

Managed Care Program Annual Report (MCPAR) for Illinois: HealthChoice Illinois (HCI)

Due date	Last edited	Edited by	Status
06/29/2026	06/29/2026	Amy Harris Roberts	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Indicator	Response
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool?	Yes, I plan on submitting it in MDCT
If “No”, please complete the following questions under each plan.	

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Illinois
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Amy Roberts
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	amy.roberts@illinois.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Amy Harris Roberts
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	amy.roberts@illinois.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	06/29/2026

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2025
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2025
A6	Program name Auto-populated from report dashboard.	HealthChoice Illinois (HCI)

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Aetna Better Health
	Blue Cross Community Health Plans
	CountyCare Health Plan
	MeridianHealth
	Molina HealthCare
	YouthCare

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Illinois Client Enrollment Broker (ICEB) - Maximus

Add In Lieu of Services and Settings (A.9)

This section must be completed if any in lieu of services or settings (ILOSs) *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** (See 42 CFR 438.3(e)(2) and 438.16).

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	3,292,791
BI.2	Statewide Medicaid risk-based managed care enrollment Enter the average number of individuals enrolled in risk-based Medicaid managed care per month during the reporting year (i.e., average member months). Include all MCOs and at-risk PIHPs and PAHPs only, and count each person only once, even if they are enrolled in multiple managed care programs or plans.	2,465,704

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	Data validation entity Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff Other state agency staff State actuaries EQRO Proprietary system(s) Other, specify – The Department has implemented Quarterly Encounter Utilization Monitoring (EUM) process to evaluate the MCPs for the completeness of the data for HealthChoice Illinois. The Department evaluates the plans for the rolling 4 quarters.
BIII.2	HIPAA compliance of proprietary system(s) for encounter data validation Were the system(s) utilized fully HIPAA compliant? Select one.	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	Payment risks between the state and plans Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	The Department's Office of the Inspector General (OIG) utilizes an interdisciplinary approach to MCP program integrity oversight activities. Each of its bureaus played an active role, having worked both independently and collaboratively, in OIG's oversight endeavors during FY2025. • BOI - Monitors and conducts investigations based on referrals submitted by the MCPs' SIU via the MCP fraud reporting portal. • BMI - Refers cases to MCPs based on FFS fraud, waste, and abuse trends and schemes identified during audits conducted by the bureau and its UPIC. • BFST - Spearheads data analysis of MCP paid claims and encounters, identifying outliers and anomalies in billing practices and innovating and improving OIG's managed care PI data analysis capabilities. • Fiscal Management Unit - Identifies providers who have received FFS overpayments for which OIG will require recovery from an MCP. • OCIG - As OIG's legal department, OCIG has been critical to the Office's managed care program integrity efforts by taking administrative action to suspend, sanction, and terminate bad actors from Medicaid including managed care. In 2025, the MCP SIUs worked on 483 audits and investigations, referred 474 cases to the OIG, and established over \$55,278,261 in overpayments. • New Provider Verification (NPV) – Reviews the provider applications for all high-risk provider types, certain moderate risk providers, and any applicant with a concern or issue flagged in their application or background.

BX.2	Contract standard for overpayments Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	Other, specify – The OIG has a hybrid system, allowing plans to retain overpayments identified and determined by them, and recoups overpayments identified and determined by the OIG. Overpayments are recouped from the plan's monthly capitated rate payment. The plans have the discretion to then recoup from the provider.
BX.3	Location of contract provision stating overpayment standard Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Sections 5.35.10, 5.35.11, and 5.35.12 of the Contract.
BX.4	Description of overpayment contract standard Briefly describe the overpayment standard selected in indicator B.X.2.	Section 5.35.10 of the Contract establishes the plans' requirement to have internal policies and procedures to identify and promptly notify the OIG of any overpayments made to a Subcontractor or Network Provider as the result of Fraud, Waste, or Abuse. The plans are required to request approval from OIG to recover any such overpayment prior to initiating recovery action. Section 5.35.12 of the Contract establishes the provisions by which the OIG identifies overpayments made by the plans to Network Enrolled Providers and OIG recovery of the same through an offset of future capitation payments.

BX.5

State overpayment reporting monitoring

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?

The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

The Department's OIG monitors the plans' established overpayments and requests for recoveries through its MCP Fraud Reporting Portal. The OIG also collects data on the plans' actual recoveries after they are approved to start collection activities.

BX.6

Changes in beneficiary circumstances

Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).

The Department sends the MCPs a daily HIPAA Compliant 834 file that contains any enrollments and disenrollments that happened within the Department's system on that day. This file contains all up-to-date information kept on each customer by the Department including status details such as address changes, new phone numbers, date of death information, estimated delivery dates and plan switch information. Monthly the Department sends the MCPs a reconciliation HIPAA Compliant 834 Audit file that contains every customer that will be enrolled in their plan for the next calendar month. The audit file includes all up-to-date information that has been captured by the Department on the customer, such as contact information, address, case updates, and the capitation payment that the Department is paying the MCP for each customer that month. The audit file ensures any updates that may have been missed through processing the daily 834 files has been provided to the MCPs and is updated in the MCPs system. This process ensures that both

systems are in sync on the first day of the following month. MCP's can contact the Department's eligibility and enrollment team if there are questions and also utilize tools that the Department has made available, such as enrollment error files that are exchanged between the Department's record and the MCPs record. The Department systematically closes recipients who become ineligible for MCP coverage weekly and on the last system day of the month. Results of the disenrollments are analyzed and reviewed by Department staff for accuracy and ensure any enrollment changes made are in compliance with Department Statutes, Contract requirements, and Program Policy.

BX.7a

**Changes in provider
circumstances: Monitoring
plans**

Yes

Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.

BX.7b

**Changes in provider
circumstances: Metrics**

No

Does the state use a metric or indicator to assess plan reporting performance? Select one.

BX.8a

**Federal database checks:
Excluded person or entities**

No

During the state's federal database checks, did the state find any person or entity excluded? Select one.
Consistent with the requirements at 42 CFR 455.436 and 438.602, the State

must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

BX.9a

Website posting of 5 percent or more ownership control

No

Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.

BX.10

Periodic audits

If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter “No such audits were conducted during the reporting year” as your response. “N/A” is not an acceptable response.

No such audits were conducted during the reporting year. The next scheduled Encounter and Financial Data Validation Audit is to occur in calendar year 2026.

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	HealthChoice Illinois (HCI)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2018
C11.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://hfs.illinois.gov/medicalproviders/cc/managedcarecontracts.html
C11.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Other, specify – 5 Managed Care Organizations (Aetna, Blue Cross, Meridian, Molina and YouthCare) and 1 Managed Care Community Network (CountyCare).

C11.4a	Special program benefits Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C11.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	2,427,868
C11.6	Changes to enrollment or benefits Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during	There were no major changes to the population or benefits during the reporting year.

the reporting year” as your response. “N/A” is not an acceptable response.

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
C1II.1	Submission Date of Most Recent MLR Report When is the last date the state submitted the MLR Summary Report in the Medicaid Data Collection Tool (MDCT) MLR Portal for this program?	01/02/2026
C1II.2	Most Recent MLR Reporting Period Please report the beginning date of that MLR reporting period.	01/01/2023
N/A	Please report the end date of that MLR reporting period.	12/31/2023
C1II.3	MLR Validation Completion Has the state completed the validation of plan MLR data for the current MCPAR reporting period by the submission date of this report for all plans? (See detailed reporting in Section D1.II by plan.)	No
C1II.3a	Anticipated Validation Date When does the state anticipate doing so?	12/2027

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	Uses of encounter data For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting
		Quality/performance measurement
		Monitoring and reporting
		Contract oversight
		Program integrity
		Policy making and decision support
C1III.2	Criteria/measures to evaluate MCP performance What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Use of correct file formats
		Overall data accuracy (as determined through data validation) Other, specify – The Department implemented a Quarterly EUM process to evaluate the MCPs for the completeness of data submissions for HCI. The State reviews and evaluates the MCPs based on data submissions for completeness on 4 rolling quarters. Health Choice Illinois MCPs are required to meet minimum 98% of overall completeness and 92% of the category level completeness to avoid monetary sanctions (financial penalties). In addition, other includes: Medical Record Procurement Rate, Second Date of Service Submission Rate, Medical Record Omission Rate, Encounter Data Omission Rate, Diagnosis Code Accuracy, Procedure Code Accuracy, Procedure Code Modifier Accuracy, and All-Element Accuracy Rate.

C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Contract Sections 1.1.73 and 5.27.3, and Attachment XI, Attachment XIII, and Attachment XXIII
C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Contract Section 7.16.6
C1III.5	Incentives for encounter data quality Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with N/A if the program does not use incentives to reward encounter data quality.	N/A
C1III.6	Barriers to collecting/validating encounter data Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no	The Department is not able to process all encounter data received by the health plans due to system issues with identifying provider license requirements. Due to this issue, some encounters were not processed and that portion of the system was suspended.

barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for “critical incidents” within the managed care program? Respond with “N/A” if the managed care program does not cover LTSS.	A Critical Incident is identified in the HCI Contract in Section 1.1.5 as any event that is indicated in Attachment XVII. Contract Section 5.23.2 and Attachment XVII outline specific critical incident definitions.
C1IV.2	State definition of “timely” resolution for standard appeals Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Timely resolution of appeals is defined in the HCI Contract Section 5.30.3.4. and says "If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. Contractor may extend this time frame for up to fourteen (14) days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate State Agency's hearing office that there is a need for additional information and the delay is in the Enrollees interest.
C1IV.3	State definition of “timely” resolution for expedited appeals Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the	Expedited resolution of appeals is defined in the HCI Contract Section 5.30.3.3 and says "If an Enrollee requests an expedited Appeal pursuant to 42 CFR §438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not

MCO, PIHP or PAHP receives the appeal.

discriminate or take punitive action against a Provider who either requests an expedited resolution of Appeal or supports an Enrollee's Appeal pursuant to 42 CFR §438.410(b).

C1IV.4

State definition of “timely” resolution for grievances

Provide the state’s definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

Timely resolution of grievances is defined in HCI Contract Section 5.30.1.5. and says "Contractor shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) days from receipt of a Grievance. Contractor may inform an Enrollee of the resolution orally or in writing.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://enrollhfs.illinois.gov/

C1IX.2**BSS auxiliary aids and services**

How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)?

CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.

The Illinois Client enrollment Broker (ICEB) provides an interactive website at Enroll HFS and a Call Center that can be reached toll-free phone at 1-877-912-8880 or with a TTY Number: 1-866-565-8576. The Call Center is staffed with both English and Spanish-speaking individuals. When a caller speaks a language other than English or Spanish, the ICEB offers and supplies interpretive services for any language at no charge to the caller. The ICEB in conjunction with the Department and with input from the Health Plans develops and maintains educational materials designed to provide Potential Enrollees and Enrollees with clear, concise, and accurate information about the Health Plans. Written materials are available in English and Spanish, and other prevalent languages determined by the agency. Written Materials are also available in alternative formats, such as large print, Braille, or audio CDs and in a manner that takes into consideration the special needs of those who, for example, are visually limited, or hearing-impaired. Materials are at or below a sixth-grade reading level for clarity and for those who have limited reading proficiency. The materials are reviewed by a health literacy group within the ICEB organization to ensure that the materials are easily understood. Key Oral Contacts are in a language the customer understands.

C1IX.3**BSS LTSS program data**

How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4). If the

Review and oversight of the LTSS program data is handled largely by the State Medicaid Agency. The ICEB largely becomes aware of LTSS system issues via customer inquiries. The ICEB maintains a Customer Call center and when the ICEB becomes aware of issue where a seemingly LTSS eligible customer is not able to

program does not offer LTSS, enter "N/A".

enroll in an LTSS plan or is enrolled and is not receiving assistance with a specific service. In either instance, the ICEB Customer Service Representative will intake the issue and submit it as an incident through the ICEB Internal Enrollment Portal as a task. Urgent requests are given a priority one and are sent to the state within 1 business day of receipt. The state regularly monitors the task queue in the internal portal throughout the day. The issues are then promptly researched and resolved by the state and outreach, if necessary is completed by the ICEB or the appropriate section within the state.

C1IX.4**State evaluation of BSS entity performance**

What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?

The Department applies a variety of methods to evaluate the quality, effectiveness, and efficiency of the ICEB's performance. The ICEB is required to submit the following reports to the Department either monthly, quarterly, or annually to demonstrate their quality of their performance. Monthly • Monthly Enrollment Summary Report • IP Address Report • Task Queue Report • Call Center Report • Enrollment Report • Enrollee Complaint and Grievance Report • Enrollee Assignment Report • Operator Availability Report • Monthly QA Call Monitoring Report • ICEB Staffing Report Quarterly • Vendor Compliance Matrix • Current Organizational Chart Annually • Annual Financial Statements • Annual Hiring Report

The Department has also established Call Center Standards that are designed to ensure a high level of customer service and assist in our evaluation of the quality, effectiveness, and efficiency of the performance of the ICEB. The performance standards are listed below and are evaluated monthly via analysis of monthly reports.

- Less than three percent (3%) of incoming calls receive a busy signal.
- All calls

are answered by the automated voice response system within 3 rings. • Average wait time after the initial automated voice pick-up until interaction with Call Center staff • is 3 minutes or less. • Average abandonment rate is no more than 7 percent. • Average time on hold after initial interaction with Call Center staff is 3 minutes or less. • Sufficient number of qualified staff are available on-site to communicate with callers who speak • English or Spanish. • Interpretive services are available via telephone 100 percent of the time when requested by • callers who speak languages other than English or Spanish. • TDD/TTY capabilities are available 100 percent of the time when requested. The Contract with the ICEB provides for the following Service Level performance Guarantees. • Pattern of Failure to Provide Services. • Charging Enrollees. • Enrollee Discrimination. • Misrepresentation. • Enrollment Materials. • Outreach Materials. • Education. • Data Systems. • Call Center. • Staffing. • Reporting. • Close Out and Turnover. A Department Bureau of Managed Care staff member randomly reviews several ICEB calls daily to ensure compliance with Department guidelines. In addition, Department staff and ICEB conduct monthly call calibration sessions with the purpose of reviewing the effects of policies, procedures, and scripting to enrich the client experience and ensure that customers are receiving unbiased, accurate education and are treated with dignity and respect. The Department and ICEB staff also conduct bi-weekly Operations meetings. At these meetings, topics such as HFS/ICEB Updates, New Projects, Current Projects, In Process Projects, Future Projects and On Hold Items are discussed and reviewed. And the ICEB prepares and presents A Year in Review Power Point

presentation which highlights their performance and accomplishments and details completed initiatives.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	Does this program include MCOs? If “Yes”, please complete the following questions.	Yes
C1XII.5	Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system? (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	Did the State or MCOs complete the most recent parity analysis(es)?	Other, specify – MCPs completed a Comparative Analysis, and the State contracted with an EQRO to perform a Parity Audit of the MCPs.
C1XII.7a	Have there been any events in the reporting period that necessitated an update to the parity analysis(es)? (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	When was the last parity analysis(es) for this program completed? States with ANY services provided to MCO enrollees by	12/30/2025

an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).

C1XII.9	When was the last parity analysis(es) for this program submitted to CMS?	12/01/2018
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States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).

C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
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C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website?	Yes
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The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO

enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.

C1XII.12b

Provide the URL link(s).

<https://hfs.illinois.gov/info/reports.html>

Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	Aetna Better Health 337,169
		Blue Cross Community Health Plans 709,846
		CountyCare Health Plan 403,930
		MeridianHealth 658,812
		Molina HealthCare 282,841
		YouthCare 35,270
D1I.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	Aetna Better Health 10.2%
		Blue Cross Community Health Plans 21.6%
		CountyCare Health Plan 12.3%
		MeridianHealth 20%
		Molina HealthCare 8.6%
		YouthCare

D1I.3**Plan share of risk-based Medicaid managed care**

What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in risk-based managed care? Numerator: Plan enrollment (D1.I.1) Denominator: Statewide Medicaid risk-based managed care enrollment (B.I.2)

Aetna Better Health

13.7%

Blue Cross Community Health Plans

28.8%

CountyCare Health Plan

16.4%

MeridianHealth

26.7%

Molina HealthCare

11.5%

YouthCare

1.4%

D1I.4: Parent**Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.**

If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.

Aetna Better Health

CVS Health/Aetna

Blue Cross Community Health Plans

Health Care Service Corporation (HCSC)

CountyCare Health Plan

Cook County Health

MeridianHealth

Centene Corporation

Molina HealthCare

Molina Healthcare

YouthCare

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
D1II.1	MLR Data Received Has the state received the MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	Aetna Better Health No
		Blue Cross Community Health Plans No
		CountyCare Health Plan No
		MeridianHealth No
		Molina HealthCare No
		YouthCare No
D1II.1c	Projected Date for Receipt of MLR Data for This Reporting Period When does the state anticipate receiving MLR data for this reporting period from this plan?	Aetna Better Health 02/2027
		Blue Cross Community Health Plans 02/2027
		CountyCare Health Plan 02/2027
		MeridianHealth 02/2027

Molina HealthCare

02/2027

YouthCare

02/2027

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	Aetna Better Health The State requires the MCPs to submit encounter data no later than 90 days after being paid.
		Blue Cross Community Health Plans The State requires the MCPs to submit encounter data no later than 90 days after being paid.
		CountyCare Health Plan The State requires the MCPs to submit encounter data no later than 90 days after being paid.
		MeridianHealth The State requires the MCPs to submit encounter data no later than 90 days after being paid.
		Molina HealthCare The State requires the MCPs to submit encounter data no later than 90 days after being paid.
		YouthCare The State requires the MCPs to submit encounter data no later than 90 days after being paid.
D1III.2	Share of encounter data submissions that met state's timely submission requirements What percent of the plan's encounter data file submissions	Aetna Better Health 100%
		Blue Cross Community Health Plans

(submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.

100%

CountyCare Health Plan

100%

MeridianHealth

100%

Molina HealthCare

100%

YouthCare

100%

D1III.3

Share of encounter data submissions that were HIPAA compliant

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.

Aetna Better Health

100%

Blue Cross Community Health Plans

100%

CountyCare Health Plan

100%

MeridianHealth

100%

Molina HealthCare

100%

YouthCare

100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	Aetna Better Health
		3,303
		Blue Cross Community Health Plans
		5,537
		CountyCare Health Plan
		2,719
		MeridianHealth
		8,735
		Molina HealthCare
		1,350
		YouthCare
		416
D1IV.1a	Appeals denied Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	Aetna Better Health
		2,819
		Blue Cross Community Health Plans
		3,208
		CountyCare Health Plan
		1,035
		MeridianHealth
		5,261
		Molina HealthCare
		694
		YouthCare

D1IV.1b**Appeals resolved in partial favor of enrollee**

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.

Aetna Better Health

20

Blue Cross Community Health Plans

47

CountyCare Health Plan

22

MeridianHealth

154

Molina HealthCare

17

YouthCare

21

D1IV.1c**Appeals resolved in favor of enrollee**

Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.

Aetna Better Health

464

Blue Cross Community Health Plans

2,282

CountyCare Health Plan

1,662

MeridianHealth

3,320

Molina HealthCare

639

YouthCare

D1IV.2**Active appeals**

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

Aetna Better Health

192

Blue Cross Community Health Plans

104

CountyCare Health Plan

15

MeridianHealth

328

Molina HealthCare

70

YouthCare

22

D1IV.3**Appeals filed on behalf of LTSS users**

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Aetna Better Health

79

Blue Cross Community Health Plans

493

CountyCare Health Plan

0

MeridianHealth

782

Molina HealthCare

170

YouthCare

D1IV.4**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether

Aetna Better Health

115

Blue Cross Community Health Plans

21

CountyCare Health Plan

0

MeridianHealth

262

Molina HealthCare

0

YouthCare

13

the filing of the appeal preceded the filing of the critical incident.

D1IV.5a

Standard appeals for which timely resolution was provided

Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

Aetna Better Health

3,234

Blue Cross Community Health Plans

2,457

CountyCare Health Plan

1,744

MeridianHealth

8,706

Molina HealthCare

1,257

YouthCare

414

D1IV.5b

Expedited appeals for which timely resolution was provided

Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.

Aetna Better Health

67

Blue Cross Community Health Plans

2,997

CountyCare Health Plan

870

MeridianHealth

40

Molina HealthCare

91

D1IV.6a**Resolved appeals related to denial of authorization or limited authorization of a service**

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Aetna Better Health

3,209

Blue Cross Community Health Plans

5,429

CountyCare Health Plan

972

MeridianHealth

4,257

Molina HealthCare

202

YouthCare

242

D1IV.6b**Resolved appeals related to reduction, suspension, or termination of a previously authorized service**

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

Aetna Better Health

70

Blue Cross Community Health Plans

25

CountyCare Health Plan

0

MeridianHealth

200

Molina HealthCare

79

YouthCare

0

D1IV.6c**Resolved appeals related to payment denial**

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Aetna Better Health

24

Blue Cross Community Health Plans

83

CountyCare Health Plan

0

MeridianHealth

76

Molina HealthCare

1

YouthCare

40

D1IV.6d**Resolved appeals related to service timeliness**

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Aetna Better Health

0

Blue Cross Community Health Plans

0

CountyCare Health Plan

0

MeridianHealth

0

Molina HealthCare

998

		YouthCare
		0
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	Aetna Better Health
		0
		Blue Cross Community Health Plans
		0
		CountyCare Health Plan
		0
		MeridianHealth
		0
		Molina HealthCare
		2
		YouthCare
		0
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO). If not applicable, enter "N/A."	Aetna Better Health
		0
		Blue Cross Community Health Plans
		0
		CountyCare Health Plan
		0
		MeridianHealth
		26
		Molina HealthCare
		46

D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability	Aetna Better Health
		0
		Blue Cross Community Health Plans
		0
		CountyCare Health Plan
		0
		MeridianHealth
		0
		Molina HealthCare
		0
		YouthCare
		0

Appeals by Service

Number of appeals resolved during the reporting period related to various services.
Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	Aetna Better Health
		98
		Blue Cross Community Health Plans
		109
		CountyCare Health Plan
		7
		MeridianHealth
		2,242
		Molina HealthCare
		10
		YouthCare
		93
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	Aetna Better Health
		3,131
		Blue Cross Community Health Plans
		252
		CountyCare Health Plan
		276
		MeridianHealth
		4,354
		Molina HealthCare
		4
		YouthCare

D1IV.7c**Resolved appeals related to inpatient behavioral health services**

Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".

Aetna Better Health

19

Blue Cross Community Health Plans

22

CountyCare Health Plan

1

MeridianHealth

16

Molina HealthCare

0

YouthCare

2

D1IV.7d**Resolved appeals related to outpatient behavioral health services**

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

Aetna Better Health

55

Blue Cross Community Health Plans

21

CountyCare Health Plan

135

MeridianHealth

1

Molina HealthCare

16

YouthCare

D1IV.7e**Resolved appeals related to covered outpatient prescription drugs**

Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".

Aetna Better Health

1,937

Blue Cross Community Health Plans

3,788

CountyCare Health Plan

1,785

MeridianHealth

5,513

Molina HealthCare

614

YouthCare

8

D1IV.7f**Resolved appeals related to skilled nursing facility (SNF) services**

Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".

Aetna Better Health

26

Blue Cross Community Health Plans

2

CountyCare Health Plan

6

MeridianHealth

0

Molina HealthCare

0

YouthCare

D1IV.7g**Resolved appeals related to long-term services and supports (LTSS)**

Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A". (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Aetna Better Health

73

Blue Cross Community Health Plans

28

CountyCare Health Plan

0

MeridianHealth

200

Molina HealthCare

36

YouthCare

0

D1IV.7h**Resolved appeals related to dental services**

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

Aetna Better Health

214

Blue Cross Community Health Plans

1,156

CountyCare Health Plan

591

MeridianHealth

665

Molina HealthCare

351

YouthCare

D1IV.7i**Resolved appeals related to non-emergency medical transportation (NEMT)**

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Aetna Better Health

0

Blue Cross Community Health Plans

0

CountyCare Health Plan

0

MeridianHealth

0

Molina HealthCare

0

YouthCare

0

D1IV.7k:**Resolved appeals related to durable medical equipment (DME) & supplies**

Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

62

Blue Cross Community Health Plans

43

CountyCare Health Plan

16

MeridianHealth

674

Molina HealthCare

73

YouthCare

D1IV.7l: Resolved appeals related to home health / hospice

Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

7

Blue Cross Community Health Plans

7

CountyCare Health Plan

22

MeridianHealth

53

Molina HealthCare

50

YouthCare

2

D1IV.7m: Resolved appeals related to emergency services / emergency department

Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

0

Blue Cross Community Health Plans

0

CountyCare Health Plan

0

MeridianHealth

11

Molina HealthCare

0

YouthCare

D1IV.7n: Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

1

Blue Cross Community Health Plans

26

CountyCare Health Plan

2

MeridianHealth

517

Molina HealthCare

6

YouthCare

62

D1IV.7o Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter "N/A".

Aetna Better Health

911

Blue Cross Community Health Plans

125

CountyCare Health Plan

2

MeridianHealth

3

Molina HealthCare

204

YouthCare

State Fair Hearings

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	Aetna Better Health
		27
		Blue Cross Community Health Plans
		39
		CountyCare Health Plan
		27
		MeridianHealth
		82
		Molina HealthCare
		39
		YouthCare
		2
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Aetna Better Health
		2
		Blue Cross Community Health Plans
		12
		CountyCare Health Plan
		6
		MeridianHealth
		17
		Molina HealthCare
		4
		YouthCare

D1IV.8c**State Fair Hearings resulting in an adverse decision for the enrollee**

Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.

Aetna Better Health

7

Blue Cross Community Health Plans

15

CountyCare Health Plan

5

MeridianHealth

35

Molina HealthCare

7

YouthCare

0

D1IV.8d**State Fair Hearings retracted prior to reaching a decision**

Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.

Aetna Better Health

18

Blue Cross Community Health Plans

48

CountyCare Health Plan

14

MeridianHealth

30

Molina HealthCare

26

YouthCare

D1IV.9a**External Medical Reviews
resulting in a favorable
decision for the enrollee**

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Aetna Better Health

11

Blue Cross Community Health Plans

111

CountyCare Health Plan

71

MeridianHealth

59

Molina HealthCare

24

YouthCare

4

D1IV.9b**External Medical Reviews
resulting in an adverse
decision for the enrollee**

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Aetna Better Health

76

Blue Cross Community Health Plans

117

CountyCare Health Plan

69

MeridianHealth

64

Molina HealthCare

25

YouthCare

Grievances Overview

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.	Aetna Better Health
		1,504
		Blue Cross Community Health Plans
		10,078
		CountyCare Health Plan
		3,719
		MeridianHealth
		2,261
		Molina HealthCare
		4,101
		YouthCare
		190
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	Aetna Better Health
		153
		Blue Cross Community Health Plans
		1,576
		CountyCare Health Plan
		235
		MeridianHealth
		0
		Molina HealthCare
		299
		YouthCare

D1IV.12**Grievances filed on behalf of LTSS users**

Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.

Aetna Better Health

125

Blue Cross Community Health Plans

1,807

CountyCare Health Plan

427

MeridianHealth

0

Molina HealthCare

526

YouthCare

0

D1IV.13**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance**

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of

Aetna Better Health

145

Blue Cross Community Health Plans

84

CountyCare Health Plan

16

MeridianHealth

0

Molina HealthCare

0

YouthCare

LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

0

D1IV.14

Number of grievances for which timely resolution was provided

Enter the number of grievances for which timely resolution was provided by plan during the reporting year.See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Aetna Better Health

1,504

Blue Cross Community Health Plans

10,066

CountyCare Health Plan

3,714

MeridianHealth

2,261

Molina HealthCare

4,101

YouthCare

190

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	Aetna Better Health
		54
		Blue Cross Community Health Plans
		32
		CountyCare Health Plan
		34
		MeridianHealth
		75
		Molina HealthCare
		60
		YouthCare
		1
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	Aetna Better Health
		1,421
		Blue Cross Community Health Plans
		1,008
		CountyCare Health Plan
		1,749
		MeridianHealth
		208
		Molina HealthCare
		222
		YouthCare

D1IV.15c**Resolved grievances related to inpatient behavioral health services**

Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

8

Blue Cross Community Health Plans

0

CountyCare Health Plan

4

MeridianHealth

0

Molina HealthCare

7

YouthCare

0

D1IV.15d**Resolved grievances related to outpatient behavioral health services**

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

21

Blue Cross Community Health Plans

3

CountyCare Health Plan

10

MeridianHealth

1

Molina HealthCare

40

YouthCare

D1IV.15e**Resolved grievances related to coverage of outpatient prescription drugs**

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

76

Blue Cross Community Health Plans

852

CountyCare Health Plan

7

MeridianHealth

77

Molina HealthCare

482

YouthCare

9

D1IV.15f**Resolved grievances related to skilled nursing facility (SNF) services**

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

11

Blue Cross Community Health Plans

22

CountyCare Health Plan

7

MeridianHealth

1

Molina HealthCare

6

YouthCare

D1IV.15g**Resolved grievances related to long-term services and supports (LTSS)**

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

128

Blue Cross Community Health Plans

118

CountyCare Health Plan

2

MeridianHealth

0

Molina HealthCare

240

YouthCare

0

D1IV.15h**Resolved grievances related to dental services**

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

124

Blue Cross Community Health Plans

777

CountyCare Health Plan

183

MeridianHealth

76

Molina HealthCare

292

YouthCare

D1IV.15i**Resolved grievances related to non-emergency medical transportation (NEMT)**

Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

483

Blue Cross Community Health Plans

2,048

CountyCare Health Plan

889

MeridianHealth

1,449

Molina HealthCare

616

YouthCare

94

D1IV.15k**Resolved grievances related to durable medical equipment (DME) & supplies**

Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

5

Blue Cross Community Health Plans

106

CountyCare Health Plan

33

MeridianHealth

426

Molina HealthCare

129

YouthCare

D1IV.15l**Resolved grievances related to home health / hospice**

Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

17

Blue Cross Community Health Plans

40

CountyCare Health Plan

10

MeridianHealth

3

Molina HealthCare

108

YouthCare

1

D1IV.15m**Resolved grievances related to emergency services / emergency department**

Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

0

Blue Cross Community Health Plans

46

CountyCare Health Plan

187

MeridianHealth

6

Molina HealthCare

96

YouthCare

D1IV.15n**Resolved grievances related to therapies**

Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health

2

Blue Cross Community Health Plans

31

CountyCare Health Plan

1

MeridianHealth

2

Molina HealthCare

27

YouthCare

2

D1IV.15o**Resolved grievances related to other service types**

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".

Aetna Better Health

741

Blue Cross Community Health Plans

5,146

CountyCare Health Plan

624

MeridianHealth

513

Molina HealthCare

2,002

YouthCare

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	Aetna Better Health
		214
		Blue Cross Community Health Plans
		3,700
		CountyCare Health Plan
		307
		MeridianHealth
		84
		Molina HealthCare
		345
		YouthCare
		9
D1IV.16b	Resolved grievances related to plan or provider care management/case management Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	Aetna Better Health
		22
		Blue Cross Community Health Plans
		241
		CountyCare Health Plan
		84
		MeridianHealth
		5
		Molina HealthCare
		192

D1IV.16c**Resolved grievances related to network adequacy or access to care/services from plan or provider**

Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

Aetna Better Health

192

Blue Cross Community Health Plans

2,182

CountyCare Health Plan

13

MeridianHealth

241

Molina HealthCare

1,722

YouthCare

4

D1IV.16d**Resolved grievances related to quality of care**

Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.

Aetna Better Health

91

Blue Cross Community Health Plans

783

CountyCare Health Plan

81

MeridianHealth

75

Molina HealthCare

YouthCare

4

D1IV.16e**Resolved grievances related to plan communications**

Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

Aetna Better Health

1

Blue Cross Community Health Plans

1,926

CountyCare Health Plan

0

MeridianHealth

5

Molina HealthCare

470

YouthCare

0

D1IV.16f**Resolved grievances related to payment or billing issues**

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

Aetna Better Health

95

Blue Cross Community Health Plans

3,553

CountyCare Health Plan

2,074

MeridianHealth

103

Molina HealthCare

1,104

YouthCare

39

D1IV.16g**Resolved grievances related to suspected fraud**

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

Aetna Better Health

0

Blue Cross Community Health Plans

104

CountyCare Health Plan

3

MeridianHealth

0

Molina HealthCare

27

YouthCare

0

D1IV.16h**Resolved grievances related to abuse, neglect or exploitation**

Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

Aetna Better Health

0

Blue Cross Community Health Plans

22

CountyCare Health Plan

1

MeridianHealth

0

Molina HealthCare

45

YouthCare

1

D1IV.16i

Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

Aetna Better Health

0

Blue Cross Community Health Plans

37

CountyCare Health Plan

0

MeridianHealth

0

Molina HealthCare

140

YouthCare

3

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited

Aetna Better Health

0

Blue Cross Community Health Plans

0

CountyCare Health Plan

0

appeal, the enrollee or their representative have the right to file a grievance.

MeridianHealth

0

Molina HealthCare

8

YouthCare

0

D1IV.16k **Resolved grievances filed for other reasons**

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.

Aetna Better Health

900

Blue Cross Community Health Plans

93

CountyCare Health Plan

1

MeridianHealth

1,322

Molina HealthCare

820

YouthCare

0

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.



Complete

D2.VII.1 Measure Name: Adults Access to Preventive/ Ambulatory Health Services - Total

1 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

71.88

Blue Cross Community Health Plans

76.54

CountyCare Health Plan

72.71

MeridianHealth

76.49

Molina HealthCare

71.66

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Blood Pressure Control for Patients With Diabetes

2 / 100

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

69.34

Blue Cross Community Health Plans

69.10

CountyCare Health Plan

72.10

MeridianHealth

72.51

Molina HealthCare

67.40

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Breast Cancer Screening (ECDS)

3 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2372

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

47.99

Blue Cross Community Health Plans

53.93

CountyCare Health Plan

57.10

MeridianHealth

52.28

Molina HealthCare

48.97

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (ECDS)

4 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

0032

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

46.26

Blue Cross Community Health Plans

58.43

CountyCare Health Plan

54.13

MeridianHealth

56.00

Molina HealthCare

50.43

YouthCare

N/A



D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits: Total 5 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

50.50

Blue Cross Community Health Plans

58.40

CountyCare Health Plan

57.87

MeridianHealth

57.86

Molina HealthCare

52.31

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Childhood Immunization Status (ECDS)-Combo 6 / 100
3

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

59.22

Blue Cross Community Health Plans

62.83

CountyCare Health Plan

55.42

MeridianHealth

62.47

Molina HealthCare

62.30

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Childhood Immunization Status (ECDS)-Combo 7 / 100
10

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

19.91

Blue Cross Community Health Plans

24.52

CountyCare Health Plan

25.46

MeridianHealth

22.66

Molina HealthCare

21.03

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women: Total

8 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0033

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

54.42

Blue Cross Community Health Plans

55.50

CountyCare Health Plan

63.30

MeridianHealth

47.16

Molina HealthCare

54.29

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening—Total

9 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

39.71

Blue Cross Community Health Plans

42.96

CountyCare Health Plan

31.79

MeridianHealth

38.76

Molina HealthCare

34.65

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure

10 / 100

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

62.29

Blue Cross Community Health Plans

61.80

CountyCare Health Plan

62.10

MeridianHealth

66.42

Molina HealthCare

60.83

YouthCare

N/A



Complete

**D2.VII.1 Measure Name: Diagnosed Mental Health Disorders: Ages 18-11 / 100
64 Years**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

33.39

Blue Cross Community Health Plans

29.42

CountyCare Health Plan

23.09

MeridianHealth

32.43

Molina HealthCare

32.50

YouthCare

N/A



D2.VII.1 Measure Name: Diagnosed Mental Health Disorders: Ages 65+¹² / 100 Years

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

33.09

Blue Cross Community Health Plans

27.63

CountyCare Health Plan

26.98

MeridianHealth

30.76

Molina HealthCare

29.66

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Eye Exam for Patients With Diabetes

13 / 100

D2.VII.2 Measure Domain

Care of acute and chronic conditions

**D2.VII.3 National Quality
Forum (NQF) number**

0055

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

53.04

Blue Cross Community Health Plans

54.50

CountyCare Health Plan

58.02

MeridianHealth

57.91

Molina HealthCare

42.93

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit 14 / 100
for Mental Illness: 7-Day Ages 6-17

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

74.47

Blue Cross Community Health Plans

59.58

CountyCare Health Plan

69.07

MeridianHealth

75.95

Molina HealthCare

75.57

YouthCare

N/A



Complete

**D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit¹⁵ / 100
for Mental Illness: 7-Day Ages 18-64**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

45.97

Blue Cross Community Health Plans

44.51

CountyCare Health Plan

31.78

MeridianHealth

46.97

Molina HealthCare

46.55

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Ages 65+ 16 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

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

Blue Cross Community Health Plans

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

CountyCare Health Plan

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

MeridianHealth

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

Molina HealthCare

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

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Ages 6-17 17 / 100

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Aetna Better Health
82.74

Blue Cross Community Health Plans
78.72

CountyCare Health Plan
75.95

MeridianHealth
82.63

Molina HealthCare
82.37

YouthCare
N/A



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit^{18 / 100} for Mental Illness: 30-Day Ages 18-64

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

55.89

Blue Cross Community Health Plans

55.37

CountyCare Health Plan

38.77

MeridianHealth

57.44

Molina HealthCare

57.24

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit¹⁹ / 100 for Mental Illness: 30-Day Ages 65+

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

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

Blue Cross Community Health Plans

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

CountyCare Health Plan

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

MeridianHealth

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

Molina HealthCare

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

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 7-Day Ages 13-17 20 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

17.71

Blue Cross Community Health Plans

24.07

CountyCare Health Plan

13.53

MeridianHealth

23.10

Molina HealthCare

17.72

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit 21 / 100
for Substance Use: 7-Day Ages 18+

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

26.67

Blue Cross Community Health Plans

27.88

CountyCare Health Plan

25.47

MeridianHealth

24.52

Molina HealthCare

28.28

YouthCare

N/A



Complete

**D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit²² / 100
for Substance Use: 30-Day Ages 13-17**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

28.13

Blue Cross Community Health Plans

31.94

CountyCare Health Plan

21.80

MeridianHealth

32.85

Molina HealthCare

25.32

YouthCare

N/A



**D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit²³ / 100
for Substance Use: 30-Day Ages 18+**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

37.45

Blue Cross Community Health Plans

38.39

CountyCare Health Plan

34.64

MeridianHealth

35.03

Molina HealthCare

41.13

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After High Intensity Care for SUD: 24 / 100 Day Ages 13-17

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

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

Blue Cross Community Health Plans

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

CountyCare Health Plan

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

MeridianHealth

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

Molina HealthCare

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

YouthCare

N/A



Complete

**D2.VII.1 Measure Name: Follow-Up After High Intensity Care for SUD: 25 / 100
Day Ages 18-64**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

40.80

Blue Cross Community Health Plans

41.24

CountyCare Health Plan

38.85

MeridianHealth

38.74

Molina HealthCare

43.83

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After High Intensity Care for SUD: 26 / 100
Day Ages 65+

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

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

Blue Cross Community Health Plans

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

CountyCare Health Plan

30.88

MeridianHealth

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

Molina HealthCare

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

YouthCare

N/A



Complete

**D2.VII.1 Measure Name: Follow-Up After High Intensity Care for SUD: 27 / 100
30-Day Ages 13-17**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

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

Blue Cross Community Health Plans

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

CountyCare Health Plan

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

MeridianHealth

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

Molina HealthCare

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

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After High Intensity Care for SUD: 28 / 100
30-Day Ages 18-64

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

57.92

Blue Cross Community Health Plans

59.73

CountyCare Health Plan

54.93

MeridianHealth

57.49

Molina HealthCare

60.91

YouthCare

N/A



Complete

**D2.VII.1 Measure Name: Follow-Up After High Intensity Care for SUD: 29 / 100
30-Day Ages 65+**

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

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

Blue Cross Community Health Plans

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

CountyCare Health Plan

51.47

MeridianHealth

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

Molina HealthCare

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

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 7-Day Ages 6-17 30 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0756

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

46.84

Blue Cross Community Health Plans

44.91

CountyCare Health Plan

44.89

MeridianHealth

43.89

Molina HealthCare

46.27

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 7-Day Ages 18-64 31 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0756

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

31.85

Blue Cross Community Health Plans

30.34

CountyCare Health Plan

25.65

MeridianHealth

30.58

Molina HealthCare

29.51

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 7-Day Ages 65+ 32 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0756

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

44.12

Blue Cross Community Health Plans

16.36

CountyCare Health Plan

15.15

MeridianHealth

30.61

Molina HealthCare

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

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 30-Day Ages 6-17 33 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0756

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

79.06

Blue Cross Community Health Plans

69.16

CountyCare Health Plan

67.68

MeridianHealth

71.74

Molina HealthCare

74.70

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 30-Day Ages 18-64 34 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0756

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

54.48

Blue Cross Community Health Plans

48.62

CountyCare Health Plan

44.04

MeridianHealth

51.84

Molina HealthCare

51.66

YouthCare

N/A



D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 30-Day Ages 65+ 35 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0756

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

64.71

Blue Cross Community Health Plans

36.36

CountyCare Health Plan

34.85

MeridianHealth

57.14

Molina HealthCare

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

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Glycemic Status Assessment for Patients With Diabetes 6 / 100

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.02

Blue Cross Community Health Plans

57.91

CountyCare Health Plan

80.49

MeridianHealth

62.29

Molina HealthCare

52.07

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents: Combo 1 37 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

86.28

Blue Cross Community Health Plans

89.18

CountyCare Health Plan

80.78

MeridianHealth

89.56

Molina HealthCare

87.15

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents: Combo 2 38 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

28.59

Blue Cross Community Health Plans

35.78

CountyCare Health Plan

40.84

MeridianHealth

35.19

Molina HealthCare

31.22

YouthCare

N/A



D2.VII.1 Measure Name: Initiation of Substance Use Treatment—Ages 13–17^{39 / 100}

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

24.16

Blue Cross Community Health Plans

43.20

CountyCare Health Plan

36.63

MeridianHealth

42.49

Molina HealthCare

46.88

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Engagement of Substance Use Treatment— 40 / 100
Ages 13–17

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

5.74

Blue Cross Community Health Plans

13.82

CountyCare Health Plan

6.69

MeridianHealth

11.06

Molina HealthCare

9.15

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing—Total

41 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.04

Blue Cross Community Health Plans

59.69

CountyCare Health Plan

61.14

MeridianHealth

58.55

Molina HealthCare

59.29

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing—Total

42 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

30.18

Blue Cross Community Health Plans

36.96

CountyCare Health Plan

35.68

MeridianHealth

32.76

Molina HealthCare

33.73

YouthCare

N/A

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing —Total

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

29.56

Blue Cross Community Health Plans

36.23

CountyCare Health Plan

34.35

MeridianHealth

32.04

Molina HealthCare

32.84

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Services: Total

44 / 100

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

2517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

44.07

Blue Cross Community Health Plans

53.35

CountyCare Health Plan

55.50

MeridianHealth

50.80

Molina HealthCare

43.74

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Pharmacotherapy for OUD: Ages 16-64

45 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

25.90

Blue Cross Community Health Plans

22.22

CountyCare Health Plan

23.45

MeridianHealth

22.31

Molina HealthCare

26.42

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Pharmacotherapy for OUD: Ages 65+

46 / 100

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

15.38

Blue Cross Community Health Plans

35.48

CountyCare Health Plan

25.60

MeridianHealth

41.46

Molina HealthCare

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

YouthCare

N/A



D2.VII.1 Measure Name: Pharmacotherapy for OUD: Total

47 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

25.67

Blue Cross Community Health Plans

22.60

CountyCare Health Plan

23.57

MeridianHealth

22.62

Molina HealthCare

26.39

YouthCare

N/A



Complete

D2.VII.1 Measure Name: PPC: Timeliness of Prenatal Care

48 / 100

D2.VII.2 Measure Domain

Maternal and perinatal health

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

84.43

Blue Cross Community Health Plans

91.97

CountyCare Health Plan

88.08

MeridianHealth

90.51

Molina HealthCare

91.00

YouthCare

N/A



Complete

D2.VII.1 Measure Name: PPC: Postpartum Care

49 / 100

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

83.45

Blue Cross Community Health Plans

85.40

CountyCare Health Plan

83.85

MeridianHealth

85.64

Molina HealthCare

82.73

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Statin Therapy for Patients With Diabetes: Received Statin Therapy

50 / 100

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

66.74

Blue Cross Community Health Plans

70.17

CountyCare Health Plan

71.12

MeridianHealth

67.99

Molina HealthCare

68.00

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Statin Therapy for Patients With Diabetes: 51 / 100
Statin Adherence 80%

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

76.26

Blue Cross Community Health Plans

64.57

CountyCare Health Plan

69.02

MeridianHealth

68.01

Molina HealthCare

67.03

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: BMI Percentile Documentation—Total

52 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

83.21

Blue Cross Community Health Plans

80.05

CountyCare Health Plan

91.60

MeridianHealth

80.05

Molina HealthCare

64.48

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Counseling for Nutrition—Total

53 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

72.75

Blue Cross Community Health Plans

71.29

CountyCare Health Plan

85.20

MeridianHealth

70.80

Molina HealthCare

63.50

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Counseling for Physical Activity—Total

54 / 100

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

74.94

Blue Cross Community Health Plans

67.64

CountyCare Health Plan

82.80

MeridianHealth

68.37

Molina HealthCare

62.29

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life 55 / 100
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

66.81

Blue Cross Community Health Plans

66.02

CountyCare Health Plan

67.86

MeridianHealth

71.17

Molina HealthCare

66.58

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life 56 / 100
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description
N/A

Measure results

Aetna Better Health
67.94

Blue Cross Community Health Plans
71.78

CountyCare Health Plan
70.88

MeridianHealth

72.37

Molina HealthCare

68.17

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Emergency Department Visits that Result in an Inpatient Admission for Children and Adolescents—Total 57 / 100

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

The percentage of ED visits for members ages 0 through 20 years with a diagnosis of mental illness or intentional self-harm, that resulted in an inpatient admission.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare

21.42



Complete

D2.VII.1 Measure Name: Follow-Up After Mobile Crisis Response Services—Not Hospitalized and Linked to Community Services—Total

58 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Percentage of MCR events without a behavioral health hospitalization within 3 days of the MCR service that resulted in a community-based behavioral health service within 30 days of the MCR service.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare

68.82

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Percentage of MCR events with a behavioral health hospitalization within 3 days of the MCR service that resulted in a community-based behavioral health service within 30 days of hospital discharge

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare

11.02



Complete

D2.VII.1 Measure Name: Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Inpatient BH Utilization—Total

60 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

This measure summarizes the utilization of acute BH inpatient care and services for members ages 0 through 20 years.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare

4.47



Complete

D2.VII.1 Measure Name: Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Average Length of Stay—Total

61 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

This measure summarizes the utilization of acute BH inpatient care and services for members ages 0 through 20 years.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare

21.40



D2.VII.1 Measure Name: Repeat Behavioral Health Hospitalizations for Children and Adolescents—Percent of Members with Repeat BH Hospitalization—Total

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

The number and percentage of repeat BH hospitalizations for members ages 0 through 20 years during the measurement period.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare



D2.VII.1 Measure Name: Repeat Behavioral Health Hospitalizations for Children and Adolescents—Average Number of Repeat BH Hospitalizations Per Member—Total

63 / 100

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

The number and percentage of repeat BH hospitalizations for members ages 0 through 20 years during the measurement period.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

MeridianHealth

N/A

Molina HealthCare

N/A

YouthCare

0.54



Complete

D2.VII.1 Measure Name: Getting Needed Care: Adult

64 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

78.30

Blue Cross Community Health Plans

77.97

CountyCare Health Plan

80.81

MeridianHealth

82.79

Molina HealthCare

87.42

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Getting Care Quickly: Adult

65 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

80.25

Blue Cross Community Health Plans

75.95

CountyCare Health Plan

81.39

MeridianHealth

79.45

Molina HealthCare

81.75

YouthCare

N/A



Complete

D2.VII.1 Measure Name: How Well Doctors Communicate: Adult

66 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

93.80

Blue Cross Community Health Plans

91.97

CountyCare Health Plan

93.13

MeridianHealth

93.78

Molina HealthCare

95.16

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Customer Service: Adult

67 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

86.02

Blue Cross Community Health Plans

86.84

CountyCare Health Plan

89.41

MeridianHealth

91.01

Molina HealthCare

90.00

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of All Health Care: Adult

68 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

45.65

Blue Cross Community Health Plans

57.41

CountyCare Health Plan

60.07

MeridianHealth

57.14

Molina HealthCare

59.92

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of Personal Doctor: Adult

69 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

67.79

Blue Cross Community Health Plans

69.68

CountyCare Health Plan

71.82

MeridianHealth

68.95

Molina HealthCare

74.52

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often: Adult 70 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health**

54.07

Blue Cross Community Health Plans

65.19

CountyCare Health Plan

63.31

MeridianHealth

72.81

Molina HealthCare

69.33

YouthCare

N/A



D2.VII.1 Measure Name: Rating of Health Plan: Adult

71 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

52.21

Blue Cross Community Health Plans

64.01

CountyCare Health Plan

70.75

MeridianHealth

65.03

Molina HealthCare

65.25

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Getting Needed Care: Child

72 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

82.23

Blue Cross Community Health Plans

74.17

CountyCare Health Plan

76.72

MeridianHealth

84.09

Molina HealthCare

83.84

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Getting Care Quickly: Child

73 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

84.70

Blue Cross Community Health Plans

80.26

CountyCare Health Plan

81.19

MeridianHealth

89.17

Molina HealthCare

86.37

YouthCare

N/A



Complete

D2.VII.1 Measure Name: How Well Doctors Communicate: Child

74 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

93.40

Blue Cross Community Health Plans

91.16

CountyCare Health Plan

93.51

MeridianHealth

94.63

Molina HealthCare

92.22

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Customer Service: Child

75 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.09

Blue Cross Community Health Plans

82.63

CountyCare Health Plan

90.01

MeridianHealth

89.38

Molina HealthCare

89.70

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of All Health Care: Child

76 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.30

Blue Cross Community Health Plans

72.84

CountyCare Health Plan

69.06

MeridianHealth

75.48

Molina HealthCare

74.50

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of Personal Doctor: Child

77 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

70.57

Blue Cross Community Health Plans

77.03

CountyCare Health Plan

73.67

MeridianHealth

80.89

Molina HealthCare

77.62

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often: Child 78 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

68.67

Blue Cross Community Health Plans

76.83

CountyCare Health Plan

77.88

MeridianHealth

74.58

Molina HealthCare

75.49

YouthCare

N/A



Complete

D2.VII.1 Measure Name: Rating of Health Plan: Child

79 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

60.18

Blue Cross Community Health Plans

75.57

CountyCare Health Plan

75.20

MeridianHealth

70.90

Molina HealthCare

71.47

YouthCare

N/A



D2.VII.1 Measure Name: Getting Needed Care: Special Needs Children (SNC) 80 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.03

Blue Cross Community Health Plans

80.33

CountyCare Health Plan

84.41

MeridianHealth

86.96

Molina HealthCare

86.93

YouthCare

79.60



Complete

D2.VII.1 Measure Name: Getting Care Quickly: Special Needs Children 81 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

88.63

Blue Cross Community Health Plans

85.38

CountyCare Health Plan

82.28

MeridianHealth

90.23

Molina HealthCare

87.47

YouthCare

90.00



Complete

D2.VII.1 Measure Name: How Well Doctors Communicate: SNC

82 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

91.74

Blue Cross Community Health Plans

90.90

CountyCare Health Plan

94.80

MeridianHealth

92.77

Molina HealthCare

92.27

YouthCare

97.14



Complete

D2.VII.1 Measure Name: Customer Service: SNC

83 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

87.18

Blue Cross Community Health Plans

88.57

CountyCare Health Plan

92.63

MeridianHealth

91.07

Molina HealthCare

90.32

YouthCare

96.55



D2.VII.1 Measure Name: Rating of All Health Care: SNC

84 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

67.38

Blue Cross Community Health Plans

67.48

CountyCare Health Plan

74.36

MeridianHealth

64.74

Molina HealthCare

63.50

YouthCare

63.43



Complete

D2.VII.1 Measure Name: Rating of Personal Doctor: SNC

85 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

75.12

Blue Cross Community Health Plans

75.60

CountyCare Health Plan

79.90

MeridianHealth

75.73

Molina HealthCare

74.29

YouthCare

68.26



Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often: SNC 86 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

69.31

Blue Cross Community Health Plans

81.63

CountyCare Health Plan

84.04

MeridianHealth

73.47

Molina HealthCare

72.22

YouthCare

57.69



Complete

D2.VII.1 Measure Name: Rating of Health Plan: SNC

87 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.91

Blue Cross Community Health Plans

67.36

CountyCare Health Plan

74.68

MeridianHealth

60.53

Molina HealthCare

61.93

YouthCare

57.78



Complete

D2.VII.1 Measure Name: Getting Needed Care: SNC CCC

88 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.69

Blue Cross Community Health Plans

84.70

CountyCare Health Plan

86.55

MeridianHealth

86.68

Molina HealthCare

86.70

YouthCare

82.55



Complete

D2.VII.1 Measure Name: Getting Care Quickly: SNC CCC

89 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.18

Blue Cross Community Health Plans

87.79

CountyCare Health Plan

83.00

MeridianHealth

90.03

Molina HealthCare

88.94

YouthCare

92.02



Complete

D2.VII.1 Measure Name: How Well Doctors Communicate: SNC CCC 90 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

93.35

Blue Cross Community Health Plans

92.31

CountyCare Health Plan

94.10

MeridianHealth

94.36

Molina HealthCare

93.45

YouthCare

96.54



Complete

D2.VII.1 Measure Name: Customer Service: SNC CCC

91 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

88.94

Blue Cross Community Health Plans

90.21

CountyCare Health Plan

92.92

MeridianHealth

90.27

Molina HealthCare

91.94

YouthCare

89.09



Complete

D2.VII.1 Measure Name: Rating of All Health Care: SNC CCC

92 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

68.00

Blue Cross Community Health Plans

68.39

CountyCare Health Plan

74.38

MeridianHealth

63.28

Molina HealthCare

62.65

YouthCare

60.30

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality
Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

77.24

Blue Cross Community Health Plans

77.18

CountyCare Health Plan

83.12

MeridianHealth

77.69

Molina HealthCare

74.41

YouthCare

73.66



Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often: SNC CC 94 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

70.45

Blue Cross Community Health Plans

83.63

CountyCare Health Plan

81.02

MeridianHealth

78.40

Molina HealthCare

74.31

YouthCare

60.40



Complete

D2.VII.1 Measure Name: Rating of Health Plan: SNC CCC

95 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

64.15

Blue Cross Community Health Plans

68.37

CountyCare Health Plan

76.67

MeridianHealth

61.19

Molina HealthCare

59.91

YouthCare

51.88



Complete

D2.VII.1 Measure Name: Access to Specialized Services: SNC CCC

96 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

69.93

Blue Cross Community Health Plans

64.47

CountyCare Health Plan

67.04

MeridianHealth

68.70

Molina HealthCare

73.58

YouthCare

68.40



Complete

D2.VII.1 Measure Name: FCC: Personal Doctor Who Knows Child: SNC 97 / 100
CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.80

Blue Cross Community Health Plans

91.19

CountyCare Health Plan

92.41

MeridianHealth

91.96

Molina HealthCare

91.42

YouthCare

93.15



Complete

D2.VII.1 Measure Name: Coordination of Care for Children with Chronic Conditions: SNC CCC

98 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

84.90

Blue Cross Community Health Plans

78.07

CountyCare Health Plan

85.76

MeridianHealth

81.69

Molina HealthCare

84.24

YouthCare

72.97



Complete

D2.VII.1 Measure Name: Access to Prescription Medicines: SNC CCC 99 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

**D2.VII.3 National Quality
Forum (NQF) number**

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

89.32

Blue Cross Community Health Plans

91.08

CountyCare Health Plan

90.82

MeridianHealth

88.36

Molina HealthCare

87.43

YouthCare

81.87



Complete

D2.VII.1 Measure Name: FCC: Getting Needed Information: SNC CCC 100 / 100

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

91.48

Blue Cross Community Health Plans

90.24

CountyCare Health Plan

88.67

MeridianHealth

90.52

Molina HealthCare

91.57

YouthCare

92.50

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

1 / 30

D3.VIII.2 Plan performance issue

Encounter Data Missed
Threshold Sanction.

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Per Contract Section 7.16.6. - Failure to meet Encounter Data submissions standards.

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

\$100,000

D3.VIII.7 Date assessed

01/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

2 / 30

D3.VIII.2 Plan performance issue

Encounter Data Missed
Threshold Sanction

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Per Contract Section 7.16.6. - Failure to meet Encounter Data submissions standards.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$100,000

D3.VIII.7 Date assessed

01/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

3 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs January 2025 Provider Directory Attestation.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

01/14/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

4 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs December 2024 Electronic Certification Attestation.

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

01/14/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

5 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

MeridianHealth

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Dental Roster Report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

03/05/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

6 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Dental Roster Report.

Sanction details

D3.VIII.5 Instances of non-compliance	D3.VIII.6 Sanction amount
1	\$5,000
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected
03/05/2025	No, no remediation
D3.VIII.9 Corrective action plan	
No	



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

7 / 30

D3.VIII.2 Plan performance issue	D3.VIII.3 Plan name
Reporting (timeliness, completeness, accuracy)	CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely Sanction payment submission.

Sanction details

D3.VIII.5 Instances of non-compliance	D3.VIII.6 Sanction amount
1	\$5,000
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected
05/13/2025	

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

8 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.3. Failed to respond timely to an ad-hoc report request.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

05/19/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

9 / 30

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
MeridianHealth

Reporting (timeliness,
completeness, accuracy)

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.3. Failed to respond timely to an ad-hoc report request.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

06/12/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

10 / 30

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Molina HealthCare

Reporting (timeliness,
completeness, accuracy)

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs VBP 2025 Report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

07/16/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

11 / 30

D3.VIII.2 Plan performance issue

Encounter Data Missed
Threshold Sanction.

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Per Contract Section 7.16.6. - Failure to meet Encounter Data submissions standards.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$100,000

D3.VIII.7 Date assessed

07/16/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

12 / 30

D3.VIII.2 Plan performance issue

Encounter Data Missed
Threshold Sanction.

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

Per Contract Section 7.16.6. - Failure to meet Encounter Data submissions standards.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

07/16/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

13 / 30

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Aetna Better Health

Reporting (timeliness, completeness, accuracy)

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Olmstead Attestation Report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

08/24/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

14 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs IP Payment Report.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1	\$5,000
D3.VIII.7 Date assessed 08/22/2025	D3.VIII.8 Remediation date non-compliance was corrected No, no remediation
D3.VIII.9 Corrective action plan No	



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

15 / 30

D3.VIII.2 Plan performance issue Reporting (timeliness, completeness, accuracy)	D3.VIII.3 Plan name Aetna Better Health
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D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Prenatal Care Report.

Sanction details

D3.VIII.5 Instances of non-compliance 1	D3.VIII.6 Sanction amount \$5,000
D3.VIII.7 Date assessed 09/22/2025	D3.VIII.8 Remediation date non-compliance was corrected No, no remediation
D3.VIII.9 Corrective action plan No	



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

16 / 30

D3.VIII.2 Plan performance issue

Failure to comply with Department instructions.

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.18. MCP did not follow the Department's ACH Payment Instructions.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

09/22/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

17 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.3. Untimely submission of an ad-hoc report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

09/22/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

18 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Annual Audited GAAP Statement.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$15,000

D3.VIII.7 Date assessed

10/09/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

19 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.17. MCP failed to respond timely to a provider resolution portal complaint.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

10/10/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

20 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.3. Untimely submission of an ad-hoc report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

11/04/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

21 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

MeridianHealth

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs PCP Panel Report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

11/17/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

22 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Quarterly Unaudited Financial Statement.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

12/09/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

23 / 30

D3.VIII.2 Plan performance issue

Timely access to care

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

The access and availability survey results identified that the MCP was noncompliant with requirements for accuracy of provider directory data and appointment availability for behavioral health and prenatal providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/02/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

24 / 30

D3.VIII.2 Plan performance issue

Timely access to care

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

The access and availability survey results identified that the MCP was noncompliant with requirements for accuracy of provider directory data and appointment availability for behavioral health and prenatal providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/02/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

25 / 30

D3.VIII.2 Plan performance issue

Timely access to care

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

The access and availability survey results identified that the MCP was noncompliant with requirements for accuracy of provider directory data and appointment availability for behavioral health and prenatal providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/02/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

26 / 30

D3.VIII.2 Plan performance

issue

Timely access to care

D3.VIII.3 Plan name

MeridianHealth

D3.VIII.4 Reason for intervention

The access and availability survey results identified that the MCP was noncompliant with requirements for accuracy of provider directory data and appointment availability for behavioral health and prenatal providers.

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/05/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

27 / 30

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
Molina HealthCare

Timely access to care

D3.VIII.4 Reason for intervention

The access and availability survey results identified that the MCP was noncompliant with requirements for accuracy of provider directory data and appointment availability for behavioral health and prenatal providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/02/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

28 / 30

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
YouthCare

Timely access to care

D3.VIII.4 Reason for intervention

The access and availability survey results identified that the MCP was noncompliant with requirements for accuracy of provider directory data

and appointment availability for behavioral health and prenatal providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/02/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

29 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Drug Utilization Review Report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

07/18/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Civil monetary penalty

30 / 30

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

MeridianHealth

D3.VIII.4 Reason for intervention

Sanction Per Contract Section 7.16.2. Untimely submission of the MCPs Collaboration Report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

08/22/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	Aetna Better Health
		5
		Blue Cross Community Health Plans
		7
		CountyCare Health Plan
		9
		MeridianHealth
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	8
		Molina HealthCare
		5
		YouthCare
		8
		Aetna Better Health
		139
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	Blue Cross Community Health Plans
		139
		CountyCare Health Plan
		246
		MeridianHealth
		290
		Molina HealthCare
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	225
		YouthCare

D1X.4**Count of resolved program integrity investigations**

How many program integrity investigations were resolved by the plan during the reporting year?

Aetna Better Health

202

Blue Cross Community Health Plans

130

CountyCare Health Plan

208

MeridianHealth

265

Molina HealthCare

240

YouthCare

68

D1X.6**Referral path for program integrity referrals to the state**

What is the referral path that the plan uses to make program integrity referrals to the state? Select one.

Aetna Better Health

Makes referrals to the State Medicaid Agency (SMA) only

Blue Cross Community Health Plans

Makes referrals to the State Medicaid Agency (SMA) only

CountyCare Health Plan

Makes referrals to the State Medicaid Agency (SMA) only

MeridianHealth

Makes referrals to the State Medicaid
Agency (SMA) only

Molina HealthCare

Makes referrals to the State Medicaid
Agency (SMA) only

YouthCare

Makes referrals to the State Medicaid
Agency (SMA) only

D1X.7

**Count of program integrity
referrals to the state**

Enter the count of program
integrity referrals that the plan
made to the state in the past
year. Enter the count of
referrals made.

Aetna Better Health

48

Blue Cross Community Health Plans

54

CountyCare Health Plan

118

MeridianHealth

106

Molina HealthCare

133

YouthCare

6

D1X.9a: Plan overpayment reporting to the state: Start Date

What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Aetna Better Health

01/01/2025

Blue Cross Community Health Plans

01/01/2025

CountyCare Health Plan

01/01/2025

MeridianHealth

01/01/2025

Molina HealthCare

01/01/2025

YouthCare

01/01/2025

D1X.9b: Plan overpayment reporting to the state: End Date

What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Aetna Better Health

12/31/2025

Blue Cross Community Health Plans

12/31/2025

CountyCare Health Plan

12/31/2025

MeridianHealth

12/31/2025

Molina HealthCare

12/31/2025

YouthCare

12/31/2025

D1X.9c: Plan overpayment reporting to the state: Dollar amount

From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?

Aetna Better Health

\$46,729,424

Blue Cross Community Health Plans

\$117,820.49

CountyCare Health Plan

\$1,109,592.76

MeridianHealth

\$558,645.15

Molina HealthCare

\$1,244,637

YouthCare

\$19,966.47

D1X.9d: Plan overpayment reporting to the state: Corresponding premium revenue

What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))

Aetna Better Health

\$3,325,431,382

Blue Cross Community Health Plans

\$6,051,889,473

CountyCare Health Plan

\$3,730,696,598

MeridianHealth

\$4,872,391,499

Molina HealthCare

\$2,477,077,812

YouthCare

\$308,249,101

D1X.10

**Changes in beneficiary
circumstances**

Select the frequency the plan
reports changes in beneficiary
circumstances to the state.

Aetna Better Health

Monthly

Blue Cross Community Health Plans

Monthly

CountyCare Health Plan

Monthly

MeridianHealth

Monthly

Molina HealthCare

Monthly

YouthCare

Monthly

Topic XI: ILOS

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	Aetna Better Health Not answered, optional Not answered
		Blue Cross Community Health Plans Not answered, optional Not answered
		CountyCare Health Plan Not answered, optional Not answered
		MeridianHealth Not answered, optional Not answered
		Molina HealthCare Not answered, optional Not answered
		YouthCare Not answered, optional Not answered

Topic XIII. Prior Authorization



Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage



Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Illinois Client Enrollment Broker (ICEB) - Maximus Enrollment Broker
EIX.2	BSS entity role What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	Illinois Client Enrollment Broker (ICEB) - Maximus Enrollment Broker/Choice Counseling Other, specify – The Enrollment Broker provides outreach, education and enrollment assistance to Potential Enrollees and Enrollees statewide. The outreach, education and enrollment functions cover all managed care programs and Health Plans available to Illinois Medicaid Clients.

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	Notes (optional)	ILOS was expanded under this program during Dec 2025. This report is for all of CY2025 (Jan 1 through Dec 31 2025). Dec 2025 is the last reporting month for the Department's CY2025 MCPAR submission and ILOS data for this period will be included in the CY2026 (Jan 1 - Dec 31 2026) MCPAR submission.