aims to resolve the initial CI and prevent subsequent CI events.
- When opportunities for improvement were identified, the health plans demonstrated actions to remediate those findings.

## CMS HCBS Waiver Performance Measures Record Review

CMS requires HFS to provide quality oversight of state health plans and employ strategies to discover successes and opportunities for improvement within the HCBS waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that HSAG conduct quarterly reviews of waiver beneficiary records. The CY 2025 reviews assessed performance during a lookback period of June 1, 2024, through August 31, 2025, and all HealthChoice and MMAI health plans were included in the reviews.

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

- **Persons with Disabilities (PD):** Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility, and can be safely maintained in the home or community-based setting with the services provided in the plan of care. Individuals 60 years of age or older, who began services before age 60, may choose to remain in this waiver.
- **Persons with HIV or AIDS (HIV):** Persons of any age who are diagnosed with human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and are at risk of placement in a nursing facility.
- **Persons with Brain Injury (BI):** Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- **Persons who are Elderly (ELD):** Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are ages 65 and older, and those who are physically disabled, ages 60 through 64.

- Persons in a Supportive Living Program (SLP): Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

For the CY 2025 review, HFS identified 15 CMS waiver performance measures for review. These performance measures were aligned with the state-approved 1915(c) waiver applications for the waiver types listed above.

### **HealthChoice Record Reviews**

During CY 2025, 1,481 HealthChoice and 1,500 MLTSS records were reviewed using HSAG’s web-based data collection tool.<sup>20</sup>

All five health plans achieved overall compliance rates of 90 percent or greater in CY 2025. Three of the five health plans performed at rates equal to or greater than the CY 2025 statewide average (aggregate across all health plans) of 96 percent.

For the HealthChoice health plans statewide, the following conclusions were made:

- Fourteen of the 15 CMS performance measures averaged 90 percent or greater compliance.
- Four of the 15 CMS performance measures achieved a statistically significant increase in performance when compared to CY 2024.
- The measures averaging 90 percent or greater compliance indicate that the health plans demonstrated strengths in documenting enrollee risks, needs, goals, and backup plans in service plans; that updates to service plans are being completed when enrollees’ needs change; and that health plans are ensuring enrollees’ choice is honored and documented when selecting services.
- All five waivers averaged greater than 90 percent compliance.
- All five health plans averaged greater than 90 percent compliance and achieved a statistically significant increase in performance in at least one performance measure.

For the health plans statewide, the following recommendations were identified:

- Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 75 percent compliance. To impact performance on Measure D6, HSAG recommended the following efforts:
  - Conduct root cause analysis to determine opportunities to effect change.
  - Conduct staff training to ensure understanding of contact requirements for all waiver types. Training should include expectations for completion of face-to-face and telephone contacts.
  - Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.

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<sup>20</sup> MLTSS enrollees are managed through HealthChoice and included in HealthChoice results. MLTSS-specific results are available upon request.

- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

### **MMAI Record Reviews**

During CY 2025, 1,278 records were reviewed using HSAG’s web-based data collection tool. HSAG computed an average of the performance achieved by each health plan on the 15 CMS waiver performance measures reviewed. All five health plans achieved overall compliance rates greater than 90 percent in CY 2025. Four of the five health plans performed at rates equal to or greater than the CY 2025 statewide average (aggregate across all health plans) of 97 percent.

For the MMAI health plans statewide, the following conclusions were made:

- Thirteen of the 15 CMS performance measures averaged 90 percent or greater compliance.
- Four of the 15 CMS performance measures achieved a statistically significant increase in performance when compared to CY 2024.
- All five waivers averaged greater than 90 percent compliance; four achieved a statistically significant increase in overall performance when compared to CY 2024.
- All five health plans averaged greater than 90 percent compliance and achieved a statistically significant increase in performance in at least one performance measure.
- Four of the five health plans achieved a statistically significant increase in overall performance when compared to CY 2024.

For the MMAI health plans statewide, the following recommendations were identified:

- Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 84 percent compliance. To impact performance on Measure D6, HSAG recommended the following efforts:
  - Conduct root cause analysis to determine opportunities to effect change.
  - Conduct staff training to ensure understanding of contact requirements for all waiver types. Training should include expectations for completion of face-to-face and telephone contacts.
  - Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
  - Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.

- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
- Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

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

HSAG conducted an annual review to assess the health plans' QA/UR/PR annual reports. HSAG completed the reviews and provided feedback to the health plans and HFS according to the established timelines. HSAG did not identify any critical elements requiring remediation from the health plans.

## Mental Health Parity (MHP) Review

Certain mental health and SUD parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) apply to the coverage provided to the enrollees of the Medicaid program and CHIP to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and SUD benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs. In accordance with the MHPAEA and its implementing regulations (including 42 CFR Parts 438, 440, and 457; and 45 CFR Part 146.136) and Illinois statute 215 ILCS 5/370c.1,<sup>21</sup> HFS and Department of Insurance (DOI) complete oversight activities related to compliance to the State and federal parity laws.

To meet MHP requirements in 42 CFR §438 Subpart K and Illinois statute 215 ILCS 5/370c.1, HFS contracted with HSAG to conduct a 2024-2025 MHP analysis of the HealthChoice and YouthCare health plans. The purpose of the review was to provide meaningful information to HFS, DOI, and the health plans regarding the evaluation of each health plan's processes to ensure compliance with MHPAEA requirements.

HSAG collaborated with HFS to define the scope of the MHP review to include applicable federal and State regulations and laws and the requirements set forth in the contract, as they relate to the scope of the review. HSAG developed a protocol and tools in alignment with guidance outlined in the toolkit provided by CMS: *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.<sup>22</sup>

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<sup>21</sup> Illinois General Assembly. Illinois Compiled Statutes, 215 ILCS 5/370c.1. Available at: <https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021500050K370c.1>. Accessed on: Feb 6, 2026.

<sup>22</sup> The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP are available at <https://www.medicare.gov/medicaid/benefits/behavioral-health-services/parity/index.html>. Accessed on: Feb 6, 2026.

The MHP analysis consisted of:

- Review of the health plans' nonquantitative treatment limitations (NQTL) Reports and comparative analyses.
- Review of the health plans' utilization management (UM) policies, procedures, and information.
- Analysis of medical and surgical (M/S) and mental, emotional, nervous, or substance use disorder or condition (MH/SUD) prior authorization (PA) denial data, which are self-reported to HFS.
- File review of adverse benefit determination (ABD) records encompassing both M/S and MH/SUD denials.

Overall, HSAG determined that the health plans demonstrated parity between M/S and MH/SUD services, with opportunity for improvement related to comparative analyses documentation. Implementation of the health plans' processes demonstrated compliance with State and federal MHP requirements and standards.

## Care Gap Plan Review

A "gap in care" is the discrepancy between recommended best practices and the care that is actually provided. Some examples of recommended best practices are making sure a patient has received a flu shot, been screened for depression or breast cancer, or has been counseled toward quitting if they are a known tobacco user. A care gap results when these events go unaddressed during care visits with providers. Making sure there is a system that can track care gaps and help practices address those gaps is vital to long-term patient care management success.

The HealthChoice and YouthCare health plans are required to have a Care Gap Plan that describes how they will ensure provision of services missed by enrollees. HFS contracted with HSAG to assess each health plan's 2025 Care Gap Plan, as well as each health plan's processes to address provider network gaps.

HSAG reviewers utilized the Care Gap Plan assessment tool to assess 17 elements and determine a performance score, which was used to identify strengths and potential opportunities for improvement. All health plans achieved a performance score of 100 percent.

## Utilization Management Service Authorization Data Analysis

To meet service authorization requirements in Illinois statute 305 ILCS 5/5-30.1, HFS completes oversight activities related to compliance with the State and federal coverage and authorization regulations. HFS contracted with HSAG to conduct a review of service authorization data and information for all HealthChoice and YouthCare health plans.

As the review and analysis were not completed at the time of this report, findings will be presented in a future technical report.

## 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 programs, CAHPS sampling and development of CAHPS supplemental questions, P4P program measures and calculations, 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 enable successful participation in EQR activities. In addition, the following TA activities were conducted in the reporting cycle.

### 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...”<sup>23</sup> 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 health plans to achieve NCQA accreditation.

HSAG developed the Illinois Managed Care Program NCQA Accreditation status sheet (status sheet), which succinctly displays each health plan’s accreditation status, along with a description of the NCQA accreditation levels. HFS features this status sheet on its website to make the information public. The most recent version can be accessed at:  
<https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/il2025hfsncqaaccreditation.pdf>.

### Freedom of Information Act (FOIA) Requests

The FOIA pertains to a person's right of access to federal agency records, except those protected from disclosure by a set of exemptions and special law enforcement exclusions. When a FOIA request is

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<sup>23</sup> H.R. 3590—Patient Protection and Affordable Care Act. Available at: <https://www.congress.gov/bill/111th-congress/house-bill/3590/text>. Accessed on: Feb 6, 2026.

received, HFS often requests HSAG's assistance to provide the necessary information to fulfill the request as required.

### ***Development of Program-Specific Performance Measures and Withhold Methodologies***

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, develop, and collect performance measures specific to each of the programs and the populations they serve.

HFS also contracts with HSAG to develop scoring mechanisms for the managed care withhold and Pay-for-Performance (P4P) and Pay-for-Reporting (P4R) programs.

### ***HFS, Health Plan, and Stakeholder Training***

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

With rapid changes in the patterns of health service needs, scientific and technological developments, and the economic and institutional contexts in which providers of health services are embedded, HFS and the health plans will need to continue to adapt. HSAG will provide trainings as needed and requested by HFS.

### ***Report and Data Collection Templates***

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

HFS understands that a key to achieving Medicaid delivery system reform is data analytic capacity. HFS seeks to offer support and solutions to health plans in building and strengthening their data analytic

capacity and develop common data sets for HFS' use in delivering improved care and driving smarter spending. HSAG has extensive experience in developing standardized data collection tools and processes as required by the analytical task, including accessing and documenting health plan compliance with federal Medicaid managed care regulations, State rules, and the associated HFS contract requirements; reporting performance measure results; reporting specific data sets, such as care management outcomes; and additional ad hoc reporting, as required by HFS.

### ***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 withhold methodologies.

## 4. Individual Health Plan Results and Conclusions











### HealthChoice Illinois



#### Aetna





HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.



















Detailed results from the EQR’s substantive findings are summarized in Table 39 for each activity. This table highlights the extent to which Aetna furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Aetna can best address issues identified for each activity.







**Table 39—Aetna Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
	<b>Strength:</b> Aetna achieved a <i>High Confidence</i> level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement for Remeasurement 2 for the <i>Improving Transportation Services</i> PIP.	
<b>PMV</b>		
	<b>Strength:</b> Aetna continued to make progress toward ensuring members received follow-up after they visited the ED or hospital for mental illness. Four submeasures of <i>Follow-Up After Emergency Department Visit for Mental Illness</i> performed at or above the 50th percentile and most submeasures of <i>Follow-Up After Hospitalization for Mental Illness</i> .	
	<b>Strength:</b> Aetna made progress in ensuring children and adolescents received important checkups and assessments as rates improved for <i>Child and Adolescent Well-Care Visits</i> , <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> , and <i>Well-Child Visits in the First 30 Months of Life</i> .	
	<b>Strength:</b> Aetna’s rates for measures related to diabetes management demonstrated improvement: <i>Blood Pressure Control for Patients With Diabetes</i> , <i>Eye Exam for Patients With Diabetes</i> , <i>Glycemic Status Assessment for Patients With Diabetes</i> , and <i>Statin Therapy for Patients With Diabetes</i> (one submeasure).	
	<b>Opportunity for Improvement:</b> Aetna’s rate on all submeasures fell below the 50th percentile for <i>Follow-Up After Emergency</i>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><i>Department Visit for Substance Use</i> and below the 25th percentile for <i>Initiation and Engagement of SUD Treatment</i>. Of note, Aetna’s rate for the <i>Initiation of SUD Treatment—Total—13–17 Years</i> submeasure declined by more than 10 percentage points.</p> <p><b>Recommendations:</b> Aetna should evaluate current care coordination for members with SUD. Plans should leverage ADT feeds from EDs to engage discharged members in follow-up care. The health plan should consider enhancing existing or developing new partnerships with SUD treatment providers and expand telehealth options to support timely access to care, the availability of care, and the receipt of referrals from facilities. The health plan’s case management team should follow up with eligible members to assist in facilitating and coordinating appointments to initiate treatment if necessary.</p>	
	<p><b>Opportunity for Improvement:</b> Children between 15 and 30 months of age did not receive recommended well-child visits. Although Aetna demonstrated improvement, the <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> submeasure performed below the 25th percentile.</p> <p><b>Recommendations:</b> HSAG recommends that Aetna work with HFS to determine where provider and member incentives could be considered to support timely well-care visits. The health plan should evaluate current member and provider education to determine opportunities for enhancing messaging with community stakeholders, and revise materials to emphasize the importance of well-care visits and preventive health care. The health plan also should consider alternative methods of member outreach and healthcare reminders based on advancements in technology, such as text messaging preventive care reminders and partnering with school-based health clinics to complete well-child visits.</p>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> Aetna had room for improvement in completing important screenings with women. Aetna performed below the 25th percentile for <i>Cervical Cancer Screening</i> and below the 50th percentile for <i>Chlamydia Screening in Women</i> and <i>Breast Cancer Screening</i>.</p> <p><b>Recommendations:</b> To improve women’s health screening rates, HSAG recommends that the health plan:</p> <ul style="list-style-type: none"> <li>• Evaluate the effectiveness of existing interventions and consider employing alternative strategies or soliciting best practices to improve its performance and address timely access to care barriers.</li> <li>• Include standing orders and reduce structural barriers by offering non-traditional clinic hours, mobile screenings, patient navigators, and streamlined administrative procedures.</li> <li>• Consider whether disparities/SDOH factors within the health plan’s populations contributed to lower access to care. Implement appropriate interventions to reduce barriers to care upon identifying root causes.</li> <li>• Address STI stigma among physicians and patients.</li> <li>• Clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update.</li> <li>• Use multi-modal approaches to contact members and promote women's screenings. Offer incentives to providers to provide screenings, increase access, and conduct outreach to eligible members in their panels.</li> </ul>	
	<p><b>Opportunity for Improvement:</b> In the <i>Adults' Access to Preventive/ Ambulatory Health Services</i> measure, Aetna’s rate continued to fall below the 25th percentile.</p> <p><b>Recommendations:</b> Aetna should work with HFS on potential incentive options to support timely preventive health visits, and evaluate the effectiveness of interventions for options for further spread and sustainability (or adapt and modify). Further, the health plan’s care management teams should support coordination and facilitation of appointment scheduling to address barriers as needed. Finally, the health plan should evaluate provider access and availability and consider where alternative hours could be offered.</p>	

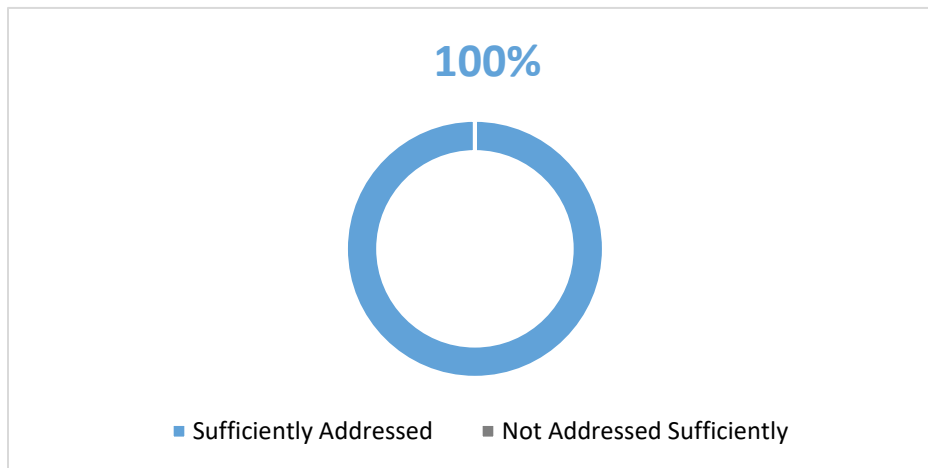
Strength/ Opportunity for Improvement	Description	Domain(s)
<b>Compliance With Standards</b>		
	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
	<b>Strength:</b> Aetna used a comprehensive array of provider data validation and updating resources to ensure provider data were as current and accurate as possible.	
	<b>Strength:</b> Aetna met the State’s time and distance standards across all public health regions for 19 of 20 HealthChoice provider categories (95 percent). Aetna met the standard for pharmacies in Regions 3 and 4. Aetna was the only statewide plan that met the standards for oral surgeons, adult and pediatric, across all public health regions, enrollees, and counties.	
	<b>Opportunity for Improvement:</b> Aetna failed to meet the 100 percent access standard for pharmacies in five counties. <b>Recommendations:</b> HSAG recommends that Aetna maintain current levels of access to care and continue to address network gaps for access to pharmacies.	
<b>Additional EQR Activities</b>		
	<b>Strength:</b> The staffing and training review identified that Aetna was compliant with all caseload requirements.	
	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
	<b>Strength:</b> The health plan achieved 100 percent compliance in the Care Gap Plan review.	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> Aetna’s adult Medicaid survey scores were below the 25th percentile for all composite measures.</p> <p><b>Recommendations:</b> HSAG recommends examining referral procedures, prior authorization requirements, and availability of in-network providers. Additionally, HSAG recommends providing training to specialists to improve the way they communicate and interact with members.</p>	
	<p><b>Opportunity for Improvement:</b> Aetna’s 2025 top-box score was statistically significantly lower than the 2024 top-box score for one measure, <i>Rating of Specialist Seen Most Often</i>, which indicates a lack of quality of care.</p> <p><b>Recommendations:</b> The health plan should examine referral procedures, prior authorization requirements, and availability of in-network providers. Additionally, HSAG recommends providing training to specialists to improve the way they communicate and interact with members.</p>	
	<p><b>Opportunity for Improvement:</b> The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to inaccurate provider location information.</p> <p><b>Recommendations:</b> The health plan should routinely run address data through the USPS CASS software program to standardize addresses and identify incorrect addresses that require follow-up and/or correction. The health plan also should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	
	<p><b>Opportunity for Improvement:</b> The access and availability survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (i.e., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral).</p> <p><b>Recommendations:</b> The health plan should consider conducting a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment; provide insurance acceptance education to provider office staff; and utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	

### Follow-Up on Prior Year Recommendations

Aetna submitted responses to all prior EQR recommendations and HSAG reviewed Aetna’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities. Figure 2 illustrates the degree to which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 2—Percentage of Prior EQR Recommendations Addressed by Aetna**



Aetna-specific prior recommendations and follow-up assessments are summarized in Table 40.

**Table 40—Assessment of Aetna’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PMV</b>	
Aetna’s rate for the <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i> measure improved compared to last year; however, the rate remained below the 50th percentile. HSAG recommended Aetna design and test interventions specific to the 20–39 age group to engage those members in accessing healthcare on a routine basis.	<b>Aetna sufficiently addressed the recommendation.</b> Aetna noted improvement and conducted community-based outreach tailored to younger populations; expanded telehealth options and member incentives; and launched new telephonic outreach initiatives, provider engagement efforts, and vendor partnerships to meet specific member needs.
Aetna performed poorly on measures related to women’s screenings, below the 25th percentile for <i>Breast Cancer Screening</i> and <i>Cervical Cancer Screening</i> and below the 50th percentile for <i>Chlamydia Screening in Women</i> . HSAG recommended Aetna consider whether there are disparities/SDOH factors that contributed to lower access to care. Upon identification of root causes,	<b>Aetna sufficiently addressed the recommendation.</b> Aetna noted improvement, launched a multi-channel strategy to improve breast cancer screening (including statewide mobile mammogram events), targeted outreach, enhanced campaigns during Breast Cancer Awareness Month, and installed CVS Minute Clinics.

Prior Recommendation	Assessment
<p>HSAG recommends that the plans implement appropriate interventions to reduce barriers to care. HSAG also recommended Aetna address STI stigma among physicians and patients; clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update as well; use multi-modal approaches to contact members to promote women's screenings with incentives to providers for screenings, increased access, and outreaching eligible members in their panels.</p>	
<p>Aetna was the lowest performing plan for <i>Child and Adolescent Well-Care Visits</i>, with a rate below the 50th percentile. HSAG recommended Aetna create or reassess PCP outreach policies and automated appointment reminder systems as well as utilize personalized outreach for hard-to-reach patients; encourage providers to partner with teenagers and use teen appropriate language; and increase the availability of telehealth options and focus personalized outreach about telehealth to 18–21-year-olds.</p>	<p><b>Aetna sufficiently addressed the recommendation.</b> Aetna noted improvement in urban areas. For rural areas, Aetna launched new initiatives to better serve children, offered enhanced support through hands-on partnerships, targeted data sharing, and increased incentives with identified rural providers. Additionally, Aetna onboarded new vendors to reach hard-to-contact members.</p>
<p>For the <i>Childhood Immunization Status</i> measure, Aetna's rate was below the 50th percentile for the <i>Combination 3</i> submeasure and below the 25th percentile for the <i>Combination 10</i> submeasure. HSAG recommended Aetna focused on parent education and clinic practice transformation. If Aetna already has a program for new parents, the plan should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Aetna should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in the clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast-track infants who are behind on their vaccination schedules.</p>	<p><b>Aetna sufficiently addressed the recommendation.</b> Aetna noted improvements in immunization and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participation; resolved data ingestion issues; targeted provider outreach to high-impact groups; fast-tracked catch-up vaccinations through community efforts; and targeted high-gap ZIP Codes through school-based clinics, mobile units, and partnerships.</p>

Prior Recommendation	Assessment
<p>Aetna struggled to engage members with opioid use disorder (OUD) and SUD in appropriate treatment. Rates decreased for all three submeasures in <i>Pharmacotherapy for OUD</i> and performed below the 50th percentile. All six submeasures in <i>Initiation and Engagement of SUD Treatment</i> declined and five submeasures performed below the 50th percentile. To improve treatment of OUD and SUD, HSAG recommended Aetna:</p> <ul style="list-style-type: none"> <li>• Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options.</li> <li>• Assess demographic variation to determine what obstacles may be present to inform solutions.</li> <li>• Consider creating a multidisciplinary workgroup to understand the eligible members’ barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD.</li> <li>• Expand treatment options with focus on convenience and accessibility.</li> <li>• Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment.</li> <li>• Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.</li> </ul>	<p><b>Aetna sufficiently addressed the recommendation.</b> Aetna noted early indicators of success, continued its robust Your Journey, Your Recovery program, implemented real-time collaboration with Federally Qualified Health Centers (FQHCs), and onboarded additional providers to expand its Virtual Care Connect program.</p>
<p>Aetna’s child members were not assessed for body mass index (BMI) or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the <i>Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)</i> measure continuing to perform below the 50th percentile. HSAG recommended Aetna conduct further analysis to consider whether certain provider groups performed lower on completing weight</p>	<p><b>Aetna sufficiently addressed the recommendation.</b> Aetna noted improvement, embedded WCC components into well-child visit outreach cohorts supported by provider partners, deployed multimodal outreach and education strategies, and targeted mobile unit deployments and care management partnerships.</p>

Prior Recommendation	Assessment
<p>assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.</p>	
<b>Compliance With Standards</b>	
<p>Results of the Children’s Behavioral Health (CBH) file reviews demonstrated an opportunity for improvement related to oversight of care management activities. HSAG recommended Aetna continue oversight and monitoring procedures as well as reporting for the CBH services requirements. Consider increasing the number of internal audits to ensure compliance with contractual requirements.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted significant improvement, established a biweekly governance process in partnership with the care management compliance team. This initiative focuses on enhancing oversight, increasing internal audits, expanding interdisciplinary care team (ICT) engagement, and improving access to services following crisis events. Additionally, Aetna added five new mobile crisis response (MCR) agencies to strengthen ICT delivery and streamline processes.</p>
<p>Results of the CBH post-implementation review identified that the health plan had an opportunity for improvement related to Family Leadership Council participation. HSAG recommended Aetna develop more robust strategies to engage their Family Leadership Council.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna launched a multi-pronged engagement strategy that included offering \$25 gift cards to members who joined online, conducting onsite meetings with increased incentives, partnering with CCSO to host co-located community stakeholder meetings with transportation support, and restructuring meeting agendas to incorporate participant feedback.</p>
<p>Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. HSAG recommended Aetna develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement, implemented a biweekly governance process with the care management compliance team to improve oversight and access. Key strategies included expanding telehealth services to reduce wait times, developing Virtual Care Connect Program flyers with QR codes to link them to providers with short wait times for appointments, increasing onsite discharge planning programs from five to 15 facilities, and partnering with SCCP for same-day</p>

Prior Recommendation	Assessment
	appointments and dedicated behavioral health follow-up referrals.
<b>NAV</b>	
<p>Aetna did not meet the 90 percent HCI time and distance standards in all counties for two provider categories: oral surgeons, adult; and oral surgeons, pediatric. Aetna did not meet the 100 percent time and distance standard in all counties for pharmacists. HSAG recommended Aetna maintain current levels of access to care and continue to address network gaps for the following provider categories: oral surgeons, adult and pediatric, and pharmacies.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement, contracted additional oral surgeons and introduced CVS’ free same-day delivery program.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. HSAG recommended Aetna address provider data deficiencies identified during the survey calls.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement, sought assistance from its internal resources to normalize provider addresses, and leveraged other Aetna partners to review provider data for other products and conduct provider outreach to remediate any differences.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. HSAG recommended Aetna conduct a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment and provide insurance acceptance education to provider office staff members.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement, continued to evaluate various methods to communicate its required appointment availability standards and health plan name recognition. Aetna partnered with a vendor, Press Ganey, to expand the frequency of the access and availability survey from annually to quarterly.</p>
<b>Additional EQR Activities</b>	
<p>Aetna’s CAHPS experience survey results were below the 50th percentile for all adult measures and for seven of eight child measures. HSAG recommended Aetna evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. Aetna should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. Aetna could consider conducting root cause analyses or focus studies to further explore members’ perceptions</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement, instituted telephonic and in-person solutions to proactively connect members to care, expanded outreach programs to facilitate timely scheduling, intensified multi-channel member enablement campaigns, implemented monthly audits of provider networks, and continued prior interventions.</p>

Prior Recommendation	Assessment
<p>regarding the access to care and services and obtain feedback from patients on their recent office visit.</p>	
<p>Results of the staffing and training review identified that the health plan had an opportunity for improvement related to ensuring qualification and education requirements were met for its SNC case managers. HSAG recommended Aetna review the qualification/education requirements for the SNC members to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plan may consider submitting exemption requests to HFS for consideration.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna corrected its staffing workbook and strengthened its recruitment process to ensure accurate verification of credentials.</p>
<p>Results of the staffing and training review identified that the health plan had an opportunity to ensure its delegate completes annual training requirements. HSAG recommended Aetna ensure that all case managers receive required trainings by the end of CY 2024.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna enhanced onboarding protocols to include immediate enrollment in required training modules, reinforced quarterly and ad hoc training sessions, clarified manager expectations to ensure timely oversight, and expanded training completion audits to specifically track new hire compliance.</p>
<p>Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. HSAG recommended Aetna ensure that staff members are educated on timely reporting and that oversight procedures examine compliance with timeliness of reporting.</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement for HCI, conducted training sessions, and utilized a weekly CI report for monitoring.</p>
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i>. HSAG recommended Aetna conduct a root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when</p>	<p><b>Aetna sufficiently addressed the recommendations.</b> Aetna noted improvement, developed lag reporting tools to provide leadership with real-time visibility for early identification of timeliness barriers and proactive interventions, launched a productivity dashboard, and introduced a new audit tool.</p>





Prior Recommendation	Assessment
contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	







### BCBSIL










HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.







Detailed results from the EQR’s substantive findings are summarized in Table 41 for each activity. This table highlights the extent to which BCBSIL furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how BCBSIL can best address issues identified for each activity.

**Table 41—BCBSIL’s Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
+	<b>Strength:</b> BCBSIL achieved a <i>High Confidence</i> level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement for Remeasurement 2 for the <i>Improving Transportation Services</i> PIP.	
<b>PMV</b>		
+	<b>Strength:</b> BCBSIL made progress in ensuring children and adolescents received important checkups and assessments as rates improved for <i>Child and Adolescent Well-Care Visits</i> , <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> , and <i>Well-Child Visits in the First 30 Months of Life</i> .	
+	<b>Strength:</b> A majority of BCBSIL’s pregnant members received recommended prenatal and postpartum care as demonstrated by performance on the <i>PPC</i> measure. The rate for the <i>Timeliness of Prenatal Care</i> submeasure exceeded the 90th percentile and the 75th percentile for the <i>Postpartum Care</i> submeasure.	
-	<b>Opportunity for Improvement:</b> BCBSIL struggled with follow-up with children and adults after hospitalization and ED visits for mental illness. In the <i>Follow-Up After Hospitalization for Mental Illness</i> measure, rates for all submeasures remained below the 50th percentile and performance declined for five of six submeasures. Though many rates for <i>Follow-Up After Emergency Department Visit for Mental Illness</i> performed above the 50th percentile, BCBSIL’s rates declined for all reportable submeasures. <b>Recommendations:</b> BCBSIL’s care management teams should establish ADT feeds with hospitals and EDs and monitor visits with a mental illness diagnosis to assist members with coordinating and scheduling follow-up appointments. The health plan should partner	

Strength/ Opportunity for Improvement	Description	Domain(s)
	with behavioral health providers to expand access, including telehealth options, and receive timely referrals. The health plan can consider strategies that focus on building the capacity of pediatric care practitioners and utilizing the Illinois DocAssist program to increase the confidence and support of these providers to see more patients.	
	<p><b>Opportunity for Improvement:</b> Children between 15 and 30 months of age did not receive recommended well-child visits. Although BCBSIL demonstrated improvement, the <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> submeasure performed below the 50th percentile.</p> <p><b>Recommendations:</b> BCBSIL should work with HFS to determine where provider and member incentives could be considered to support timely well-care visits. The health plan should evaluate current member and provider education to determine opportunities for enhancing messaging with community stakeholders, and revise materials to emphasize the importance of well-care visits and preventive health care. The health plan also should consider alternative methods of member outreach and healthcare reminders based on advancements in technology, such as text messaging preventive care reminders and partnering with school-based health clinics to complete well-child visits.</p>	
	<p><b>Opportunity for Improvement:</b> In the <i>Adults' Access to Preventive/Ambulatory Health Services</i> measure, BCBSIL's rate continued to fall below the 50th percentile.</p> <p><b>Recommendations:</b> BCBSIL should work with HFS on potential incentive options to support timely preventive health visits and evaluate the effectiveness of interventions for options for further spread and sustainability (or adapt and modify). Further, the health plan's care management teams should support coordination and facilitation of appointment scheduling to address barriers as needed. Finally, the health plan should evaluate provider access and availability and consider where alternative hours could be offered.</p>	
<b>Compliance With Standards</b>		
	<p><b>Strength:</b> The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.</p>	

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>NAV</b>		
+	<b>Strength:</b> BCBSIL established a robust process to ensure provider data remains accurate and up to date. This process included multiple initiatives such as multilevel outreach to providers, quarterly reminder calls and attestations, and both quarterly and semiannual provider performance oversight audits.	
+	<b>Strength:</b> BCBSIL met the State’s time and distance standards across all public health regions for 17 of 20 (85 percent) provider categories.	
+	<b>Strength:</b> BCBSIL’s pharmacy results remained stable from 2024 to 2025, continuing to provide access within standards for 99.0 percent to 100 percent of enrollees. BCBSIL improved its performance on both oral surgeon indicators (adult and pediatric), improving to meet standards in Region 1, which resulted in meeting standards in a total of three regions this year (Regions 1, 4, and 5).	
-	<b>Opportunity for improvement:</b> BCBSIL did not meet the network standards for oral surgeons, adult and pediatric; pharmacies; and nursing facilities. <b>Recommendations:</b> HSAG recommends that BCBSIL maintain current levels of access to care and continue to address network gaps for the following provider categories: oral surgeons, adult and pediatric, and pharmacies.	
<b>Additional EQR Activities</b>		
+	<b>Strength:</b> The staffing and training review identified that BCBSIL was compliant with all caseload requirements and all qualification and education requirements for waiver case managers.	
+	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
+	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	<b>Strength:</b> The health plan achieved 100 percent compliance in the Care Gap Plan review.	

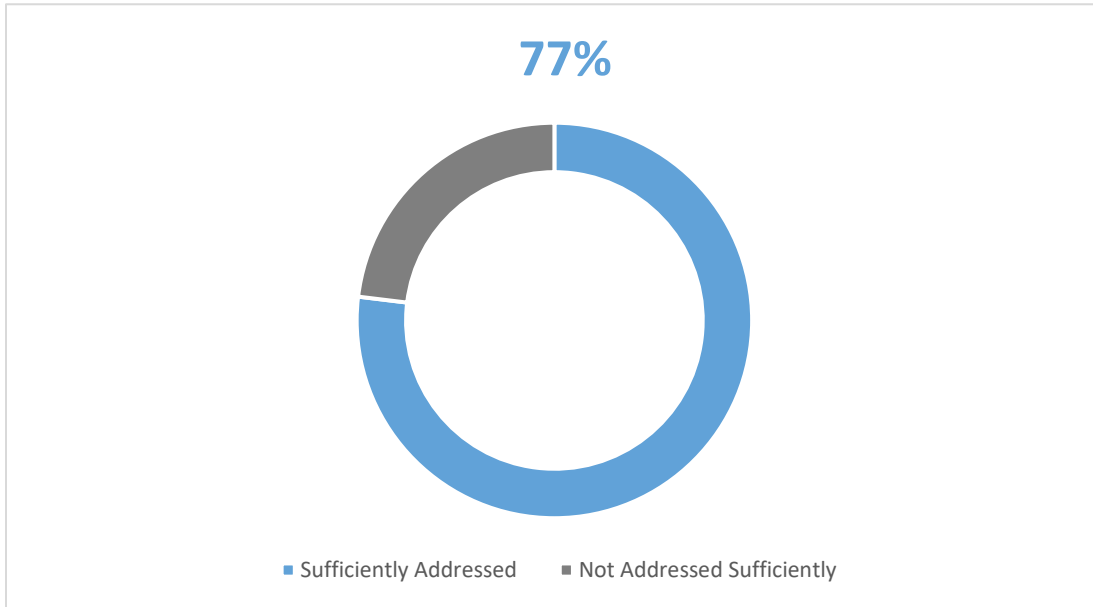
Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for improvement:</b> For all four composite measures, BCBSIL’s adult experience survey results were below the 50th percentile and below the 25th percentile for the child Medicaid survey.</p> <p><b>Recommendations:</b> HSAG recommends that BCBSIL evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. BCBSIL should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. BCBSIL could consider conducting root cause analyses or focus studies to further explore members’ perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.</p>	
	<p><b>Opportunity for Improvement:</b> The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to inaccurate provider location information.</p> <p><b>Recommendations:</b> The health plan should routinely run address data through the USPS CASS software program to standardize addresses and identify incorrect addresses that require follow up and/or correction. The health plan also should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	
	<p><b>Opportunity for Improvement:</b> The access and availability survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (e.g., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral).</p> <p><b>Recommendations:</b> The health plan should consider conducting a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment; provide insurance acceptance education to provider office staff; and utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	

### Follow-Up on Prior Year Recommendations

BCBSIL submitted responses to all prior EQR recommendations and HSAG reviewed BCBSIL’s approach to addressing the recommendations and/or findings issued in the prior technical report while

conducting the CY 2025 EQR activities. Figure 3 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 3—Percentage of Prior EQR Recommendations Addressed by BCBSIL**



BCBSIL-specific prior recommendations and follow-up assessments are summarized in Table 42.

**Table 42—Assessment of BCBSIL’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PMV</b>	
<p>BCBSIL’s child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three sub measures in the <i>Weight Assessment and Counseling for Nutrition and Physical Activity</i> measure continuing to perform below the 50th percentile. HSAG recommended Aetna conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL noted improvement, implemented a monthly text and email education campaign, shared provider education materials, and implemented a coding/mapping initiative to improve documentation.</p>

Prior Recommendation	Assessment
<p>missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.</p>	
<p>BCBSIL struggled to engage members with OUD in appropriate treatment. Although some improvements were made, rates for all three sub measures in <i>Pharmacotherapy for OUD</i> performed below the 50th percentile. To improve treatment of OUD and SUD, HSAG recommends BCBSIL:</p> <ul style="list-style-type: none"> <li>• Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options.</li> <li>• Assess demographic variation to determine what obstacles may be present to inform solutions.</li> <li>• Consider creating a multidisciplinary workgroup to understand the eligible members’ barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD.</li> <li>• Expand treatment options with focus on convenience and accessibility.</li> <li>• Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment.</li> <li>• Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.</li> </ul>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL noted a small improvement, described its continued efforts for ongoing interventions and plans to administer a quarterly survey to address member access and barriers to medication treatment.</p>
<b>Compliance Review</b>	
<p>Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. HSAG recommended BCBSIL develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL enhanced care coordination documentation through staff training. BCBSIL’s provider network and care coordination teams collaborated to identify, address, and educate providers on the key area of missing and untimely delivery of IM-CATs from</p>

Prior Recommendation	Assessment
	MCR providers. Additionally, BCBSIL received grant funding for a peer-led non-clinical alternative for mental health crisis and the development of the DuPage County Health Department Crisis Recovery Center.
<b>NAV</b>	
<p>BCBSIL did not meet the 90 percent HCI time and distance standards in all counties for two provider categories: oral surgeons, adult; and oral surgeons, pediatric. BCBSIL did not meet the 100 percent time and distance standard in all counties for pharmacists. HSAG recommended BCBSIL maintain current levels of access to care and continue to address network gaps for the following provider categories: oral surgeons, adult and pediatric, and pharmacies.</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL closed all previously identified county-level gaps for oral surgeons and continued its efforts to identify pharmacies for potential contracting opportunities.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. HSAG recommended BCBSIL address provider data deficiencies identified during the survey calls.</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL conducted an outreach campaign to contact providers who were identified with inaccurate data, collected survey data from providers to remind them of the importance of updating their rosters, provided additional provider education, and implemented a robust auditing process.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. HSAG recommended BCBSIL conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL targeted an outreach campaign to behavioral health and prenatal care providers to gather additional information on their scheduling practices, hosted a provider forum and distributed the presentation, increased telehealth options, and refreshed provider training materials.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. HSAG recommended BCBSIL conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL targeted an outreach campaign to providers who were identified as being unable to secure an appointment within the appropriate time frame, contacted larger behavioral health and prenatal care provider groups, and provided additional provider education.</p>

Prior Recommendation	Assessment
<p>management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.</p>	
<p><b>Additional EQR Activities</b></p>	
<p>BCBSIL’s experience survey results were below the 50th percentile for seven of eight child measures. HSAG recommended BCBSIL evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. BCBSIL should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. BCBSIL could consider conducting root cause analyses or focus studies to further explore members’ perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.</p>	<p><b>BCBSIL did not sufficiently address the recommendation.</b> BCBSIL described ongoing interventions but did not identify new efforts or address the specific recommendations in its response.</p>
<p>For CAHPS, BCBSIL’s child experience survey results were below the 50th percentile for every measure. For child CAHPS, HSAG recommended BCBSIL prioritize improving parents’/caretakers’ overall experiences with their child’s personal doctor and determine a root cause for the lower performance. BCBSIL should continue promoting the results of its member experience with its contracted providers and staff members.</p>	<p><b>BCBSIL did not sufficiently address the recommendation.</b> BCBSIL described ongoing interventions but did not identify new efforts or address the specific recommendations in its response.</p>
<p>Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, MMAI file reviews identified an opportunity for improvement related to the timeliness of reporting. HSAG recommended BCBSIL ensure that staff members are educated on timely reporting and that oversight procedures examine compliance of timeliness of reporting.</p>	<p><b>BCBSIL did not sufficiently address the recommendation.</b> BCBSIL identified inconsistent managerial oversight as a cause for low performance. Although BCBSIL described providing training, no intervention was implemented to improve oversight and no improvements were noted.</p>






Prior Recommendation	Assessment
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i>. HSAG recommended BCBSIL consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	<p><b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL created a work plan for all lines of business. Senior leadership meets with managers on a weekly basis for continuous monitoring and oversight. Additionally, a member engagement letter was created to inform members when a new care coordinator is assigned.</p>



### CountyCare



HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.















Detailed results from the EQR’s substantive findings are summarized in Table 43 for each activity. This table highlights the extent to which CountyCare furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how CountyCare can best address issues identified for each activity.










**Table 43—CountyCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
+	<b>Strength:</b> CountyCare achieved a <i>High Confidence</i> level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement for Remeasurement 2 for the <i>Improving Transportation Services</i> PIP.	
<b>PMV</b>		
+	<b>Strength:</b> CountyCare improved its follow-up with children and adults after hospitalization and ED visits for mental illness. Although all rates continued to perform below the 50th percentile for the <i>Follow-Up After Hospitalization for Mental Illness</i> measure, rates for five of six submeasures improved. CountyCare’s performance improved for three of four reportable submeasures for <i>Follow-Up After Emergency Department Visit for Mental Illness</i> .	
+	<b>Strength:</b> CountyCare made progress in ensuring children and adolescents received important checkups and assessments as rates improved for <i>Child and Adolescent Well-Care Visits</i> , <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> , and <i>Well-Child Visits in the First 30 Months of Life</i> . CountyCare was the highest performing plan for the <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> measure, with all submeasures performing at or above the 75th percentile.	
+	<b>Strength:</b> CountyCare’s rates improved for both submeasures for <i>Prenatal and Postpartum Care</i> and performed between the 50th and 74th percentiles.	
+	<b>Strength:</b> CountyCare’s rates for measures related to diabetes management demonstrated improvement: <i>Blood Pressure Control for Patients With Diabetes</i> , <i>Eye Exam for Patients With Diabetes</i> ,	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<i>Glycemic Status Assessment for Patients With Diabetes, and Statin Therapy for Patients With Diabetes</i> (one submeasure).	
	<p><b>Opportunity for Improvement:</b> CountyCare demonstrated improvement, but continued its struggle with follow-up with children and adults after hospitalization and ED visits for mental illness. Performance for all rates of the <i>Follow-Up After Hospitalization for Mental Illness</i> remained below the 50th percentile, and CountyCare’s performance for <i>Follow-Up After Emergency Department Visit for Mental Illness</i> fell below the 50th percentile for members 18–64 years of age.</p> <p><b>Recommendations:</b> CountyCare’s care management teams should establish ADT feeds with hospitals and EDs and monitor visits with a mental illness diagnosis to assist members with coordinating and scheduling follow-up appointments. The health plan should partner with behavioral health providers to expand access, including telehealth options, and receive timely referrals. The health plan can consider strategies that focus on building the capacity of pediatric care practitioners and utilizing the Illinois DocAssist program to increase the confidence and support of these providers to see more patients.</p>	
	<p><b>Opportunity for Improvement:</b> CountyCare’s rate on all submeasures fell below the 50th percentile for <i>Follow-Up After Emergency Department Visit for Substance Use</i> and <i>Initiation and Engagement of SUD Treatment</i>.</p> <p><b>Recommendations:</b> CountyCare should evaluate current care coordination for members with SUD. Plans should leverage ADT feeds from EDs to engage discharged members in follow-up care. The health plan should consider enhancing existing or developing new partnerships with SUD treatment providers and expand telehealth options to support timely access to care, the availability of care, and the receipt of referrals from facilities. The health plan’s case management teams should follow up with eligible members to assist in facilitating and coordinating appointments to initiate treatment if necessary.</p>	
	<p><b>Opportunity for Improvement:</b> Children between 15 and 30 months of age did not receive recommended well-child visits. Although CountyCare demonstrated improvement, the <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> submeasure performed below the 50th percentile.</p> <p><b>Recommendations:</b> CountyCare should work with HFS to determine where provider and member incentives could be considered to support timely well-care visits. The health plan should evaluate</p>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p>current member and provider education to determine opportunities for enhancing messaging with community stakeholders, and revise materials to emphasize the importance of well-care visits and preventive health care. The health plan also should consider alternative methods of member outreach and healthcare reminders based on advancements in technology, such as text messaging preventive care reminders and partnering with school-based health clinics to complete well-child visits.</p>	
	<p><b>Opportunity for Improvement:</b> CountyCare had room for improvement in completing important screenings with women. CountyCare performed below the 25th percentile for <i>Breast Cancer Screening</i> and demonstrated a decline in performance for <i>Chlamydia Screening in Women</i> and <i>Cervical Cancer Screening</i>.</p> <p><b>Recommendations:</b> To improve women’s health screening rates, HSAG recommends that the health plan:</p> <ul style="list-style-type: none"> <li>• Evaluate the effectiveness of existing interventions and consider employing alternative strategies or soliciting best practices for high performing plans to improve its performance and address timely access to care barriers.</li> <li>• Include standing orders and reduce structural barriers by offering non-traditional clinic hours, mobile screenings, patient navigators, and streamlined administrative procedures.</li> <li>• Consider whether disparities/SDOH factors within the health plan’s populations contributed to lower access to care. Implement appropriate interventions to reduce barriers to care upon identifying root causes.</li> <li>• Address STI stigma among physicians and patients.</li> <li>• Clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update.</li> <li>• Use multi-modal approaches to contact members to promote women's screenings. Offer incentives to providers to provide screenings, increase access, and conduct outreach to eligible members in their panels.</li> </ul>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> In the <i>Adults' Access to Preventive/Ambulatory Health Services</i> measure, CountyCare's rate continued to fall below the 50th percentile.</p> <p><b>Recommendations:</b> CountyCare should work with HFS on potential incentive options to support timely preventive health visits, and evaluate the effectiveness of interventions for options for further spread and sustainability (or adapt and modify). Further, the health plan's care management teams should support coordination and facilitation of appointment scheduling to address barriers as needed. Finally, the health plan should evaluate provider access and availability and consider where alternative hours could be offered.</p>	
<b>Compliance With Standards</b>		
	<p><b>Strength:</b> The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.</p>	
<b>NAV</b>		
	<p><b>Strength:</b> CountyCare established robust processes to ensure provider data remains accurate and up to date. These processes included several key initiatives. CountyCare also conducted monthly and ad hoc audits to verify the accuracy and consistency of provider data within the rosters, implemented automated tools, and partnered with an external vendor.</p>	
	<p><b>Strength:</b> CountyCare met all access standards. CountyCare's results on pharmacies and oral surgeons for both adults and children remained stable from 2024 to 2025. CountyCare continued to meet the State's time and distance standards across all 20 applicable provider categories in the single public health region where it provides coverage.</p>	
<b>Additional EQR Activities</b>		
	<p><b>Strength:</b> The staffing and training review identified that CountyCare was compliant with all caseload requirements.</p>	
	<p><b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.</p>	
	<p><b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.</p>	

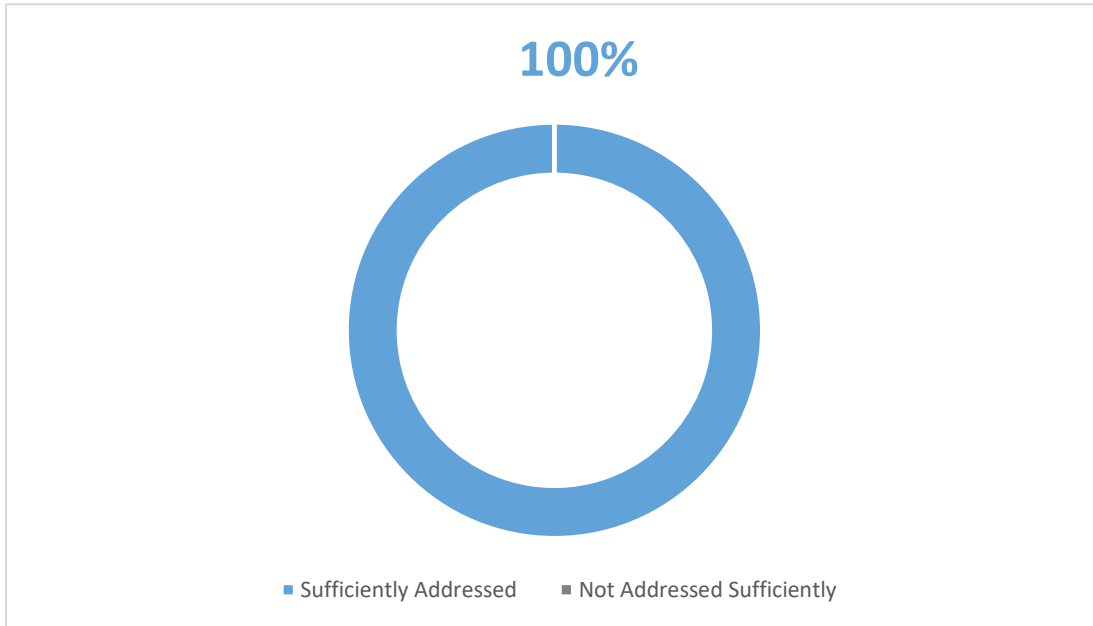
Strength/ Opportunity for Improvement	Description	Domain(s)
	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
	<b>Strength:</b> The health plan achieved 100 percent compliance in the Care Gap Plan review.	
	<b>Opportunity for improvement:</b> For the child Medicaid survey, CountyCare’s 2025 top-box score was statistically significantly lower than the 2024 top-box score for one measure, <i>Rating of All Health Care</i> , which indicates a lack of quality of care. <b>Recommendations:</b> The health plan should obtain feedback from parents/caretakers of the child members on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies to address healthcare concerns.	
	<b>Opportunity for Improvement:</b> The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to inaccurate provider location information. <b>Recommendations:</b> The health plan should routinely run address data through the USPS CASS software program to standardize addresses and identify incorrect addresses that require follow up and/or correction. The health plan also should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.	
	<b>Opportunity for Improvement:</b> The access and availability survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (e.g., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral). <b>Recommendations:</b> The health plan should consider conducting a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment; provide insurance acceptance education to provider office staff; and utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.	

### Follow-Up on Prior Year Recommendations

CountyCare submitted responses to all prior EQR recommendations and HSAG reviewed CountyCare’s approach to addressing the recommendations and/or findings issued in the prior technical report while

conducting the CY 2025 EQR activities. Figure 4 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 4—Percentage of Prior EQR Recommendations Addressed by CountyCare**



CountyCare-specific prior recommendations and follow-up assessments are summarized in Table 44.

**Table 44—Assessment of CountyCare’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PIPs</b>	
CountyCare continued to show declines in performance compared to the baseline for the <i>Timeliness of Prenatal Care</i> PIP. HSAG recommended CountyCare revisit its causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	<b>CountyCare sufficiently addressed the recommendation.</b> CountyCare convened a new PIP workgroup with both internal and external stakeholders, designed a text message campaign for women of reproductive age, and developed and coordinated trainings for south side clinics.
<b>PMV</b>	
CountyCare’s rate for the <i>Adults’ Access to Preventive/ Ambulatory Health Services—Total</i> measure improved compared to last year; however, the rate remained below the 50th percentile. HSAG recommended CountyCare design and test interventions specific to the 20-39	<b>CountyCare sufficiently addressed the recommendation.</b> CountyCare noted improvement, implemented a multimodal outreach campaign to impact the performance of the 20–39 age stratification; incentivized this measure and the 20–39 population, specifically in

Prior Recommendation	Assessment
<p>age group to engage these members in accessing healthcare on a routine basis.</p>	<p>value-based contracts; and partnered with key provider groups based on their member populations for targeted outreach.</p>
<p>CountyCare struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for all three submeasures in <i>Pharmacotherapy for OUD</i> and performed below the 25th percentile. Rates for two of six submeasures in <i>Initiation and Engagement of SUD Treatment</i> declined and five performed below the 50th percentile. Three of four submeasures for <i>Follow-Up After Emergency Department Visit for Substance Use</i> performed below the 50th percentile. To improve treatment of OUD and SUD, HSAG recommends CountyCare:</p> <ul style="list-style-type: none"> <li>• Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options.</li> <li>• Assess demographic variation to determine what obstacles may be present to inform solutions.</li> <li>• Consider creating a multidisciplinary workgroup to understand the eligible members’ barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD.</li> <li>• Expand treatment options with focus on convenience and accessibility.</li> <li>• Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment.</li> <li>• Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.</li> </ul>	<p><b>CountyCare sufficiently addressed the recommendation.</b> CountyCare’s pharmacy department identifies members referred to the medication-assisted treatment (MAT) program who have not yet filled their prescription and flags these cases for outreach by the care management team.</p>
<p>CountyCare’s rates for the <i>Controlling High Blood Pressure</i> measure continued to perform below the 25th percentile. HSAG recommended CountyCare educate and consider incentive plans</p>	<p><b>CountyCare sufficiently addressed the recommendation.</b> CountyCare noted improvement, collaborated with provider groups on improving their supplemental data, regularly</p>

Prior Recommendation	Assessment
for providers on appropriate submission of Current Procedural Terminology (CPT) II codes for improving administrative capture of blood pressure control results.	reviewed quality data reports and supplemental data impact reporting, added a data feed through Athena Payer Data Exchange, and contracted with a vendor to increase direct connections to providers.
<b>Compliance With Standards</b>	
Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. HSAG recommended CountyCare develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	<b>CountyCare sufficiently addressed the recommendation.</b> CountyCare noted improvement, implemented CARES rounds to facilitate an opportunity for training and open forums to address CARES gaps and compliance; reviewed quarterly audit results to provide an overview of current practices and procedures in relation to CARES follow-up requirements; and updated the monthly joint operating meeting executive summary to include a CARES tab.
Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. HSAG recommended CountyCare continue oversight and monitoring procedures as well as reporting for the CBH services requirements. Consider increasing the number of internal audits to ensure compliance with contractual requirements	<b>CountyCare sufficiently addressed the recommendation.</b> CountyCare noted improvement, increased behavioral health providers (including telehealth providers) and worked with MCR providers to schedule members for follow-up within their agency.
<b>NAV</b>	
The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. HSAG recommended CountyCare address provider data deficiencies identified during the survey calls.	<b>CountyCare sufficiently addressed the recommendation.</b> CountyCare noted improvement, increased provider data management/provider relations monthly audits from 100 to 200 providers to survey the access and availability standards for new and existing patients and also to survey knowledge of participation with the health plan.
The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. HSAG recommended CountyCare conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	<b>CountyCare sufficiently addressed the recommendation.</b> CountyCare increased monthly audits to include 200 randomly selected providers to survey the access and availability standards and also to provide knowledge of participation with the health plan. CountyCare followed up with providers who failed the audit to understand the reasons they were unable to meet the access and availability standards.

Prior Recommendation	Assessment
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. HSAG recommended CountyCare conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.</p>	<p><b>CountyCare sufficiently addressed the recommendation.</b> CountyCare’s provider relations team incorporated the health plan’s access and availability standards on all provider meeting agendas to provide continued education; updated its monthly audit process to require follow-up and additional education to providers who did not accept health plan members or meet access and availability standards; and updated its provider orientation to include additional information on the access and availability standards and offer the orientation monthly to new providers entering the network.</p>
<p><b>Additional EQR Activities</b></p>	
<p>Results of the staffing and training review identified that the health plan had an opportunity to ensure its internal and delegated case managers complete annual training requirements. HSAG recommended CountyCare ensure that all case managers receive required trainings by the end of CY 2024.</p>	<p><b>CountyCare sufficiently addressed the recommendation.</b> CountyCare reported that all case managers in the delegated care management entities completed their required CY 2024 training, implemented training into the new hire training curriculum, sent quarterly training reminders, offered critical incident training online, and provided additional details to staff regarding the completion of training.</p>
<p>Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. HSAG recommended CountyCare ensure that staff members are educated on timely reporting and that oversight procedures examine compliance with the timeliness of reporting.</p>	<p><b>CountyCare sufficiently addressed the recommendation.</b> CountyCare developed a critical incident refresher training course for delegates and expects this effort to result in compliance improvement.</p>
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i>. HSAG recommended the following: Consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members;</p>	<p><b>CountyCare sufficiently addressed the recommendation.</b> CountyCare noted improvement, held quarterly staff training, sought to fill contractor positions, and enhanced its management oversight tool.</p>





Prior Recommendation	Assessment
<p>conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	





## Meridian





HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.



















Detailed results from the EQR’s substantive findings are summarized in Table 45 for each activity. This table highlights the extent to which Meridian furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Meridian can best address issues identified for each activity.





**Table 45—Meridian Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
+	<b>Strength:</b> Meridian achieved a <i>High Confidence</i> level for adhering to acceptable methodology for the <i>Improving Timeliness of Prenatal Care</i> PIP.	
-	<b>Opportunity for improvement:</b> For the <i>Improving Transportation Services</i> PIP Validation Rating 2, Meridian did not achieve a <i>High Confidence</i> level that the PIP achieved significant improvement for Validation Rating 2. <b>Recommendations:</b> Meridian should develop a process or plan to evaluate the effectiveness of each individual intervention listed in the barriers/interventions table in the PIP Submission Form, and use Plan-Do-Study-Act (PDSA) cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.	
<b>PMV</b>		
+	<b>Strength:</b> Meridian improved its follow-up with children and adults after hospitalization for mental illness. Although all rates continued to perform below the 50th percentile for the <i>Follow-Up After Hospitalization for Mental Illness</i> measure, rates for all six submeasures improved. The <i>30-Day Follow-Up—65+ Years</i> submeasure improved by over 20 percentage points.	
+	<b>Strength:</b> Meridian made progress in ensuring children and adolescents received important checkups and assessments as rates improved for <i>Child and Adolescent Well-Care Visits</i> , <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> , and <i>Well-Child Visits in the First 30 Months of Life</i> .	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	<p><b>Strength:</b> A majority of pregnant members received recommended prenatal and postpartum care as Meridian’s rates for both submeasures of <i>Prenatal and Postpartum Care</i> performed between the 75th and 89th percentiles.</p>	
+	<p><b>Strength:</b> Meridian’s rates for measures related to diabetes management demonstrated improvement: <i>Blood Pressure Control for Patients With Diabetes</i>, <i>Eye Exam for Patients With Diabetes</i>, <i>Glycemic Status Assessment for Patients With Diabetes</i>, and <i>Statin Therapy for Patients With Diabetes</i> (one submeasure).</p>	
-	<p><b>Opportunity for Improvement:</b> Meridian demonstrated improvement, but continued its struggle with follow-up with children and adults after hospitalization and ED visits for mental illness. Performance for all but one submeasure of the <i>Follow-Up After Hospitalization for Mental Illness</i> remained below the 50th percentile, and Meridian’s performance declined for all reportable submeasures for <i>Follow-Up After Emergency Department Visit for Mental Illness</i>.</p> <p><b>Recommendations:</b> Meridian should determine which interventions were effective in realizing improvements in the prior year’s rates for <i>Follow-Up After Hospitalization for Mental Illness</i>; expand or spread those interventions for continued improvement, and determine if successful interventions could be applied to achieve improvement in the rates for <i>Follow-Up After Emergency Department Visit for Mental Illness</i>.</p>	
-	<p><b>Opportunity for Improvement:</b> Meridian’s rates declined for <i>Follow-Up After Emergency Department Visit for Substance Use</i> on the two submeasures that were above the 50th percentile and fell below the 50th percentile for two submeasures. For <i>Initiation and Engagement of SUD Treatment</i>, Meridian performed below the 50th percentile for the <i>Engagement of SUD Treatment—Total—13–17 Years</i> submeasure and performance declined for the <i>Initiation of SUD Treatment—Total—13–17 Years</i> submeasure.</p> <p><b>Recommendations:</b> Meridian should evaluate current care coordination for members with SUD. Plans should leverage ADT feeds from EDs to engage discharged members in follow-up care. The health plan should consider enhancing existing or developing new partnerships with SUD treatment providers and expand telehealth options to support timely access to care, the availability of care, and the receipt of referrals from facilities. The health plan’s case management teams should follow up with eligible members to assist in facilitating and coordinating appointments to initiate treatment and if necessary.</p>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> Meridian had room for improvement in completing important screenings with women. Meridian performed below the 25th percentile for <i>Chlamydia Screening in Women</i> and below the 50th percentile for <i>Breast Cancer Screening</i>.</p> <p><b>Recommendations:</b> To improve women’s health screening rates, HSAG recommends that the health plan:</p> <ul style="list-style-type: none"> <li>• Evaluate the effectiveness of existing interventions and consider employing alternative strategies or soliciting best practices for high performing plans to improve its performance and address timely and access to care barriers.</li> <li>• Include standing orders and reduce structural barriers by offering non-traditional clinic hours, mobile screenings, patient navigators, and streamlined administrative procedures.</li> <li>• Consider whether disparities/SDOH factors within the health plan’s populations contributed to lower access to care. Implement appropriate interventions to reduce barriers to care upon identifying root causes.</li> <li>• Address STI stigma among physicians and patients.</li> <li>• Clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update.</li> <li>• Use multi-modal approaches to contact members to promote women's screenings. Offer incentives to providers to provide screenings, increase access, and conduct outreach to eligible members in their panels.</li> </ul>	
	<p><b>Opportunity for Improvement:</b> In the <i>Adults' Access to Preventive/ Ambulatory Health Services</i> measure, Meridian’s rate continued to fall below the 50th percentile.</p> <p><b>Recommendations:</b> Meridian should work with HFS on potential incentive options to support timely preventive health visits, and evaluate the effectiveness of interventions for options for further spread and sustainability (or adapt and modify). Further, the health plan’s care management teams should support coordination and facilitation of appointment scheduling to address barriers as needed. Finally, the health plan should evaluate provider access and availability and consider where alternative hours could be offered.</p>	

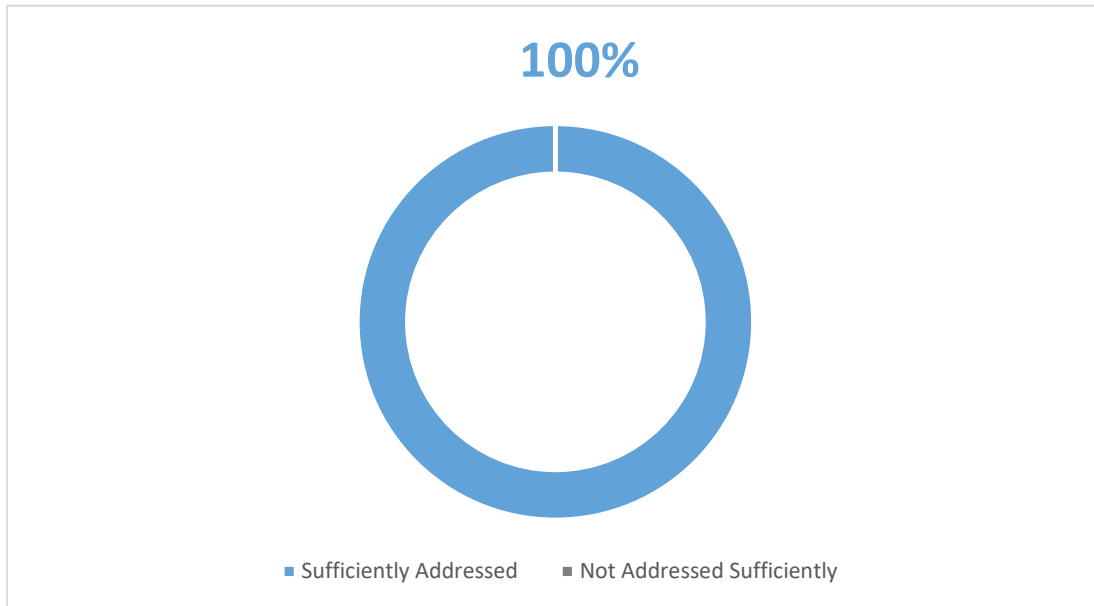
Strength/ Opportunity for Improvement	Description	Domain(s)
<b>Compliance With Standards</b>		
	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
	<b>Strength:</b> Meridian developed a strong feedback loop with providers, including quarterly provider mock audits to verify provider data, reviewing fallout reports to confirm valid PCP assignments, and weekly validation against the IMPACT file, to ensure provider data were as accurate and up to date as possible.	
	<b>Strength:</b> Meridian met the State’s time and distance standards across all public health regions for 17 of 20 provider categories (85 percent). Meridian maintained its performance from last year in Region 3 and Region 4 for pharmacies, and for Region 1, Region 2, and Region 3 in the oral surgery, adult and pediatric provider categories.	
	<b>Opportunity for improvement:</b> Meridian did not meet the State’s time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. <b>Recommendations:</b> HSAG recommends that Meridian maintain the current level of access to care and continue to address network gaps for pharmacies and oral surgeons for HCI enrollees.	
<b>Additional EQR Activities</b>		
	<b>Strength:</b> The staffing and training review identified that Meridian was compliant with all caseload requirements and all qualification and education requirements for waiver case managers.	
	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
	<b>Strength:</b> The health plan achieved 100 percent compliance in the Care Gap Plan review.	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to inaccurate provider location information.</p> <p><b>Recommendations:</b> The health plan should routinely run address data through the USPS CASS software program to standardize addresses and identify incorrect addresses that require follow up and/or correction. The health plan also should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	
	<p><b>Opportunity for Improvement:</b> The access and availability survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (e.g., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral).</p> <p><b>Recommendations:</b> The health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment; provide insurance acceptance education to provider office staff; and utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	

### Follow-Up on Prior Year Recommendations

Meridian submitted responses to all prior EQR recommendations and HSAG reviewed Meridian's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities. Figure 5 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 5—Percentage of Prior EQR Recommendations Addressed by Meridian**



Meridian-specific prior recommendations and follow-up assessments are summarized in Table 46.

**Table 46—Assessment of Meridian’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PIPs</b>	
Meridian demonstrated statistically significant decline in Remeasurement 1 for the <i>Improving Transportation Services</i> PIP for all three lines of business (HealthChoice, MLTSS, and SNC). HSAG recommended Meridian revisit its causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	<b>Meridian sufficiently addressed the recommendation.</b> Meridian noted improvement, expanded provider access and vehicle availability, recruited additional providers in rural areas, implemented enhancements to the MTM Health (MTM) portal for trip completion and claim submission, and piloted a new intervention to identify a specific transportation provider to service a specific IL facility.
<b>PMV</b>	
For the <i>Childhood Immunization Status</i> measure, Meridian’s rate was below the 25th percentile for both submeasures. HSAG recommended focusing on parent education and clinic practice transformation. If Meridian already has a program for new parents, the plan should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason	<b>Meridian sufficiently addressed the recommendation.</b> Meridian launched a pilot at the beginning of MY 2025 to educate parents and guardians on the correct vaccination schedule with a series of text message reminders, gifted magnet reminders to members, reorganized member rewards to incentivize every immunization visit, and partnered with low-performing providers to engage with parents and guardians.

Prior Recommendation	Assessment
<p>for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Meridian should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in the clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast track infants who are behind on their vaccination schedules.</p>	
<p>Meridian performed poorly on measures related to women’s screenings, below the 50th percentile for <i>Breast Cancer Screening</i> and <i>Cervical Cancer Screening</i> and below the 25th percentile for <i>Chlamydia Screening in Women</i>. HSAG recommended Meridian consider whether there are disparities/SDOH factors that contribute to lower access to care. Upon identification of root causes, HSAG recommends that Meridian implement appropriate interventions to reduce barriers to care. HSAG also recommends Meridian address STI stigma among physicians and patients; clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update; use multi-modal approaches to contact members to promote women's screenings, and incentives to provide screenings, increase access, and outreach eligible members in their panels.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian noted improvement, implemented targeted campaigns, hosted several “Mammogram Mondays” events, and increased the member incentive for mammogram and cervical cancer screenings.</p>
<p>Meridian’s reported rate for the <i>Timeliness of Prenatal Care</i> submeasure decreased by nearly six percentage points and fell below the 50th percentile. HSAG recommended the following: Analyze further what were the drivers of the significant decrease in the timeliness of prenatal care submeasure. In addition to any member related findings, Meridian should analyze its provider network further to see whether any changes occurred in its provider network that impacted timely identification of newly pregnant members and access to timely prenatal care appointments. Meridian should analyze whether</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian noted improvement, streamlined the notification of pregnancy form to encourage more timely submissions from both members and providers, enhanced its process to expand outreach, extended case management services to include moderate- and high-risk pregnant members, added incentives for providers, and created additional educational resources for providers.</p>

Prior Recommendation	Assessment
<p>any particular provider group disproportionately decreased in its performance of the <i>Timeliness of Prenatal Care</i> submeasure and perform a deeper dive with the provider group to understand any changes in access to care or staffing. Meridian should create an action plan based on its findings to address barriers to timely appointments including targeted outreach to specific populations to assist with appointment scheduling and working with identified providers that are experiencing access and staffing issues.</p>	
<p>Meridian’s child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the <i>Weight Assessment and Counseling for Nutrition and Physical Activity</i> measure continuing to perform below the 50th percentile. HSAG recommended Meridian conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian noted improvement, created a new project manager position to support supplemental data implementation and data capture improvements for this measure; presented provider education; targeted providers without a supplemental data connection to provide education and support mapping improvements; and shared medical record examples with providers.</p>
<p>Meridian struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for two of three submeasures in <i>Pharmacotherapy for OUD</i> and performed below the 50th percentile. Rates for five of six submeasures in <i>Initiation and Engagement of SUD Treatment</i> declined and three submeasures performed below the 50th percentile. To improve treatment of OUD and SUD, HSAG recommends Meridian:</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian noted initial improvement, conducted outreach to prescribing providers to provide education on coverage for 90-day prescriptions for OUD medications; developed and continued to refine a new ADT feed-based report methodology to identify members requiring timelier follow-up; created roles for a new clinical excellence team that included hiring three registered nurses and three behavioral health licensed staff to support member outreach efforts; implemented an SMS messaging</p>

Prior Recommendation	Assessment
<ul style="list-style-type: none"> <li>• Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options.</li> <li>• Assess demographic variation to determine what obstacles may be present to inform solutions.</li> <li>• Consider creating a multidisciplinary workgroup to understand the eligible members’ barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD.</li> <li>• Expand treatment options with focus on convenience and accessibility.</li> <li>• Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment.</li> <li>• Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.</li> </ul>	<p>campaign to help connect members to providers; and expanded telehealth providers.</p>
<p><b>Compliance With Standards</b></p>	
<p>Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. HSAG recommended the plan continue oversight and monitoring procedures as well as reporting for the CBH services requirements. Also, the plan should consider increasing the number of internal audits to ensure compliance with contractual requirements.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian conducted two process audits of staff per month, made improvements to daily compliance reporting, and conducted staff training.</p>
<p>Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. HSAG recommended the health plan develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian developed a tracker, held joint operational committee meetings with community agencies, and reported increased compliance.</p>

Prior Recommendation	Assessment
<b>NAV</b>	
<p>Meridian did not meet the HCI time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for pharmacies and oral surgeons.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian reported that it contracts with all available oral surgeons in the identified counties and no additional pharmacies are available. Meridian described reviewing network adequacy reports quarterly and monitoring out-of-network claims to identify contracting opportunities.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. HSAG recommended the health plan address provider data deficiencies identified during the survey calls.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian performed a targeted assessment and outreach to confirm the accuracy of provider information, semi-annual claim reviews, and HFS IMPACT file reviews. Meridian reported a 15 percent increase in the accuracy of appointment phone numbers.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. HSAG recommended the health plan conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian described conducting a biannual accessibility analysis and receiving member feedback through advisory committees. Meridian noted improvements across several appointment types.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. HSAG recommended the health plan conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian described conducting a biannual accessibility analysis and developing interventions, including targeted outreach to providers who failed the appointment availability audit or were reported by members. Meridian noted improvements across several appointment types.</p>





Prior Recommendation	Assessment
<b>Additional EQR Activities</b>	
<p>Meridian’s experience survey results were below the 50th percentile for five of eight child measures. HSAG recommended the health plan evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. Meridian should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. Meridian could consider conducting root cause analyses or focus studies to further explore members’ perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian appointed a program manager dedicated to enhancing member experience, overseeing survey data sharing with provider groups, and conducting education. Meridian reported results for eight of nine child CAHPS measures.</p>
<p>Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. HSAG recommended the health plan ensure that staff members are educated on timely reporting and that oversight procedures examine compliance with timeliness of reporting.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian began conducting monthly internal audits to identify reporting delays. Meridian’s QI unit provided strategic oversight through daily CI reviews.</p>
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i>. HSAG recommended the health plan conduct a root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	<p><b>Meridian sufficiently addressed the recommendation.</b> Meridian conducted quarterly training with LTSS case managers, utilized a daily dashboard to track completion and due dates, implemented a date calculator, and established compliance-based production expectations. Meridian noted performance improvements for Measure D6.</p>





## Molina



HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.











Detailed results from the EQR’s substantive findings are summarized in Table 47 for each activity. This table highlights the extent to which Molina furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Molina can best address issues identified for each activity.

















**Table 47—Molina Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**





Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
+	<b>Strength:</b> Molina achieved a <i>High Confidence</i> level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement for Remeasurement 2 for the <i>Improving Transportation Services</i> PIP.	
-	<b>Opportunity for improvement:</b> Molina, continued to show declines in performance compared to the baseline for the <i>Timeliness of Prenatal Care</i> PIP. <b>Recommendations:</b> Molina should revisit its causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	
-	<b>Opportunity for improvement:</b> Molina was assigned a <i>Low Confidence</i> level for adhering to acceptable methodology for the <i>Improving Transportation Services</i> PIP. <b>Recommendations:</b> Molina should develop a process or plan to evaluate the effectiveness of each individual intervention listed in the barriers/interventions table in the PIP Submission Form. The overall indicator for the PIP should not be used to determine effectiveness for the interventions. Intervention data are specific to the intervention and typically collected over short time periods as part of plan-do-study-act cycles or based on the type of data and frequency of availability.	
<b>PMV</b>		
+	<b>Strength:</b> Molina made progress in ensuring children and adolescents received important checkups as rates improved for <i>Child and Adolescent Well-Care Visits</i> and <i>Well-Child Visits in the First 30 Months of Life</i> .	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	<p><b>Strength:</b> Molina’s rate improved for the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> submeasure and performed between the 75th and 89th percentiles.</p>	
-	<p><b>Opportunity for Improvement:</b> Molina demonstrated slight improvement, but continued its struggle with follow-up with children and adults after hospitalization and ED visits for mental illness. In the <i>Follow-Up After Hospitalization for Mental Illness</i> measure, rates for three of four reportable submeasures remained below the 50th percentile. Although rates for the four reportable submeasures for <i>Follow-Up After Emergency Department Visit for Mental Illness</i> were above the 50th percentile, Molina’s performance declined for all reportable submeasures.</p> <p><b>Recommendations:</b> Molina’s care management teams should establish ADT feeds with hospitals and EDs and monitor visits with a mental illness diagnosis to assist members with coordinating and scheduling follow-up appointments. The health plan should partner with behavioral health providers to expand access, including telehealth options, and receive timely referrals. The health plan can consider strategies that focus on building the capacity of pediatric care practitioners and utilizing the Illinois DocAssist program to increase the confidence and support of these providers to see more patients.</p>	
-	<p><b>Opportunity for Improvement:</b> Molina’s rate on all submeasures fell below the 50th percentile for <i>Follow-Up After Emergency Department Visit for Substance Use</i> and <i>Initiation and Engagement of SUD Treatment</i>.</p> <p><b>Recommendations:</b> Molina should evaluate current care coordination for members with SUD. The health plan should leverage ADT feeds from EDs to engage discharged members in follow-up care. The health plan should consider enhancing existing or developing new partnerships with SUD treatment providers and expand telehealth options to support timely access to care, the availability of care, and the receipt of referrals from facilities. The health plan’s case management teams should follow up with eligible members to assist in facilitating and coordinating appointments to initiate treatment if necessary.</p>	
-	<p><b>Opportunity for Improvement:</b> Children between 15 and 30 months of age did not receive recommended well-child visits. Although Molina demonstrated improvement, the <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> submeasure performed below the 25th percentile.</p>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Recommendations:</b> Molina should work with HFS to determine where provider and member incentives could be considered to support timely well-care visits. The health plan should evaluate current member and provider education to determine opportunities for enhancing messaging with community stakeholders, and revise materials to emphasize the importance of well-care visits and preventive health care. The health plan also should consider alternative methods of member outreach and healthcare reminders based on advancements in technology, such as text messaging preventive care reminders and partnering with school-based health clinics to complete well-child visits.</p>	
	<p><b>Opportunity for Improvement:</b> Molina had room for improvement in completing important screenings with women. Molina performed below the 25th percentile for <i>Breast Cancer Screening</i> and below the 50th percentile for <i>Cervical Cancer Screening</i> and <i>Chlamydia Screening in Women</i>.</p> <p><b>Recommendations:</b> To improve women’s health screening rates, HSAG recommends that the health plan:</p> <ul style="list-style-type: none"> <li>• Evaluate the effectiveness of existing interventions and consider employing alternative strategies or soliciting best practices for high performing plans to improve its performance and address timely access to care barriers.</li> <li>• Include standing orders and reduce structural barriers by offering non-traditional clinic hours, mobile screenings, patient navigators, and streamlined administrative procedures.</li> <li>• Consider whether disparities/SDOH factors within the health plan’s populations contributed to lower access to care. Implement appropriate interventions to reduce barriers to care upon identifying root causes.</li> <li>• Address STI stigma among physicians and patients.</li> <li>• Clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update.</li> <li>• Use multi-modal approaches to contact members to promote women's screenings. Offer incentives to providers to provide screenings, increase access, and conduct outreach to eligible members in their panels.</li> </ul>	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> In the <i>Adults' Access to Preventive/Ambulatory Health Services</i> measure, Molina's rate fell below the 25th percentile.</p> <p><b>Recommendations:</b> Molina should work with HFS on potential incentive options to support timely preventive health visits, and evaluate the effectiveness of interventions for options for further spread and sustainability (or adapt and modify). Further, the health plan's care management teams should support coordination and facilitation of appointment scheduling to address barriers as needed. Finally, the health plan should evaluate provider access and availability and consider where alternative hours could be offered.</p>	
<b>Compliance With Standards</b>		
	<p><b>Strength:</b> The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.</p>	
<b>NAV</b>		
	<p><b>Strength:</b> Molina maintained processes that ensured its enrollee information was accurate and complete. Although there was potential for an enrollee to be populated twice within QNXT, Molina notified the State of any overlapping coverage and ran weekly reports to identify duplicative enrollee records prior to performing network adequacy calculations.</p>	
	<p><b>Strength:</b> Molina met the State's time and distance standards across all public health regions for 17 of 20 provider categories (85 percent). Molina's performance remained steady from 2024, with no changes for pharmacies, but a slight decrease of 1.0 percentage point or less in the percentage of enrollees with access to oral surgeons, adult and pediatric.</p>	
	<p><b>Opportunity for improvement:</b> Molina did not meet the time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations.</p> <p><b>Recommendations:</b> Molina should maintain the current level of access to care and continue to address network gaps for pharmacies and oral surgeons, both adult and pediatric.</p>	

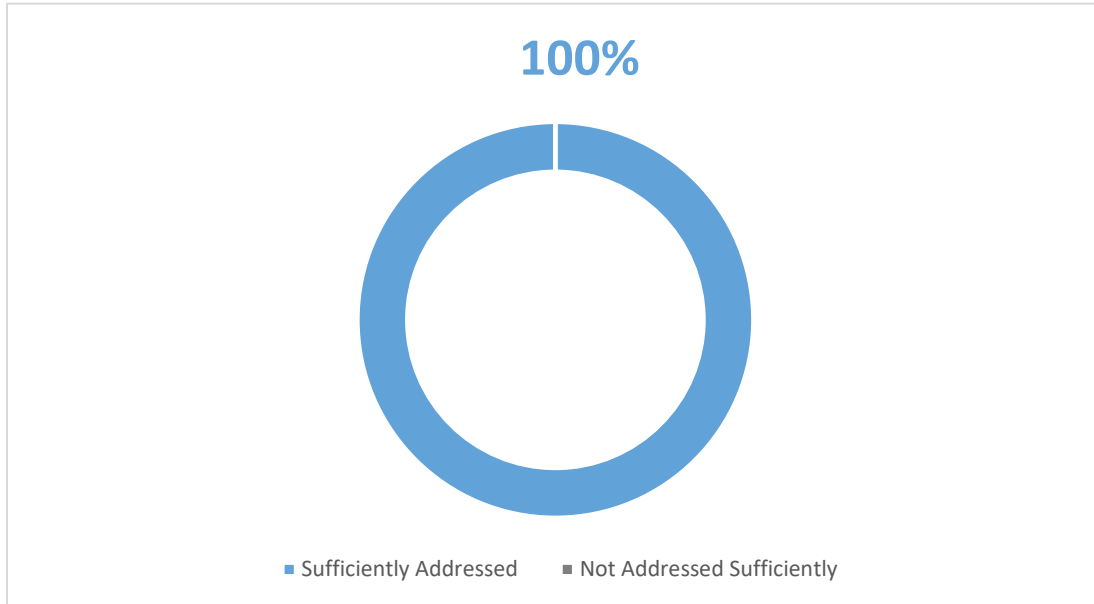
Strength/ Opportunity for Improvement	Description	Domain(s)
<b>Additional EQR Activities</b>		
	<b>Strength:</b> The staffing and training review identified that Molina was compliant with all case load requirements and all qualification and education requirements for waiver case managers.	
	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
	<b>Strength:</b> The health plan achieved 100 percent compliance in the Care Gap Plan review.	
	<b>Strength:</b> For the adult experience survey, Molina was the highest performing plan, with all eight measures scoring above the 50th percentile.	
	<b>Strength:</b> Molina’s 2025 top-box scores for the child Medicaid survey were statistically significantly higher than the 2024 top-box scores for the following measures: <i>Getting Care Quickly</i> , <i>Rating of All Health Care</i> , and <i>Rating of Health Plan</i> .	
	<b>Opportunity for improvement:</b> Molina’s experience survey results were below the 50th percentile for six of eight child measures. <b>Recommendations:</b> HSAG recommends that Molina evaluate the process of care delivery and identify whether any operational issues contributed to access-to-care barriers for members. Molina should also review member-to-provider ratios within access requirements to determine whether enough in-network providers are available to allow for timely appointment scheduling. Molina could consider conducting root cause analyses or focus studies to further explore members’ perceptions regarding access to care and services and obtain feedback from patients on their recent office visit.	

Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for Improvement:</b> The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to inaccurate provider location information.</p> <p><b>Recommendations:</b> The health plan should routinely run address data through the USPS CASS software program to standardize addresses and identify incorrect addresses that require follow-up and/or correction. The health plan also should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	
	<p><b>Opportunity for Improvement:</b> The access and availability survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (e.g., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral).</p> <p><b>Recommendations:</b> The health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment; provide insurance acceptance education to provider office staff; and utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.</p>	

### Follow-Up on Prior Year Recommendations

Molina submitted responses to all prior EQR recommendations and HSAG reviewed Molina's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities. Figure 6 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 6—Percentage of Prior EQR Recommendations Addressed by Molina**



Molina-specific prior recommendations and follow-up assessments are summarized in Table 48.

**Table 48—Assessment of Molina’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PIP</b>	
Molina continued to show declines in performance compared to the baseline for the <i>Timeliness of Prenatal Care</i> PIP. HSAG recommended the health plan revisit its causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	<b>Molina sufficiently addressed the recommendation.</b> Molina implemented several interventions, including partnering with a telehealth provider to receive referrals for pregnant members, modifying outreach strategies, and developing a more robust program with maternal health navigators.
Molina was assigned a <i>Low Confidence</i> level for adhering to acceptable methodology for the <i>Improving Transportation Services</i> PIP. HSAG recommended the health plan develop a process or plan to evaluate the effectiveness of each individual intervention listed in the barriers/interventions table in the PIP Submission Form. The overall indicator for the PIP should not be used to determine effectiveness for the interventions. Intervention data are specific to the intervention and typically collected over short	<b>Molina sufficiently addressed the recommendation.</b> Molina obtained technical assistance from HSAG to improve adherence to PIP methodology, revised the health plan’s submission template, and reported improvement.

Prior Recommendation	Assessment
<p>time periods as part of plan-do-study-act cycles or based on the type of data and frequency of availability.</p>	
<p><b>PMV</b></p>	
<p>Molina’s rate for the <i>Adults’ Access to Preventive/ Ambulatory Health Services—Total</i> measure improved compared to last year; however, the rate remained below the 50th percentile. HSAG recommended the health plan design and test interventions specific to the 20-39 age group to engage these members in accessing healthcare on a routine basis.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina implemented text, email, and portal messaging for members who needed an annual preventive care visit and noted improvements among the age groups targeted by the messaging campaign.</p>
<p>Molina’s rates were below the 50th percentile for <i>Breast Cancer Screening</i> and <i>Cervical Cancer Screening</i>. HSAG recommended the health plan consider whether there are disparities/SDOH factors that contribute to lower access to care. Upon identification of root causes, HSAG recommends that the plans implement appropriate interventions to reduce barriers to care. HSAG also recommends Molina address STI stigma among physicians and patients; clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update; use multi-modal approaches to contact members to promote women’s screenings, along with incentives to providers to provide screenings, increase access, and outreach eligible members in their panels.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina’s mobile help center obtained its Clinical Laboratory Improvement Amendments certification to perform STI testing. Molina also conducted multi-modal member outreach campaigns and noted improvement.</p>
<p>Molina continues to significantly underperform in the <i>Eye Exam for Patients with Diabetes</i> submeasure with results below the 25th percentile and a 5 percent decrease in the rate from MY 2022 to MY 2023. HSAG recommended the health plan complete further analysis to determine the root cause of the decrease. Molina should determine whether any changes occurred in the provider network that impacted timely access to care and identify any other potential key drivers including whether there are disparities and/or SDOH barriers contributing to lower performance. Molina should engage with providers with access issues, expanding available providers, and offering incentives to providers to expand access.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina began a partnership to address disease management and meets with these groups monthly. Value-based contracts with five providers include diabetic measures. Molina’s measures demonstrate some improvement.</p>

Prior Recommendation	Assessment
<p>Member outreach and engagement activities should be started early in the CY and the impact of performance monitored to continue, pivot, or enhance the approach by mid-Q3.</p>	
<p>For the <i>Childhood Immunization Status</i> measure, Molina’s rate was below the 50th percentile for the <i>Combination 3</i> submeasure and below the 25th percentile for the <i>Combination 10</i> submeasure. HSAG recommended the health plan focus on parent education and clinic practice transformation. If Molina already has a program for new parents, the plan should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Molina should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in the clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast track infants who are behind on their vaccination schedules.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina targeted key provider groups to engage with its medical directors to review barriers that pediatricians experience. Molina created member materials and modified outreach calls to assist parents in tracking immunization schedules. Molina also noted significant improvement in the <i>Combination 3</i> submeasure.</p>
<p>Molina’s child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the <i>Weight Assessment and Counseling for Nutrition and Physical Activity</i> measure continuing to perform below the 50th percentile. HSAG recommended the health plan conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low-performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina offered educational materials to providers who are available on the provider website and continued to increase access to remote electronic medical record (EMR) systems.</p>

Prior Recommendation	Assessment
<p>continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.</p>	
<p>Molina struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for two of three submeasures in <i>Pharmacotherapy for OUD</i> and all submeasures performed below the 25th percentile. Rates for two of six submeasures in <i>Initiation and Engagement of SUD Treatment</i> performed below the 50th percentile. To improve treatment of OUD and SUD, HSAG recommends Molina:</p> <ul style="list-style-type: none"> <li>• Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options.</li> <li>• Assess demographic variation to determine what obstacles may be present to inform solutions.</li> <li>• Consider creating a multidisciplinary workgroup to understand the eligible members’ barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD.</li> <li>• Expand treatment options with focus on convenience and accessibility.</li> <li>• Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment.</li> <li>• Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.</li> </ul>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina completed a system analysis and specification review; partnered with a pharmacy group that conducts provider education on best practices for treating and prescribing opioids with key FQHCs; and added behavioral health case managers to increase focused outreach. Molina reported improvement for both measures.</p>
<b>Compliance With Standards</b>	
<p>HSAG identified that the health plan had an opportunity for improvement related to standardized language in its policies and procedures. HSAG recommended the health plan implement oversight and monitoring procedures</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina reviewed policies and procedures at least annually and achieved 100 percent compliance in its most recent review.</p>

Prior Recommendation	Assessment
to ensure accurate identification of State and federal requirements within its policies and procedures.	
Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. HSAG recommended the health plan continue oversight and monitoring procedures for the CBH services requirements.	<b>Molina sufficiently addressed the recommendation.</b> Molina revised its CBH work process to align with contract amendments and policies, incorporated urgent assignment notifications to care management staff, updated its CBH training, and retrained staff.
Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. HSAG recommended the health plan develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	<b>Molina sufficiently addressed the recommendation.</b> Molina began a partnership with In Home Medical Group to provide daily notification and immediate outreach to identified members. CBH members are connected to Molina care management.
<b>NAV</b>	
Molina did not meet the HCI time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for pharmacies and for oral surgery specialists adult and pediatric.	<b>Molina sufficiently addressed the recommendation.</b> Molina contracted with all available Medicaid-certified oral surgeons and pharmacies, and actively conducted an out-of-network review to identify additional contracting opportunities.
Molina did not meet the MMAI standard for nursing facilities in all counties. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.	<b>Molina sufficiently addressed the recommendation.</b> Molina conducted a county-level gap analysis and prioritized outreach to non-contracted facilities in gap counties.
The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. HSAG recommended the health plan address provider data deficiencies identified during the survey calls.	<b>Molina sufficiently addressed the recommendation and reported improvement.</b> Molina implemented multiple programs to conduct data validation and reconciliation of the provider directory, conducted quarterly audits, and made system updates.
The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. HSAG recommended the health plan conduct a review of the provider offices’	<b>Molina sufficiently addressed the recommendation.</b> Molina targeted outreach to provider offices, partnered with the grievance and appeals team to identify high-impact providers and provide education, and continued secret shopper surveys and provider education.

Prior Recommendation	Assessment
<p>requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment and provide insurance acceptance education to provider office staff members.</p>	
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. HSAG recommended the health plan conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina identified compliance issues to determine why appointments were not available, specified impacted appointment types, reviewed and analyzed scheduling constraints and provider shortages, evaluated member complaints via the CAHPS survey, and initiated targeted outreach to telehealth providers to fill gaps in areas with physician shortages. Molina reported contracting with additional telehealth providers to increase access.</p>
<p><b>Additional EQR Activities</b></p>	
<p>Molina’s experience survey results were below the 50th percentile for six of eight child measures. HSAG recommended the health plan evaluate the process of care delivery and identify whether there are any operational issues contributing to access-to-care barriers for members. Aetna should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. Meridian could consider conducting root cause analyses or focus studies to further explore members’ perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina regularly conducted provider webinars, worked to increase provider capacity and reduce administrative burden by expanding the mobile help center program, and collected feedback from members.</p>
<p>Results of the staffing and training review identified that the health plan had an opportunity for improvement related to ensuring qualifications and education requirements were met for its SNC case managers. HSAG recommended the health plan review the qualification/education requirements for the SNC members to ensure that only staff with those qualifications are assigned</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina identified exemptions submitted by staff and received approval, thereby achieving full compliance.</p>

Prior Recommendation	Assessment
<p>caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plan may consider submitting exemption requests to HFS for consideration.</p>	
<p>Results of the staffing and training review identified that the health plan had an opportunity to ensure its internal and delegated case managers complete annual training requirements. HSAG recommended the health plan ensure that all case managers receive required trainings by the end of CY 2024.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina reviewed training requirements during monthly leadership meetings and tracked staff completion on a quarterly basis per the requirements for case management roles and the population being served.</p>
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i>. HSAG recommended the health plan consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina completed root cause data analyses and identified an opportunity to improve the frequency of supervisory oversight and enhance internal reporting logic. Molina provided quarterly training to staff to ensure their understanding of contact requirements and reported significantly improved compliance.</p>
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i>. HSAG recommended the health plan consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina completed root cause data analyses and identified an opportunity to improve the frequency of supervisory oversight and enhance internal reporting logic. Molina provided quarterly training to staff to ensure their understanding of contact requirements and reported significantly improved compliance.</p>









Prior Recommendation	Assessment
<p>justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	
<p>As identified during the Care Gap Plan review, care gaps were visible on the enrollee portal; however, the portal did not include a link to additional information, nor did it provide details to the enrollee about next steps to address the gap. The health plan provided information regarding current system enhancements to address the recommendation; however, an estimated time frame for completion was not reported. HSAG recommended the health plan ensure enhancements to the enrollee portal to assist enrollees with understanding of care gaps.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina launched one-way secure messaging that led members to the enrollee portal to receive reminders for preventive care and additional information on how to address care gaps.</p>

















## YouthCare

HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.

Detailed results from the EQR’s substantive findings are summarized in Table 49 for each activity. This table highlights the extent to which YouthCare furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how YouthCare can best address issues identified for each activity.

**Table 49—YouthCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
	<p><b>Opportunity for improvement:</b> Meridian/YouthCare demonstrated statistically significant decline in Remeasurement 1 for the <i>Improving Transportation Services</i> PIP for the YouthCare line of business.</p> <p><b>Recommendations:</b> Meridian/YouthCare should revisit its causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement</p>	
<b>PMV</b>		
	<p><b>Strength:</b> The health plan demonstrated its knowledge of the systems, processes, and measure reporting through the PMV audit process, as evidenced by submission of auditor-approved Interactive Data Submission System (IDSS) performance measures data.</p>	
<b>Compliance With Standards</b>		
	<p><b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.</p>	
<b>NAV</b>		
	<p><b>Strength:</b> YouthCare developed a strong feedback loop with providers, including quarterly mock audits to verify provider data, reviewing fallout reports to confirm valid PCP assignments, and weekly validation against the IMPACT file to ensure provider data were as accurate and up to date as possible.</p>	

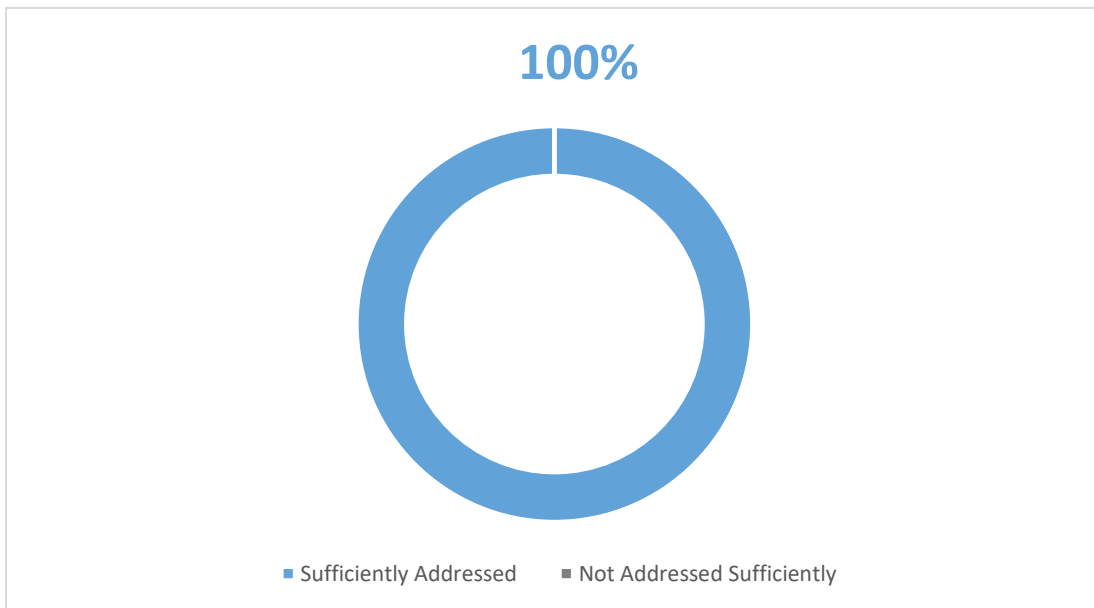
Strength/ Opportunity for Improvement	Description	Domain(s)
	<b>Strength:</b> YouthCare met the State’s time and distance standards across all public health regions for 17 of 20 provider categories (85 percent).	
	<b>Opportunity for improvement:</b> YouthCare did not meet the time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. <b>Recommendations:</b> HSAG recommends that YouthCare maintain the current level of access to care and continue to address network gaps for pharmacies, and oral surgeons, adult and pediatric.	
<b>Additional EQR Activities</b>		
	<b>Strength:</b> The staffing and training review identified that YouthCare was compliant with all case load requirements and all qualification and education requirements for case manager supervisors and case managers.	
	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
	<b>Strength:</b> The health plan achieved 100 percent compliance in the Care Gap Plan review.	
	<b>Opportunity for Improvement:</b> The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to inaccurate provider location information. <b>Recommendations:</b> The health plan should routinely run address data through the USPS CASS software program to standardize addresses and identify incorrect addresses that require follow up and/or correction. The health plan also should utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.	
	<b>Opportunity for Improvement:</b> The access and availability survey identified several barriers to obtaining appointment dates, including pre-registration or specific requirements (e.g., personal information before scheduling, a questionnaire or interview prior to scheduling, or a referral). <b>Recommendations:</b> The health plan should consider conducting a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment; provide insurance acceptance education to	

Strength/ Opportunity for Improvement	Description	Domain(s)
	provider office staff; and utilize available data sources, such as claims, to investigate instances of provider inactivity and address any potential gaps in care or network inefficiencies.	

**Follow-Up on Prior Year Recommendations**

YouthCare submitted responses to all prior EQR recommendations and HSAG reviewed YouthCare’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities. Figure 7 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 7—Percentage of Prior EQR Recommendations Addressed by YouthCare**



YouthCare-specific prior recommendations and follow-up assessments are summarized in Table 50.

**Table 50—Assessment of YouthCare’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PIPs</b>	
<p>YouthCare demonstrated statistically significant decline in Remeasurement 1 for the Improving Transportation Services PIP. HSAG recommended the health plan revisit its causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare noted improvement through its interventions including, expanding provider access and vehicle availability, partnering with public transit to increase service options, recruiting additional providers in rural areas, implementing enhancements to the portal for trip completion and claim submission, and piloting a new intervention to identify a specific transportation provider to service a specific IL facility.</p>
<b>Compliance With Standards</b>	
<p>Results of CBH file reviews demonstrated an opportunity for improvement related to timely post-discharge care management activities. HSAG recommended the health plan consider process improvements to ensure compliance with contacting the member or a family member within 48 hours of discharge.</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare reported reaching 100 percent compliance with outreach within 48 hours of discharge. YouthCare continued its MCR improvement project by making enhancements to the transition of care follow-up process, providing additional training, and launching comprehensive internal auditing.</p>
<p>Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. HSAG recommended the health plan develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare continued its MCR improvement project by making enhancements to the TOC follow up process, providing additional training, launching comprehensive internal auditing, and expanding telehealth access. YouthCare noted improvements in the <i>FUH-7</i>, <i>FUH-30</i>, and <i>FUM-7</i> HEDIS measure indicators.</p>
<b>NAV</b>	
<p>YouthCare did not meet the HCI time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. This was also identified during the Care Gap Plan review. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for pharmacies, and oral surgery specialists adult and pediatric. The health plan should ensure that it has</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare resolved all pharmacy deficiencies, identified all available oral surgeons, and conducted outreach. YouthCare also enhanced its network adequacy logic.</p>

Prior Recommendation	Assessment
<p>specific examples of regional barriers/challenges and recruitment strategies to address network gaps for pharmacy and oral surgery providers.</p>	
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. HSAG recommended the health plan address provider data deficiencies identified during the survey calls.</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare conducted a targeted assessment of phone numbers via phone outreach, reviewed claims to identify providers for outreach, collaboratively reviewed data with provider groups, and reconciled internal comprehensive rosters. YouthCare noted a general increase in appointment availability and the accuracy of appointment phone numbers.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. HSAG recommended the health plan conduct a review of the provider offices’ requirements to ensure the barriers are not unduly burdening the enrollee’s ability to schedule an appointment and provide insurance acceptance education to provider office staff members.</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare described conducting biannual accessibility analyses, receiving member feedback through advisory committees, and providing ongoing education to network practitioners. The health plan noted improvements across several appointment types.</p>
<p>The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. HSAG recommended the health plan conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards and incorporate appointment availability standards into educational materials.</p>	<p><b>YouthCare sufficiently addressed the recommendation.</b> YouthCare described conducting biannual accessibility analyses and developing interventions, including targeted outreach and education to providers who failed the appointment availability audit or were reported by members. The health plan noted improvements across several appointment types.</p>











## MMAI






### Aetna

HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.

Detailed results from the EQR’s substantive findings are summarized in Table 51 for each activity. This table highlights the extent to which Aetna furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Aetna can best address issues identified for each activity.

**Table 51—Aetna Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
	<b>Strength:</b> Aetna achieved a <i>High Confidence</i> level for adhering to acceptable methodology for both validation ratings for the <i>Improving Transportation Services</i> QIP and demonstrated statistically significant improvement for Remeasurement 2.	
<b>PMV</b>		
	<b>Strength:</b> PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of <i>Reportable</i> with high confidence.	
<b>Compliance With Standards</b>		
	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
	<b>Strength:</b> Aetna used a comprehensive array of provider data validation and updating resources to ensure provider data were as current and accurate as possible.	
	<b>Strength:</b> Aetna met the State’s time and distance standards for nursing facilities.	

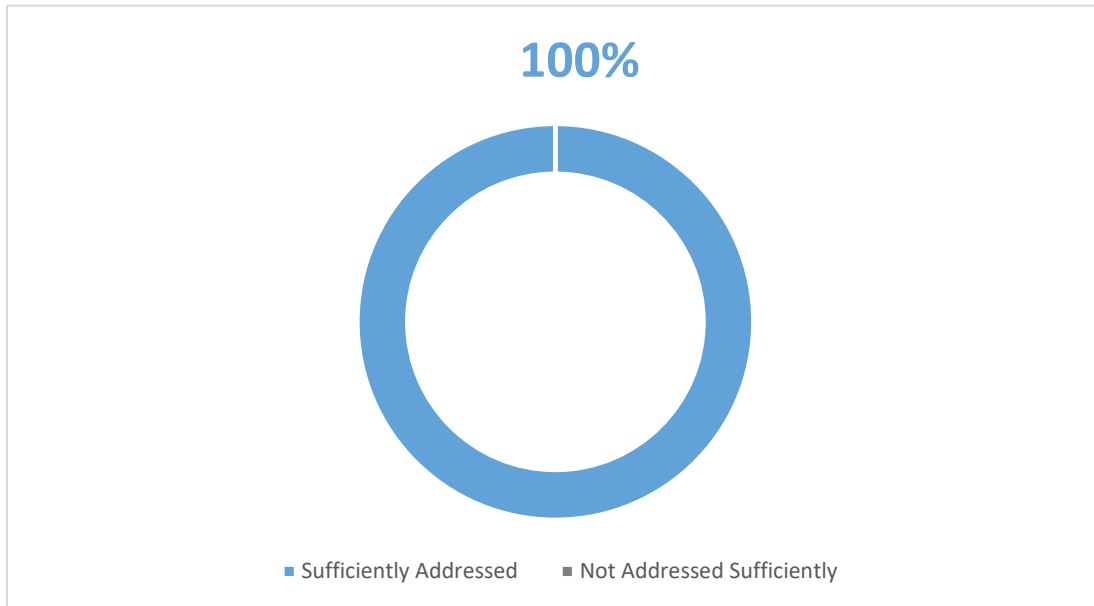
Strength/ Opportunity for Improvement	Description	Domain(s)
<b>Additional EQR Activities</b>		
+	<b>Strength:</b> The staffing and training review identified that Aetna was compliant with all caseload requirements and all qualification and education requirements for waiver case managers.	
+	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
+	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
-	<p><b>Opportunity for improvement:</b> Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record.</i></p> <p><b>Recommendations:</b> The health plan should consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	

### Follow-Up on Prior Year Recommendations

Aetna submitted responses to all prior EQR recommendations and HSAG reviewed Aetna’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities.

Figure 8 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 8—Percentage of Prior EQR Recommendations Addressed by Aetna**



Aetna-specific prior recommendations and follow-up assessments are summarized in Table 52.

**Table 52—Assessment of Aetna’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>NAV</b>	
Aetna did not meet the 100 percent MMAI time and distance standard in all counties for nursing facilities. HSAG recommended Aetna maintain current levels of access to care and continue to address network gaps for nursing facilities.	<b>Aetna sufficiently addressed the recommendations.</b> Aetna continued to monitor this provider specialty deficiency monthly with reviews of available providers, and noted that skilled nursing facility providers in Alexander County or contiguous counties are not sufficient to close the network deficiency.
The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. HSAG recommended Aetna conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met,	<b>Aetna sufficiently addressed the recommendations.</b> Aetna noted an increase in all MMAI provider specialties; continued to evaluate different methods to communicate its required appointment availability standards; and increased the frequency of the access survey to quarterly to routinely monitor the provider's network and quickly address access barriers.



Prior Recommendation	Assessment
address questions or reeducate providers and office staff on HFS standards and incorporate appointment availability standards into educational materials.	
<b>Additional EQR Activities</b>	
Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. HSAG recommended Aetna ensure that staff members are educated on timely reporting and that oversight procedures examine compliance with timeliness of reporting.	<b>Aetna sufficiently addressed the recommendations.</b> Aetna noted steady improvement for MMAI, conducted targeted staff training, provided ongoing reinforcement, introduced a tracking mechanism, enforced mandatory remediation for performance deficiencies, and enhanced reporting templates.















### BCBSIL

HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.

Detailed results from the EQR’s substantive findings are summarized in Table 53 for each activity. This table highlights the extent to which BCBSIL furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how BCBSIL can best address issues identified for each activity.

**Table 53—BCBSIL Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
+	<b>Strength:</b> BCBSIL achieved a <i>High Confidence</i> level for adhering to acceptable methodology for both validation ratings for the <i>Improving Transportation Services</i> QIP and demonstrated statistically significant improvement for Remeasurement 2.	
<b>PMV</b>		
+	<b>Strength:</b> PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of <i>Reportable</i> with high confidence.	

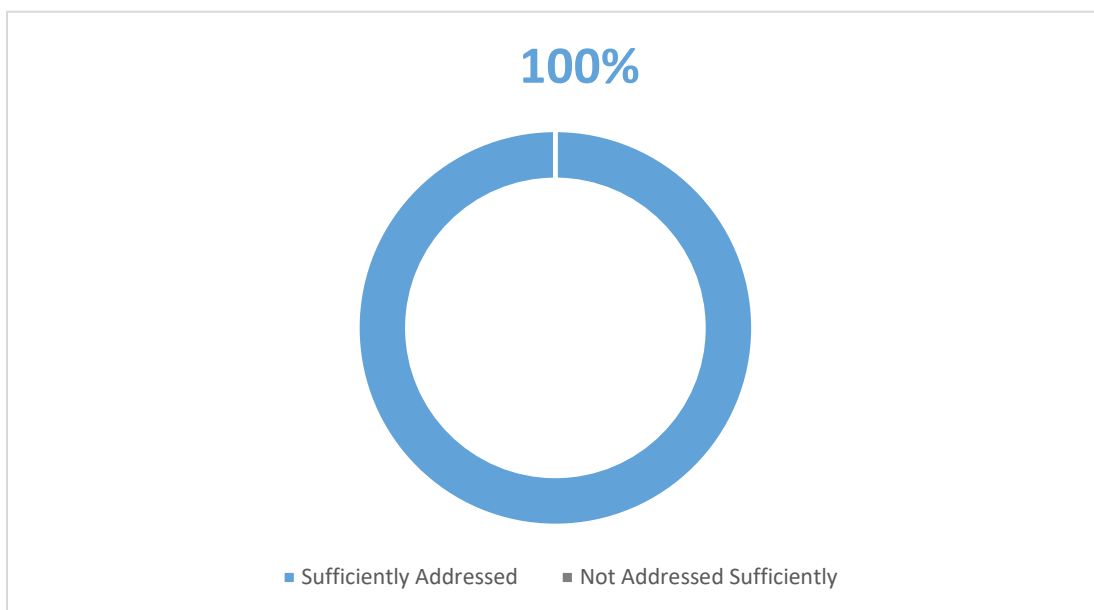
Strength/ Opportunity for Improvement	Description	Domain(s)
<b>Compliance With Standards</b>		
	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
	<b>Strength:</b> BCBSIL established a robust process to ensure provider data remains accurate and up to date. This process included multiple initiatives such as multilevel outreach to providers, quarterly reminder calls and attestations, and both quarterly and semiannual provider performance oversight audits.	
<b>Additional EQR Activities</b>		
	<b>Strength:</b> The staffing and training review identified that BCBSIL was compliant with all caseload requirements and all qualification and education requirements for waiver case managers.	
	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
	<b>Opportunity for improvement:</b> Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record.</i> <b>Recommendations:</b> The health plan should consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

### Follow-Up on Prior Year Recommendations

BCBSIL submitted responses to all prior EQR recommendations and HSAG reviewed BCBSIL’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities.

Figure 9 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 9—Percentage of Prior EQR Recommendations Addressed by BCBSIL**



BCBSIL-specific prior recommendations and follow-up assessments are summarized in Table 54.

**Table 54—Assessment of BCBSIL’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>NAV</b>	
BCBSIL did not meet the 100 percent MMAI time and distance standard in all counties for nursing facilities. HSAG recommended BCBSIL maintain current levels of access to care and continue to address network gaps for nursing facilities.	<b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL closed all previously identified gaps for nursing facilities.
<b>Additional EQR Activities</b>	
Results of the MMAI staffing and training review identified that the health plan had an opportunity to ensure its case managers complete annual	<b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL’s care management team conducts continuous tracking within its



Prior Recommendation	Assessment
training requirements. HSAG recommended BCBSIL ensure that all case managers receive required trainings by the end of CY 2024.	staffing workbook with an assigned project coordinator as well as unit manager oversight and accountability.
Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i> . HSAG recommended BCBSIL consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	<b>BCBSIL sufficiently addressed the recommendation.</b> BCBSIL created a work plan for all lines of business. Senior leadership meets with managers on a weekly basis for continuous monitoring and oversight. Additionally, a member engagement letter was created to inform members when a new care coordinator is assigned.













### Humana





HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.

Detailed results from the EQR’s substantive findings are summarized in Table 55 for each activity. This table highlights the extent to which Humana furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Humana can best address issues identified for each activity.

**Table 55—Humana Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
	<p><b>Strength:</b> Humana achieved a <i>High Confidence</i> level for adhering to acceptable methodology for both validation ratings for the <i>Improving Transportation Services</i> QIP and demonstrated statistically significant improvement for Remeasurement 2.</p>	

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PMV</b>		
	<b>Strength:</b> Humana demonstrated its knowledge of systems, processes, and measures reporting through the PMV audit process.	
	<b>Strength:</b> PMV of the state-specific IL 3.6 measure revealed no concerns related to the assignment of members to the correct reporting elements and resulted in a rating of <i>Reportable</i> with high confidence.	
	<p><b>Opportunity for improvement:</b> During the virtual review, HSAG was unable to confirm numerator compliance for case #3 for the <i>Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment</i> sub-rate and requested a root cause analysis of the issue. For this case, Humana indicated that both administrative and supplemental claims were submitted for the same encounter with two different provider numbers: individual NPI number for the supplemental claim and facility/center provider number for the administrative claim. Cotiviti’s certified logic looked for several criteria to determine the same visit with a different provider, including the provider number. An additional 14 cases were identified by Humana as being impacted by the same issue. Due to the different provider numbers, some cases were erroneously counted toward numerator compliance.</p> <p><b>Recommendations:</b> Although Humana identified a manual process to correct the issue for MY 2023, HSAG recommends further analysis to identify a permanent solution that does not involve a manual fix during future MYs.</p>	
<b>Compliance With Standards</b>		
	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
	<b>Strength:</b> Humana maintained a robust process to ensure provider data were accurate and up to date. New or updated provider contracts underwent a series of validation checks and reviews by multiple teams within Humana to ensure the information was correct and complete prior to finalizing the provider records.	
	<b>Strength:</b> Humana demonstrated strong methodologies for monitoring network adequacy in accordance with State standards	

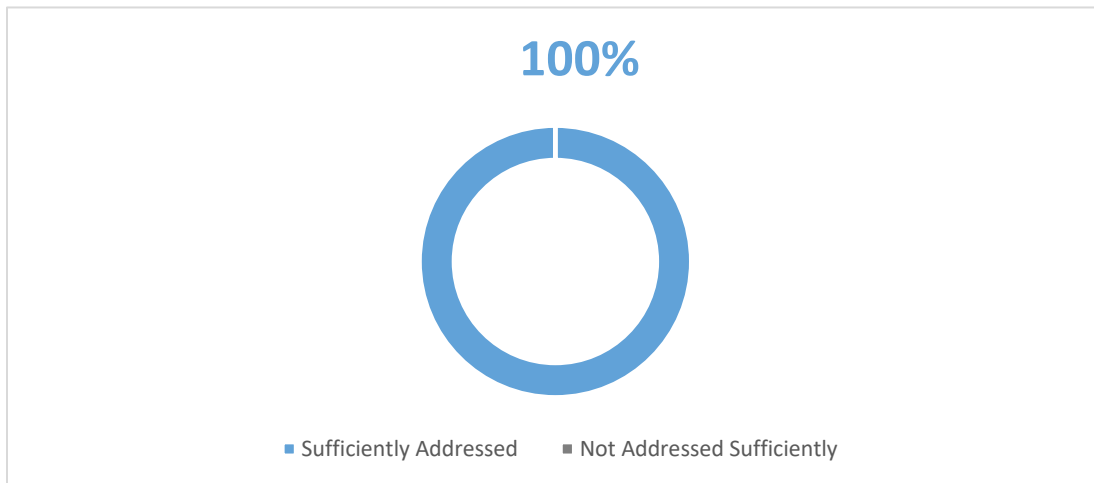
Strength/ Opportunity for Improvement	Description	Domain(s)
	and met the State’s time and distance standard for nursing facilities across three of the five public health regions.	
<b>Additional EQR Activities</b>		
+	<b>Strength:</b> The staffing and training review identified that Humana was compliant with all caseload requirements and all qualification and education requirements for waiver case managers.	
+	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall.	
+	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	

### Follow-Up on Prior Year Recommendations

Humana submitted responses to all prior EQR recommendations and HSAG reviewed Humana’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities.

Figure 10 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 10—Percentage of Prior EQR Recommendations Addressed by Humana**



Humana-specific prior recommendations and follow-up assessments are summarized in Table 56.

**Table 56—Assessment of Humana’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>Compliance With Standards</b>	
<p>The compliance review identified that the MMP had an opportunity for improvement related to enrollee engagement in review of enrollee materials. HSAG recommended the health plan consider using its Consumer Advisory Committee or Community Stakeholder Committee meetings to solicit feedback from stakeholders about enrollee materials.</p>	<p><b>Humana sufficiently addressed the recommendation.</b> Humana requested feedback on materials from members who attended the Consumer Advisory Committee and Stakeholder Advisory Committee meetings beginning in Q4 2024. Open-ended questions allowed members and stakeholders to provide feedback on all member-facing materials and benefits. HRSB-focused questions offered an opportunity to identify concerns and gather additional feedback. Humana noted improvement in on-time arrivals.</p>
<p>The compliance review identified an opportunity for effective oversight and monitoring to ensure accurate identification of State and federal requirements within its policies and procedures. HSAG recommended the health plan establish procedures for monitoring appointment availability requirements. The procedures must cover all contractually required appointment standards.</p>	<p><b>Humana sufficiently addressed the recommendation.</b> Humana established procedures to ensure that an adequate network of primary care and specialty provider offices can provide timely member access to medical care for routine and urgent care appointments. Humana also conducted annual monitoring of appointment availability, drafted scripts to utilize clinical perspectives, and refined survey phone lists.</p>
<b>NAV</b>	
<p>Humana did not meet the MMAI standard for nursing facilities in all counties. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.</p>	<p><b>Humana sufficiently addressed the recommendation.</b> Humana’s network development team initiated a goal to improve access to nursing facilities for the MMAI product. Through this initiative, Humana implemented provider contracting activities aimed at maintaining current network access and increasing access in underserved areas. Humana noted improvements in network adequacy for nursing facilities.</p>
<b>Additional EQR Activities</b>	
<p>During the virtual review, HSAG was unable to confirm numerator compliance for case #3 for the Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment sub-rate and requested a root cause analysis of the issue. For this case, Humana indicated that both an</p>	<p><b>Humana sufficiently addressed the recommendation.</b> Humana vetted several solutions to ensure feasibility of the most risk-averse approach given the volume of data housed and sent to the certified HEDIS vendor. Given the challenges to implement a systematic approach,</p>











Prior Recommendation	Assessment
<p>administrative claim and supplemental claim were submitted to Humana for the same encounter with two differing provider numbers (individual NPI number on the supplemental claim and facility/center provider number on the administrative claim). Cotiviti’s certified logic looked for several criteria to determine the same visit with a different provider, including provider number. An additional 14 cases were identified by Humana as being impacted by the same issue. Due to the differing provider numbers, some cases were erroneously counted toward numerator compliance. HSAG recommended that even though Humana identified a manual process to correct the issue for MY 2023, the health plan should conduct further analysis to identify a permanent solution that does not involve a manual fix during future MYs.</p>	<p>Humana employed a more frequent review of this measure to proactively identify any members impacted to ensure these members are appropriately reflected in the results.</p>













## Meridian

HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.

Detailed results from the EQR’s substantive findings are summarized in Table 57 for each activity. This table highlights the extent to which Meridian furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Meridian can best address issues identified for each activity.

**Table 57—Meridian Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
	<b>Strength:</b> For the <i>Improving Transportation Services</i> QIP, Meridian achieved all validation criteria for the first six steps of the QIP (i.e., selection of the QIP topic, defining the Aim statement, identifying the QIP population, sampling methodology, defining the performance indicator, and defining the data collection process).	
	<b>Opportunity for improvement:</b> Meridian had incorrect calculations in the intervention worksheet. <b>Recommendations:</b> Meridian must ensure that data are calculated accurately to assess outcomes. Meridian should apply lessons learned and successes from this QIP to future QIPs and other QI activities.	
<b>PMV</b>		
	<b>Strength:</b> PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of <i>Reportable</i> with high confidence.	
<b>Compliance With Standards</b>		
	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
	<b>Strength:</b> Meridian developed a strong feedback loop with providers, including quarterly provider mock audits to verify provider data, reviewing fallout reports to confirm valid PCP assignments, and weekly validation against the IMPACT file, to ensure provider data were as accurate and up to date as possible.	

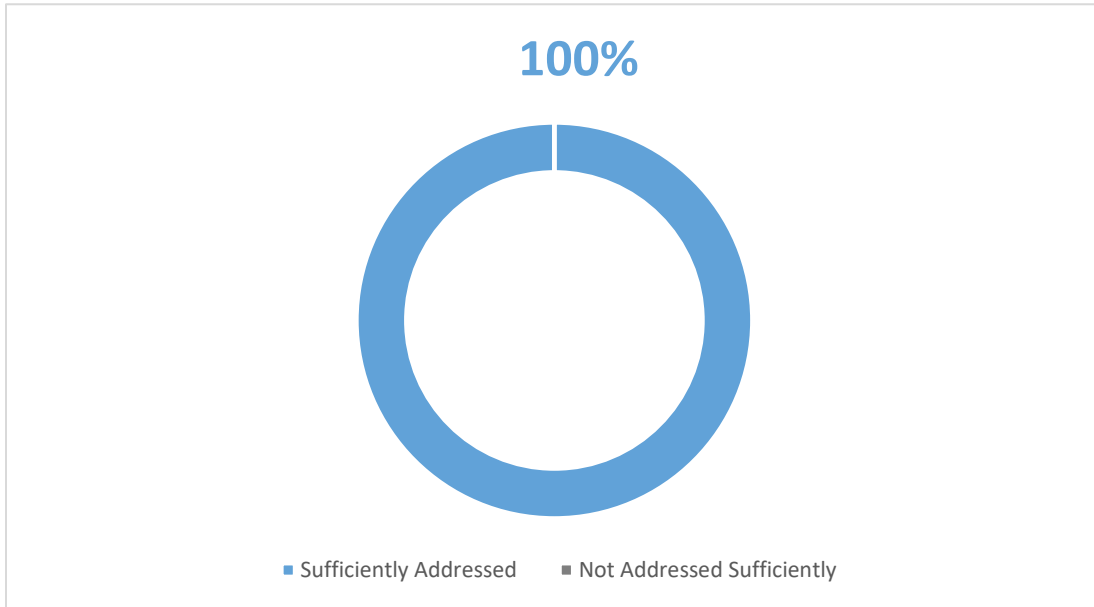
Strength/ Opportunity for Improvement	Description	Domain(s)
	<p><b>Opportunity for improvement:</b> Meridian did not meet the State’s time and distance standards in all counties for nursing facilities.</p> <p><b>Recommendations:</b> HSAG recommends that Meridian maintain the current level of access to care and continue to address network gaps for nursing facilities.</p>	
<b>Additional EQR Activities</b>		
	<p><b>Strength:</b> The staffing and training review identified that Meridian was compliant with all caseload requirements and all qualification and education requirements for waiver case managers.</p>	
	<p><b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.</p>	
	<p><b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.</p>	
	<p><b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.</p>	
	<p><b>Opportunity for improvement:</b> Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record.</i></p> <p><b>Recommendations:</b> The health plan should consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	

### Follow-Up on Prior Year Recommendations

Meridian submitted responses to all prior EQR recommendations and HSAG reviewed Meridian’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities.

Figure 11 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG during the in the prior technical report.

**Figure 11—Percentage of Prior EQR Recommendations Addressed by Meridian**



Meridian-specific recommendations and follow-up assessments are summarized in Table 58.

**Table 58—Assessment of Meridian’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>NAV</b>	
Meridian did not meet the MMAI standard for nursing facilities in all counties. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.	<b>Meridian sufficiently addressed the recommendation.</b> Meridian reported compliance with nursing facilities and described continuous monitoring of network adequacy.
<b>Additional EQR Activities</b>	
Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. HSAG recommended the health plan ensure that staff members are educated on timely reporting and	<b>Meridian sufficiently addressed the recommendation.</b> Meridian began conducting monthly internal audits to identify reporting delays. Meridian’s QI unit provided strategic oversight through daily CI reviews.



Prior Recommendation	Assessment
that oversight procedures examine compliance with timeliness of reporting.	
Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, <i>the case manager made timely contact with the enrollee or there is valid justification in the record</i> . HSAG recommended the health plan conduct a root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	<b>Meridian sufficiently addressed the recommendation.</b> Meridian conducted quarterly trainings with LTSS case managers, utilized a daily dashboard to track completion and due dates, implemented a date calculator, and established compliance-based production expectations. Meridian noted performance improvements for Measure D6.









### Molina

HSAG assessed the strengths and opportunities for improvement of each health plan with respect to the quality, timeliness, and accessibility of healthcare services.

Detailed results from the EQR’s substantive findings are summarized in Table 59 for each activity. This table highlights the extent to which Molina furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Molina can best address issues identified for each activity.

**Table 59—Molina’s Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services**

Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PIPs</b>		
	<p><b>Strength:</b> Molina achieved a <i>High Confidence</i> level for adhering to acceptable methodology for both Validation Rating 2 for the <i>Improving Transportation Services</i> QIP and demonstrated statistically significant improvement for Remeasurement 2.</p>	

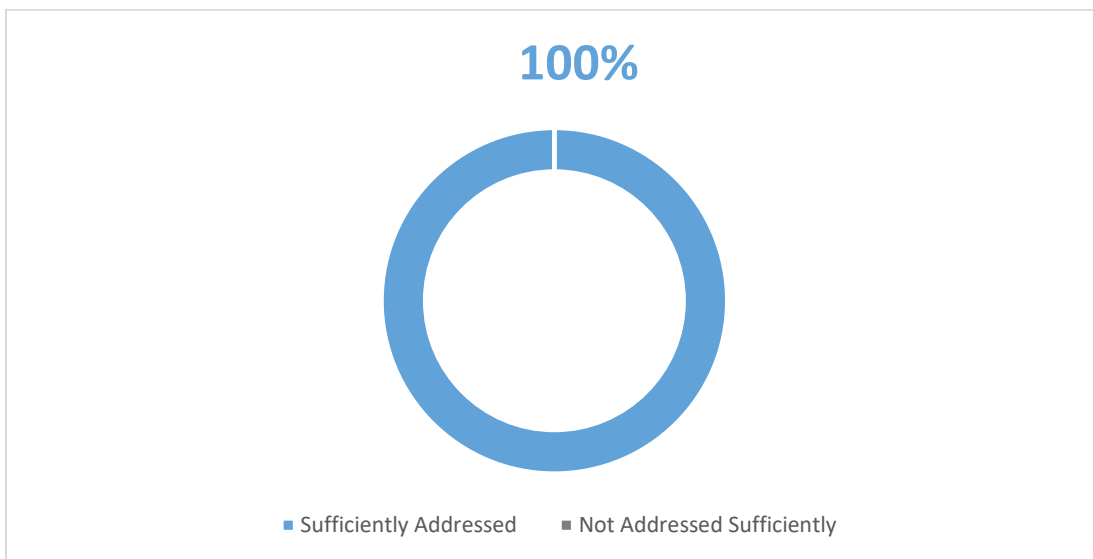
Strength/ Opportunity for Improvement	Description	Domain(s)
<b>PMV</b>		
+	<b>Strength:</b> PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of <i>Reportable</i> with high confidence.	
<b>Compliance With Standards</b>		
+	<b>Strength:</b> The health plan’s policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
<b>NAV</b>		
+	<b>Strength:</b> Molina maintained processes that ensured its enrollee information was accurate and complete. Although there was potential for an enrollee to be populated twice within QNXT, Molina notified the State of any overlapping coverage and ran weekly reports to identify duplicative enrollee records prior to performing network adequacy calculations.	
-	<b>Opportunity for improvement:</b> Molina did not meet the time and distance standards in all counties for nursing facilities. <b>Recommendations:</b> Molina should maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.	
<b>Additional EQR Activities</b>		
+	<b>Strength:</b> The staffing and training review identified that Molina was compliant with all caseload requirements.	
+	<b>Strength:</b> The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	<b>Strength:</b> For the HCBS waiver reviews, the health plan performed at greater than 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2024.	
+	<b>Strength:</b> Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	

### Follow-Up on Prior Year Recommendations

Molina submitted responses to all prior EQR recommendations and HSAG reviewed Molina’s approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2025 EQR activities.

Figure 12 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

**Figure 12—Percentage of Prior EQR Recommendations Addressed by Molina**



Molina-specific prior recommendations and follow-up assessments are summarized in Table 60.

**Table 60—Assessment of Molina’s Approach to Addressing Previous Annual Recommendations**

Prior Recommendation	Assessment
<b>PIPs</b>	
Molina was assigned a Low Confidence level for adhering to acceptable QIP methodology for the <i>Improving Transportation Services</i> QIP and failed to achieve statistically significant improvement for Remeasurement 1. HSAG recommended the health plan revisit their causal barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	<b>Molina sufficiently addressed the recommendation.</b> Molina obtained technical assistance from HSAG to improve adherence to QIP methodology, revised the health plan’s submission template, and reported improvement.

Prior Recommendation	Assessment
<b>Compliance With Standards</b>	
<p>HSAG identified that the health plan had an opportunity for improvement related to standardized language in its policies and procedures. HSAG recommended the health plan implement oversight and monitoring procedures to ensure accurate identification of State and federal requirements within its policies and procedures.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina reviewed policies and procedures at least annually and achieved 100 percent compliance in its most recent review.</p>
<b>NAV</b>	
<p>Molina did not meet the MMAI standard for nursing facilities in all counties. HSAG recommended the health plan maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina conducted a county-level gap analysis and prioritized outreach to non-contracted facilities in gap counties.</p>
<b>Additional EQR Activities</b>	
<p>Results of the staffing and training review identified that the health plan had an opportunity for improvement related to ensuring qualification and education requirements were met for its HCBS waiver case managers. HSAG recommended the health plan review the qualification/education requirements for the HCBS waivers to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plan may consider submitting exemption requests to HFS for consideration.</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina implemented a pre-assignment checklist to ensure that all qualification requirements are verified before staff are assigned to waiver-specific caseloads. Molina noted a decline in compliance issues.</p>
<p>Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, the case manager made timely contact with the enrollee or there is valid justification in the record. HSAG recommended the health plan consider the EQRO’s recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact</p>	<p><b>Molina sufficiently addressed the recommendation.</b> Molina completed root cause data analyses and identified an opportunity to improve the frequency of supervisory oversight and enhance internal reporting logic. Molina provided quarterly training to staff to ensure their understanding of contact requirements and reported significantly improved compliance.</p>

Prior Recommendation	Assessment
<p>requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.</p>	

### PIP/QIP

#### Objective

As part of the State’s Quality Strategy, each health plan is required to conduct PIPs/QIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the BBA, HSAG, as the State’s EQRO, validated the PIPs/QIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG used CMS’ publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* (CMS Protocol 1), February 2023.<sup>24</sup>

Additionally, HSAG’s PIP/QIP process facilitates frequent communication with the health plans. HSAG provides detailed validation feedback and provides technical assistance and webinar trainings for further guidance.

HFS requires its health plans to conduct PIPs/QIPs annually and include clinical and nonclinical focused PIPs/QIPs. The topics submitted for validation were:

- *Improving Timeliness of Prenatal Care*
- *Improving Transportation Services*

#### Approach to PIP/QIP Validation

To assess and validate PIPs/QIPs, HSAG used a standardized scoring methodology to rate a health plan’s compliance with each of the nine steps listed in the CMS EQR Protocol 1. With HFS’ input and approval, HSAG developed a PIP/QIP Validation Tool to ensure uniform assessment of the PIP/QIP. This tool is used to evaluate each PIP/QIP for the following nine CMS protocol steps:

**Table 61—CMS EQR Protocol 1 Steps**

Protocol Steps	
Step Number	Description
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population

<sup>24</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 3, 2026.

Protocol Steps	
Step Number	Description
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

### Validation Scoring

Each required step is evaluated on one or more elements that form a valid PIP/QIP. The HSAG PIP/QIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP/QIP process as critical elements. For a PIP/QIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP/QIP validation ratings, summarizing overall performance. One validation rating reflects HSAG’s confidence that the health plan adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP/QIP validation tool. The second validation rating is only assigned for PIPs/QIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG’s confidence that the performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP/QIP validation tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

#### 1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP/QIP (Steps 1 Through 8)

- *High Confidence*: High confidence in reported PIP/QIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP/QIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP/QIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.

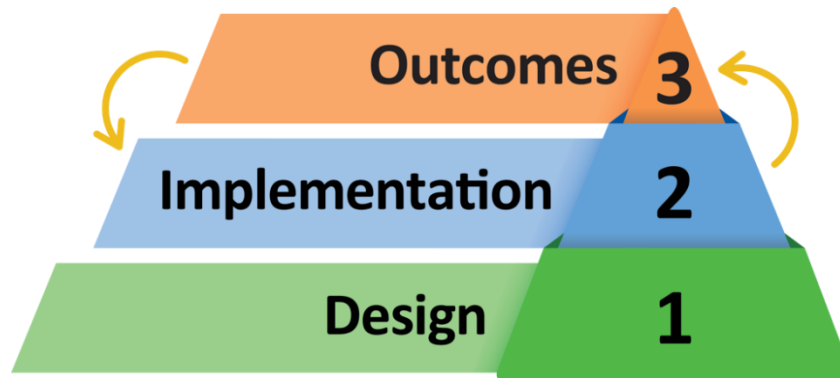
- *No Confidence*: No confidence in reported PIP/QIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

## 2. Overall Confidence That the PIP/QIP Achieved Significant Improvement (Step 9)

- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
  - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
  - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
  - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

Figure 13 illustrates the three stages of the PIP/QIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage (Steps 1–6) establishes the methodological framework for the PIP/QIP. The steps in this section include development of the PIP/QIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP/QIP design is necessary.

Figure 13—Stages of the PIP Process



Once the health plan establishes its design, the PIP/QIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the health plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, the health plan should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

## PMV

HSAG conducted the validation activities in accordance with CMS' Protocol 2 cited earlier in this report. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **IS Review:** HSAG utilized each plan's completed Information System Capabilities Assessment Tool (ISCAT) and relevant supplemental documentation to assess the integrity of ISs and data processes used for collecting and processing data, and processes used for performance measure calculation. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification. Where applicable, HSAG used the information provided in each ISCAT to begin completing the review tools.
- **Source code (programming language) for performance measures:** HSAG required each plan that calculated the performance indicators using computer programming language to submit source code for each performance indicator being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the state-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact on the indicator and assessing the degree of bias (if any). HSAG required plans that did not use

computer programming language to calculate the performance indicators to submit documentation describing the steps the plan took for indicator calculation.

- **Performance indicator reports:** HSAG reviewed each plan’s prior rate reports along with the current reports to assess trending patterns and rate reasonability.
- **Primary Source Verification (PSV):** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirmed entry; and detected errors. HSAG selected cases across evaluated measures to verify that each plan had appropriately applied measure specifications for accurate rate reporting. Each plan provided HSAG with a list of the data it had reported to HFS, from which HSAG randomly selected a sample of cases. Prior to and during the virtual site visit, screenshots of the data and each plan’s live systems were reviewed for verification. This approach enabled each plan to explain its processes regarding any exception processing or unique, case-specific nuances that may or may not impact final measure reporting.\
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

The PMV review of each plan’s reported data consisted of remote validation and post-validation activities focusing on enrollment and eligibility processes, claims and encounter processes, and performance measure production. HSAG conducted a virtual site review with each plan during 2024. The virtual site review included:

- A review of key ISs and the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff members familiar with the collection, processing, and monitoring of the plan’s data used in producing performance measures.
- A review of the database management systems and processes used to integrate key source data and the plan’s calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- A demonstration of key ISs, database management systems, and analytic systems to support documented evidence and interview responses.

## Network Adequacy Validation

NAV consists of several activities that fall into three phases: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the health plans, HSAG obtained all HFS-defined network adequacy standards and indicators that HFS requires for validation.

HSAG prepared and submitted a document request packet to each health plan outlining the activities that HSAG conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the health plans' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents that HSAG requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the health plans to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained data and documentation from the health plans, such as network data files or directories and enrollee enrollment files, through a single documentation request packet that HSAG provided to each health plan.

HSAG hosted a health plan-wide webinar focused on providing technical assistance to the health plans to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

HSAG conducted validation activities via interactive virtual review, which this report refers to as "virtual review," as these activities are the same in both virtual and on-site formats.

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

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring:** HSAG conducted an ISCA using each health plan's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the health plan tracks providers over time, across multiple office locations, and through changes in participation in the health plan's network. HSAG used the ISCAT to assess the ability of the health plan's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the health plan's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Validate network adequacy logic for calculation of network adequacy indicators:** HSAG required each health plan that calculated the HFS-defined indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG identified

whether the required variables were in alignment with the HFS-defined indicators used to produce the health plan's indicator calculations. HSAG required each health plan that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the health plan took for indicator calculation.

- **Validate network adequacy data and methods:** HSAG assessed data and documentation from the health plans that included, but was not limited to, network data files or directories, enrollee enrollment data files, and appointment availability surveys. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results:** HSAG assessed the health plan's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support health plan and HFS network adequacy monitoring results. HSAG validated network adequacy health plan-submitted reporting against HFS-defined indicators. HSAG assessed whether the results were valid, accurate, and reliable, and if the health plan's interpretation of the data was accurate.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

### **Virtual Review Validation Activities**

HSAG conducted a virtual review with each health plan. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities are described below:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key health plan staff enrollees involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.
- **Review of the ISCAT and supporting documentation:** HSAG designed this session to be interactive with key health plan staff enrollees so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT, and understand systems and processes for maintaining and updating provider data and assessing the health plan's information systems required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.
- **Evaluation of underlying systems and processes:** HSAG evaluated the health plan's information systems, focusing on the health plan's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; health plan oversight of external information systems, processes, and data; and knowledge of the staff enrollees involved in

collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff enrollees familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff enrollees included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff enrollees familiar with network adequacy monitoring and reporting activities.

- Overview of data collection, integration, methods, and control procedures:** The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the health plan produced the analytics files to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

### Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each health plan’s ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the health plan and HFS network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that the health plan used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator’s validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG’s CMS EQR Protocol 4 Worksheet 4.6, noted in Table 62.

**Table 62—Validation Score Calculation**

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Validation Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG’s overall confidence that the health plan used acceptable methodology for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, as shown in Table 63. HSAG assigns a rating once it has calculated the validation score for each indicator.

**Table 63—Indicator-Level Validation Rating Categories**

Validation Score	Validation Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	<i>No Confidence</i>

Table 64 and Table 65 present example validation rating determinations. Table 64 presents an example of a validation rating determination based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table 65 presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

**Table 64—Example Validation Rating Determination—No Significant Bias**

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of <i>Met</i> elements	16	<i>Moderate Confidence</i>
B. Total number of <i>Not Met</i> elements	3	
Validation Score = $A / (A + B) \times 100\%$	84.2%	
Number of <i>Not Met</i> elements determined to have significant bias on the results	0	

**Table 65—Example Validation Rating Determination—Includes Significant Bias**

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of <i>Met</i> elements	15	<i>No Confidence</i>
B. Total number of <i>Not Met</i> elements	4	
Validation Score = $A / (A + B) \times 100\%$	78.9%	
Number of <i>Not Met</i> elements determined to have significant bias on the results	1	

HSAG determined significant bias based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results as follows:

- HSAG requested that the health plan provide a root cause analysis of the finding.
- HSAG worked with the health plan to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- HSAG’s NAV Oversight Review Committee reviewed the root cause, proposed corrective action and a timeline for corrections, and estimated impact to determine the degree of bias.
- HSAG’s NAV Oversight Review Committee finalized a bias determination based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or HSAG was unable to quantify the impact and therefore determined the potential for significant bias.

## Network Monitoring

### *Access and Availability Survey*

#### Eligible Population

The eligible population included primary care and MH/SUD locations associated with providers that were actively contracted with the Illinois Medicaid program, accepting new patients, and loaded in the online directory as of the May 9, 2025, provider network submission files.

#### Data Collection

HSAG received provider data files from the health plans on approximately May 9, 2025. Health plan data included the following minimum data elements for each provider’s location: demographic information (e.g., provider name, address, phone number, Medicaid ID), provider type (e.g., MH, SUD, PCP), county location, contract status, appropriate provider directory inclusion, and panel information (i.e., open or closed). Upon receipt of the data, HSAG reviewed the address and telephone number information to assess potential duplication and completeness of key data fields.

To minimize duplicated provider records between the health plans, HSAG standardized the providers’ address data to align with the USPS CASS software program. Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population.

#### Case Identification Approach

HSAG employed a case identification approach with the aim of minimizing provider burden. HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple

addresses within a health plan, HSAG randomly assigned the number to a single plan and standardized address, prioritizing assignment to the least-represented plans. Service locations that did not accept Medicaid, new patients, or were not loaded in the online provider directory were excluded from the sample frame, as identified from an indicator in the health plans' data submissions to HSAG. HSAG selected a statistically valid number of provider locations based on a 95 percent confidence interval and  $\pm 5$  percent margin of error. A 25 percent oversample was included to increase the probability of capturing appointment availability information from a statistically valid number of service locations.

### Telephone Survey Process

HSAG conducted the survey during June and July 2025. Survey callers requested appointment availability with the sampled health plan for the sampled location. Callers collected survey responses using an HFS-approved script for all survey calls.

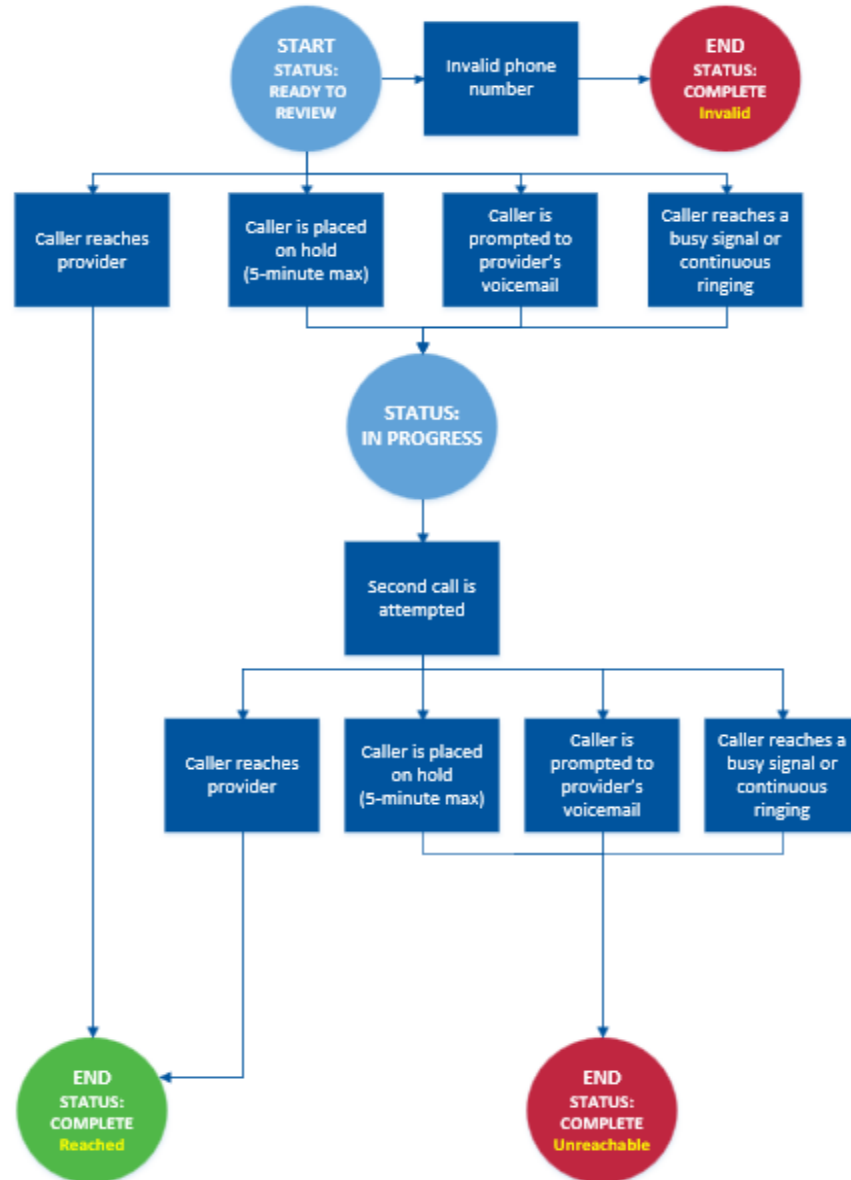
During the survey, callers attempted up to two calls to each sampled case during standard operating hours (i.e., 9:00 a.m.–5:00 p.m. Central Time).<sup>25</sup> Callers who were put on hold at any point during the call waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number in the health plan's data file connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical provider, practice, or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the call was answered by an automated answering service or call center that prevented the caller from speaking with office staff).
- The caller was placed on an extended hold with additional unsuccessful attempts.

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<sup>25</sup> HSAG did not consider a call attempted when the caller reaches an office outside of the office's usual business hours. For example, if the caller reached a recording that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. Callers attempted to contact the office up to two times outside of the known lunch hour.

The following diagram outlines the survey stop points for this activity.



### Survey Indicators

Using the survey script, HSAG classified survey indicators into domains that consider provider data accuracy and appointment availability by health plan. Provider data accuracy was evaluated based on survey responses. In general, matched information received a “Yes” response and non-matched information received a “No” response. For data collected on the first available appointment, the average and median wait times were calculated based on call date and earliest appointment date.

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's identification as offering primary care or MH/SUD services
- Affiliation with the requested Medicaid health plan

HSAG collected the following access-related information when calling sampled cases:

- Information concerning whether the provider location accepted new patients.
- Next available primary care or MH/SUD appointment date with any practitioner at the sampled location for a new patient.
- Any limitations to accepting new patients or scheduling an appointment. Limitations included, but were not limited to, the following:
  - Location required a review of the enrollee's medical records prior to offering an appointment.
  - Location required registration with the practice prior to offering an appointment.
  - Location required verification of the enrollee's Medicaid eligibility prior to offering an appointment.

### Study Limitations

Due to the nature of the survey, the following limitations should be considered when generalizing survey results across all providers contracted with the health plans to serve Medicaid enrollees:

- Survey calls were conducted at least four weeks following HSAG's receipt of each health plan's provider data, resulting in the possibility that provider locations updated their contact information with the health plan prior to HSAG's survey calls.
- Time to the first available appointment is based on appointments requested with the sampled provider location. Cases were counted as being unable to offer an appointment if the case offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which Medicaid enrollees are willing to travel to an alternate location.
- Survey findings were compiled from self-reported responses supplied to HSAG's callers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication. The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- Health plans are responsible for ensuring that enrollees have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of the health plans' processes for aiding enrollees who require timely appointments.

## Time and Distance Study

### Study Population

The study population for the time and distance study consisted of all HealthChoice Illinois Medicaid Managed Care Program providers contracted and loaded in the health plan database submitted by the health plans. One time and distance standard applicable to the MMAI plans was also included, as indicated in Table 66. The provider data included all providers active as of the second quarter of 2024. Provider categories for inclusion in the report have been chosen in collaboration with HFS based on available HealthChoice Illinois Managed Care program contract standards and are guided by definitions contained in the Provider Network Data Submission Instruction Manual.<sup>26</sup> Provider categories are shown in Table 66, as are the enrollee populations for the analyses.

**Table 66—Provider Categories**

Provider Type	Enrollee Population
PCPs*	Adult and Pediatric
Behavioral Health Service Providers**	Adult and Pediatric
Obstetrician/Gynecologist (OB/GYN) Providers	Adult
Dental Providers	Pediatric
<b>Specialty Providers</b>	
Allergy and Immunology	Adult and Pediatric
Endocrinology	Adult and Pediatric
Neurosurgery	Adult and Pediatric
Oral Surgery	Adult and Pediatric
Pulmonology	Adult and Pediatric
Audiology	Adult and Pediatric
<b>Facilities</b>	
Hospitals	All
Pharmacies	All
Skilled Nursing Facilities	MMAI population (Dual Eligibles)

\* PCPs: Adult PCPs include Family Practice, General Practice, Internal Medicine, Nurse Practitioners, Physician Assistants. Pediatric PCPs include Pediatric Medicine, Pediatric Nurse Practitioners, Pediatric Physician Assistants.

\*\* Behavioral Health Providers: Adult Behavioral Health Providers include Licensed Professional/Licensed Clinical Counselors, Psychiatrists, Psychologists, Social Workers. Pediatric Behavioral Health Providers include Pediatric Psychiatrists, Pediatric Psychologists, Licensed Practitioners of the Healing Arts, Mental Health Counselors, and Qualified Mental Health Professional (QMHP).

<sup>26</sup> HFS Provider Network Data Submission Instruction Manual, April 2022, Version 3.0.

HSAG worked with HFS to assign individual providers to the appropriate specialty based on the health plan provider data and determine key data fields to be used in identifying unique providers (e.g., HFS Medicaid provider ID number).

### Study Indicators

HSAG used geospatial analytic software to review the enrollee and provider addresses to ensure they could be geocoded to exact geographic locations (i.e., latitude and longitude). Geocoded enrollee and provider addresses were assembled into datasets used to conduct spatially-derived analyses for each health plan using geospatial analytic software. HSAG conducted the following analyses for each health plan:

- For each county and region, the percentage of enrollees with access to providers within the time and distance standards.
- The percentage of counties in which contractual access standards are met.
- Identification of counties in which contractual access standards are not met.

HSAG used the definitions for urban and rural counties as defined in the Medicaid Model Contract—Attachment II. Illinois has 19 urban counties and 83 rural counties.

HSAG used the analytic results to evaluate the extent to which a health plan’s provider/enrollee distribution meets HFS’ time and distance standards. For each health plan, HSAG determined the level of compliance by determining the percentage of health plan enrollees who have access to their nearest provider(s) within the required time or distance standard.

### Stratification and Targeting of Results

As in the time and distance analyses performed for HFS in previous years, for 2024, HSAG stratified these analyses by race, ethnicity, age, and sex, and highlighted results for ZIP Codes that qualify as DIAs as identified by the Illinois Department of Commerce & Economic Opportunity (DCEO).<sup>27</sup>

HSAG conducted the following analyses for each stratification of interest, as determined in collaboration with HFS:

- The percentage of enrollees with network access required by the time and distance standards, stratified by race, ethnicity, age, and sex, as well as by urbanicity. Results are reported by region.

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<sup>27</sup> Illinois Department of Commerce & Economic Opportunity. *Zip Codes that Qualify as Disproportionately Impacted Areas for the Illinois Back to Business (B2B) Grant Program*. Available at: <https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipodelist.pdf>. Accessed on: Feb 6, 2026.



## Member Experience Surveys

### Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. Aetna, BCBSIL, CountyCare, Meridian, and Molina were responsible for contracting with a CAHPS vendor to administer the CAHPS surveys to their adult and child Medicaid populations on their behalf.<sup>28</sup> Results for all five health plans were provided 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, the SNC populations, YouthCare, and FYiC, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS.

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on the levels of members' experience with their healthcare.

### Overview

HFS contracted with five health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Four of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only.

### Technical Methods of Data Collection and Analysis

#### HealthChoice Health Plans

The technical method of data collection was through the administration of the CAHPS 5.1H Adult Medicaid Survey to the adult populations and the CAHPS 5.1H Child Medicaid Survey to the child populations. Aetna, BCBSIL, CountyCare, Meridian, and Molina used a mixed-mode methodology, which included both mail and telephone surveys for data collection, including the option to complete a web-based survey via the Internet. Aetna, BCBSIL, CountyCare, and Meridian included the option to complete the surveys in English and Spanish for both the adult and child populations. Molina included the option to complete the surveys in English for both the adult and child populations.

#### All Kids and Illinois Medicaid Statewide, SNC, YouthCare, and FYiC Surveys

The technical method of data collection was through the administration of the CAHPS 5.1 Child Medicaid Survey with the CCC measurement set to a statewide sample of the child population enrolled in each program/SNC plan/YouthCare/FYiC. 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

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<sup>28</sup> In 2024 and 2025, the Center for the Study of Services (CSS) administered the CAHPS surveys on behalf of Aetna. In 2024 and 2025, Press Ganey administered the CAHPS surveys on behalf of BCBSIL, CountyCare, Meridian, and Molina.

chronic condition) were selected from each program/SNC plan/YouthCare/FYiC. A standard mixed-mode methodology for data collection was used, which included mail, web, and telephone surveys for data collection, with the option to complete the survey in English and Spanish.

### Survey Measures for CAHPS

The survey questions were categorized into measures of experience. 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, SNC population, YouthCare, and FYiC, the CAHPS survey also included the CCC measurement set of survey questions, which are categorized into five additional measures of experience. These measures included three CCC composite measures and two CCC individual item measures. The CCC composites and items are sets of questions and individual questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

NCQA requires a minimum of 100 responses on each item to report the measure as a valid CAHPS Survey result; however, for this report, if available, plans'/populations' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box score). For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," and "Always." For the composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), a positive, or top-box response, was defined as a response of "Usually" or "Always." Composite measure scores were calculated by averaging the percentage of positive responses for each item. The percentage of top-box responses was referred to as a global proportion (or top-box score) for the composite measures.

For each of the CCC composites and items for the CCC population, the percentage of respondents who chose a positive response was calculated. CAHPS CCC composite measure/item question response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2) "No" and "Yes." For three of the CCC composite measures/items (*Access to Specialized Services*, *Access to Prescription Medicines*, and *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 2025 top-box scores were compared to their corresponding 2024 scores to determine whether there were statistically significant differences. Statistically significant differences between the 2025 top-box scores and the 2024 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2025 than 2024 are noted with black upward triangles (▲). Scores that were statistically significantly lower in 2025 than 2024 are noted with black downward triangles (▼). Scores that were not statistically significantly different between years are not noted with triangles.

Additionally, for each CAHPS measure, the resulting 2025 top-box scores were compared to NCQA’s 2024 Quality Compass Benchmark and Compare Quality Data and the resulting 2024 top-box scores were compared to NCQA’s 2023 Quality Compass Benchmark and Compare Quality Data.<sup>29,30</sup> 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 67.

**Table 67—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

<sup>29</sup> National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2024*. Washington, DC: NCQA. September 2025.

<sup>30</sup> National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA. September 2024.

## Appendix B. PIP Aim Statements and Interventions

### Aim Statements

**Table 68—PIP Aim Statements**

Health Plan	Aim Statement
<b><i>Improving Timeliness of Prenatal Care PIP</i></b>	
Aetna	By the end of Remeasurement Period 2 (ending December 31, 2026), Aetna Beter Health of Illinois will use targeted interventions to improve the Timeliness of Prenatal Care HEDIS® measure for the entire eligible population, increasing compliance from 84.4% to State of Illinois target rate of 90.41%.
BCBSIL	Do targeted interventions increase the percentage of members that deliver a live birth and receive a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the BCBSIL organization during the reported remeasurement period.
CountyCare	CountyCare will use targeted interventions to achieve a statistically significant improvement in timely entry into prenatal care among the eligible population for HEDIS <i>PPC</i> in the measurement period.
Meridian	By 12/31/2026, Meridian aims to demonstrate Year over Year (YoY) statistically significant improvement for prenatal care visits among women in their first trimester of pregnancy, on or before the enrollment start date or within 42 days of enrollment, using administrative data through targeted interventions including, but not limited to, member and provider engagement and community partnerships to support the needs of this population.
Molina	Do targeted interventions increase HEDIS <i>PPC</i> Prenatal rates for Molina Medicaid members who deliver a live birth during the measurement year?
<b><i>Improving Transportation Services PIP</i></b>	
Aetna	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
BCBSIL	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
CountyCare	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Meridian	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Molina	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?

**Table 69—QIP Aim Statements**

MMP	Aim Statement
<b><i>Improving Transportation Services QIP</i></b>	
Aetna	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
BCBSIL	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Humana	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Meridian	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Molina	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?

## Interventions

HSAG’s PIP/QIP process includes three stages—Design, Implementation, and Outcomes. During the 2024 validation, the Implementation and Outcomes stages, including QI processes, interventions, and second remeasurement outcomes, were validated for the *Improving Timeliness of Prenatal Care* PIPs. The *Improving Transportation Services* PIPs/QIPs quality improvement processes and interventions were validated along with the Implementation and Outcomes stages which included QI processes, interventions, and first remeasurement outcomes. HFS requires the health plans/MMPs to focus at least one intervention on addressing health equities that they identified within the eligible population for each PIP/QIP.

### *Improving Timeliness of Prenatal Care PIP*

Table 70 through Table 67 illustrate the progression of interventions for the *Improving Timeliness of Prenatal Care* PIP.

**Table 70—Intervention Status for Aetna Better Health**

Intervention	Identified Disparities	Status
TwentyEight Health digital healthcare platform which offers telehealth services.	<i>Race: Black Members</i>	<i>New</i>
Maternal and Child Health Special Provider Incentive Program.	<i>None specified</i>	<i>New</i>

Intervention	Identified Disparities	Status
Voice Messaging Outreach Initiative to Improve Timeliness of Prenatal Care.	<i>None specified</i>	<i>New</i>

**Table 71—Intervention Status for Blue Cross Blue Shield of Illinois**

Intervention	Identified Disparities	Status
Outreach: Member education, SDOH screening with resource referrals, and appointment scheduling support.	<i>African American members residing in Cook County</i>	<i>New</i>

**Table 72—Intervention Status for County Care Health Plan**

Intervention	Identified Disparities	Status
Brighter Beginnings text message campaign for members.	<i>None specified</i>	<i>New</i>
Provider and clinic staff training on Brighter Beginnings and HEDIS PPC prenatal coding/scheduling best practices.	<i>Residence: Disproportionately impacted geographic areas</i>	<i>New</i>

**Table 73—Intervention Status for Meridian Health**

Intervention	Identified Disparities	Status
MomCare Connect, a comprehensive maternity care program to provide members with tools for self-advocacy, knowledge, access, and member-specific referrals.	<i>None specified</i>	<i>New</i>
Improving NOP (Notification of Pregnancy) form utilization and completion timeliness.	<i>None specified</i>	<i>New</i>
OSF HealthCare’s OnCall Connect Mobile Van.	<i>Residence: Disproportionately impacted geographic areas</i>	<i>New</i>
Clinical Outreach for Adolescent Mothers.	<i>Age:0–17</i>	<i>New</i>
Pomelo, a vendor that focuses on prenatal care with a dedicated care team that provides a custom care plan for members.	<i>Residence: Disproportionately impacted geographic areas</i> <i>Age:0–17</i>	<i>New</i>

**Table 74—Intervention Status for Molina Healthcare of Illinois**

Intervention	Identified Disparities	Status
Member reward: BumpBox or Car Seat when a timely prenatal appointment is scheduled.	<i>Race: Non-White Members Residence: Disproportionately impacted geographic areas</i>	<i>New</i>

### Improving Timeliness of Transportation Services PIP

Table 75 through Table 79 illustrate the interventions for the *Improving Transportation Services PIP* by Lines of Business.

**Table 75—Intervention Status for Aetna Better Health**

Intervention	Identified Disparities	Status
<b>HealthChoice, MLTSS, SNC</b>		
<b>Real-time, GPS-enabled Mobile App:</b> A pilot of the new Transport Mobile App was implemented in mid-2022. The pilot focused on the top 1,000 transport users since 2021. After seeking member feedback via surveys, the Mobile App was updated prior to a full-scale rollout in early 2023. The Mobile App features a user interface, allowing members to request their rides and track them in real time.	<i>Race: Non-Hispanic Black Residence: Disproportionately impacted geographic areas</i>	<i>Continued</i>
<b>VIP Programs:</b> The member VIP Program was implemented in Quarter 2 (Q2) 2022, offering members experiencing transportation barriers high-touch support. Members who meet the criteria due to trip challenges are offered a more personalized collaboration with a Customer Advocate team to support trip reservations and the Member Experience team to support them from pickup to drop-off.	<i>None specified</i>	<i>Continued</i>
<b>Champion Provider Programs:</b> The Champion Provider Program was launched in Q3 2022 to address barriers from a provider angle and offer financial incentives for providers to service hotspots with elevated wait times and no-show rates.	<i>Race: Non-Hispanic Black Residence: Disproportionately impacted geographic areas</i>	<i>Continued</i>
<b>Fleet expansion efforts:</b> Target areas are determined based on member complaints, no-show rates, and vehicle availability per region.	<i>Race: Non-Hispanic Black Residence: Disproportionately impacted geographic areas</i>	<i>Continued</i>

Intervention	Identified Disparities	Status
Based on data analysis, fleet expansion recruitment efforts with existing contracted providers focused on regions 1, 2, and 3 addressed ambulatory and wheelchair-assist vehicle shortages. Future expansion efforts will focus on regions 3 and 4.		
<b>Data-driven enhancements:</b> An internal transport escalations tracker was created to log issues reported by the Case Management, Medical Management, and Member Services teams.	<i>None specified</i>	<i>Continued</i>
<b>Know Your Ride Member outreach:</b> Outreach via emails, newsletters, website postings, and flyer campaigns. Simplified mileage reimbursement process for members through the Mobile App.	<i>None specified</i>	<i>Continued</i>
<b>Performance Improvement Plans:</b> Transportation Provider review and Effectiveness.	<i>None specified</i>	<i>Continued</i>
<b>Mass Transit:</b> Public transportation passes for members in select DIA ZIP Codes.	<i>Race: Non-Hispanic Black Residence: Disproportionately impacted geographic areas</i>	<i>Continued</i>
<b>Digitized and Increased use of incentive process:</b> Milage and gas reimbursement.	<i>None specified</i>	<i>Continued</i>
Performance Improvement Plans for Transportation Providers.	<i>Race: Non-Hispanic Black Residence: Disproportionately impacted geographic areas</i>	<i>Continued</i>
Digitized and increased use of incentive process.	<i>None specified</i>	<i>Continued</i>

**Table 76—Intervention Status for Blue Cross Blue Shield of Illinois**

Intervention	Identified Disparities	Status
<b>HealthChoice, MLTSS, SNC</b>		
<b>Driver Training:</b> Training to address and educate ModivCare drivers on BCBSIL expectations when interacting with BCBSIL members. Training included modules on professional boundaries, trauma-informed care,	<i>Not Applicable: The health plan indicated that the PIP would focus on all members as there were no trends noted across race and ethnicity as well as at the individual</i>	<i>Continued</i>

Intervention	Identified Disparities	Status
emotional intelligence, and mini medical training.	<i>ZIP Code level. This was observed across all three lines of business.</i>	
<b>Performance Improvement Plans for transportation providers:</b> Assessed how many providers graduated from being on a performance improvement plan.	<i>Not Applicable</i>	<i>Continued</i>
<b>Telephonic Outreach:</b> Integrated education opportunities into the telephonic engagement. Members were educated on their rights as BCBSIL members, the process they should follow if they feel unsafe, preferred provider selection, ride share opportunities, care coordination services, and grievance procedures for ModivCare and BCBSIL.	<i>Not Applicable</i>	<i>Continued</i>
<b>VIP List:</b> Members with transportation issues had follow-up and case review to identify root causes.	<i>Not Applicable</i>	<i>Continued</i>
<b>Improving Network Adequacy:</b> ModivCare started utilizing Lyft and Uber as a credentialed Provider to help with network adequacy needs.	<i>Not Applicable</i>	<i>Continued</i>

**Table 77—Intervention Status for County Care Health Plan**

Intervention	Identified Disparities	Status
<b>HealthChoice, MLTSS, SNC</b>		
<b>Implementation of ModivCare:</b> To replace Transdev as the transportation broker and improve transportation services. more vehicles in DIAs and the West Side of Chicago.	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<b>Customer Support Call Monitoring and Analysis:</b> To improve the quality and accuracy of customer service interactions.	<i>None Specified</i>	<i>Continued</i>
<b>Expanded Mobility Solutions:</b> Integrates on-demand transportation options like Lyft and Uber.	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<b>Monetary Penalties for Non-Performance:</b> Enforcement of monetary fines for underperformance for both Transdev and ModivCare.	<i>None Specified</i>	<i>Continued</i>

**Table 78—Intervention Status for Meridian Health**

Intervention	Identified Disparities	Status
<b>HealthChoice, MLTSS, SNC</b>		
<p><b>Increase Medical Provider Network Adequacy:</b> The Meridian team collaborating with Network Contracting and Adequacy teams to increase the number of specialty providers, especially in rural areas.</p>	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<p><b>On-Time Trips by Recruited Transportation Providers:</b> Meridian’s transportation vendor, MTM, continues to recruit transportation providers, with a focus on specific counties/areas with higher numbers of late trips as identified in the monthly trip reports.</p>	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<p><b>Partnership with Public Transit and Paralift Services:</b> MTM identified and continues to partner with counties with a public transit solution/paratransit service to provide transportation to specific members in need.</p>	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<p><b>Short Notice Ride Technology:</b> MTM Link feature prevents the assignment of trips to transportation providers who have exceeded capacity for the day or do not serve a particular geographic area.</p>	<i>None Specified</i>	<i>Continued</i>
<p><b>Unassigned Trip Technology Enhancements:</b> MTM uses an online dispatching tool called MTM Marketplace, which allows transportation providers to log in and quickly find available trips in their area. This tool facilitates the placement of unassigned or reassigned trips in a timely manner and allows for increased automation and reduction in late trips.</p>	<i>None Specified</i>	<i>Continued</i>
<p><b>Delayed Trip Technology Enhancements:</b> If a trip is going to be delayed, the MTM Link feature generates a notification so MTM or the transportation provider can reassign trips to an alternate driver or provider in the area if necessary.</p>	<i>None Specified</i>	<i>Continued</i>
<p><b>Pilot to Assign Dedicated Provider for Facility Trips:</b> A dedicated non-emergency medical transportation (NEMT) provider with ambulatory and wheelchair capabilities was assigned to a high-volume facility servicing members in select counties.</p>	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>New</i>

**Table 79—Intervention Status for Molina Healthcare of Illinois**

Intervention	Identified Disparities	Status
<i>HealthChoice, MLTSS, SNC</i>		
Molina health educators directly schedule members into appointments to address gaps in care and schedule the members’ transportation, allowing the health educators to address issues as they arise. <i>(Not Applicable to SNC)</i>	<i>DIA ZIP Codes and Non-White Members</i>	<i>Continued</i>
Recruit new transportation providers to network.	<i>None Specified</i>	<i>Continued</i>
Collaborating with existing providers to expand service in target areas.	<i>None Specified</i>	<i>Continued</i>
MTM Link feature to prevent assignment of trips to providers that have exceeded capacity.	<i>None Specified</i>	<i>Continued</i>
MTM dispatch tool, MTM Marketplace, allows providers to find available trips in their areas.	<i>None Specified</i>	<i>Continued</i>
Upgrade of MTM Link feature generates a notification that allows MTM to reassign trips if the provider is going to be late.	<i>None Specified</i>	<i>Continued</i>
MTM monitoring on-time performance for providers monthly. Providers not meeting requirements are placed on a Performance Improvement Plan.	<i>None Specified</i>	<i>Continued</i>

**Improving Timeliness of Transportation Services QIP**

Table 73 through Table 77 illustrate the progression of interventions for the *Improving Transportation Services QIP*.

**Table 80—Intervention Status for Aetna Better Health**

Intervention	Identified Disparities	Status
<b>MTM Link:</b> Implementation of MTM Link (MTM’s transportation tool), which allows for real-time, drag-and-drop alterations to providers’ schedules, as needed.	<i>None Specified</i>	<i>Continued</i>
<b>Performance Improvement Plan:</b> MTM identified provider network adequacy concerns in existing and expansion regions.	<i>None Specified</i>	<i>Continued</i>

Intervention	Identified Disparities	Status
MTM identified providers that were adversely influencing overall member on-time arrival and used a performance improvement plan (QIP) to hold vendors accountable.		
<b>MTM Marketplace:</b> MTM incorporated an online dispatching tool called MTM Marketplace. This tool allows providers to log in and find available trips in their area. The tool facilitates unassigned or reassigned trips in a timely manner allowing for increased automation and potentially a reduction in late arrivals.	<i>None Specified</i>	<i>Continued</i>
<b>New Vendor Recruitment:</b> MTM implemented a campaign to actively recruit new vendors into its existing provider network to increase provider availability.	<i>None Specified</i>	<i>Continued</i>

**Table 81—Intervention Status for Blue Cross Blue Shield of Illinois**

Intervention	Identified Disparities	Status
<b>Driver Training:</b> Training to address and educate ModivCare drivers on BCBSIL expectations when interacting with BCBSIL members. Training included modules on professional boundaries, trauma-informed care, emotional intelligence, and mini medical training.	<i>Not Applicable: The health plan indicated that the PIP would focus on all members as there were no trends noted across race and ethnicity as well as at the individual ZIP Code level. This was observed across all three lines of business</i>	<i>Continued</i>
<b>Performance Improvement Plans for transportation providers:</b> Assessed how many providers graduated from being on a performance improvement plan.	<i>Not Applicable</i>	<i>Continued</i>
<b>Telephonic Outreach:</b> Integrated education opportunities into the telephonic engagement. Members were educated on their rights as BCBSIL members, the process they should follow if they feel unsafe, preferred provider selection, ride share opportunities, care coordination services, and grievance procedures for ModivCare and BCBSIL.	<i>Not Applicable</i>	<i>Continued</i>
<b>VIP List:</b> Members with transportation issues had follow-up and case review to identify root causes.	<i>Not Applicable</i>	<i>Continued</i>

Intervention	Identified Disparities	Status
<b>Improving Network Adequacy:</b> ModivCare started utilizing Lyft and Uber as a credentialed provider to help with network adequacy needs.	<i>Not Applicable</i>	<i>Continued</i>

**Table 82—Intervention Status for Humana Medical Plan, Inc.**

Intervention	Identified Disparities	Status
<b>Transportation Providers not meeting metrics:</b> MTM identified transportation providers who were adversely influencing overall member on-time arrival and used a QIP to hold identified providers accountable.	<i>None Specified</i>	<i>Continued</i>
<b>Increase Network Adequacy:</b> MTM identified areas requiring additional transportation providers and began a campaign to actively recruit new providers.	<i>None Specified</i>	<i>Continued</i>
<b>Implementation of MTM Link:</b> 1) Prevents the assignment of trips to transportation providers who have exceeded capacity for the day or do not service a particular geographic area. 2) Offers a real-time provider view of scheduled trips, allowing for modifications to accommodate specific needs. 3) Provides system notifications for the trip reassignment to an alternate driver or provider if needed.	<i>None Specified</i>	<i>Continued</i>
<b>Long Term Care:</b> Targeted on-site visits to provide a one-page educational document to long-term care (LTC) facilities that have the highest volume of LTC membership. Targeted on-site training offered to provide one pager education to LTCs with high unique member utilizers not residing in high volume facilities.	<i>Members Residing in LTC Facilities</i>	<i>Continued</i>
<b>Regional Care Coordination:</b> Utilization of assigning a preferred/ specific provider.	<i>None Specified</i>	<i>New</i>

**Table 83—Intervention Status for Meridian Health**

Intervention	Identified Disparities	Status
<b>Increase Medical Provider Network Adequacy:</b> The Meridian team collaborating with Network Contracting and Adequacy teams to increase the number of specialty providers, especially in rural areas.	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<b>On-Time Trips by Recruited Transportation Providers:</b> Meridian’s transportation vendor, MTM, continues to recruit transportation providers, with a focus on specific counties/areas with higher numbers of late trips as identified in the monthly trip reports.	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<b>Partnership with Public Transit and Paralift Services:</b> MTM identified and continues to partner with counties with a public transit solution/paratransit service to provide transportation to specific members in need.	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>Continued</i>
<b>Short Notice Ride Technology</b> MTM Link feature prevents the assignment of trips to transportation providers who have exceeded capacity for the day or do not serve a particular geographic area.	<i>None Specified</i>	<i>Continued</i>
<b>Unassigned Trip Technology Enhancements:</b> MTM uses an online dispatching tool called MTM Marketplace, which allows transportation providers to log in and quickly find available trips in their area. This tool facilitates the placement of unassigned or reassigned trips in a timely manner and allows for increased automation and reduction in late trips.	<i>None Specified</i>	<i>Continued</i>
<b>Delayed Trip Technology Enhancements:</b> If a trip is going to be delayed, the MTM Link feature generates a notification so MTM or the transportation provider can reassign trips to an alternate driver or provider in the area if necessary.	<i>None Specified</i>	<i>Continued</i>
<b>Pilot to Assign Dedicated Provider for Facility Trips:</b> A dedicated NEMT provider with ambulatory and wheelchair capabilities was assigned to a high-volume facility servicing members in select counties.	<i>DIA ZIP Codes Across All Lines of Business</i>	<i>New</i>

**Table 84—Intervention Status for Molina Healthcare of Illinois**

Intervention	Identified Disparities	Status
Reduce transportation issues that cause the member to be late or miss the appointment by providing in-home and telehealth appointments for members in DIAs ZIP Codes by bringing care to members.	<i>DIA ZIP Codes</i>	<i>Continued</i>
Recruit new transportation providers to network.	<i>None Specified</i>	<i>Continued</i>
Collaborating with existing providers to expand service in target areas.	<i>None Specified</i>	<i>Continued</i>
MTM Link feature to prevent assignment of trips to providers that have exceeded capacity.	<i>None Specified</i>	<i>Continued</i>
MTM dispatch tool, MTM Marketplace, allows providers to find available trips in their areas.	<i>None Specified</i>	<i>Continued</i>
Upgrade of MTM Link feature generates a notification that allows MTM to reassign trips if the provider is going to be late.	<i>None Specified</i>	<i>Continued</i>
MTM monitoring on-time performance for providers monthly. Providers not meeting requirements are placed on a Performance Improvement Plan.	<i>None Specified</i>	<i>Continued</i>

## Appendix C. Performance Measure 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.

To evaluate performance levels and to provide an objective, comparative review of Illinois health plans’ quality-of-care outcomes and performance measures, HFS required its health plans to report results following NCQA’s HEDIS protocols.<sup>31</sup>

In this appendix, Illinois health plans’ performance for required HEDIS MY 2024 measures are compared to NCQA’s Quality Compass national Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2024, which is an indicator of health plan performance on a national level (referred to as “percentiles” throughout this section of the report). Performance results reflect updates relative to the most current benchmarks available for each measurement year displayed. Additionally, MY 2023 rates included updates following the close of prior year’s reporting period, which included the transition to Electronic Clinical Data Systems (ECDS) methodology, where applicable.<sup>32</sup>

Details regarding the methodology are provided in Appendix A—Methodology of this report.

### Star Ratings

The star ratings in Table 85 represent the following percentile comparisons.

**Table 85—Star Ratings**

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

<sup>31</sup> National Committee for Quality Assurance. HEDIS and Performance Measurement. Available at: <http://www.ncqa.org/hedis-quality-measurement>. Accessed on: Feb 6, 2026.

<sup>32</sup> 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 MY 2023 results are calculated using CY 2023 data and HEDIS MY 2024 results are calculated using CY 2024 data.

## HealthChoice Results

Table 86 presents the HEDIS MY 2022 through HEDIS MY 2024 rates for the health plans and the statewide average, which represents the average of all the health plans’ performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable.

**Table 86—HealthChoice Performance Measure Results for HEDIS MY 2022–2024**

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b>Adults’ Access to Preventive/Ambulatory Health Services</b>							
<i>Total</i>	MY 2022	★★ 68.12%	★★★★ 73.48%	★★ 69.56%	★★★★ 73.09%	★★ 70.00%	★★ 71.43%
	MY 2023	★ 69.06%	★★ 74.65%	★★ 70.76%	★★ 74.70%	★★ 71.27%	★★ 72.69%
	MY 2024	★ 71.88%	★★ 76.54%	★★ 72.71%	★★ 76.49%	★ 71.66%	★★ 74.56%
<b>Blood Pressure Control for Patients With Diabetes</b>							
<i>Blood Pressure Control for Patients With Diabetes</i>	MY 2022	★ 49.88%	★★ 63.75%	★★ 58.15%	★★ 61.80%	★★ 61.56%	★★ 59.79%
	MY 2023	★ 61.07%	★★ 66.67%	★★ 65.45%	★★ 63.75%	★★ 68.13%	★★ 64.93%
	MY 2024	★★ 69.34%	★★ 69.10%	★★★★ 72.10%	★★★★ 72.51%	★★ 67.40%	★★ 70.49%
<b>Cervical Cancer Screening (ECDS)<sup>^</sup></b>							
<i>Cervical Cancer Screening</i>	MY 2022	★ 49.64%	★★★★ 59.85%	★★★★ 60.51%	★★ 56.45%	★★ 55.72%	★★ 56.83%
	MY 2023*	★ 45.75%	★★ 56.50%	★★ 56.06%	NR	★★ 49.76%	★★ 52.94%
	MY 2024	★ 46.26%	★★★★ 58.43%	★★★★ 54.13%	★★★★ 56.00%	★★ 50.43%	★★★★ 54.31%
<b>Child and Adolescent Well-Care Visits</b>							
<i>Total</i>	MY 2022	★★ 43.62%	★★★★ 52.32%	★★★★ 50.73%	★★★★ 51.04%	★★ 47.91%	★★★★ 49.99%
	MY 2023	★ 46.30%	★★★★ 55.10%	★★★★ 54.36%	★★★★ 54.59%	★★ 49.96%	★★★★ 53.10%
	MY 2024	★★ 50.50%	★★★★ 58.40%	★★★★ 57.87%	★★★★ 57.86%	★★ 52.31%	★★★★ 56.46%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b>Childhood Immunization Status (ECDS)^</b>							
<i>Combination 3</i>	MY 2022	★★ 58.64%	★★ 60.83%	★★ 60.58%	★★ 60.34%	★ 58.39%	★★ 60.05%
	MY 2023*	★ 57.19%	★★ 60.16%	★ 58.51%	NR	★ 57.02%	★ 58.63%
	MY 2024	★★ 59.22%	★★★★ 62.83%	★★ 55.42%	★★★★ 62.47%	★★★★ 62.30%	★★ 61.00%
<i>Combination 10</i>	MY 2022	★ 20.92%	★★ 27.74%	★★★★ 32.36%	★ 24.33%	★ 21.17%	★★ 25.63%
	MY 2023*	★ 19.50%	★★ 25.69%	★★★★ 28.35%	NR	★ 21.04%	★★ 24.25%
	MY 2024	★★ 19.91%	★★★★ 24.52%	★★★★ 25.46%	★★ 22.66%	★★ 21.03%	★★ 23.11%
<b>Chlamydia Screening in Women</b>							
<i>Total</i>	MY 2022	★★ 55.32%	★★ 56.01%	★★★★★ 65.08%	★ 46.13%	★★★★ 57.21%	★★ 54.23%
	MY 2023	★★ 55.32%	★★★★ 56.58%	★★★★★ 64.42%	★ 47.03%	★★★★ 56.12%	★★ 54.65%
	MY 2024	★★ 54.42%	★★ 55.50%	★★★★ 63.30%	★ 47.16%	★★ 54.29%	★★ 53.86%
<b>Controlling High Blood Pressure</b>							
<i>Controlling High Blood Pressure</i>	MY 2022	★ 53.77%	★★★★ 61.56%	★ 53.53%	★★ 58.39%	★★★★ 61.31%	★★ 57.96%
	MY 2023	★ 57.18%	★★ 63.99%	★ 54.63%	★★ 62.04%	★ 59.37%	★★ 60.15%
	MY 2024	★ 62.29%	★ 61.80%	★ 62.10%	★★ 66.42%	★ 60.83%	★ 63.12%
<b>Diagnosed Mental Health Disorders</b>							
<i>18–64 Years</i>	MY 2022	★★ 28.76%	★★ 25.48%	★ 20.74%	★★ 28.43%	★★ 28.69%	★★ 26.56%
	MY 2023	★★ 30.35%	★★ 26.66%	★ 21.36%	★★ 29.68%	★★ 29.95%	★★ 27.67%
	MY 2024	★★ 33.39%	★★ 29.42%	★ 23.09%	★★ 32.43%	★★ 32.50%	★★ 30.17%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
65+ Years	MY 2022	★★★ 31.29%	★★ 27.69%	★★ 26.87%	★★★ 28.49%	★★★ 35.11%	★★★ 29.12%
	MY 2023	★★★ 31.86%	★★ 27.84%	★★ 26.96%	★★ 29.87%	★★★ 40.20%	★★★ 30.19%
	MY 2024	★★★ 33.09%	★★ 27.63%	★★ 26.98%	★★ 30.78%	★★ 29.66%	★★ 29.26%
<b>Eye Exam for Patients With Diabetes</b>							
Eye Exam for Patients With Diabetes	MY 2022	★★ 46.47%	★ 45.01%	★★★ 52.31%	★★ 51.09%	★ 44.28%	★★ 48.29%
	MY 2023	★★ 52.31%	★★★ 56.69%	★★★ 56.45%	★★ 52.80%	★ 39.28%	★★ 52.93%
	MY 2024	★★ 53.04%	★★ 54.50%	★★★ 58.02%	★★★ 57.91%	★ 42.93%	★★ 54.76%
<b>Follow-Up After Emergency Department Visit for Mental Illness</b>							
7-Day Follow-Up—6–17 Years	MY 2022	★★★★★ 77.45%	★★★★★ 71.91%	★★★★★ 70.93%	★★★★★ 77.94%	★★★★★ 79.68%	★★★★★ 76.06%
	MY 2023	★★★★★ 74.90%	★★★★★ 73.45%	★★★★★ 62.58%	★★★★★ 76.78%	★★★★★ 77.75%	★★★★★ 74.45%
	MY 2024	★★★★★ 74.47%	★★★★★ 69.58%	★★★★★ 69.07%	★★★★★ 75.95%	★★★★★ 76.57%	★★★★★ 73.51%
7-Day Follow-Up—18–64 Years	MY 2022	★★★★★ 45.79%	★★★ 43.72%	★★ 33.18%	★★★★★ 47.38%	★★★ 44.71%	★★★ 44.15%
	MY 2023	★★★★★ 45.29%	★★★★★ 45.04%	★★ 31.77%	★★★★★ 50.22%	★★★★★ 50.12%	★★★★★ 45.67%
	MY 2024	★★★ 45.97%	★★★ 44.51%	★★ 31.78%	★★★ 46.97%	★★★ 46.55%	★★★ 44.06%
7-Day Follow-Up—65+ Years	MY 2022	NA	NA	NA	NA	NA	★★★ 36.36%
	MY 2023	NA	NA	NA	NA	NA	★★★ 39.08%
	MY 2024	NA	NA	NA	NA	NA	★★★ 39.60%
30-Day Follow-Up—6–17 Years	MY 2022	★★★★★ 83.33%	★★★★★ 80.39%	★★★ 77.00%	★★★★★ 83.56%	★★★★★ 87.90%	★★★★★ 82.75%
	MY 2023	★★★★★ 81.18%	★★★★★ 79.76%	★★★ 72.33%	★★★★★ 83.97%	★★★★★ 83.80%	★★★★★ 81.37%
	MY 2024	★★★★★ 82.74%	★★★★★ 78.72%	★★★ 75.95%	★★★★★ 82.63%	★★★★★ 82.37%	★★★★★ 80.94%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
30-Day Follow-Up— 18–64 Years	MY 2022	★★★★ 56.12%	★★★★ 54.01%	★★★ 43.23%	★★★★ 56.48%	★★★★ 55.62%	★★★★ 54.13%
	MY 2023	★★★★ 54.71%	★★★★ 56.11%	★★★ 40.30%	★★★★★ 59.63%	★★★★★ 60.25%	★★★★ 55.46%
	MY 2024	★★★★ 55.89%	★★★★ 55.37%	★ 38.77%	★★★★ 57.44%	★★★★ 57.24%	★★★★ 54.08%
30-Day Follow-Up— 65+ Years	MY 2022	NA	NA	NA	NA	NA	★★ 42.42%
	MY 2023	NA	NA	NA	NA	NA	★★ 50.57%
	MY 2024	NA	NA	NA	NA	NA	★★ 48.51%
<b>Follow-Up After Emergency Department Visit for Substance Use</b>							
7-Day Follow-Up— 13–17 Years	MY 2022	★ 13.68%	★★ 17.30%	★ 12.22%	★★★★ 25.56%	★★★★ 22.99%	★★★★ 19.92%
	MY 2023	★★★★ 20.30%	★★★★ 24.27%	★★★★ 19.50%	★★★★ 26.01%	★★★★ 19.13%	★★★★ 22.86%
	MY 2024	★★ 17.71%	★★★★ 24.07%	★ 13.53%	★★★★ 23.10%	★★ 17.72%	★★ 20.60%
7-Day Follow-Up— 18+ Years	MY 2022	★★★★ 24.62%	★★★★ 27.72%	★★ 19.20%	★★★★ 26.92%	★★★★ 28.64%	★★★★ 25.63%
	MY 2023	★★★★ 25.47%	★★★★ 27.51%	★★★★ 24.22%	★★ 23.76%	★★★★ 25.96%	★★★★ 25.29%
	MY 2024	★★ 26.67%	★★★★ 27.88%	★★ 25.47%	★★ 24.52%	★★★★ 28.28%	★★ 26.39%
30-Day Follow-Up— 13–17 Years	MY 2022	★ 20.00%	★★ 27.03%	★ 16.67%	★★★★ 34.96%	★★★★ 34.48%	★★ 28.63%
	MY 2023	★★ 25.56%	★★★★ 31.55%	★★ 27.67%	★★★★ 33.75%	★★★★ 34.78%	★★★★ 31.20%
	MY 2024	★★ 28.13%	★★ 31.94%	★ 21.80%	★★★★ 32.85%	★★ 25.32%	★★ 29.46%
30-Day Follow-Up— 18+ Years	MY 2022	★★ 34.83%	★★★★ 38.02%	★ 27.11%	★★★★ 37.31%	★★★★ 41.16%	★★ 35.86%
	MY 2023	★★ 35.10%	★★★★ 37.27%	★★ 32.76%	★★ 33.67%	★★★★ 39.43%	★★ 35.32%
	MY 2024	★★ 37.45%	★★ 38.39%	★★ 34.64%	★★ 35.03%	★★★★ 41.13%	★★ 36.97%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b><i>Follow-Up After High-Intensity Care for Substance Use Disorder</i></b>							
<i>7-Day Follow-Up— 13–17 Years</i>	MY 2022	NA	NA	NA	NA	NA	★★ 25.00%
	MY 2023	NA	NA	NA	NA	NA	★★★★ 20.00%
	MY 2024	NA	NA	NA	NA	NA	★★★★ 16.67%
<i>7-Day Follow-Up— 18–64 Years</i>	MY 2022	★★★★ 38.44%	★★★★ 37.55%	★★★★ 38.58%	★★★★ 37.74%	★★★★★ 40.19%	★★★★ 38.28%
	MY 2023	★★★★ 36.51%	★★★★ 38.05%	★★★★ 35.57%	★★★★ 36.41%	★★★★ 36.93%	★★★★ 36.69%
	MY 2024	★★★★ 40.80%	★★★★ 41.24%	★★★★ 38.85%	★★★★ 39.74%	★★★★ 43.63%	★★★★ 40.55%
<i>7-Day Follow-Up— 65+ Years</i>	MY 2022	NA	NA	★★★★ 26.32%	★★ 22.58%	NA	★★★★ 28.46%
	MY 2023	NA	NA	★★★★ 30.19%	NA	NA	★★★★ 29.92%
	MY 2024	NA	NA	★★ 30.88%	NA	NA	★★★★★ 40.14%
<i>30-Day Follow-Up— 13–17 Years</i>	MY 2022	NA	NA	NA	NA	NA	★★ 43.18%
	MY 2023	NA	NA	NA	NA	NA	★★ 31.43%
	MY 2024	NA	NA	NA	NA	NA	★★ 22.22%
<i>30-Day Follow-Up— 18–64 Years</i>	MY 2022	★★★★ 55.34%	★★★★ 53.68%	★★★★ 54.04%	★★★★ 55.43%	★★★★ 57.54%	★★★★ 55.03%
	MY 2023	★★★★ 54.03%	★★★★ 56.67%	★★★★ 54.10%	★★★★ 53.93%	★★★★ 55.04%	★★★★ 54.74%
	MY 2024	★★★★ 57.92%	★★★★ 59.73%	★★ 54.89%	★★★★ 57.49%	★★★★ 60.91%	★★★★ 57.97%
<i>30-Day Follow-Up— 65+ Years</i>	MY 2022	NA	NA	★★ 38.60%	★★ 38.71%	NA	★★ 39.84%
	MY 2023	NA	NA	★★★★ 50.94%	NA	NA	★★ 40.16%
	MY 2024	NA	NA	★★★★ 51.47%	NA	NA	★★★★ 56.34%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b>Follow-Up After Hospitalization for Mental Illness</b>							
7-Day Follow-Up— 6–17 Years	MY 2022	★★ 46.27%	★★★ 48.42%	★★ 37.74%	★★ 42.28%	★★ 43.27%	★★ 43.99%
	MY 2023	★★★ 49.21%	★★★ 47.50%	★ 36.81%	★★ 41.47%	★★ 44.09%	★★ 43.85%
	MY 2024	★★ 46.84%	★★ 44.91%	★★ 44.69%	★★ 43.89%	★★ 46.27%	★★ 45.02%
7-Day Follow-Up— 18–64 Years	MY 2022	★★ 27.69%	★★ 23.99%	★ 18.93%	★★ 25.50%	★★ 24.48%	★★ 24.45%
	MY 2023	★★ 31.59%	★★ 28.07%	★ 19.42%	★★ 27.33%	★★ 29.09%	★★ 27.33%
	MY 2024	★★ 31.85%	★★ 30.34%	★ 25.65%	★★ 30.58%	★★ 29.51%	★★ 29.85%
7-Day Follow-Up— 65+ Years	MY 2022	NA	★ 19.35%	★★ 19.57%	★ 12.96%	NA	★ 15.85%
	MY 2023	★★★★ 40.00%	★★ 26.67%	★ 19.05%	★ 20.83%	NA	★★ 26.42%
	MY 2024	★★★★ 44.12%	★ 16.36%	★ 15.15%	★★ 30.61%	NA	★★ 24.55%
30-Day Follow-Up— 6–17 Years	MY 2022	★★ 70.58%	★★★ 74.46%	★ 62.37%	★★ 68.65%	★★ 69.54%	★★ 69.71%
	MY 2023	★★★ 78.02%	★★ 72.19%	★ 61.90%	★★ 67.96%	★★★ 74.19%	★★ 70.54%
	MY 2024	★★★ 79.06%	★★ 69.16%	★★ 67.68%	★★ 71.74%	★★★ 74.70%	★★ 72.06%
30-Day Follow-Up— 18–64 Years	MY 2022	★★ 46.99%	★ 42.18%	★ 34.17%	★★ 44.55%	★★ 46.16%	★ 43.12%
	MY 2023	★★ 53.69%	★★ 49.20%	★ 36.85%	★★ 46.24%	★★ 51.68%	★★ 47.65%
	MY 2024	★★ 54.48%	★ 48.62%	★ 44.04%	★★ 51.84%	★★ 51.66%	★★ 50.23%
30-Day Follow-Up— 65+ Years	MY 2022	NA	★ 35.48%	★ 36.96%	★ 37.04%	NA	★ 33.54%
	MY 2023	★★★★ 57.78%	★★ 42.67%	★ 33.33%	★ 33.33%	NA	★ 41.06%
	MY 2024	★★★★ 64.71%	★ 36.36%	★ 34.85%	★★★ 57.14%	NA	★★ 45.00%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b><i>Glycemic Status Assessment for Patients With Diabetes</i></b>							
<i>Glycemic Status &lt;8.0%</i>	MY 2022	★★★★ 57.18%	★★ 51.58%	★★ 48.91%	★★ 49.64%	★ 44.04%	★★ 50.55%
	MY 2023	★★★ 58.15%	★★★★ 61.07%	★★★ 58.15%	★★ 54.99%	★★ 54.50%	★★★ 57.61%
	MY 2024	★★★ 63.02%	★★ 57.91%	★★ 60.49%	★★★ 62.29%	★ 52.07%	★★ 59.78%
<b><i>Immunizations for Adolescents (ECDS)^</i></b>							
<i>Combination 1</i>	MY 2022	★★★ 85.16%	★★★★★ 89.09%	★★★ 83.94%	★★★★★ 90.27%	★★★★★ 86.70%	★★★★★ 87.94%
	MY 2023*	★★★★ 85.76%	★★★★★ 88.44%	★★★★ 85.54%	NR	★★★★ 86.72%	★★★★ 86.90%
	MY 2024	★★★★ 86.28%	★★★★★ 89.18%	★★★ 80.78%	★★★★★ 89.56%	★★★★ 87.15%	★★★★ 87.44%
<i>Combination 2</i>	MY 2022	★ 27.25%	★★★ 36.14%	★★★ 38.69%	★ 28.22%	★★ 31.24%	★★ 31.89%
	MY 2023*	★ 26.96%	★★★ 35.20%	★★★★ 42.04%	NR	★★ 32.02%	★★★ 34.61%
	MY 2024	★ 28.59%	★★★ 35.78%	★★★★ 40.84%	★★ 33.19%	★★ 31.22%	★★★ 34.24%
<b><i>Initiation and Engagement of Substance Use Disorder Treatment</i></b>							
<i>Engagement of SUD Treatment—Total—13–17 Years</i>	MY 2022	★★ 9.63%	★★★ 13.84%	★★ 10.33%	★★★ 13.06%	★ 6.55%	★★★ 11.58%
	MY 2023	★ 5.38%	★★★ 15.15%	★ 4.90%	★ 7.61%	★ 7.71%	★★ 8.67%
	MY 2024	★ 5.74%	★★★ 13.82%	★ 6.69%	★★ 11.06%	★★ 9.15%	★★ 9.46%
<i>Initiation of SUD Treatment—Total—13–17 Years</i>	MY 2022	★★★ 47.81%	★★★★ 50.00%	★★★ 46.20%	★★★★ 49.22%	★★★★ 49.51%	★★★ 48.77%
	MY 2023	★★ 38.66%	★★★★ 50.26%	★★ 40.47%	★★★ 46.59%	★★★ 43.55%	★★★ 44.86%
	MY 2024	★ 24.16%	★★★ 43.20%	★★ 36.63%	★★★ 42.49%	★★★ 46.88%	★★ 37.77%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics (ECDS)^</b>							
<i>Blood Glucose Testing—Total</i>	MY 2022	★★★★ 62.35%	★★★★ 64.90%	★★★ 58.28%	★★★ 59.32%	★★★ 58.15%	★★★★ 60.79%
	MY 2023	★★★★ 61.28%	★★★ 60.39%	★★★ 59.42%	NR	★★★ 58.64%	★★★ 60.07%
	MY 2024	★★★ 61.04%	★★★ 59.69%	★★★ 61.14%	★★★ 58.55%	★★★ 59.29%	★★★ 59.58%
<i>Cholesterol Testing—Total</i>	MY 2022	★★ 32.46%	★★★ 39.78%	★★ 34.70%	★★ 32.29%	★★ 31.01%	★★ 34.04%
	MY 2023	★ 29.44%	★★ 36.13%	★★★ 38.82%	NR	★★ 32.44%	★★ 33.96%
	MY 2024	★ 30.18%	★★ 36.96%	★★ 35.68%	★★ 32.76%	★★ 33.73%	★★ 33.72%
<i>Blood Glucose and Cholesterol Testing—Total</i>	MY 2022	★★ 31.76%	★★★ 38.75%	★★ 33.51%	★★ 31.51%	★★ 30.34%	★★ 33.19%
	MY 2023	★ 28.72%	★★ 35.22%	★★★ 37.06%	NR	★★ 31.49%	★★ 32.96%
	MY 2024	★ 29.56%	★★ 36.23%	★★ 34.35%	★★ 32.04%	★★ 32.84%	★★ 32.94%
<b>Oral Evaluation, Dental Services</b>							
<i>Total</i>	MY 2023	NC 40.70%	NC 31.52%	NC 53.70%	NC 48.61%	NC 41.33%	NC 43.04%
	MY 2024	★★ 44.07%	★★★★ 53.35%	★★★★ 55.50%	★★★ 50.80%	★★ 43.74%	★★★ 50.57%
<b>Pharmacotherapy for Opioid Use Disorder</b>							
<i>16–64 Years</i>	MY 2022	★★ 27.26%	★★ 24.92%	★★ 22.11%	★★ 26.07%	★ 7.68%	★★ 21.75%
	MY 2023	★★ 22.75%	★★★ 26.74%	★★ 18.71%	★★ 21.46%	★ 7.35%	★★ 19.11%
	MY 2024	★★ 25.90%	★★ 22.22%	★★ 23.45%	★★ 22.31%	★★ 26.42%	★★ 23.68%
<i>65+ Years</i>	MY 2022	★★ 35.85%	★ 26.79%	★★★ 36.99%	★ 18.06%	★ 1.82%	★ 27.38%
	MY 2023	★★ 25.71%	★★★ 31.82%	★★ 28.40%	★★ 20.93%	★ 2.27%	★★ 22.67%
	MY 2024	★ 15.38%	★★★ 35.48%	★★ 25.60%	★★★ 41.46%	NA	★★ 28.62%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<i>Total</i>	MY 2022	★★ 27.46%	★★ 24.96%	★★ 22.91%	★★ 25.91%	★ 7.56%	★★ 21.91%
	MY 2023	★★ 22.81%	★★★ 26.83%	★★ 19.01%	★★ 21.45%	★ 7.27%	★★ 19.17%
	MY 2024	★★ 25.67%	★★ 22.60%	★★ 23.57%	★★ 22.62%	★★ 26.39%	★★ 23.82%
<b><i>Prenatal and Postpartum Care</i></b>							
<i>Timeliness of Prenatal Care</i>	MY 2022	★★ 81.51%	★★★★ 89.78%	★★★ 84.23%	★★★★ 89.29%	★★★★ 89.78%	★★★ 87.54%
	MY 2023	★★★ 85.64%	★★★★ 89.05%	★★★ 86.89%	★★ 83.21%	★★★★ 89.78%	★★★ 86.51%
	MY 2024	★★ 84.43%	★★★★★ 91.97%	★★★ 88.08%	★★★★ 90.51%	★★★★ 91.00%	★★★★★ 89.79%
<i>Postpartum Care</i>	MY 2022	★★ 77.37%	★★★ 79.08%	★★ 76.70%	★★★ 81.51%	★★ 77.86%	★★★ 79.09%
	MY 2023	★★★ 81.02%	★★★★ 85.40%	★★★ 81.64%	★★★★ 86.37%	★★★ 82.73%	★★★★★ 84.23%
	MY 2024	★★★ 83.45%	★★★★★ 85.40%	★★★ 83.85%	★★★★ 85.64%	★★★ 82.73%	★★★ 84.65%
<b><i>Statin Therapy for Patients With Diabetes</i></b>							
<i>Received Statin Therapy</i>	MY 2022	★★★ 66.88%	★★★★★ 70.06%	★★★★★ 70.34%	★★★ 67.14%	★★★ 66.77%	★★★★★ 68.42%
	MY 2023	★★★ 66.79%	★★★★★ 70.57%	★★★★★ 70.04%	★★★ 67.05%	★★★ 66.45%	★★★★★ 68.43%
	MY 2024	★★ 66.74%	★★★ 70.17%	★★★★★ 71.12%	★★★ 67.99%	★★★ 68.00%	★★★ 68.99%
<i>Statin Adherence 80%</i>	MY 2022	★★★ 70.14%	★★★ 66.77%	★★★ 71.56%	★★★ 67.45%	★★★★★ 87.52%	★★★ 70.38%
	MY 2023	★★★ 71.91%	★★ 67.56%	★★★ 72.93%	★★★ 69.65%	★★ 65.95%	★★★ 69.69%
	MY 2024	★★★★★ 76.26%	★★ 64.57%	★★★ 69.02%	★★ 68.01%	★★ 67.03%	★★ 68.38%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>							
<i>BMI percentile—Total</i>	MY 2022	★ 64.72%	★★ 74.21%	★★★★ 85.14%	★ 66.67%	★★ 78.10%	★★ 72.16%
	MY 2023	★ 73.72%	★★ 75.18%	★★★★ 87.85%	★ 72.02%	★★ 80.78%	★★ 76.37%
	MY 2024	★★ 83.21%	★★ 80.05%	★★★★ 91.60%	★★ 80.05%	★ 64.48%	★★ 80.28%
<i>Counseling for Nutrition—Total</i>	MY 2022	★★ 65.21%	★★ 65.94%	★★★★ 81.08%	★★ 63.02%	★ 61.31%	★★ 66.40%
	MY 2023	★★ 65.45%	★★ 65.45%	★★★★ 83.33%	★★ 67.15%	★★ 65.94%	★★ 68.72%
	MY 2024	★★ 72.75%	★★ 71.29%	★★★★ 85.20%	★★ 70.80%	★ 63.50%	★★ 72.40%
<i>Counseling for Physical Activity—Total</i>	MY 2022	★★ 61.07%	★★ 63.50%	★★★★ 78.72%	★ 57.91%	★★ 60.58%	★★ 62.93%
	MY 2023	★★ 63.99%	★★ 63.02%	★★★★★ 82.29%	★★ 65.69%	★★ 64.72%	★★ 67.09%
	MY 2024	★★★ 74.94%	★★ 67.64%	★★★★ 82.80%	★★ 68.37%	★★ 62.29%	★★★ 70.32%
<b>Well-Child Visits in the First 30 Months of Life</b>							
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	MY 2022	★★★ 58.90%	★★★★ 66.22%	★★ 54.96%	★★★ 58.64%	★★★ 61.64%	★★★ 60.47%
	MY 2023	★★★ 61.59%	★★★ 64.12%	★★★ 63.40%	★★★★ 66.60%	★★★ 63.94%	★★★ 64.41%
	MY 2024	★★★ 66.81%	★★★ 66.02%	★★★★ 67.86%	★★★★ 71.17%	★★★ 66.58%	★★★★ 68.05%
<i>Well-Child Visits for Age 15 Months—30 Months—Two or More Well-Child Visits</i>	MY 2022	★ 59.59%	★★★ 67.87%	★ 60.38%	★★ 64.07%	★ 61.37%	★★ 63.59%
	MY 2023	★ 63.49%	★★★ 69.51%	★★ 68.11%	★★ 68.79%	★★ 65.57%	★★ 67.81%
	MY 2024	★ 67.94%	★★ 71.78%	★★ 70.88%	★★★ 72.37%	★ 68.17%	★★ 70.87%

\*Measure was reported using the ECDS method, however was compared to non ECDS benchmark due to the ECDS benchmark unavailable in MY2023.

^ Measure was reported using the ECDS method.

NC: No comparison. Historical performance results not available.

NA-The organization followed the specifications, but the denominator was too small (e.g., less than 30) to report a valid rate.

NR-Not reported. The organization chose not to report the measure.

Table 87 presents the Breast Cancer Screening (BCS-E) and Colorectal Cancer Screening (COL-E) measures, which were validated under the HSAG MY 2024 PMV scope of activities.

**Table 87-HealthChoice HEDIS Measure Results for MY 2024 PMV Audited Rates**

*Measure	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
<i>Breast Cancer Screening—Total</i>	★ 47.99%	★★ 53.93%	★★★ 57.10%	★★★ 52.28%	★ 48.97%	★★ 52.73%
<i>Colorectal Cancer Screening—Total</i>	★★ 39.71%	★★★ 42.96%	★ 31.79%	★★★ 38.76%	★ 34.65%	★★ 38.26%

\*MY 2024, performance measure results audited through MY 2024 PMV activities compared to HEDIS MY 2024 National Benchmarks and Statewide Average

## YouthCare Results

Table 88 presents the HEDIS MY 2024 rates for YouthCare.

**Table 88—YouthCare Performance Measure Results for MY 2024**

Measure	YouthCare
<i>Emergency Department Visits that Result in an Inpatient Admission for Children and Adolescents—Total</i>	21.42%
<i>Follow-Up After Mobile Crisis Response Services—Not Hospitalized and Linked to Community Services—Total</i>	68.82%
<i>Follow-Up After Mobile Crisis Response Services —Hospitalized and Linked to Community Services—Total</i>	11.02%
<i>Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Inpatient BH Utilization—Total</i>	4.47
<i>Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Average Length of Stay—Total</i>	21.40
<i>Repeat Behavioral Health Hospitalizations for Children and Adolescents—Percent of Members with Repeat BH Hospitalization—Total</i>	32.05%
<i>Repeat Behavioral Health Hospitalizations for Children and Adolescents—Average Number of Repeat BH Hospitalizations Per Member—Total</i>	0.54

## MMAI

Table 89 presents MY 2024 MMAI rates for Humana.

**Table 89—MMAI HEDIS Performance Measure Results for MY 2024**

Measure	Humana
<b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b>	
<i>20–44 Years</i>	79.90%
<i>45–64 Years</i>	88.93%
<i>65+ Years</i>	88.44%
<i>Total</i>	87.61%
<b><i>Initiation and Engagement of Substance Use Disorder Treatment</i></b>	
<i>Initiation of SUD Treatment—Total—18–64 Years</i>	51.24%
<i>Initiation of SUD Treatment—Total—65+ Years</i>	51.56%
<i>Initiation of SUD Treatment—Total—Total</i>	51.40%
<i>Engagement of SUD Treatment—Total—18–64 Years</i>	5.28%
<i>Engagement of SUD Treatment—Total—65+ Years</i>	4.06%
<i>Engagement of SUD Treatment—Total—Total</i>	4.67%

Table 90 presents MY 2024 rates for the IL 3.6 measure for each MMP.

**Table 90—MMAI IL 3.6 Performance Measure Results for MY 2024**

Health Plan	Percentage of Members Who Were Classified as Being in LTC as of the First Day of the Reporting Period.	Percentage of Members Who Were Classified as Being in LTC as of the Last Day of the Reporting Period.	Percentage of Members Who Were Not Classified as Being in LTC as of the First Day of the Reporting Period.	Percentage of Members Who Were Not Classified as Being in LTC as of the Last Day of the Reporting Period.
Aetna	7.20%	8.60%	92.80%	91.40%
BCBSIL	4.40%	5.00%	95.60%	95.00%
Humana	6.00%	6.10%	94.00%	93.90%
Meridian	8.10%	8.70%	91.90%	91.30%
Molina	8.10%	8.90%	91.90%	91.10%

## Appendix D. Network Adequacy Validation Performance Results

Table 91 through Table 94 display the network adequacy standards for the Medicaid and MMAI plans for validation.

**Table 91—Time and Distance Standards for Medicaid Enrollees**

Network Category Description	Required Within Standard	Urban Time and Distance Standard	Rural Time and Distance Standard
Primary Care Practitioner	2 Practitioners	90% of enrollees within 30 miles or 30 minutes	—
Primary Care Practitioner	1 Practitioner	—	90% of enrollees within 60 miles or 60 minutes
Behavioral Health Service Provider	2 Practitioners	90% of enrollees within 30 miles or 30 minutes	—
Behavioral Health Service Provider	1 Practitioner	—	90% of enrollees within 60 miles or 60 minutes
OB/GYN Provider	2 Practitioners	90% of enrollees within 30 miles or 30 minutes	—
OB/GYN Provider	1 Practitioner	—	90% of enrollees within 60 miles or 60 minutes
Pediatric Dentist	1 Practitioner	90% of enrollees within 30 miles or 30 minutes	90% of enrollees within 60 miles or 60 minutes
Allergy and Immunology—Adult	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Allergy and Immunology—Pediatric	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Endocrinology—Adult	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes

Network Category Description	Required Within Standard	Urban Time and Distance Standard	Rural Time and Distance Standard
Endocrinology—Pediatric	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Neurosurgery—Adult	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Neurosurgery—Pediatric	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Oral Surgery—Adult	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Oral Surgery—Pediatric	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Pulmonology—Adult	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Pulmonology—Pediatric	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Audiology—Adult	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Audiology—Pediatric	1 Practitioner	90% of enrollees within 60 miles or 60 minutes	90% of enrollees within 90 miles or 90 minutes
Hospitals	1 Hospital	90% of enrollees within 30 miles or 30 minutes	90% of enrollees within 60 miles or 60 minutes
Pharmacies	1 Pharmacy	100% of enrollees within 15 miles or 15 minutes	100% of enrollees within 60 miles or 60 minutes

**Table 92—Time and Distance Standards for MMAI Enrollees**

Network Category Description	Required Within Standard	Time and Distance Standard
Nursing Facilities	2 Nursing Facilities	Percentage of enrollees within 15 miles or 30 minutes from enrollee’s ZIP Code of residence within each county of service area

**Table 93—Maximum Panel Size for Medicaid and MMAI Enrollees**

Provider Category and Population	Panel Size
PCPs—children and families, Affordable Care Act (ACA) adults	Maximum panel size of PCPs (medical doctor [MD], doctor of osteopathic medicine [DO]) for families, children, and adult ACA enrollees shall be 1,800 enrollees—all regions
PCP extenders—children and families, ACA adults	Maximum panel size of PCPs (resident physician, nurse practitioner [NP], physician assistant [PA], and advanced practice nurse [APN]) for families, children, and ACA adult enrollees—may add 900 enrollees per each practitioner—all regions
PCPs—seniors and people with disabilities	Maximum panel size of PCPs (MD, DO) for seniors and people with disabilities shall be 600 enrollees—all regions
PCP extenders—seniors and people with disabilities	Maximum panel size of PCPs (resident physician, NP, PA, and APN) for seniors and people with disabilities—may add 300 enrollees per each practitioner—all regions

**Table 94—Maximum Wait Times for Medicaid and MMAI Enrollees**

Medical Need	Maximum Wait Time
PCP and behavioral health (BH) services preventive care	Percentage of enrollees requiring primary care and behavioral health services who receive a preventive care appointment within five (5) weeks from request
Infant routine preventive care (Medicaid only)	Percentage of infants under age six (6) months who receive a routine preventive care appointment within two (2) weeks from request
Urgent care where medically necessary	Percentage of enrollees with more serious problems not deemed emergency medical conditions who are triaged, and, if necessary or appropriate, immediately referred for urgent medically necessary care or provided with an appointment within one (1) business day after request
Nonserious but requiring medical attention	Percentage of enrollees with problems or complaints that are not deemed serious, but require medical attention who receive an appointment within seven (7) business days after request

Medical Need	Maximum Wait Time
Nonserious	Percentage of enrollees with problems or complaints that are not deemed serious, who receive an appointment within three (3) weeks after request
Prenatal visits 1st trimester	Percentage of enrollees in the first trimester of pregnancy without expressed problems who receive an appointment for an initial prenatal visit within two (2) weeks after request
Prenatal visits 2nd trimester	Percentage of enrollees in the second trimester of pregnancy without expressed problems who receive an appointment for an initial prenatal visit within one (1) week after request
Prenatal visits 3rd trimester	Percentage of enrollees in the third trimester of pregnancy without expressed problems who receive an appointment for an initial prenatal visit within three (3) days after request
Hours of operation (MMAI only)	Percentage of providers that offer hours of operation for MMAI enrollees that are no less than those offered to individuals who are not enrollees
Network capacity (MMAI only)	Plan contracts with 80 percent of HCBS providers that rendered services in the prior year, including adult day care, homemaker, day habilitation, supported employment, home delivered meals, home health aides, nursing services, occupational therapy, speech therapy, and physical therapy

Appendix D presents tables detailing the aggregated health plans’ compliance with time and distance standards by region in 2025.

## Validation Results

Table 95 through Table 101 display, the percentage of counties meeting time and distance standard, by region, as calculated by HSAG and each health plan.

**Table 95—Aetna Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	95.8	95.8	91.4	91.4	100	100	100	100	87.5	87.5
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100
Audiology, Pediatric	100	100	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	100 <sup>^</sup>	91.4 <sup>^</sup>	100	100	100	100	100	100
Oral Surgery, Pediatric	100	100	100 <sup>^</sup>	91.4 <sup>^</sup>	100	100	100	100	100	100
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100
Nursing Facilities	100	100	100	100	97.1	97.1	100	100	100	100

The percentages were calculated using a denominator (n) of the total number of counties in each region. Red shaded cells with a caret (^) denotes instances where HSAG’s results differ from those reported by Aetna.

**Table 96—BCBSIL Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	95.8	95.8	88.6	88.6	100	100	100	100	87.5	87.5
Allergy and Immunology, Adult	100 <sup>^</sup>	95.8 <sup>^</sup>	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100 <sup>^</sup>	95.8 <sup>^</sup>	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100
Audiology, Pediatric	100	100	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	97.1 <sup>^</sup>	91.4 <sup>^</sup>	58.8 <sup>^</sup>	82.4 <sup>^</sup>	100	100	100	100
Oral Surgery, Pediatric	100	100	97.1 <sup>^</sup>	91.4 <sup>^</sup>	58.8 <sup>^</sup>	82.4 <sup>^</sup>	100	100	100	100
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100

The percentages were calculated using a denominator (n) of the total number of counties in each region.  
 Red shaded cells with a caret (^) denotes instances where HSAG's results differ from those reported by BCBSIL.

**Table 97—CountyCare Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 4 (n = 1)	
	HSAG (%)	MCO (%)
PCPs, Adult	100	100
PCPs, Pediatric	100	100
Behavioral Health Providers, Adult	100	100
Behavioral Health Providers, Pediatric	100	100
OB/GYN Providers	100	100
Dentists, Pediatric	100	100
Hospitals	100	100
Pharmacies	100	100
Allergy and Immunology, Adult	100	100
Allergy and Immunology, Pediatric	100	100
Audiology, Adult	100	100
Audiology, Pediatric	100	100
Endocrinology, Adult	100	100
Endocrinology, Pediatric	100	100
Neurosurgery, Adult	100	100
Neurosurgery, Pediatric	100	100
Oral Surgery, Adult	100	100
Oral Surgery, Pediatric	100	100
Pulmonology, Adult	100	100
Pulmonology, Pediatric	100	100

The percentages were calculated using a denominator (n) of the total number of counties in each region.

**Table 98—Humana Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
Nursing Facilities	100 <sup>^</sup>	0.0 <sup>^</sup>	94.3 <sup>^</sup>	0.0 <sup>^</sup>	85.3 <sup>^</sup>	0.0 <sup>^</sup>	100	100	100 <sup>^</sup>	37.5 <sup>^</sup>

The percentages were calculated using a denominator (n) of the total number of counties in each region. Red shaded cells with a caret (^) denotes instances where HSAG’s results differ from those reported by Humana.

**Table 99—Meridian Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	95.8 <sup>^</sup>	91.7 <sup>^</sup>	88.6 <sup>^</sup>	85.7 <sup>^</sup>	100	100	100	100	87.5	87.5
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
Audiology, Pediatric	100	100	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	100	100	41.2^	76.5^	100	100	100	100
Oral Surgery, Pediatric	100	100	100	100	41.2^	76.5^	100	100	100	100
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100
Nursing Facilities	100	100	100	100	97.1^	100^	100	100	100	100

The percentages were calculated using a denominator (n) of the total number of counties in each region.  
 Red shaded cells with a caret (^) denotes instances where HSAG’s results differ from those reported by Meridian.

**Table 100—Molina Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100

Provider Category	Region 1 (n = 24)		Region 2 (n = 35)		Region 3 (n = 34)		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	95.8^	100^	91.4^	100^	100	100	100	100	87.5^	100^
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100^	83.3^	100^	97.1^	100	100	100	100	100	100
Audiology, Pediatric	100^	83.3^	100^	97.1^	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	79.2^	100^	77.1^	97.1^	41.2^	44.1^	100	100	100	100
Oral Surgery, Pediatric	79.2^	100^	77.1^	100^	41.2^	100^	100	100	100	100
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100
Nursing Facilities	95.8	95.8	97.1^	100^	91.2^	100^	100	100	100^	87.5^

The percentages were calculated using a denominator (n) of the total number of counties in each region. Red shaded cells with a caret (^) denotes instances where HSAG’s results differ from those reported by Molina.

**Table 101—YouthCare Percentage of Counties Meeting the Standard by Region**

Provider Category	Region 1 (n = 24)*		Region 2 (n = 35)*		Region 3 (n = 34)*		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100 <sup>^</sup>	97.1 <sup>^</sup>	100	100	100	100	100	100
Pharmacies	95.8	95.8	91.4	91.4	100	100	100	100	87.5	87.5
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100
Audiology, Pediatric	100 <sup>^</sup>	95.8 <sup>^</sup>	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	93.9	93.9	41.9 <sup>^</sup>	45.2 <sup>^</sup>	100	100	100	100
Oral Surgery, Pediatric	100	100	94.3	94.3	41.2	41.2	100	100	100	100

Provider Category	Region 1 (n = 24)*		Region 2 (n = 35)*		Region 3 (n = 34)*		Region 4 (n = 1)		Region 5 (n = 8)	
	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)	HSAG (%)	MCO (%)
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100

Red shaded cells with a caret (^) denotes instances where HSAG’s results differ from those reported by YouthCare.

The percentages were calculated using a denominator (n) of the total number of counties in each region.

\*Since YouthCare did not have enrollees in all counties, HSAG did not include counties without members in its calculation of the percentage of counties meeting the standard. In Region 1, HSAG identified 23 out of 24 counties with adult members. In Region 2, HSAG identified 33 out of 35 counties with adult members. In Region 3, HSAG identified 31 out of 34 counties with adult members. In some instances, the use of a different denominator contributed to a discrepancy between the results calculated by HSAG and YouthCare.

## Statewide Time and Distance Results

Table 102 aggregates data across the state, and displays, for each health plan, the percentage of all HCI enrollees who had a provider within the applicable standards as well as the percentage of the counties across the state where each health plan’s provider network met the standard.

**Table 102—Percentage of HCI Enrollees With Access Required by Time and Distance Standards and Percentage of Counties Meeting Standards by Health Plan**

Provider Categories	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)
PCPs, Adult	100	100	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100	100	100



	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
Provider Categories	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100	100	100
Pharmacies	>99.9^	95.1^	99.9^	94.1^	100	100	>99.9^	94.1^	99.8^	95.1^	99.9^	95.1^
<b>Physician Specialists</b>												
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	>99.9	100	>99.9	100	100	100	100	100	>99.9	100	100	100
Audiology, Pediatric	>99.9	100	>99.9	100	100	100	100	100	>99.9	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100	100	100

Provider Categories	Aetna		BCBSIL		CountyCare		Meridian		Molina		YouthCare	
	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	96.8	85.3^	100	100	96.1	80.4^	85.7^	67.6^	94.4	79.2^
Oral Surgery, Pediatric	100	100	97.6	85.3^	100	100	96.9	80.4^	85.5^	67.6^	92.3	78.4^
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100	100	100

Red shaded cells with a caret (^) denotes instances where the health plan did not meet minimum geographic access standards for a specific provider category.

Table 103 displays the percentage of MMAI enrollees who had a provider within the applicable standards as well as the percentage of the counties in which each health plan’s provider network met the standard.

**Table 103—Percentage of MMAI Enrollees With Access Required by Time and Distance Standards and Percentage of Counties Meeting Standards by Health Plan**

Provider Categories	Aetna		Humana		Meridian		Molina	
	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)	Enrollees (%)	Counties (%)
Nursing Facilities	>99.9^	99.0^	99.6^	93.1^	>99.9^	99.0^	99.8^	95.1^

Red shaded cells with a caret (^) denotes instances where the health plan did not meet minimum geographic access standards for a specific provider category.

This section presents the percentages of enrollees with access within the time and distance standard by the assessed stratifications for each region and health plan. Each of the tables presents the percentage of enrollees residing within the time and distance standards by stratifications identified in the titles.

## Urbanicity

**Table 104—Percentage of Enrollees Residing Within Time and Distance-Based Access Standards by Urbanicity in Region 1**

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	99.9^	100	99.7^	100	99.9^	100	>99.9^	100	>99.9^	100
<b><i>Physician Specialists</i></b>										
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	99.7	100	99.8	100	100	100	99.9	100	100	100
Audiology, Pediatric	99.7	100	99.8	100	100	100	99.9	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Oral Surgery, Adult	100	100	100	100	100	100	47.5 <sup>^</sup>	95.7	100	100
Oral Surgery, Pediatric	100	100	100	100	100	100	48.0 <sup>^</sup>	95.6	100	100
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100

Note: This table presents the percentage of plan enrollees in urban and rural areas in Region 1 with access to providers within provider category-specific time and distance standards. The percentage of enrollees with required network access by urbanicity is calculated based on 24 counties located in Region 1, with 5 classified as urban and 19 classified as rural.

\* Red shaded cells with a caret (^) denotes instances where less than 90 percent of a plan’s enrollees have access to providers (less than 100 percent for Pharmacy) within the time and distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

**Table 105—Percentage of Enrollees Residing Within Time and Distance-Based Access Standards by Urbanicity in Region 2**

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	99.6 <sup>^</sup>	100	99.4 <sup>^</sup>	100	99.4 <sup>^</sup>	100	98.9 <sup>^</sup>	100	99.0 <sup>^</sup>	100

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
<b>Physician Specialists</b>										
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100
Audiology, Pediatric	100	100	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	62.6 <sup>^</sup>	100	98.5	100	85.4 <sup>^</sup>	82.7 <sup>^</sup>	99.3	87.7 <sup>^</sup>
Oral Surgery, Pediatric	100	100	58.0 <sup>^</sup>	100	98.3	100	90.2	84.1 <sup>^</sup>	98.1	87.5 <sup>^</sup>
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100

Note: This table presents the percentage of plan enrollees in urban and rural areas in Region 2 with access to providers within provider category-specific time and distance standards. The percentage of enrollees with required network access by urbanicity is calculated based on 35 counties located in Region 2, with 5 classified as urban and 30 classified as rural.

\* Red shaded cells with a caret (^) denotes instances where less than 90 percent of a plan’s enrollees have access to providers (less than 100 percent for Pharmacy) within the time and distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

**Table 106—Percentage of Enrollees Residing Within Time and Distance-Based Access Standards by Urbanicity in Region 3**

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	100	100	100	100	100	100	100	100	100	100
<b>Physician Specialists</b>										
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100
Audiology, Pediatric	100	100	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	100	57.0 <sup>^</sup>	100	46.7 <sup>^</sup>	100	53.5 <sup>^</sup>	100	50.0 <sup>^</sup>
Oral Surgery, Pediatric	100	100	100	59.7 <sup>^</sup>	100	50.3 <sup>^</sup>	100	53.9 <sup>^</sup>	100	54.8 <sup>^</sup>

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100

Note: This table presents the percentage of plan enrollees in urban and rural areas in Region 3 with access to providers within provider category-specific time and distance standards. The percentage of enrollees with required network access by urbanicity is calculated based on 34 counties located in Region 3, with 2 classified as urban and 32 classified as rural.

\* Red shaded cells with a caret (^) denotes instances where less than 90 percent of a plan’s enrollees have access to providers (less than 100 percent for Pharmacy) within the time and distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

**Table 107—Percentage of Enrollees Residing Within Time and Distance-Based Access Standards by Urbanicity in Region 4**

Provider Categories	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
	Urban	Urban	Urban	Urban	Urban	Urban
PCPs, Adult	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100
Dentists, Pediatric	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100
Pharmacies	100	100	100	100	100	100
<b>Physician Specialists</b>						
Allergy and Immunology, Adult	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100

	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Provider Categories	Urban	Urban	Urban	Urban	Urban	Urban
Audiology, Pediatric	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100
Oral Surgery, Adult	100	100	100	100	100	100
Oral Surgery, Pediatric	100	100	100	100	100	100
Pulmonology, Adult	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100

Note: This table presents the percentage of plan enrollees in urban and rural areas in Region 4 with access to providers within provider category-specific time and distance standards. The percentage of enrollees with required network access by urbanicity is calculated based on 1 counties located in Region 4, with 1 classified as urban and 0 classified as rural.

\* Red shaded cells with a caret (^) denotes instances where less than 90 percent of a plan’s enrollees have access to providers (less than 100 percent for Pharmacy) within the time and distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

**Table 108—Percentage of Enrollees Residing Within Time and Distance-Based Access Standards by Urbanicity in Region 5**

	Aetna		BCBSIL		Meridian		Molina		YouthCare	
Provider Categories	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
PCPs, Adult	100	100	100	100	100	100	100	100	100	100
PCPs, Pediatric	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Adult	100	100	100	100	100	100	100	100	100	100
Behavioral Health Providers, Pediatric	100	100	100	100	100	100	100	100	100	100
OB/GYN Providers	100	100	100	100	100	100	100	100	100	100

Provider Categories	Aetna		BCBSIL		Meridian		Molina		YouthCare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Dentists, Pediatric	100	100	100	100	100	100	100	100	100	100
Hospitals	100	100	100	100	100	100	100	100	100	100
Pharmacies	>99.9 <sup>^</sup>	100	99.9 <sup>^</sup>	100	>99.9 <sup>^</sup>	100	>99.9 <sup>^</sup>	100	99.9 <sup>^</sup>	100
<b>Physician Specialists</b>										
Allergy and Immunology, Adult	100	100	100	100	100	100	100	100	100	100
Allergy and Immunology, Pediatric	100	100	100	100	100	100	100	100	100	100
Audiology, Adult	100	100	100	100	100	100	100	100	100	100
Audiology, Pediatric	100	100	100	100	100	100	100	100	100	100
Endocrinology, Adult	100	100	100	100	100	100	100	100	100	100
Endocrinology, Pediatric	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Adult	100	100	100	100	100	100	100	100	100	100
Neurosurgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Adult	100	100	100	100	100	100	100	100	100	100
Oral Surgery, Pediatric	100	100	100	100	100	100	100	100	100	100
Pulmonology, Adult	100	100	100	100	100	100	100	100	100	100
Pulmonology, Pediatric	100	100	100	100	100	100	100	100	100	100

Note: This table presents the percentage of plan enrollees in urban and rural areas in Region 5 with access to providers within provider category-specific time and distance standards. The percentage of enrollees with required network access by urbanicity is calculated based on 8 counties located in Region 5, with 6 classified as urban and 2 classified as rural.

\* Red shaded cells with a caret (^) denotes instances where less than 90 percent of a plan’s enrollees have access to providers (less than 100 percent for Pharmacy) within the time and distance standards. Urban and rural areas are defined at the county level by the Medicaid Model Contract 2018-24-001.

## Appendix E. Activity Timelines

### Mandatory Activities

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
<b>Validation of PIPs</b>				
<i>Improving Timeliness of Prenatal Care</i>	Annual	CY 2024	Health plan submission of PIP Submission Form: August 2025 Initial validation findings and health plan responses: September 2025	Final validation findings provided to HFS and health plans: October 2025
<i>Improving Transportation Services</i>	Annual	CY 2024	Health plan submission of PIP Submission Form: August 2025 Initial validation findings and health plan responses: September 2025	Final validation findings provided to HFS and health plans: October 2025
<b>PMV</b>				
HEDIS Compliance, PMV	Annual	MY 2024	February 2025	Final audit reports delivered July 2025
MMAI IL 3.6	Annual	MY 2024	September 2025	Final report delivered December 2025
<b>Compliance Monitoring</b>				
Compliance Monitoring Review	Once every three years; conducted over two-year period with the three-year cycle	CY 2025	September 2025	February 2026

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Readiness Review	As directed for new programs or populations	CY 2025	July 2025	January 2026
<b>NAV</b>				
NAV	Annual	CY 2025	ISCA submission by health plans: June 2025 Virtual reviews and system demonstrations: July–August 2025	January 2026

### Optional/Additional Activities

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
<b>Optional Activities</b>				
Beneficiary Experience With Care (CAHPS)	Annual	2025 survey	Member letters mailed April 2025 Computer-assisted telephone interviewing for non-respondents completed June 2025	Final reports delivered December 2025
Encounter Data Validation (EDV)	Once every three years	Data span: July 2023–June 2024	May 2025	March 2026 (to be reported in a future technical report)
Quality Rating System	Annual	MY 2024	Data receipt: June 2025	Production of consumer report card: August 2025

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
<b>Additional Activities</b>				
Network Adequacy Monitoring	Quarterly	Provider network data submitted by the health plans: February 2025 May 2025 August 2025 November 2025	February 2025 May 2025 August 2025 November 2025	April 2025 July 2025 October 2025 December 2025
Access and Availability Survey	Annual	Provider network data submitted by the health plans in May, 2025	Survey: June–July 2025	Final report delivered December 2025
Time and Distance Study	Annual	Provider network data submitted by the health plans in May 2025 Enrollee data provided by HFS in May 2025	Analysis: August 2025 Validation: September 2025	Final report delivered: January 2026
Case Management Staffing and Training Reviews	Biannual	CY 2025 First review inclusive of data for staff with hire dates on or before April 1, 2025 Second review inclusive of data for staff with hire dates on or before November 1, 2025	First review Submission of health plan data: April 2025 Analysis: April–May 2025 Second review Submission of health plan data: November 2025 Analysis: November–December 2025	First review report delivery: June 2025 Second review report delivery: January 2026

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Critical Incident Monitoring Review	Quarterly	CY 2025 Health plan data submissions occur two months prior to each quarter.	Q1 reviews: January–March 2025 Q2 reviews: April–June 2025 Q3 reviews: August–September 2025 Q4 reviews: November–December 2025	Reports developed and submitted one month post-quarter end
CMS HCBS Waiver Performance Measure Record Review	Quarterly	CY 2025 The CY 2025 reviews assessed performance during a lookback period (retrospective review) of case management activities conducted and documented from June 1, 2024, through August 31, 2025.	Q1 reviews: January–March 2025 Q2 reviews: April–June 2025 Q3 reviews: July–September 2025 Q4 reviews: October–December 2025	Reports developed and submitted one month post-quarter end
QA/UR/PR Annual Report Review	Annual	SFY 2025	October 2025	January 2026
Care Gap Plan Review	Annual	CY 2025	Health plan submissions: May 2025 Review and analysis: June 2025	Reports delivered August 2025
MHP Review	Annual	CY 2024–CY 2025	September 2025	December 2025
UM Service Authorization Data Analysis	Annual	July-September 2025	November 2025	April 2026 (to be reported in a future technical report)

## Appendix F. EQR Technical Report Requirements

Table 109 lists the required and recommended elements for the EQR technical report, per 42 CFR §438.364 and recent CMS technical report feedback received by states. Table 109 also identifies the page number where the corresponding information that addresses each element is located in the EQR technical report, if applicable. In the table below, NA represents “not applicable” to indicate that this information will be included in subsequent reports and page numbers will be able to be determined.

**Table 109—EQR Technical Report Requirements**

Item #	Required Elements	Page Number
1.	The state submitted its EQR technical report by April 30th.	NA
2.	Include a clickable or hyperlinked table of contents for easy navigation throughout the report.	i
3.	All eligible Medicaid and CHIP plans are included in the report.	1–2, 6
4.	Describe the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, or PAHP, or PCCM entity.	3-4, Appendix A
5.	Validation of PIPs: A description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	12–20, Appendix A, Appendix B
6.	Validation of performance measures: A description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	21–24, Appendix A, Appendix C
7.	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information on a review, conducted within the previous three-year period, to determine each MCO’s, PIHP’s, PAHP’s or PCCM’s compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	25–28, Appendix A
8.	Network Adequacy Validation: A description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	28–33, Appendix A, Appendix D
9.	Include an assessment of each MCE’s strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries. Include recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, or PAHP.	64–143

Item #	Required Elements	Page Number
10.	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid or CHIP beneficiaries.	9–11
11.	Ensure methodologically appropriate, comparative information about all MCEs, consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e).	Throughout report
12.	Include an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	64–143
13.	Include the names of the MCOs exempt from external quality review by the State, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.	6
14.	EQR technical reports should share the EQRO's timeline for conducting EQR activities.	Appendix E
15.	The information included in the technical report must not disclose the identity or other protected health information of any patient. 42 CFR 438.364(d).	NA